South West Cancer Access Policy
Final v10 – 16 October 2018

This document sets out the core issues for Cancer Access that should be consistent across the South West. Local operational policies describing how good access is achieved will still be necessary.

The best interest of the patient should be at the forefront of decisions on how to manage patients. This should override any permission allowed in this policy for referring patients back to their GP. This is of particular importance for children and vulnerable adults[1].

1. National Guidance

This policy is based on the national guidance and is designed to clarify local policies where the national guidance is not explicit. The two pieces of guidance are:

- Cancer Waiting Times a Guide (version 9.0)
- Addendum to Version 9.0 of the CWT guidance

Details of the national standards and dataset can be found here. Cancer Waiting Times Standards are also in Appendix 1.

2. Primary Care Responsibilities

The responsibilities of GPs and dentists when making 2 week wait referrals (including symptomatic breast referrals) are to:

1. Ensure that the patient meets the clinical criteria for a 2 week wait referral.
2. Carry out all relevant investigations and tests as specified on the referral proforma.
3. Complete the referral proforma in full.
4. Initiate the referral through the use of the national Electronic Referrals System (ERS)
5. Respond quickly to queries raised by the receiving Trust for more information.
6. Ensure the patient understands the nature of the referral and the need for urgency. NB booking staff will assume patient has this understanding. The referral will indicate that this information has been given to the patient and if not the reason for not giving the information will be given.
7. Ensure patient is able and willing to be seen within 2 weeks.

3. Receiving Organisation Responsibilities

This Access Policy applies to all NHS commissioned providers of cancer diagnosis and treatment in the South West. This includes the provision of nationally mandated data by independent sector providers.

[1] Including but not limited to; patients with learning difficulties or psychiatric problems; patients with physical disabilities or mobility problems and elderly patients who require community care

3.1. Two Week Wait Appointments

8. Contact the referrer immediately if the required information is not complete.
9. The Directory of Services should make clear which providers should be sent which referrals. Providers should forward immediately to an appropriate provider any referral that is for a service not provided where this is possible within the rules about use of ERS for all GP outpatient bookings, where not possible the GP should be notified of where to refer instead.
10. A 2 week wait referral can only be withdrawn or downgraded by the referrer.
11. Enable 2 week wait referrals to be booked via ERS
12. Offer one reasonable appointment or investigation date within 2 weeks[2]. An appointment must not be made in circumstances where it is known that the patient will be unavailable to attend thus to induce a series of DNAs resulting in referral back to the referrer.
13. If a patient does not attend their first appointment a second appointment should be made.
14. If an adult patient does not attend their second appointment the provider may refer the patient back to their GP[3].
15. If a patient has not booked an appointment within 28 days of first being contacted the provider may refer the patient back to their GP following clinical discussion.
16. Patients should be able to cancel and re-book their first appointment.
17. Patients who cancel their second appointment may be referred back to their GP but only if this has been agreed with the patient[4].

3.1.1. Straight to test pathway innovations

18. Where there is an agreed pathway for GP direct access referral for specific investigations, in line with NICE suspected cancer guidance or National Cancer Rapid Diagnostic and Assessment Pathways, providers have the option to 'convert' patients whose investigation report is highly suggestive of cancer, onto a 62 day GP suspected cancer referral pathway, if this has been agreed between the provider and representative CCG. The provider may request the GP simultaneously submit a GP suspected cancer referral. Where this is requested receipt of the referral would constitute day 0 on the GP suspected cancer 62 day pathway.

    If the simultaneously requested GP suspected cancer referral is received after the patient has been discharged from the suspected cancer pathway on the grounds of a further normal investigation excluding cancer this and only this specific GP suspected cancer referral can be deemed as actioned without further management. Local tracking systems may need to be adapted to enable this.

