Trust Policy	Worcestershire Acute Hospitals NHS Trust

CANCER OPERATIONAL ESCALATION POLICY: FOR MONITORING CANCER 14/28/31/62 DAY TARGETS

Department / Service:	Cancer Services
Originator:	Anne-Marie Williams Cancer Services Manager
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Approved by:	Cancer Board
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Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All clinical areas, Admin & Clerical
Target staff categories	All clinical staff, Divisional Medical and Clinical Directors, Divisional Operational Directors, Directorate Managers, Directorate Support Managers, Directorate Support Officers, Consultants, Clinical Nurse Specialists, Cancer team, MDT coordinators, Cancer trackers, Cancer Patient Navigators Secretaries, Booking Coordinators and NHS

Policy Overview:

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

Key amendments to this Document:

Date	Amendment	By:
08.05.17	Minor amendments throughout the document	Clare Hibbert
19.08.19	Document extended until end of October whilst document is approved at Cancer Board	Tina Wright/ Lisa Rowberry
20.11.19	Document extended for 3 months. No cancer board meetings, now planned for New year	Tina Wright/ Lisa Rowberry
May 2020	Document extended for 6 months whilst review process is finalised due to COVID 19	Lisa Rowberry

June 2021	Document extended for 6 months to allow for thorough review	Lisa Rowberry
December 2021	Document extended for 6 months to allow for thorough review	Lisa Rowberry
June 2022	Document extended for 6 months to allow for thorough review	Lisa Rowberry/ Anne-Marie
January 2023	Document extended for 3 months to allow for thorough review	Anne-Marie Williams
April 2023	Document updated to include cancer waiting times guidance (v11.1) changes and best practice timed pathways	Laura Throssell

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1.0 Introduction

The Government document 'Improving Outcomes: A Strategy for Cancer' set out that cancer waiting times remain an important issue for cancer patients and the NHS should continue to ensure that cancer services are delivered to patients in a timely manner. The standards that NHS Providers will be expected to meet are: -

- 2 weeks from receipt of urgent referral by GP/ GDP/ Optometrist for suspected cancer to first seen date to include both in person and virtual consultations, as well as specialist review of images in specific cases.
- 2 weeks from receipt of referral of any patient with breast symptoms (where cancer not suspected) to first hospital assessment.
- 28 days from receipt of two week wait referral for suspected cancer, receipt of referral from a cancer screening programme (breast, bowel, cervical), and receipt of two week wait referral of any patient with breast symptoms (where cancer not suspected), to the date the patient is informed of a diagnosis or ruling out of cancer
- 31 days from decision to treat to first definitive treatment for cancer;
- 31 days from decision to treat or earliest clinically appropriate date (ECAD) to subsequent treatment (surgery, drug or radiotherapy) for all cancer patients including those with a recurrence;
- 38 days from urgent GP referral to Inter Provider Transfer (IPT), where a patient is being referred to a tertiary centre for treatment;
- 62 days from urgent GP referral for suspected cancer to first definitive treatment for cancer (31 days for suspected Children's cancers, Testicular cancer, and Acute Leukaemia);
- 62 days from referral from NHS Cancer Screening Programmes (Breast, Cervical and Bowel) to first treatment for cancer;
- 62 days from a consultant's decision to upgrade the urgency of a patient (e.g. following a non- urgent referral) to first treatment for cancer.

2.0 Scope of the Policy

This policy relates to all patients with suspected, diagnosed or recurrent cancer and those referred via a NHS screening programme (Breast, Cervical and Bowel) and healthcare professionals who care for these patients within Worcestershire Acute Hospitals NHS Trust.

3.0 Definitions

3.1 2 week wait standard

The 2 week wait standard applies to patients who are referred with urgent suspected cancer or breast symptoms from one of the following referrers: -

- General Medical Practitioner (GMP)
- General Dental Practitioner (GDP)
- Optometrist
- Any other referral source as agreed locally by commissioners and providers.

Referrals into non-specific symptoms pathways should be recorded in the same way as urgent suspected cancer referrals.

3.2 The 28-day Faster diagnosis standard (FDS)

The 28-day faster diagnosis applies to patients who are referred through: -

- The 2ww referral route by GP (GMP, GDP or Optometrist) for suspected cancer,
- Breast symptomatic referral
- Urgent screening referral

To point at which patient is told they have cancer, or cancer is definitively excluded.

3.3 Best practice timed pathways (BPP): -

The best practice timed pathways (BPPs) or optimal pathways aim to support improvements in operational performance, patient experience by achieving a timelier diagnosis and to support care providers in being able to meet the 28day Faster Diagnosis Standard. In 2018, NHS England published six national best practice timed pathways suspected prostate, colorectal, Lung oesophago-gastric (OG), head & neck cancers and skin cancers.

The timed pathways should inform local guidance and local agreement of early booking of investigations in line with BPP milestones with a reduced turnaround time of less 14 days with an optimal turnaround time of request to performed/ booked of 0-7 days. Summary of BBP pathway milestones is shown in Appendix 8.

3.4 The 31-day standard applies to treatments for all: -

- NHS patients with a newly diagnosed invasive cancer (localised or metastatic), regardless of the route of referral.
- NHS patients with a recurrence of a previously diagnosed cancer, regardless of the route of referral
- Patients who choose initially to be seen privately but are then referred for first and/or subsequent treatments in the NHS

3.5 The 62-day standard applies to all NHS patients who are referred: -

- Through the two week wait referral route by their General Practitioner (GP)/General Dental Practitioner (GDP) with suspected cancer
- To a specialist because of breast symptoms (irrespective of whether cancer is suspected)
- Where cancer is suspected from any of the three national screening programmes (Breast, Cervical or Bowel)
- Upgraded by a consultant (or authorised member of the team) because cancer is suspected
- On suspicion of one cancer but diagnosed with a different cancer.

Patients remain on the 62-day pathway until cancer is downgraded by the clinician as having a very low risk of cancer. Patients excluded from the 62-day pathway will then remain on the 18 week wait pathway.

4.0 Responsibility and Duties

4.1 Chief Executive

The overall and final responsibility for this policy in the Trust rests with the Chief Executive.

4.2 Executive Directors

The Trust's Executive team is responsible for ensuring effective delegation of

responsibilities within their areas of responsibility, and effective support of their managers' decisions and recommendations in terms of the provision of appropriate resources.

4.3 Director of Performance and Head of Elective Performance and Elective Access

It is the responsibility of the Trust Cancer Manager in addition to the Director of Performance and Head of Elective Performance and Elective Access to ensure that the Cancer Operational Escalation Policy is implemented, they will be responsible for monitoring compliance via the reports developed by the Cancer Team and information department.

4.4 Divisional Directors of Operations and Operational Managers

It is the responsibility of the Divisional Directors of Operations and Operational Managers to ensure compliance with the Cancer Operational Escalation Policy and that all data entered into PAS is accurate. They will ensure that all relevant staff including Cancer Patient Navigators attend training sessions and take appropriate action when staff are not adhering to the policy. They will view and monitor the Cancer PTL and ensure that pathway actions are updated appropriately. They will ensure that the NHS e-referral directory of services (DOS) is accurate and up to date.

