South West Cancer Access Policy
Version 11 – April 2019

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 guidance is:

- Cancer Waiting Times version 10

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.

3.1. Two Week Wait Appointments

8. Contact the referrer immediately if the required information is not complete.

[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

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].

3.2. Cancer Treatment

3.2.1. Inpatient or Day-case Admission

18. 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.
19. Patients should be able to cancel and re-book their first offered admission date.
20. 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.
21. 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

[2] See CWT 2.3
[3] See CWT 2.4.5
[4] See CWT 2.4.5

palliative care should liaise in a timely way to agree the place of treatment is recorded correctly.

22. 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.
23. 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
24. 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

25. 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.
26. 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

27. The Cancer Waiting Times Guidance states; "*Patients should only be referred back to their GP after multiple DNAs following a clinical decision to do so.*"[5]

    Therefore, providers may remove from cancer pathways patients who DNA two appointments (including those for tests) during their pathway, following their first appointment.
28. 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 from the relevant clinician stating that the patient has been discharged and may be re-referred when they wish to be seen.
29. 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.

[5] CWT 2.4.5

3.4.2. Active Monitoring

30. 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".*[6]
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[6],

3.4.3. Nurse led clinics

31. A nurse clinic can be counted as a clock stop for a two week wait referral providing the nurse is part of the consultant team and the consultation is face to face.

3.4.4. Interval scanning

32. The Cancer Waiting Times Guidance (section 3.4.2) states: "In the case of where a patient is ordered an interval scan or test, the faster diagnosis standard clock will stop.

    The CANCER FASTER DIAGNOSIS STANDARD PATHWAY END DATE should be recorded as the date the patient is told that this is the plan. The CANCER FASTER DIAGNOSIS STANDARD PATHWAY END REASON should be recorded as '02 – Ruling out cancer'."

33. This also applies to the 62 day standard
34. The guidance goes to state that this should only be applied where "*this is in line with clinical guidance (e.g. pulmonary nodules for lung); or where explicit clinical guidance does not exist, it should be clear what the interval is and reason for this is that the risk of malignancy is too low to justify further diagnostics at this stage."*
35. The guidance states that a clock stop for interval scanning cannot be applied where repeat or further diagnostics are required due to inconclusive results of previous diagnostics; the clinical recommendation is that the scan or test is done as soon as possible; a patient chooses to delay their scan or test against clinical recommendation; or a patient is unfit for diagnostics due to another condition which needs to be treated first.
36. The guidance states that it is important that patients having interval scans are tracked and monitored to ensure the scan or test is completed when planned.

[6] CWT 4.8.5
[7] CWT 4.15

37. The guidance also states that where a patient is subsequently diagnosed with cancer following an interval scan, a new pathway should be recorded. It would be good practice at this stage, to upgrade the patient on to the 62 day upgrade standard
38. The following have been identified by the Alliance as examples that meet the criteria mentioned for interval scanning above. This list is not exclusive and other appropriate clinical uses of interval scanning may also exist.
    a. Repeat radiology scans for lung nodules
    b. Photographs and clinical review against photographs after a defined timescale for skin lesions
    c. Prostate Specific Antigen (PSA) monitoring pre-diagnosis for prostate patients
    d. A programme of endoscopy surveillance

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 National or Regional 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. Transfer for MDT discussion only does not count as an Inter-Provider Transfer under the waiting times rules. However in order to track patients an inter-provider transfer should be made as per the practice under previous versions of the guidance. In some instances this may necessitate providers deleting such transfers retrospectively to prevent their upload to the waiting times system. Providers should reconcile their interprovider transfer information on shared cases on an ongoing basis to ensure information is correct at the time of upload.

45. Transfer for a diagnostic test does not count as an Inter-Provider Transfer unless the patient is also going to be seen in outpatients. However failing to do so could pose a

risk to patients who will not be visible to the provider conducting the test and may thus be delayed or lost. As such inter-provider transfers for such patients should be made and deleted afterwards to avoid inappropriate upload.

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).
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. This applies only where the receiving Trust is seeing the patient in outpatients as part of the process i.e. where the inter-provider transfer is applicable to Cancer Waiting Times.
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. 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.
51. Appendix 4 sets out the agreed tracking and data for inter-trust referral forms.

3.4.6. Performance Allocation

52. Allocation of performance between providers will be undertaken in line with the national rules laid out in the Version 10 of the Cancer Waiting Times Guidance, from April 2019.
53. 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.
54. 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.
55. 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

56. Providers will record all waiting times adjustments as part of the CWT Dataset.
57. Breach reasons will be recorded in accordance with national guidance and grouped as set out in Appendix 5.