[2] See CWT 2.1.1
[3] See CWT 4.11
[4] See CWT 4.11

3.2. Cancer Treatment

3.2.1. Inpatient or Day-case Admission

19. A patient requiring inpatient or day-case admission should be given at least two reasonable offers of an admission date within the *Referral to Treatment* and *Decision to Treat to Treatment* standards. Reasonable is defined as any offered appointment between the start and end of the 31 or 62 day standard.
20. Patients should be able to cancel and re-book their first offered admission date.
21. Patients who cancel their second offered admission date may be discharged but only if this has been agreed with the patient. The patient should fully understand that they are removing themselves from the cancer or suspected cancer pathway.
22. Where a patient's treatment is non-interventional non-admitted palliative care or active monitoring to be undertaken by an organisation to whom the cancer waiting times do not apply (e.g. community palliative care team, district nurses, hospice) , the organisation which communicates and agrees the decision with the patient is responsible for the treatment and should be recorded as the place of treatment. There should be a clear written record of the communication with the patient. This may be in an outpatient appointment or over the telephone, and may be recorded via a clinic letter, in patient notes, or in a CNS contact. Where numerous conversations have been held with the patient, it is the first conversation where palliative care/active monitoring is discussed as the only or first treatment, rather than as a possibility whilst other immediate options are on offer. Providers sharing patients whose pathway ends with palliative care should liaise in a timely way to agree the place of treatment is recorded correctly.
23. Where a patient's palliative care is initiated in an NHS provider inpatient setting, that provider should be recorded as the treating provider. Where an interventional treatment is provided by an NHS provider as the start of palliative care e.g. pleural drainage, the provider undertaking the intervention should be recorded as the treating provider.
24. Where patients are seen in peripheral clinics or by consultants who work across different providers, the provider who is paid for the activity (i.e. records it on their PAS system and reports to Hospital Episode Statistics) is responsible for the activity and thus should be recorded as the place of treatment (if treatment is given) or as the provider undertaking that activity from the point of view of inter-provider transfer
25. Where patients are prescribed an anti-cancer drug in clinic for patients to take at home or have administered by the GP, the treatment start date is the day the oncologist agrees the treatment with the patient.

3.3. Decision to Treat

26. Where a patient is consented for a surgical investigation and a separate surgical treatment simultaneously, this will be recorded as the DTT for tracking purposes.
27. If at the time of decision there was still uncertainty as to the likelihood of surgery, for example if alternative treatment modalities are still being considered or it is not clear if the patient is resectable or if the disease has spread, the decision to treat should be considered to be the date on which surgery was confirmed as the most suitable treatment option and the patient agreed to this. This may be via a telephone conversation if the patient was not brought back to clinic. Where this is the case, the CNS should document the call and decision to treat date agreement.

3.4. Waiting time rules and adjustments

Rules for waiting time adjustments and clock stops for cancer are defined as per CWT guidance, in addition below there is some local clarity around this guidance:

3.4.1. Patients who are hard to engage

28. The cancer waiting times guidance states that;
    The Provider cannot deliver on a patient who is not prepared to "be on the pathway"[5].

    It also states that;
    "Patients should only be referred back to their GP after multiple (two or more) DNAs"[6]

    The guidance is also explicit about the circumstances in which a patient cannot be discharged.
    Therefore, providers may remove from cancer pathways patients who DNA two appointments (including those for tests) consecutively during their pathway, following their first appointment.
29. Patients who DNA or cancel multiple appointments after the initial first outpatient appointment should be encouraged to come in via interventions from the CNS and GP. Discharge to the GP should be as a last resort and should wherever possible be explained to the patient first and should be accompanied by a letter to the GP stating that the patient has been discharged and may be re-referred when they wish to be seen.
30. Patients should be kept on a 62 day pathway for tracking purposes until they are treated, cancer is ruled out or the patient is discharged.

3.4.2. Active Monitoring

31. The cancer waiting times guidance states that;
    "*If a patient has active anti-cancer treatment planned, but has other comorbidities, as a result of the cancer, which need to be addressed before the active cancer treatment can commence, then active monitoring can be used".*[7]
    Examples of conditions and comorbidities as a result of the cancer that may require such treatment first, include:
    - Malnutrition (except in non-metastatic skin cancer, where malnutrition is unlikely to be caused by the cancer).
    - Anaemia, deranged blood test results (e.g. electrolytes, bilirubin, liver function), hormone imbalances.
    - Respiratory problems in patients with lung cancer, lung metastases, or extra-pulmonary tumours affecting the lung e.g. laryngeal or oesophageal.
    - Jaundice.
    - Poor performance status as a result of the cancer (i.e. where performance status deteriorated in line with the tumour becoming apparent/progressing), where there is anticipation that this can be improved to allow active treatment.