4.5 Cancer Services Team

It is the responsibility of the Clinical Lead and Deputy Clinical Lead for Cancer to ensure each Multi-Disciplinary Team (MDT) lead is familiar with the contents of this policy. The Macmillan Lead Cancer Nurse will ensure all cancer Clinical Nurse Specialists (CNS) and Cancer Support workers are aware of the policy. The Trust Cancer Manager/Deputy Cancer Manager and Cancer Services Support Managers will ensure all MDT Coordinators/ Cancer trackers and MDT Coordinator Assistants familiarise themselves with and adhere to the policy and chase any escalations accordingly.

4.6 MDT Coordinators and Cancer Trackers

It is the responsibility of the MDT Coordinators and Cancer Trackers to ensure that all suspected cancer patients are actively tracked throughout their pathway until either a low suspicion or non-diagnosis of cancer is confirmed or until the patient has received first definitive treatment. All tracking comments will end with a confirmed 'next step' planned for the patient or an 'action' required to move the patient pathway forward.

These are also available electronically on an automated LIVE PTL report on the trust WREN reporting platform. Following a non-diagnosis of cancer patients will continue to be tracked on an additional PTL list by the MDT Coordinators and Cancer Trackers until the diagnosis has been communicated with the patient and a faster diagnosis date has been recorded. All investigations and details regarding the patient's pathway are recorded on Somerset Cancer Register (SCR). SCR is the WAHNHST Cancer Waiting Times Database and was introduced into the Trust in January 2010.

4.7 Two Week Wait Booking Coordinators

It is the responsibility of the Two Week Wait Booking Coordinators to ensure that appointments are allocated within 14 days from receipt of referral and to the agreed booking rules within each specialty / hospital. They are also responsible for initiating the escalation policy if an appointment cannot be booked within the 14 days. If an appointment cannot readily be made within 14 days, the patient referral details will be entered onto SCR and will be included on the 2ww escalation report on the WREN reporting platform.

4.8 The Ward/Department Manager

It is the responsibility of the ward/department manager to ensure a copy of the current policy is available to all employees in the area, that they are aware of its location and that they familiarise themselves with it.

4.9 Employees

It is the responsibility of each employee of the Trust who is likely to either come into contact with suspected cancer patients or diagnosed patients that are currently on the pathway, to familiarise themselves with the contents of this policy and to practice within the confines of the policy at all times.

5.0 Policy Detail

When a GMP/GDP sees a patient and suspects that the patient may have cancer, the Acute Trust is obliged to see that patient in accordance with Best Practice Pathways timeframes with a maximum wait of 14 days from receipt of referral; if the patient meets the nationally agreed suspected cancer, recognition and referral NICE Guidelines (NG12) and the referral was received through the agreed ERS route. Urgent referrals for suspected cancer will be made on a standard Trust pro-forma via Electronic Referral System (ERS). Patient addresses and their preferred location to be seen will be taken into account when booking appointments at the different hospital sites; however, priority is to be given to seeing the patient within 14 days. All referrals are to a team – not to a nominated Consultant. All referrals should adhere to the guidelines for referral set out nationally with required pre requisite information or tests requested such as bloods/ tumour markers.

A patient referred via their GP/GDP on a two week wait referral proforma, which is completed correctly, cannot be downgraded by the receiving consultant. If a consultant thinks the referral is inappropriate this should be discussed with the referrer. Only the referrer can downgrade or withdraw a referral. This includes where it is considered that insufficient information has been provided.

The Integrated Care System (ICS) responsibility for achieving the 14-day wait target lies with GP's and referrers in primary care to only send two week wait referrals for patients that are available to attend an appointment within the next 14 days and also to inform the patients that they are being referred as a suspected cancer.

Coordinators in the two week wait office are responsible for allocating appointments to agreed booking rules within each speciality/hospital. They are also responsible for initiating the escalation policy if an appointment cannot be booked within the 14 days. If an appointment cannot readily be made within 14 days, the patient referral details will be entered onto SCR and will be included on the automatic 2ww escalation report on WREN. The Directorate Manager/ Directorate Support Manager will be expected to ensure that all avenues have been considered to give the patient an appointment within 14 days. In the absence of the Directorate Manager there is a list of alternative contacts, appendix 5. These escalation lists are also checked daily and escalated by the Deputy Cancer Manager/ Cancer Services Support Managers if the patient is appointment is still undated after 7 days.

There are allocated two week wait slots for most specialties, and for those that the 2 Week Booking Coordinators cannot book directly, Haematology, Colposcopy and Open Access Haematuria, these referrals are sent to the relevant secretary/clinic who will then date them and inform the two week wait office of the appointment date to record on the Somerset Cancer

Register (SCR). Directorate Managers, in partnership with clinicians, will be responsible for identifying capacity and ensuring that all referrals are seen within 14 days.

A patient referred on an urgent Colorectal cancer suspected pathway, in line with the Best Practice Timed Pathway, is required to have a first seen date which should be clinical triage appointment with the patient and can be performed virtually/by telephone. This process is led by a clinical nurse specialist with oversight from a consultant. Referrals with a rectal or anal mass will be booked directly into a face to face clinic.

A patient referred on an urgent Lung cancer suspected pathway, in line with the Best Practice Timed Pathway, is required to have a first seen date which could be a straight to CT scan which has been requested by GP at point of referral and will count as first appointment in their pathway.

All patients referred under the two week wait rule, referred via an NHS screening programme or upgraded by a Consultant will count as potential 62-day wait patients. A Consultant (or an authorised member of the consultant team) can upgrade a non two week wait referral at any point on or before the MDT date, this patient will then become a 62-day wait, from the date the consultant upgrades the patient, and the 62-day standard applies.

All new, recurrences and subsequent cancer treatments with an agreed treatment plan are counted under the 31-day wait rule.

Some patients will follow a difficult clinical pathway and will take longer to diagnose and agree a treatment plan. Within any patient pathway there should be no delay caused by administrative processes.

A tertiary alert form will be emailed, within 2 working days of the MDT meeting, to the treating trust if the MDT decision was to refer the patient for a diagnostic test or treatment for cancer. Referrals to a tertiary centre should be sent by day 38 to allow the tertiary centre time to arrange first treatment by day 62.

Consultants and Directorate Managers or deputy for each speciality are responsible for ensuring that patients on the 31 and 62-day pathway do not breach the target. A Patient Tracking List (PTL), produced from SCR, will be sent out weekly by the cancer team and will include all patients that are currently on the cancer tracking pathway and do not have a treatment start date. The MDT Co-ordinators will track patients 2 working days from the last activity or event and escalate to the teams of any delays or problems within the pathway. It is the responsibility of the MDT Co-ordinator to ensure that they have explored all avenues in bringing a clinic or diagnostic test appointment forward and liaised with the CNS or Clinician to prevent a breach occurring.