5. The 28 day Faster Diagnosis Standard

58. Data for the 28 day Faster Diagnosis Standard must be collected and submitted from April 2019.
59. Where a patient is seen at more than one organisation, the provider who communicates the diagnosis is responsible for recording the clock stop and accountable for the performance of that patient pathway against the standard. The Somerset Cancer Register will record the 'faster diagnosis organisation' as the place first seen as a default, this needs to be amended where the diagnosis is communicated by an organisation other than the one who first saw the patient.
60. For patients referred to the screening service, the organisation who gave the patient their result should be recorded as the diagnosing organisation, not the screening service itself. This is because it is not possible for cancer services teams teams organisations hosting screening services to quality assure the data for patients managed at other providers. The 'clock' for screening patients starts at the same point as the 62 day pathway for screening.
61. Ensuring the quality of communication is outside the scope of measuring Cancer Waiting Times and as such provided there is evidence that the diagnosis was communicated this will be counted as a 'clock stop'. It is not the responsibility of administrative staff to judge the quality of communication. It would be good practice for appropriately qualified staff within providers to undertake audits of communication quality, but this is separate from the waiting times recording.
62. In line with clinical coding rules, if a patient is told that cancer is 'probable' it is acceptable to record this as the diagnosis. For lung cancer patients given a 'Herder' score, any score of 75% or more should be considered a cancer diagnosis i.e. the patient has been informed that it is more likely than not that they have cancer. Likewise if a patient is given a 'probable' benign diagnosis it is acceptable to stop the pathway and record any subsequent cancer finding as an unexpected finding on a new pathway.
63. As per the British Medical Association's guidance, it may be appropriate for a GP to communicate the result of a test ordered by secondary care, if that is the agreed process between the hospital and the GP. It is also appropriate where the GP has ordered the test themselves, as in some straight-to-test models, unless a different arrangement has been agreed. In such cases, the clock stop should be the date in which the GP was given the information they required to undertake the communication. This may be a discussion with the GP for unusual cases, or the test result being made available on the results system.
64. The Cancer Waiting Times guidance states that when a diagnosis is communicated by the GP, the provider "can only be recorded as the cancer faster diagnosis pathway end date where the secondary care provider has a clear record of this communication". However this is unlikely to be possible to obtain in reality and it would not be appropriate or in the interests of patients to waste GP time asking for this on a regular basis. Where the patient has been informed by the GP, and no other secondary care communication will be made, the date should be recorded as described in point 65 above, to enable the pathway to be properly recorded. To do otherwise would result in pathways never being submitted. The organisation responsible should be the secondary care provider who informs the GP of the diagnosis.
65. The Cancer Waiting Times guidance states 'Where a patient has expressed a preference for telephone communication, calls to confirm test results should be booked in the same way as triage appointments or outpatient appointments'. However this may not be possible in providers where telephone activity is not recognised by commissioners and therefore cannot be appropriately recorded as activity. In such cases providers will ensure a record of the call is made on the Cancer Register or in the written notes. Commissioners should be encouraged to commission telephone activity that saves outpatient or GP attendances.
66. Where a patient requests further tests for their reassurance, despite having been given a non-cancer diagnosis, the faster diagnosis pathway should stop at the point the clinician has given the reassurance that they do not suspect cancer.

67. Where a patient undergoes an endoscopy and is given the result on the day of the test, this shall be recorded as the faster diagnosis pathway end. All patients are given a copy of their endoscopy report to take home (required for Joint Advisory Group for endoscopy accreditation) and thus will have the information in written form as well.
68. Where histology is taken in a test that is otherwise unremarkable, it is acceptable to end the pathway if the endoscopy report or other record of patient communication indicates the histology is only to test for differential benign diagnoses
69. A faster diagnosis clock stop applies if a patient is having further tests, provided it is clear that those tests are only to differentiate between benign conditions or confirm a benign diagnosis, and the patient has been told that plan
70. The faster diagnosis standards permit a patient to be removed from a pathway following multiple patient initiated cancellations, however they also state that this cannot be applied where a patient has a rescheduled appointment pending. This would potentially cause a discrepancy between the 62 day and 28 day standards, as patients cannot be removed from a 62 day pathway for cancellations. It is noted however that if patients cannot be removed for multiple cancellations if they still have an appointment, this negates the rule about their removal. The only circumstance in which a patient wouldn't have a test booked is where they have refused all tests, and as such would be removed from both pathways anyway.
71. The needs of patients with suspected or proven cancer are the priority for cancer services staff and where there is insufficient resource to collect all data, tracking and management of patients in whom cancer is not excluded must take priority. As such there may be occasions where providers are forced to make pragmatic decisions about the recording of data on faster diagnosis clock stops for ruling out cancer. Where this is the case, the provider in question should make a record of the decision making process and this should be agreed at executive level. No cancer patient should be delayed or harmed as a result of the additional data burden associated with the faster diagnosis standard for non-cancer patients.
72. The following would be sufficient evidence to record a clock stop for any cancer type:
    a. A clinic letter confirming patient was told a diagnosis or cancer exclusion in clinic (clinic date is clock stop date)
    b. A letter to a patient confirming cancer has been excluded or giving a benign diagnosis (date letter sent is clock stop date)
    c. A documented telephone call to a patient confirming diagnosis or exclusion of cancer has been communicated (date of call is clock stop date)
    d. A discharge summary or other written evidence confirming a patient was told their diagnosis or cancer exclusion during an inpatient admission (clock stop date is date told if this is clear, date of admission if precise date of discussion is not recorded)
    e. Written confirmation of decision to treat for a potential cancer
    f. A health professional contact record detailing discussion with the patient that confirms the patient was given a cancer diagnosis or cancer was excluded
73. The following would be sufficient evidence to record a clock stop for specific cancers:
    a. A negative endoscopy report (provided no other tests are planned). Patients are given their results as standard on the day if negative and provided with a copy of the test report that also includes that information (date of procedure is clock stop date)
    b. Where a cancer diagnostic test has been requested by a GP e.g. in some colorectal straight-to-test models, a report having been made available to the GP (date report made available is clock stop date). This is in line with the British Medical Association's position on the requestor of a test being responsible for communication of the result to the patient.
    c. A negative hysteroscopy report, if no histology is taken and no other tests are planned (date of procedure is clock stop date). If the report makes clear the histology is only to differentiate between benign causes (e.g. to investigate for endometriosis) then it is acceptable to stop the clock.

74. Where a patient lacks capacity (e.g. dementia, learning disabilities, child) to understand medical information and manage their own healthcare, communication to a person with responsibility for that patient (e.g. carer, parent, power of attorney) is equivalent to communication with the patient themselves

Date approved at Cancer Alliance Board: 7th June 2019

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

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 4

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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