The following cannot be treated as active monitoring:

- Treatment of a metastasis prior to treatment of the primary[8],

[5] See CWT 3.2.3
[6] See CWT 4.11
[7] CWT 6.6.5
[8] CWT 6.11

3.4.3. Nurse led clinics

32. A nurse clinic can be counted as a clock stop for a two week wait referral providing the
    - The nurse is part of the consultant team.
    - The triage makes an active decision about which is the appropriate next step. This therefore applies to nurse triage clinics for straight to test in suspected colorectal cancer. Such clinics need not be face to face.

3.4.4. Lung nodules

33. Patients with lung nodules with the following features should not be entered onto the Cancer Wait time pathway:
    a. Those that can be discharged:
        i. Nodules <5mm maximum diameter or <80mm^3 volume.
        ii. New nodules, not seen on a previous CT that are <3mm maximum diameter or 30mm^3 volume.
        iii. Nodules with benign features, including calcified nodules and perifissural nodules.
        iv. Nodules that on previous imaging for at least 2 years show no growth.
    b. Those that should have interval imaging;
        i. Those 5 to 8mm maximum diameter or 80 to 300mm^3
        ii. Those ≥8mm maximum diameter that have a Brock model risk of <10% chance of cancer
34. Patients with lung nodules should start on the CWT pathway when:
    a. They are referred on the two week wait system (they may be removed at first review as in 4 below).
    b. They have a Brock risk of ≥10% (in practice, this will include all nodules >20mm diameter).
35. Patients should be upgraded onto the CWT pathway when:
    a. They undergo PET-CT as part of risk assessment or general work-up (see below for criteria for removal).
    b. Significant growth is confirmed on surveillance imaging (it is recognised that this may, for smaller nodules, require more than one interval image).
36. Patients with lung nodules should be taken off the Cancer wait time pathway when:
    a. After PET-CT, they have a risk of malignancy of <10% following re-assessment of risk with the Herder risk prediction model; they then enter imaging surveillance.
    b. The patient is told that cancer is no longer suspected, or is given a benign diagnosis as per the national Cancer Waiting Times guidance
37. All patients with pulmonary nodules under follow up must be actively tracked through a pulmonary nodule service to avoid missing the few that are cancers.
38. Appendix 3 sets out the Lung Nodules and Cancer Waiting Time Monitoring background.

3.4.5. Inter-trust Referrals

39. Providers will refer patients on for discussion, tests or treatment as determined by locally agreed pathways and MDT management decisions. Referring providers should complete the activities set out in the Network Timed Pathways prior to referral.
40. A provider that normally performs a pathway step but cannot do so in the required timeframe can transfer the care to another provider with the agreement of the patient and the receiving provider.