If the Directorate Manager or deputy for the speciality is unable to resolve the potential breach, then he/she will escalate to the relevant Divisional Director.

If the Divisional Director is unable to resolve he/she should escalate to the Director of Performance.

All breaches are investigated and a root cause analysis will be completed for each one by the MDT Co-ordinator. This will be in a table format identifying how many days each part of the pathway took, and will be sent to the relevant Directorate Manager and Consultant with a reason for the breach.

Two week wait - Operational Policy

5.1 Standard Referral Pro-formas

All GP practices have received a copy of:

- The national referral guidelines for suspected cancer
- Referral pro-forma for Breast, Lung, Colorectal, Upper GI, Urology, Gynaecology, Skin, Head & Neck and Haematology
- Guidance on referring

These pro-formas are to be used instead of referral letters and need to be completed by the GP/GDP or other relevant clinician and sent via ERS.

Urgent referrals received outside these points will result in a delay of the patient being first seen in line with Best Performance Pathway timeframes or within a maximum of 14 days and then receiving communication, whether that is to inform them of a diagnosis of cancer, a ruling out within the 28 day FDS standard.

For referrals that are received on standard pro-formas the GPs will be able to accompany the standard pro-forma with a letter containing additional relevant information including past medical history, if required.

5.2 Receipt of Referrals

On receipt of referral, the Two Week Wait Booking Coordinator will record on SCR the patient details, the date that the referral was sent and the date that the referral was received.

5.3 Booking of Appointments

All referrals should be considered as being referred to a team, not to an individual consultant. Priority is given to booking the appointment by the two week wait office for the patient to be first seen in line with Best Performance Pathway timeframes or within a maximum of 14 days.

The Two Week Wait Booking Coordinator (or nominated individual) will identify a potential date and will telephone the patient to agree the appointment date and time. Written details will be sent to the patient to confirm the appointment. Patients should be informed that they will be offered the first appointment available and this may require travel to any hospital in the Trust.

5.4 Pro-Forma/Letter Not Adhering to National Guidelines

If the referral form is incomplete or clearly does not meet the national criteria, this will be immediately returned to the GP/GDP, by the Two Week Wait Booking Coordinator, for amending.

If the referral does not meet national guidance (NG12), this information will be shared with the referrer with a request to change the priority of the referral. However, if the referrer does not confirm that the appointment should be changed, the referral will still be counted as a 2 week wait urgent suspected cancer referral.

5.5 Booking Rules

Each specialty is responsible for agreeing the booking rules for their service with the two week wait office. This will be regularly reviewed by the Directorate Managers to ensure

that adequate provision is made on each site to accommodate the needs of the local community.

5.6 Potential Breaches

If the Two Week Wait Booking Coordinator anticipates that an appointment cannot be made in line with Best Performance Pathway timeframes or within a maximum of 14 days, the patient referral details will be entered onto SCR and will be included on the automatic 2ww escalation report on WREN. The Directorate Manager or deputy will be expected to ensure that all avenues have been considered to give the patient an appointment within the timeframes required by the Best Practice Pathway timeframes or within a maximum of 14 days - such as referral to another hospital within the Trust or if an appointment is still unavailable, transfer to another hospital within the Cancer Network.

If an appointment still cannot be secured in line with Best Performance Pathway timeframes or within a maximum of 14 days, the relevant Directorate Manager or deputy will be responsible for informing the Divisional Director of Operations within 48 hours following receipt of the referral, to allow time to consider alternative arrangements for that patient. This will be done with the support of the Clinical Director to avoid a breach.

Operational Policy for 31 and 62-day waiting times

5.7 31 & 62 Day Waits

- All patients referred under the two week wait rule, referred via an NHS screening program or upgraded by a Consultant will count as potential 62-day wait patients.
- All new, recurrences and subsequent cancers with an agreed treatment plan are counted under the 31-day wait rule.
- Some patients will follow a difficult clinical pathway and will take more than the time available to agree a diagnosis and treatment plan.
- Within any patient pathway there should be no delay caused by administrative processes.
- All cancer patients should be noted or discussed by an MDT

5.8 62-day wait patients

- All 2 week wait referrals will be logged on SCR by the two week wait office and all patient will be classified as potential cancer until proven otherwise.
- A live tracking list of patients will be maintained by the MDT Co-ordinators and Cancer trackers on SCR. They will be responsible for regularly tracking these patients 2 working days following last activity or event and ALL patients will be tracked weekly, SCR will be updated in a timely manner, ensuring the operational policy is followed.
- At any point in the patient pathway - as soon as a patient has cancer excluded, this must be entered onto SCR by the MDT Co-ordinator.

5.9 Stops, Pauses and Adjustments

The 31 day and 62-day pathways end when a patient:

- Commences treatment
- Refuses treatment
- Is given a non-cancer diagnosis

Pauses and adjustments can only be applied to cancer pathways in the following circumstances:

- When a patient DNAs their first 2WW appointment the clock start is reset to the date of the DNA. In all other parts of the pathway a DNA will not pause or restart the clock.
- An adjustment for treatment can be applied if a patient declines a 'reasonable' offer of admission for treatment (for both admitted and non-admitted pathways). The adjustment would be the time between the date of the declined appointment to the point when the patient could make themselves available for an alternative appointment.
- Where a patient makes themselves unavailable for treatment for a set period, then this may mean that offering actual dates which meet the reasonableness criteria would be inappropriate. In these circumstances the clock can be paused from the date of the earliest reasonable appointment that the provider would have been able to offer that patient.
- An adjustment can be applied if it is deemed clinically essential to treat another medical condition before treatment for cancer can be given, after a decision to treat the cancer has been made. In such cases the adjustment would apply from the point at which it is confirmed that a patient needs treatment for the other medical condition, to the point at which after receiving treatment for this condition the patient is deemed clinically fit to commence their cancer treatment.
- Where a patient opts for egg harvesting prior to their cancer treatment, an adjustment can be applied from the point at which the decision is made until eggs are harvested. An adjustment is applied only from the point at which the patient is seen by the service and agrees to egg harvesting to the point where harvesting takes place.
- Urgent treatment of another condition applied to patients with COVID-19 or influenza. This can be applied where a clinical decision is taken to offer a patient treatment now (i.e. the clinical view is that the risk of delay outweighs the COVID19 or influenza risk), but the patient declines and requests a later date, an adjustment can be taken from the offered date to the date the patient is willing to come for treatment. In such situations, a process should be put in place to review the patient at fixed intervals to check whether their view has changed. Or when a patient with a DTT then tests positive for COVID-19, the adjustment would apply from the point at which it is confirmed that a patient has tested positive, to the point at which it is deemed that it is clinically appropriate to proceed with treatment.

5.10 Appointments and Diagnostics

To achieve the 28 and 62-day target the internal aspirations must be followed to ensure patients meet their pathway milestones. Suspected and diagnosed cancer patients must have a 2WW priority assigned for all appointments and diagnostics throughout their entire pathway. To access an imaging or endoscopy 2WW slot the patient must have been referred in by the GP on a suspected cancer pathway or a "consultant upgrade" to a 2ww priority.