41. Where a cancer or suspected cancer patient is referred from one provider to another at some point in the pathway, each provider is responsible for ensuring their part of the pathway proceeds in a timely way. The treating provider is responsible for uploading the patient pathway, including all inter-provider transfers, and other providers involved in the pathway should ensure the uploaded information reconciles with their own records and discuss in a timely way with the treating provider if it does not.
42. In all circumstances an Inter-Provider Transfer (IPT) form should be sent at first inter-Trust referral to ensure the receiving organisation has the relevant details to allow for effective tracking of this patient. This will include the type of pathway a patient is on, any previous inter-provider transfer dates and details, and the pathway start dates. For referrals between North Bristol Trust and UH Bristol, where the cancer register is shared, 'sign over' on the register replaces the IPT. Where the Inter-Provider Transfer details are not provided, a receiving provider will not consider the referral to have been 'received' and the referring provider will remain liable for that section of the pathway.
43. The received date of the inter-provider transfer will be the date by which the receiving Trust has all the information needed to proceed with that part of the patient's pathway. This will always include the IPT, and also (depending on individual case) include the results of relevant tests (such as histology slides and radiology images) that are required to determine the next step, and sufficient clinical information as required for that step (e.g. clinic letter, MDT record(s), MDT referral form). Where a patient will be invited to attend the receiving provider, the patient must be adequately informed by the referring provider such that the receiving provider can contact them, prior to the referral being considered 'received'.
44. As per section 3.1 of the Addendum to Version 9 of the Cancer Waiting Times guidance, referral for MDT discussion at a different provider counts as an Inter-Provider Transfer, and an Inter-Provider Transfer must be recorded by both providers in this situation.
45. Where an MDT covers several providers, either as a specialist or local meeting or combination, the responsible provider will be the one who completes the Quality Surveillance assessment for that MDT. As such, providers referring into that MDT must provide an IPT form and the responsible provider will be a partner in the shared pathway for these patients.
46. All MDT operational policies should state the clinical content, method of communication and timescales for the passing of clinical information for inter-provider transfer.
47. Where a patient is transferred multiple times between the same two providers, the inter-provider transfer form itself does not need to be sent every time (as the pathway information does not change). Where a patient has been transferred for MDT discussion only, and the next step lies with the referring provider, the MDT outcome (provided this clearly states the next step and who is carrying it out) will act as the transfer back. The referral received date will be the date that the MDT outcome is sent via email. In this case an IPT must be recorded by each of the Trusts involved, but the IPT form itself does not need to be physically sent in addition.
48. Where a patient is being managed by two providers simultaneously (i.e. is having a test at the receiving Trust and the referring Trust in the same week), the referring provider (i.e. whoever saw the patient first) will retain responsibility until their step is completed, at which point responsibility transfers to the receiving provider if their own step is not yet complete.
49. Where a patient is referred to Alliance Medical for a PET scan, the provider who makes the referral will be responsible for that stage of the pathway and for liaising with Alliance to ensure the step is undertaken without delay.

50. Network Site Specific Groups will review MDT operational policies to make ensure referring and receiving providers operate compatible policies.
51. All clinical letters and Inter-Provider Transfer forms should be in the form of e-mails or attached to e-mails (ie not posted or faxed). Email must be secure (NHS.net to NHS.net or between Trusts where a secure link is in place). Where it is in place, the Somerset Cancer Register e-Tertiary function is also acceptable for transfer of IPT information, but must be accompanied by relevant clinical information.
52. Appendix 4 sets out the agreed tracking and data for inter-trust referral forms.

3.4.6. Performance Allocation

53. Allocation of performance between providers will be undertaken in line with the national rules laid out in the Addendum to Version 9 of the Cancer Waiting Times guidance, from patients treated in October 2018. Prior to this, performance will be allocated according to the original rules (provider first seen and provider of treatment, 50/50 split regardless of pathway).
54. Providers must communicate regularly to ensure all parties agree on which patients are currently 'shared' – both on open pathways and those who have been treated in the reporting period under current validation (the previous month). All providers who have been involved in a patient's 62 day pathway must be kept informed about relevant information including diagnosis, decision-to-treat and treatment date, and the dates and organisations of any other inter-provider transfers.
55. All providers must upload their data to the NHS Digital Cancer Waiting Times system at least a week before the submission deadline, to enable any remaining discrepancies to be rectified.
56. All providers must liaise well in advance of the submission deadlines to ensure information is reconciled in good time

4. Monitoring of the Access Policy

57. Providers will record all waiting times adjustments as part of the CWT Dataset.
58. Breach reasons will be recorded in accordance with national guidance and grouped as set out in Appendix 5.
59. Providers will report to their CCG all patients referred back to primary care under the rules allowed in this Policy. This information should be submitted each quarter to their host CCG.

Appendix 1

National Operational Standards

Measure	Operational Standard
All Cancer Two Week Wait	93%
Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	93%
62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	85%
62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	90%
62-Day Wait For First Treatment From Consultant Upgrade: All Cancers	90%
31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	96%
31-Day Wait For Second Or Subsequent Treatment: Anti-Cancer Drug Treatments	98%
31-Day Wait For Second Or Subsequent Treatment: Surgery	94%
31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	94%

Appendix 2

Minimum Dataset for 2 week referrals from GP

- Full name of patient (correctly spelt)
- Patient's DOB
- Patient's gender
- Patient's full address
- Patient's up-to-date contact telephone number (where possible also a mobile number)
- Patient's NHS number
- Full clinical details on the reason for the referral in line with NICE suspected cancer referral guidance. The specific data required for each tumour is defined as completion of the South West proforma for that tumour.
- Referrer details (including telephone and fax number)
- In the case of breast referrals – stating whether the patient is a suspected cancer patient or a symptomatic patient.
- Indication of whether the patient is aware of the nature and urgency of the referral.
- Indication of whether the patient is available during the 2 weeks following referral.
- All referrals should include a 2ww proforma; however additional information (i.e. in the form of a clinic letter) may be included.

Appendix 3

Lung Nodules and Cancer Waiting Time Monitoring

Background

Pulmonary nodules are well or poorly circumscribed, approximately rounded structures that appear on imaging as focal rounded opacities and by traditional definition are ≤3cm in diameter and surrounded by aerated lung. They may be single or multiple and do not have associated abnormalities in the thorax such as lymphadenopathy or pleural disease. This definition is now commonly extended to include nodules in contact with the pleura. The now widespread use of helical multi-detector row CT has made it commonplace to detect, incidentally, nodules <1cm in diameter as well as sub-solid nodules (SSNs) that are partly or wholly ground glass opacities. Pulmonary nodules are most commonly small and benign. Between 15 and 20% of CTs of the thorax will detect pulmonary nodules. They are increasingly, but variably, entered onto the cancer waiting times pathway. The relevance to the cancer pathway relates to the chance that they are malignant. Those with a high chance of malignancy should be managed on the cancer pathway and only removed if the chance of malignancy is lowered by further investigations, or on confirmation of benignity. In contrast those with a low chance of malignancy should not be entered onto the cancer pathway unless initial nodule management suggests they have a higher chance of malignancy. The precise management of pulmonary nodules has long been debated but in July 2015, the British Thoracic Society (BTS) published NHS evidence accredited guidelines on their management[1]. These have been widely implemented in the UK. Thus, management of nodules should be according to these. A Quality Standard is to be published in the next few months.

The BTS guidelines used the available research evidence to enable accurate classification on nodules according to their risk of malignancy. Low risk is defined as <10%, intermediate as 10 to 70% and high as >70%. Although 10% may at first sight seem high, the evidence supports an even higher threshold for low risk. This is because very few patients have the diagnosis delayed significantly enough to influence prognosis but many more may be harmed by over aggressive investigation. There is also some evidence that the threshold for high risk could be higher, although evidence from British practice in the United Kingdom Lung Cancer Screening Trial suggests a low rate of invasive surgery for benign nodules[2].

The BTS guidelines recommend discharge for nodules that confer no extra risk of malignancy over baseline cancer risk (see recommendations below). Otherwise surveillance imaging is recommended for smaller nodules and those with a probability of malignancy of <10%, as measured by a validated risk prediction model[3]. These nodules will all have 3 month interval CT. It is clearly not appropriate for these to be on the cancer waiting time pathway unless surveillance imaging suggests malignancy; this is detected by measuring growth over 3 months or 12 months.

For nodules that have a chance of malignancy of 10% or more, a PET-CT is recommended with subsequent assessment of malignancy using a further validated model[4]. Patients who have a risk of 10 to 70% are preferably biopsied although resection for those at the higher end or surveillance imaging for those at the lower end of the range is also allowed according to the patient's fitness and preferences. Where the risk is greater than 70% treatment is the preferred option, with fully informed consent; biopsy may also be done to provide confirmation. It can be appreciated that where the risk of malignancy, after PET-CT is 10% or more the patient is best managed by cancer physicians and should be on the cancer pathway, to avoid delays and ensure the correct sequence of investigations is offered. Where probability is <10%, the patient should not be on the cancer pathways so as to avoid unnecessary tests that may be harmful e.g. biopsies and high radiation imaging.

References

1. Callister ME, Baldwin DR, Akram AR, Barnard S, Cane P, Draffan J, Franks K, Gleeson F, Graham R, Malhotra P, et al: **British Thoracic Society guidelines for the investigation and management of pulmonary nodules.** *Thorax* 2015, **70 Suppl 2:**ii1-ii54.
2. Field JK, Duffy SW, Baldwin DR, Brain KE, Devaraj A, Eisen T, Green BA, Holemans JA, Kavanagh T, Kerr KM, et al: **The UK Lung Cancer Screening Trial: a pilot randomised controlled trial of low-dose computed tomography screening for the early detection of lung cancer.** *Health Technol Assess* 2016, **20:**177.
3. McWilliams A, Tammemagi MC, Mayo JR, Roberts H, Liu G, Soghrati K, Yasufuku K, Martel S, Laberge F, Gingras M, et al: **Probability of cancer in pulmonary nodules detected on first screening CT.** *N Engl J Med* 2013, **369:**910-919.
4. Herder GJ, van Tinteren H, Golding RP, Kostense PJ, Comans EF, Smit EF, Hoekstra OS: **Clinical prediction model to characterize pulmonary nodules: validation and added value of 18F-fluorodeoxyglucose positron emission tomography.** *Chest* 2005, **128:**2490-2496.