For specialties with a best practice pathway, the timed pathways should inform local guidance and local agreement of early booking of investigations in line with BPP milestones with a reduced turnaround time of less 14 days and an optimal turnaround time of request to performed/ booked of 0-7 days.

For all diagnostics, wherever possible an ICE request should be made immediately at MDT or the patient's outpatient appointment and should be marked priority 2ww so that the relevant department is alerted to the urgency.

Patients should be informed that they will be offered the first diagnostic test available and this may require travel to any hospital in the Trust.

5.11 Radiological investigations

Radiology investigations for suspected cancer patients will be indicated on the request form by ensuring the two week wait priority is chosen. Radiology booking coordinators will then allocate an appointment, where possible, within 7 days. If an appointment cannot be booked within 14 days of the request date, then the MDT Co-ordinator will ensure that the escalation policy is followed.

5.12 Endoscopy Investigations

Endoscopy investigations for suspected cancer patients will be indicated on the request form as a two week wait by ticking the 31/62 pathway box. Endoscopy booking coordinators will then allocate an appointment within 7 days where possible. If the date of the test is 15 days or more from the request date this should be escalated to appropriate Directorate Manager or deputy.

5.13 Tertiary Referrals

Referrals to another Trust for treatment count, for waiting times purposes, as shared activity. Due to the nature of the case it is likely that these patients may have followed a complex diagnostic route and are at higher risk of breaching.

MDT Co-ordinators will ensure that notification of a referral is emailed to the tertiary centre within 2 working days of the MDT meeting where the transfer was agreed. This is to ensure that the receiving Trust are aware of target dates.

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

Clinicians should ensure that the clinical referral is dictated, typed and emailed to the treating Trust within 2 working days of the MDT meeting where the transfer was agreed. This is to ensure that referrals are dealt with promptly and do not get delayed or lost in the post. Tertiary referrals should be made by day 38 to give the treating Trust time to see the patient, plan and book their treatment with the 62 days.

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5.14 Breach Analysis

Due to the nature of a patient's clinical symptoms there will be occasions where it has not been possible to avoid a breach. If this occurs the MDT coordinator will complete a root cause analysis (RCA) for each patient with every step of their pathway listed using a breach analysis template within SCR.
Breaches are allocated to an overall reason as per the cancer waiting times dataset:

- Administrative delay
- Clinic Cancellation
- Complex Diagnostic Pathway
- Delay due to Recovery After an Invasive Test
- Diagnosis Delayed for Medical Reasons
- Elective Cancellation
- Elective Capacity Inadequate
- Health Care Provider Initiated Delay to Diagnostic Test of Treatment Planning.
- Patient Choice

The RCA breach report will be emailed for sign off by the relevant clinician and copied to the appropriate Directorate Manager. Breach reasons are uploaded onto the national cancer waiting times system (NHS Digital).

In addition to the RCA breach report a summary report of patient numbers diagnosed and treated over 104 days by speciality will be completed for update at the monthly Cancer Board by the Cancer Manager/ Deputy Cancer Manager.

5.15 Submission of Information to NHS England and National Team

The Cancer Manager/ Deputy will ensure that all cancer waiting times and COSD data is submitted on a monthly basis to the national cancer waiting times system (NHS Digital platform) the BI informatics will use this data to produce the required directorate monthly performance packs and Trust board reports.

Returns are to be by tumour site and by Trust (amalgamating all hospitals within that trust). For the national minimum dataset, information will be identifiable.

5.16 Performance monitoring, escalation and reporting

Daily performance summary:

A daily performance email generated from the data held within SCR will be sent to all levels within the trust with a responsibility and involvement towards cancer performance and pathways.

The report is to show current month end performance against cancer waiting time standards for 2ww, 28-day and 62-day. The report is split by specialty and shows month end performance for the current and previous calendar month. Patient referral details, delay reason and tracking information is available for all breaches by clicking on the underlined numbers in red. (Shown in Appendix 7). Exception reports for 2ww and 28-day performance are also available on WREN categorised by breach reason.

Daily escalation summary:

A daily escalation email generated from the data held within SCR will be sent to all levels within the trust with a responsibility and involvement towards cancer performance and pathways.

The report is to show all patients by specialty, currently tracked on the live cancer PTL. Patients are grouped by day on pathway from the referral received date to current date (0-14, 15-27, 28-39, 40-62, 63-103 and over 104 days) and further split by diagnosed (treatment dated or undated) and suspected.

There are PTL totals for each grouping and an overall trust PTL size total. Patient referral and tracking information is available in each column by clicking on the underlined numbers. Tracking comments will end in the ‘next step’ planned for the patient or ‘action’ required to move the patient forward on the pathway. (Shown in Appendix 7)

Live PTL reporting:

The patient tracking list is a report with data pulled from Somerset Cancer Register split by cancer specialty site. This report shows all patients including 2ww, upgraded and screening referrals that are on a live tracked pathway awaiting exclusion of cancer or diagnosis and first definitive treatment. This is a live report that lists all tracking comments from the patient pathway ending with a next step or action required

Best practice pathway reporting:

Pathway reports per specialty and/or specialty subtype with a national best practice timed

pathway are available on the WREN reporting platform to track patient pathway compliance against BPP milestone timeframes. With reporting available against turnaround times from 2ww referral received to the milestone event being performed.

PTL meetings:

Weekly PTL meetings by specialty

PTL meetings will occur weekly per specialty attended by the speciaility directorate manager or support manager, the deputy cancer services manager/ Cancer services support manager and also optimally include the specialty MDT lead or clinical colleague.

The meeting will be used to monitor and ensure:

- All patients in the red and amber sections of the PTL have been tracked and comments updated on SCR
- Potential breaches are identified and escalated to specialty directorate lead and actions are agreed to bring forward if possible.
- Any issues or bottlenecks in the patients' pathway are escalated to support services managers

Fortnightly PTL meetings by specialty

PTL meetings will occur fortnightly per specialty attended by the specialty directorate manager/support manager, the cancer services manager/ deputy and chaired by the head of elective performance and access. A performance report will be updated and circulated ahead of the fortnightly PTL meeting by the Deputy Cancer Manager/ Cancer Services Support Managers.

The meeting will be used to monitor and ensure:

- Performance against cancer waiting times standards is reviewed and breaches discussed by exception
- All actions from the weekly PTL meetings are raised/ resolved.

6.0 Background

6.1 Equality requirements

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. The assessment confirms that there should be no patients, staff or visitors discriminated against with the use of this Policy (attached Appendix 6).