Appendix 4

Inter Trust Referral (ITR)

Data Transfer Process

Agreed Actions and Timescales

Action	When	Tracking
First Seen Trust		
Decision to Refer	In MDT, in clinic, other	
Send ITR form to safe e-mail account (where possible to a generic account to prevent delays and encourage consistency)	As soon as MDT Coordinator knows of referral, but within 1 working day of Decision to Refer	Logged when sent
Send clinical letter to safe e-mail account (where possible to a generic account to prevent delays and encourage consistency).	With ITR form if available, otherwise within 3 working days	Logged when sent
Send weekly Referral List (highlighting any referrals not acknowledged).	Weekly	Logged when sent
For third Trust referrals second trusts sends their ITR form and clinical letter and the one from the first Trust to safe e-mail account	As soon as MDT Coordinator knows of third Trust referral	Logged when sent
Treating Trust		
Check safe e-mail account for ITR form	Daily (week days)	Logged when received Acknowledge receipt
Check for clinical letter	As soon as ITR received. MDT coordinator to chase after 3 days if not with ITR	Logged when received Acknowledge receipt
Notify sending trust of onward referral to third trust	As soon as MDT Coordinator knows of onward referral	Logged when sent
Send ITR, DTT and treatment data to First Seen Trust	Within 5 working days of date of treatment	Logged when sent

ITR - Inter Trust Referral

Third Trust
Where receiving Trust refers patient on to a third Trust for treatment

Safe e-mail accounts
Each provider to list the safe e-mails accounts for referral to each tumour site.

ITR Form Data
Data to be sent from First Seen Trust to other provider

- Patient pathway identifier
- NHS Number
- Patient Name
- Date of Birth
- Consultant referred to

- Tumour Site
- Cancer Referral Decision Date (GP)
- Urgent Cancer Referral Type
- Wait category (2ww, 62 day , consultant upgrade, 31 day only etc.)
- Primary Diagnosis (if known)
- Proposed treatment type (if known)
- Decision to Treat Trust (if appropriate)
- Waiting time adjustment (first seen)
- Delay reasons (provide separately for before and after first seen periods)
- Reason for referral (i.e. first treatment, subsequent treatment, diagnostics only, etc…)

ITR Treatment Data

Data to be sent from Treating Trust to other Trusts involved in pathway

- Patient pathway identifier (PPI)
- NHS Number
- Patient Name
- Date of Birth
- First Definitive Treatment type e.g. surgery
- First Definitive Treatment Date and Trust
- Cancer Status
- Primary Diagnosis (ICD)
- Waiting time adjustment
- Delay reason (to cover the 62 day period, for agreement between organisations)
- Any other interprovider transfers (date received, organisation from and to)

If applicable:

- First Seen By Specialist Date and Trust
- Multidisciplinary Team Discussion Date

E-mail Addresses

	Generic	Brain	Breast	CR	Gynae	H&N	Haem	Lung	Skin	Upper GI	Uro
Gloucestershire Hospitals											
Great Western Hospitals											
North Bristol	cancerservices@nhs.net	Always use generic account									
Northern Devon Healthcare											
Plymouth Hospitals	rk9cancerservices@nhs.net	Always use generic account									
Royal Cornwall Hospitals	rch-tr.ref12cancerservices@nhs.net	Always use generic account									
Royal Devon And Exeter	Rh8.cancerservices@nhs.net	Always use generic account									
Royal United Hospital Bath	cancerservicesruh@nhs.net										
Salisbury	isshc-tr.salisbury-rapidreferralcentre@nhs.net	Always use generic account									
South Devon Healthcare	cancerservices.sdhcft@nhs.net										
Taunton And Somerset	tsn-tr.CancerServices@nhs.net	Always use generic account									
University Hospitals Bristol	ubh-tr.cancerreferrals@nhs.net	Always use generic account									
Weston Area Health	wnt-tr.cancerservicewaht@nhs.net	Always use generic account									
Yeovil District Hospital											