6.2 Financial risk assessment

There are no financial implications for the implementation of this policy (attached appendix 5)

6.3 Consultation

The following staff have been involved in the consultation of this document:

- Divisional Medical and Clinical Director
- Deputy Chief Operating Officer
- Head of Nursing
- Directorate Managers
- Trust Cancer Team
- Two Week Wait Office
- NHS Worcestershire Cancer Commissioner

7.0 Implementation

7.1 Plan for dissemination

A dissemination plan has been completed (appendix 4)

7.2 Training and awareness

It is the responsibility of the individual professional to ensure they are aware of the contents of this policy. It is the responsibility of managers to identify any training needs.

8.0 Monitoring and compliance

Monitoring and compliance of the effectiveness of this policy will be undertaken by the Deputy Chief Operating Officer through the monthly Access/Performance meetings, individual MDTs, the Cancer Information Manager and the Cancer Services team

9.0 Policy Review

This policy will be reviewed 2 years after the date of approval.

Appendix 1

General Escalation pathway

Pathway	Standard (by day on pathway)
GP Suspected Cancer referral – Appointment or straight to test *Reduced locally agreed time within 0-7 days for some best practice pathways	Day 0-14
Appointment for diagnostic test: Radiology, Endoscopy etc. 0-14 days from request to performed *Reduced locally agreed aspirational time within 0-7 days for some best pathways	Day 0-25
Diagnostics reached – MDT discussion	Day 25
Patient advised of diagnosis	Day 28
Decision to treat agreement reached wit patient	Day 31
Tertiary referral completed if required	Day 38
Patient booked for treatment – Surgery, Chemotherapy, Radiotherapy and TCI performed	Day 62

The above days may differ from site specific best practice pathways.

Appendix 2

Escalation points- Daily/Weekly/Monthly

DAILY		
Event	Description	Expectation/ Responsibility
Performance email sent 8.00am	Report to show current and previous month performance listed for 2ww/ 28 and 62 days. Patient level data available for breached patients	Directorates to be aware of current breaches and take mitigating action where possible to date within target
Escalation/ PTL tracker email sent 8.00am	Report to show all patients by specialty, currently tracked on the live cancer PTL. Patients are grouped by day on pathway from the referral received date to current date (0-14, 15-27, 28-39, 40-62, 63-103 and over 104 days) and further split by diagnosed (treatment dated or undated) and suspected.	Directorates to be aware of current breaches and take mitigating action where possible to date within target. Directorates to be aware of current undated diagnosed patients and take action where possible to date within target.
Patients awaiting first appointment/ straight to test	2ww booking team to process referral from ERS and add to SCR. Patients to show on 2ww escalation report on WREN.	Cancer team (including 2ww booking team) to monitor and escalate potential breaches to directorate teams for those patients at day 7 and above. Directorates to be aware of potential breaches and take mitigating action where possible to date within target.
Patients tracked on SCR (2 working days from last event)	MDT Coordinators and Cancer trackers to update SCR with tracking comments. All patients on the PTL to be tracked at least once per week and updated 2 day's post event or activity. Tracking comments will end with 'next step' for a dated next event or 'action' required to move the patient pathway forward. Tracking comments will be date stamped when last tracked and available on LIVE PTL on WREN	Specialty Directorate teams and SCSD Directorate teams to update on actions required and take action where possible to date within target.

WEEKLY		
Event	Description	Expectation/ Responsibility
PTL report	Cancer team to update PTL report per speciality with actions required from directorate teams, radiology, endoscopy, oncology and histology.	Directorate teams, radiology, endoscopy, oncology and histology to respond to actions within 2 working days of PTL being sent.
Speciality PTL Meetings	Weekly speciality PTL meeting, attendance not limited to but to include as a minimum DM/DSM, Cancer Services Support Manager/ Deputy Cancer Services Manager (and where possible MDT lead)	PTL reviewed at patient by patient level. Actions required identified and assigned to a member present at the meeting. To be actioned/ update sent back to the Cancer team prior to next PTL meeting.

FORTNIGHTLY		
Event	Description	Expectation/ Responsibility
Speciality PTL Meetings	Fortnightly speciality PTL meeting, attendance not limited to but to include as a minimum Head of Elective Access and Performance/ Trust Cancer Services Manager, Deputy Cancer Services Manager/ Cancer Services Support Manager, DM/DSM. Review of current performance against all CWT standards and outstanding actions on PTL.	Actions required are identified and assigned for -Performance queries -Outstanding actions from weekly PTL meetings - Potential or experienced delays in pathway identified and escalated to radiology, endoscopy, oncology and histology services.

Appendix 3

Tertiary Alert

Referring organisation name:		Contact name:	
Referring organisation code:		Contact phone:	
Referring clinician (in full):		Contact email:	

Patient details

Family name:		Local patient identifier:	
First name:			
Title:		Contact details (patient):	
Date of birth:		Lead contact name if not patient:	
NHS number:			
Correspondence address:		Contact home tel:	
		Contact work tel:	
		Contact mobile:	
Post code:		Contact email:	

GP details

GP name: (in full)		GP practice code:	
GP practice name:			

Cancer information

Confirmed cancer?:		Referral for:	Please select...
PRIMARY DIAGNOSIS:			
62 day standard?		**31 day standard?**	
Standard type:		Standard type:	
Date decision to refer:		Date decision to treat:	
Date received:		**Adjustment(s)?**	(reason and number of days)
Date first seen:			
Date decision to upgrade:			
Target date for 62 day:			

18wk Referral To Treatment information

Is this patient on an active 18 weeks pathway?		Unique pathway identifier (if available):	124804174RWP00000000
Status:			
Allocated by (Trust):		Clock start date:	
Referring clinician code:			
Date of decision to refer to other organisation (existing pathways only)			

Receiving organisation details

Receiving organisation name:		Speciality/Treatment:	
Receiving clinician (in full):			
Date Minimum DataSet sent:		-	

Notes

For receiving organisation

Date received:	

Appendix 4

Tertiary Referral Centre Contact Leads

Trust	Cancer Trust Manager	Cancer Trust Manager Email
University Hospitals Birmingham	Chris Darby, Head of Cancer Services	Chris.Darby@uhb.nhs.uk;
Royal Orthopaedic Hospital NHS Foundation Trust		
	Coralie Duff, Cancer Services Manager	coralieduff@nhs.net;
Birmingham Children's / Women's	Children's - Sabah Ijaz	sabah.ijaz@nhs.net;
	Women's -	
University Hospital Coventry and Warwickshire	John Elliott, Interim Head of Cancer Services	John.Elliott@uhcw.nhs.uk;
South Warwickshire University NHS Foundation Trust	Nicky Mills	Nicola.mills@swft.nhs.uk;
George Eliot Hospital	Cathryn Evans, New Acting Operational Manager for Cancer Services and Patient Access Performance (Jan 2023)	cathryn.evans@geh.nhs.uk
Worcestershire Acute Hospitals NHS Trust	Anne-Marie Williams	anne-marie.williams4@nhs.net
Worcestershire Acute Hospitals NHS Trust	Clare Hibbert	clare.hibbert@nhs.net
Wye Valley NHS Trust	Katherine (Kat) Barker	Katherine.Barker@wvt.nhs.uk;
Wye Valley NHS Trust	Stephen Heptinstall	amanda.radley@wvt.nhs.uk;
Wye Valley NHS Trust	Amanda Radley	Stephen.heptinstall@wvt.nhs.uk;
Gloucestershire NHS Trust	Val Ryland	val.ryland@nhs.net
Shrewsbury and Telford Hospitals	Jessica Greenwood	jessica.greenwood2@nhs.net
Robert Jones and Agnes Hunt	Laura Crump	lauracrump@nhs.net;
Robert Jones and Agnes Hunt	Cheryl Mills, Assistant Performance Manager	cheryl.mills2@nhs.net;
University Hospital North Midlands	April Davis	april.davis@uhnm.nhs.uk;
University Hospital North Midlands	Rowena Dring	Rowena.Dring@uhnm.nhs.uk;
University Hospitals Derby & Burton FT	Anna Fletcher	anna.fletcher@nhs.net
Royal Wolverhampton Trust	Helen Milward	helen.milward@nhs.net;