Other generic mailboxes for reference:

TRUST	Generic Mailbox
EXETER MEDICAL	exetermedicallimited@nhs.net
LEEDS	leedsth-tr.LeedsCancerCentre@nhs.net
UNIVERSITY COLLEGE LONDON	ucl-tr.CancerTransfers@nhs.net

Appendix 5

Recording Breach Reasons

DELAY REASON REFERRAL TO TREATMENT (CANCER)

From Addendum to the National Cancer Waiting Times Monitoring Dataset Guidance v9.0

National Code	Description
01	**Clinic cancellation** *When any care provider initiated a cancelled outpatient clinic along any part of the pathway.*
02	**Out-patient capacity inadequate (i.e. no cancelled clinic, but not enough slots for this PATIENT)**
03	**Administrative delay** *Reasons can include but are not limited to: delay in letters, incorrect referral, inaccurate or insufficient data to proceed* *Includes administrative delays internal and external to the care provider.*
04	**Elective cancellation (for non-medical reason) for treatment in an admitted care setting** *When the cancellation has been initiated by the health care provider.* *Reasons can include but are not limited to: capacity or workforce issues, inaccurate or insufficient information to proceed with treatment.*
05	**Elective capacity inadequate (PATIENT unable to be scheduled for treatment within standard time) for treatment in an admitted care setting**
07	**Complex diagnostic pathway (many, or complex, diagnostic tests required)**
10	**Treatment delayed for medical reasons (PATIENT unfit for treatment episode, excluding planned recovery period following diagnostic test) in an admitted care setting** *Includes any clinical contra-indication to commencing treatment.* *Includes delay for investigations to determine if fit-to –proceed e.g. angiography*
11	**Diagnosis delayed for medical reasons (PATIENT unfit for diagnostic episode, excluding planned recovery period following diagnostic test)**
13	**Delay due to recovery after an invasive test (PATIENT DIAGNOSIS or treatment delayed due to planned recovery period following an invasive diagnostic test)**
14	**PATIENT Did Not Attend treatment APPOINTMENT** *Applicable to non-admitted only* *Excludes treatment planning (code 20).* *Excludes when patient fails to present for treatment in an admitted care setting (code 21).*
16	**PATIENT Choice (PATIENT declined or cancelled an offered Appointment Date for treatment)** **Includes admitted and non-admitted care.** **Excludes diagnostic tests (code 19).**
17	**PATIENT choice delay relating to first Out-Patient Appointment** **Includes appointments as part of new care models such as straight-to-test appointments and telephone consultation.**
18	**Health Care Provider initiated delay to diagnostic test or treatment planning** **HCP in this setting would be any organisation with appropriately trained staff to provide a treatment or diagnostic service.** **Excludes delay due to patient being medically unfit.**
19	**PATIENT initiated (choice) delay to diagnostic test or treatment planning, advance notice given**

20	**PATIENT Did Not Attend an APPOINTMENT for a diagnostic test or treatment planning event (no advance notice)**
21	**PATIENT failed to present for elective treatment (choice) in an admitted care setting**
22	**PATIENT care not commissioned by the NHS in England (waiting time standard does not apply) for treatment in an admitted care setting**
23	**Equipment breakdown** **Includes diagnostic and therapeutic equipment breakdown.**
24	**Inconclusive diagnostic result**
25	**Health Care Provider unable to make contact with PATIENT by telephone** **Form of contact not limited to telephone only**
26	**PATIENT choice (PATIENT declined or cancelled an offered Appointment Date for follow up APPOINTMENT)** **Not limited to face-to- face follow-up appointments**
97	**Other reason (not listed)**

Definitions of complex

Any patient where:

- investigations are required that are not within the normal pathway;
- investigations need to be repeated (as long as this wasn't due to equipment breakdown);
- referral was originally into a different cancer site;
- advice from another clinical team is required due to another condition that needs to be checked or treated (apart from general anaesthetic reviews).

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