Sandwell and West Birmingham Hospitals NHS Trust	Jennifer Donovan	jennifer.donovan@nhs.net;
Walsall Healthcare NHS Trust	Alison Fletcher	Alison.fletcher1@walsallhealthcare.nhs.uk ;
The Dudley Group NHS Foundation Trust	Cynthia Wright John Schneider (Deputy)	cynthia.wright1@nhs.net; john.schneider@nhs.net;

Appendix 5

Worcester Acute Escalation Leads

Directorate	Lead	Deputy/Support Lead	MDT Lead
Breast	Sophie Dorrell	Beth Flynn	Mr Ben Wild
Colorectal	Tina Wright	Cheryl Hough Annette Smith	Ms Deborah Nicol
Endoscopy	Lynne Mazzocchi	Gina Gill	
Gynaecology	Sophie Dorrell	Beth Flynn Denise Riches	Ms Manon Van Seters
Haematology/ Oncology	Karen McCredie	Gaynor Jenkins Laura Ashby (Oncology) Janice Tilsley (Haematology)	Dr Juliet Mills
Head & Neck	Ami Chatha	Rebecca Pritchard Laura Andrews	Mr Chris Ayshford
Pathology	Dhakir Ghaleb	Sue Lovelock Laura Preston	
Radiology	Deena Smith	Maria Rew – WRH Deborah Wilkes - KTC Katherine Allington – Alex	
Skin	Ami Chatha	Rebecca Pritchard Laura Andrews	Dr Renu Raghavendran
Respiratory	Matthew Manners	Kellie Gebhard	Dr Kate Cusworth
Upper GI	Caroline Lister (Gastro) Tina Wright (Surgical)	Laura Birchley (Gastro) Cheryl Hough Annette Smith	Mr Martin Wadley
Urology	Neil Harvey	Cheryl Hough Nathan Pullen	Mr Adel Makar

Appendix 6

Cancer Targets: What you really need to know **(**Page 1 of 2)

28 day Faster Diagnosis – 75%

Patients referred by their GP have a maximum of four weeks (28 days) from receipt of urgent GP (GMP, GDP or Optometrist) referral for suspected cancer, breast symptomatic or urgent screening referral, to point at which patient is told they have cancer, or cancer is definitely excluded. The only waiting time adjustment which can be recorded for the Faster Diagnosis Standard are those applicable to the first seen date where a patient DNAs their 1st attendance. The Faster Diagnosis Standard pathway ends only at the point of communication with the patient, whether that is to inform them of a diagnosis of cancer, a ruling out, or if they are going to have treatment before a clinical diagnosis of cancer can be made.

Two-Week Wait – 93%

Patients referred by their GP as a suspected cancer should have their first appointment within a maximum of 14 calendar days. The 'clock' will start at time of receipt of referral. No adjustments can be made in relation to patient choice i.e. if we offer an appointment within the required 14-day period and the patient declines/defers that appointment to a date after the 14-day deadline, we will not be able to apply any legitimate adjustments to the pathway and will 'breach' that target. If a patient DNA's there first appointment, then an adjustment can be added and the clock will re-start from the date the appointment is re booked.

31 Day Standard – 96%

Once the decision to treat a patient has been made and agreed with the treating consultant and the patient, the first definitive treatment (i.e. treatment with a curative or therapeutic intent) must be delivered within 31 calendar days. This standard applies to all disease, irrespective of whether new or recurrent / relapsed. We cannot make adjustments for patient DNA or medical suspension. Pauses are allowed for patient choice (if a patient was offered a date within target) for patients being treated electively (inpatient / day case).

62 Day Standard – 85%

This applies to those patients initially referred via the GP 2 week wait route. First definitive treatment must be delivered within 62 calendar days from the date of receipt of referral. This standard applies to all specialities. Additionally, no pauses/ adjustments will be allowed during the diagnostic phase of the 62-day pathway (i.e. between date first seen and date of decision to treat being made), and patient pauses will only be allowed for a patient being treated electively (i.e. as an inpatient or day case).

Screening Referrals – 90%

Referrals from screening services (Bowel Screening, Cervical Screening and Breast Screening) are subject to a 62-day pathway. The 'clock' will start at date of referral receipt. Standards as set out above for 62-day pathways apply to screening referrals.

Consultant Upgrades – no operational standard

Consultants are able to 'upgrade' a patient at any time from point of receipt of referral to date of decision to treat. The 'upgrade' cannot happen once a decision to treat has been made. Upgrading of referral DOES NOT make the referral a 2 week wait referral. The 62 day 'clock' starts at point of decision to upgrade, and not date of original referral receipt.

31 Day Target: Surgery as a subsequent treatment, including recurrence – 94%

All subsequent surgical treatments (not just first definitive treatment), for all cancer patients including those with a recurrence are subject to a 31-day standard, e.g. a patient receiving surgery post neo-adjuvant chemo / radiotherapy must receive surgery within 31 days of the decision to treat surgically being made. The same rules apply as above for the 31-day target.

31 Day Target: Drug Therapy as a subsequent treatment, including recurrence – 98%

All subsequent drug treatments (not just first definitive treatment) for all cancer patients including those with a recurrence will be subject to a 31-day standard e.g. patient receiving adjuvant chemotherapy post-surgery. Same rules for adjustments and start dates apply as above for the 31-day standard. This standard relates to therapies such as hormonal and chemotherapy.

31 Day Target: Radiotherapy and all other subsequent treatment types, including recurrence – 94%

All subsequent treatments (not just surgery and drug therapy) for all cancer patients including those with a recurrence will be subject to a 31-day standard e.g. every new and subsequent treatment will need to be delivered within 31 days of a decision to treat date or an 'earliest clinically appropriate date'. Same rules for adjustments and start dates apply as above for new 31-day standard. This relates to all treatment types including radiotherapy.

Two Week Wait: Breast Symptoms – 93%

All patients referred with any breast symptoms should have their first appointment within 14 calendar days of receipt of referral. Same rules for adjustments and start dates apply as above for the 2 week wait standard.

How will all the above be tracked/monitored?

All patients with a suspected diagnosis of cancer referred via the 2 week wait route or any other route will be tracked on the Somerset Cancer Register by an MDT Co-Ordinator until either a non-malignant diagnosis is made or, if cancer diagnosis is confirmed, they receive their first and subsequent treatments and are discharged.

Consultant Upgrades (of a routine referral on to a 62-day pathway) should be notified to the Trust Two Week Wait Office in accordance with local protocols.

Appendix 7

Example of Daily performance email:

Daily Cancer PTL Breakdown - Escalation

Specialty	104+ Days			63-103 Days			40-62 Days			28-39 Days			15-27 Days			0-14 Days		PTL Totals			Total PTL Size
	Diagnosed (no treatment date)	Diagnosed (with treatment date)	Suspected	Diagnosed (no treatment date)	Diagnosed (with treatment date)	Suspected	Diagnosed (no treatment date)	Diagnosed (with treatment date)	Suspected	Diagnosed (no treatment date)	Diagnosed (with treatment date)	Suspected	Diagnosed (no treatment date)	Diagnosed (with treatment date)	Suspected	Diagnosed (no treatment date)	Suspected	Diagnosed (no treatment date)	Diagnosed (with treatment date)	Suspected	
Breast	0	0	0	7	18	3	24	13	10	20	3	8	11	1	44	1	127	63	35	192	290
Colorectal	2	1	4	10	3	35	8	2	118	1	0	132	0	0	263	2	216	23	6	768	797
CUP	0	0	0	1	0	0	0	0	1	0	0	1	0	0	0	0	0	1	0	2	3
Gynaecology	4	0	1	8	0	13	7	0	23	1	0	31	1	0	91	1	78	22	0	237	259
Haematology	1	0	1	4	0	2	1	0	5	1	0	3	2	0	11	3	29	12	0	51	63
Head and Neck	1	0	9	4	0	12	2	0	43	1	0	48	0	0	73	0	70	8	0	255	263
Lung	8	1	5	17	1	21	12	1	22	0	0	7	1	0	26	0	31	38	3	112	153
Skin	1	0	6	6	0	17	4	0	79	1	0	77	1	0	160	1	169	14	0	508	522
Upper GI	1	0	3	2	0	10	3	2	15	0	0	18	2	1	38	3	69	11	3	153	167
Urology	66	0	38	38	0	43	24	0	87	1	0	74	6	0	113	8	106	143	0	461	604
Total	84	2	67	97	22	156	85	18	403	26	3	399	24	2	819	19	895	335	47	2739	3121

Example of Daily escalation email:

Daily Cancer Performance Update - 2WW / 28 day / 62 day

Specialty	Mar-23				Mar-23				Mar-23			
	2ww (93%)				28 Day - FDS (75%)				62 day (85%)			
	Seen In Month	Dated In Target	Current breaches	Current Performance at Month End	FDS date recorded in month	Dated In Target	Current breaches	Current Performance at Month End	Treated In Month	Dated In Target	Current breaches	Current Performance at Month End
Breast	329	317	12	96.35%	437	413	24	94.51%	31	22	9	70.97%
Colorectal	692	690	2	99.71%	548	421	127	76.82%	37	18	19	48.65%
Gynaecology	233	205	28	87.98%	223	125	98	56.05%	11	5	6	45.45%
Haematology	15	15	0	100.00%	12	4	8	33.33%	8	4	4	50.00%
Head and Neck	312	297	15	95.19%	229	190	39	82.97%	7	2	4	28.57%
Lung	46	39	7	84.78%	61	45	16	73.77%	7	2	5	28.57%
Skin	544	529	15	97.24%	444	311	133	70.05%	31	28	3	90.32%
Upper GI	197	177	20	89.85%	174	150	24	86.21%	11	8	3	72.73%
Urology	359	355	4	98.89%	270	95	175	35.19%	65	22	43	33.85%
Total	2727	2624	103	96.22%	2398	1754	644	73.14%	208	111	96	53.37%

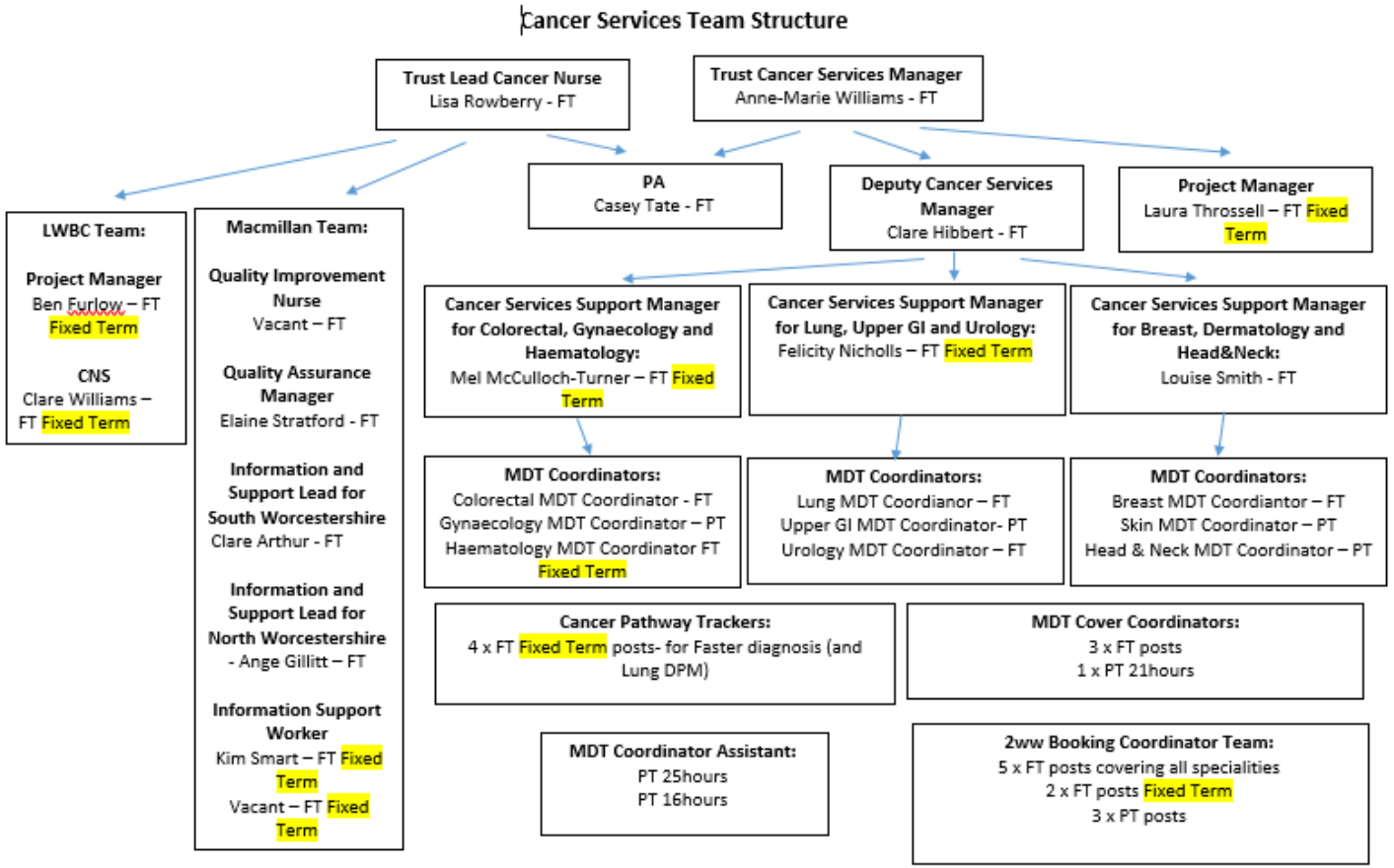
Specialty	2ww - Breast Symtomatic			
	Seen In Month	Dated In Target	Current breaches	Current Performance at Month End
Breast Symptomatic	112	110	2	98.21%

Appendix 8

Best practice Pathways (BPP) Summary table:

		Days from from 2ww referral received date					
Speciality	**Pre referral- Primary**	**0-7**	**7-14**	**14-21**	**By Day 21**	**By Day 28**	
Colorectal (All subtypes)	**nice criteria- Proposed new 2ww proforma changes include- FIT sample with positive result (Age +40 and appropriate symptoms)**	Clinical triage including telepone triage and FIT result from GP	Straight to Test including Colonoscopy, CTC, OGD, Flexi sig, CT Or outpatients if not fit for STT	Staging investigations- Staging CT or MRI	MDT discussion	Clinical review diagnosis or exclusion of cncer confirmed with patient	
		0-3	**3-9**	**By Day 18**		**By Day 28**	
Gynaecology (All subtypes)	**2ww referral meeting nice criteria**	Clinical triage	Straight to onestop clinic (PMB- Hysteroscopy/ Ultrasound) Straight to CT MRI to be requested	GA Hysteroscopy or LA Hysteroscopy MRI to be performed Local MDT discussion/ PET or staging CT request required		PET / CT performed. Discussion at local or specialist MDT	
		0-3	**By Day 10**	**By Day 10**	**By Day 20**	**By Day 28**	
Head & Neck (All subtypes)	**2ww referral meeting nice criteria**	Clinical triage	**ENT** - Straight to One stop clinic - Nasendoscopy/ MRI **OMAF** - Straight to onestop OMAF/ OPG/ Xray **Neck lump** - Straight to One stop- US/ FNA	LA biopsy MRI/ staging CT to be requested	MRI Head/ Neck performed and reported Staging CT performed and reported Discussion at local MDT	Speciailist MDT and FU OPA to confirm diagnosis	** PET CT scan to be request- reported within 10 days
		0-3	**By Day 6**	**By Day 14**	**By Day 21**	**By Day 28**	
Lung (All subtypes)	**CT chest requested as 2ww/ 2ww referral meeting nice criteria**	Clinical triage led by radiography/ respratory- Currently DPM meeting (Every Tuesday)	Lung cancer OPA	Test bundles to include PET CT, PFTs, Echo, Spiro	MDT (Every Thursday)	FU OPA to confirm diagnosis	
		0-3	**By Day 7**	**By Day 14**	**By Day 21**	**By Day 27**	**By Day 28**
Upper GI (OG subtype only)	**2ww referral meeting nice criteria**	Clinical triage- There is no clinical triage- booking team triage referral details against clinicl protocol and send any queries to clinician for advise. Confirmation receveid from national team will accept proxy date of OGD/ OPA request date as clinical triage date.	Straight to Test- OGD (+/- biopsy). CT to be requested	Discuss at local MDT meeting- PET CT to be requested	PET scan to be performed, discuss at specialist MDT	Staging LAP/ EUS to be performed	FU OPA to confirm diagnosis/ treatment plan
		0-3	**By Day 14**		**By Day 21**	**By Day 28**	
Urology (Prostate subtype only)	**PSA required/ 2ww referral meeting nice criteria**	Clinical triage- Booked into f2f OPA in UIC- MRI/ Prostate biopsy requested	MRI request- Reported by day 8 (5-7 days from request) Prostate biopsy performed by day 9 Histology report required in 5 days from performed Further investigations to be requested if required		Further investigations performed Discuss at Local MDT	FU OPA to confirm diagnosis/ treatment plan	
			By Day 14		**By Day 28**		
Skin (All subtypes)	**2ww referral meeting nice criteria/ Telederm referral**		F2F OPA - standard skin clinic, one stop see and treat clinic or spot clinic		Surgical treatment either biopsy to confirm diagnosis or excision Referral onto plastics / OMAF or other speciality clinic Pathology reported Discuss at MDT		

Appendix 9
Cancer Services Team Structure



Appendix 10

Plan for Dissemination of Key Documents

To be completed by the key document author and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Title of document:	Operational Escalation Policy for Monitoring Cancer 14/31/62 Day Targets		
Date finalised:		**Dissemination lead: Print Contact details**	Cancer Team Secretary Ext
Previous document already being used? Yes			
If yes, in what format and where? PDF			
Proposed action to retrieve out-of-date copies of the document:			

To be disseminated to:	**How will it be disseminated, who will do it and when?**	**Paper or Electronic**	**Comments**
Core Cancer Team Members	Core Cancer Team Meeting	Electronic/ Paper	To go Deputy Chief Operating Officer for approval then Kate Atkinson in Clinical Governance for review.
Core Cancer Team Members	Core Cancer Team Meeting	Electronic/ Paper	To be put to April Cancer Board and then TMC for final approval.
Cancer Board Members	Cancer Board	Electronic/ Paper	To go to TMC for final approval then back to Cancer Board
Trust Management Committee (TMC) Members	TMC	Electronic	Approved with suggestions.
Cancer Board Members	Cancer Board	Electronic/ Paper	TMC suggestions accepted. To go Kate Atkinson in Clinical Governance for review and then for circulation.

Dissemination Record – to be used once document is approved

Date put on register/library of procedural documents:	Date to be reviewed:

Disseminated to: (either directly or via meetings, etc	**Format (i.e. paper or electronic):**	**Date Disseminated:**	**No. of Copies Sent:**	**Contact Details / Comments:**

Appendix 11

Financial Risk Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

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

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration before progressing to the relevant committee for approval

Appendix 12
Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document	Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	NO	
	• Ethnic origins (including gypsies and travellers)	NO	
	• Nationality	NO	
	• Gender	NO	
	• Culture	NO	
	• Religion or belief	NO	
	• Sexual orientation including lesbian, gay and bisexual people	NO	
	• Age	NO	
2.	**Is there any evidence that some groups are affected differently?**	NO	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	NO	
4.	**Is the impact of the policy/guidance likely to be negative?**	NO	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this key document, please refer it to Assistant Manager of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Assistant Manager of Human Resources.