South West
Cancer Access Policy

South West Cancer Access Policy

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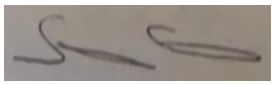
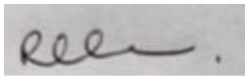
Policy prepared by:	*South West Cancer Alliances CWT Policy Sub Group*
Policy Owner:	*South West Regional Cancer Team*
Policy approved by and Date:	*South West Regional Cancer Team* *See signatory sheet*
Brief summary of changes since previous version:	Changes from Version 13.2 Updated references Removed section on recording TLHC cases as now explicit in national guidance Active monitoring section rewritten to reflect significant change in guidance Prostate risk classification section rewritten in line with change to the methodology in the guidance Other minor additions and amendments to retain compliance with the updated national guidance
Review process:	The SW Cancer regional team will bring together the SW Cancer Alliances CWT Policy Sub Group, including representation from the regional cancer

	team, SW Cancer Alliances and Trusts, to review the policy on an annual basis, or following changes to CWT. All trusts will be consulted on any required changes and / or additions, and the policy updated. The draft policy will then be reviewed by the national performance team, NHSE for review against CWT guidance and sign off. The policy will then be countersigned by the Director of Performance and Improvement in the SW Regional Team and Regional SRO for Cancer. Cancer Alliances hold the responsibility for deployment within systems for implementation.

Signatories

Stephen Scott Senior Lead (Operational Performance) National Cancer Programme	Sign  …… Date 22/07/2025…….
Martin Wilkinson Director of Performance and Delivery / Chief Operating Officer SW Regional Team	Sign ……  Date 30/07/2025…….

This policy has been adopted for deployment by SWAG Cancer Alliance signed and dated by managing director of cancer alliance.

Cancer Alliance Managing Director	Name Ruth Carr Sign  Date 30 July 2025

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Purpose

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 operationally.

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 12.1

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 primary care personnel when making urgent suspected cancer referrals (including symptomatic breast referrals) are to:

1. Ensure that the patient meets the clinical criteria for an urgent suspected cancer 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, particularly noting that Trusts cannot change the referral received date even if information is incomplete or completely absent.
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 First appointments following GP suspected cancer referral

8. Providers should contact the referrer immediately if the required information is not complete – noting that the 'referral received' date cannot be changed in this instance.
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. An urgent suspected cancer referral can only be withdrawn or downgraded by the referrer. (This does not apply to referrals to a breast symptomatic referral where cancer is not suspected, where it is acceptable for secondary care to discharge with advice or refer to a community breast pain service (see section 2.3.1 of the Cancer Waiting Times guidance.)
11. Urgent suspected cancer referrals for outpatients should be received via ERS (straight to test pathways may use alternative systems as appropriate)
12. Providers should offer at least one reasonable appointment or investigation date within 2 weeks[1]. 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 a patient does not attend their second appointment the provider may refer the patient back to their GP[2]. Care should be taken to check the patient's contact details are correct and if there is a need to instigate safeguarding processes (e.g. for children, patients with dementia/learning disabilities etc.).
15. Patients should be able to cancel and re-book their first appointment.
16. An adjustment may be applied for patients who do not attend one or more first appointments, provided the criteria specified in section 2.3.6 of the national CWT guidance are met.

3.2 Cancer treatment

3.2.1 Inpatient or Day-case admission

[1] See CWT 2.3

[2] See CWT 2.3

17. 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. Adjustments are not permitted for patients who delay tests, only treatments.

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

19. Patients who repeatedly cancel their surgery should be reviewed by the responsible clinician as steps may need to be taken to support them to attend and ensure they understand the risks of delaying treatment. Patients who refuse treatment should always be reviewed by a clinician, checked to ensure they have mental capacity, and the GP informed.

20. 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.

21. 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.

22. 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

23. 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. If a patient is prescribed a drug directly by an MDT via instruction to the GP without any secondary care contact with the patient, section 4.9.7 of the guidance should be followed. In this instance the organisation hosting the MDT is responsible for the treatment. Where this provider is different from the one that has seen the patient, an inter-provider transfer should be added on the MDT date (as transfer for MDT discussion alone does not count as an inter-provider transfer, but in this instance a transfer would be necessary to enable the treatment to be recorded). It is recognised that this scenario would be extremely rare as it is good practice for secondary care to see the patient to

discuss their diagnosis and treatment and discussing treatment should not be delegated to GP except in exceptional circumstances (usually where a patient is at end of life and too unwell to attend even virtual appointments).

3.3 Decision to treat

24. 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.

25. 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

26. 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."*[3]

    Therefore, providers may remove from cancer pathways patients who DNA two appointments (including those for tests) during their pathway, following their first appointment.

27. 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.

28. 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] CWT 2.3.11

3.4.2 Active monitoring

29. The cancer waiting times guidance states that:

"Active Monitoring can be recorded where a patient is currently considered clinically unfit for cancer treatment but receiving support to improve their overall fitness"

The guidance gives specific examples of dietetics support for malnourished patients, respiratory support for those with breathing difficulties, and haematology input for anaemic patients. The guidance no longer specifies that these conditions must be caused by the cancer. Section 3.8 of the guidance should also be checked as some interventions may be more appropriately recorded as enabling treatments.

The guidance states that active monitoring cannot be used when a decision to treat has already been made i.e. the active monitoring cannot overlap with an existing 31 day treatment pathway. Where a patient already has a decision to treat and needs treatment for an unrelated condition first, a pause may be applicable (see section of the guidance). If a treatment plan changes and the original decision to treat no longer stands i.e. is not associated with a treatment that is taking place, then use of active monitoring would be permissible. For example, if a prostate patient agrees to surgery, but then changes their mind and requests long term active monitoring instead.

The guidance states that active monitoring cannot be used where treatment is 'likely to be planned and the pathway is progressing'. Any patient on active monitoring has the possibility of having treatment at some future date (or there would not be a purpose in monitoring them), and in many cases it could be considered 'likely' that at some point in future, maybe many years away, a treatment will be recommended. Clearly the exclusion is not intended to apply to such cases. For practical purposes, 'treatment is likely to be planned and the pathway progressing' can be defined as when a patient remains on a waiting list for a cancer treatment (surgery or oncology) during the period of 'active monitoring'. If a patient is kept on such a waiting list, it suggests treatment is probable, and in the near enough future for it to be desirable to have them appearing in the demand figures for the service's planning purposes. It is normal practice to err on the side of inclusion when adding to waiting lists, because of the value in forecasting demand. Therefore if a patient is not on such a list during the active monitoring period, it suggests the balance of probabilities is against the patient imminently having treatment.

The guidance reiterates that active monitoring cannot be applied automatically because a patient is undergoing pre-habilitation or has been given advice on 'lifestyle changes', as this will be done as standard for any patient before undergoing a cancer treatment and applying in all such situations would mean the majority of 62 day cancer pathways ending prematurely with active monitoring. Providers need to differentiate between this standard practice, and more serious interventions that meet the definition above of a patient being 'clinically unfit for treatment and receiving support to improve their overall fitness'. In practice many such interventions will be delivered by the same team offering standard prehabilitation, which can make it more challenging to identify appropriate patients.

To identify patients who meet the criteria for application of active monitoring due to poor fitness, and differentiate from those undergoing standard prehabilitation and pre-treatment readiness, providers should consider the following:

- At the point of deciding to offer interventions for poor fitness, is it recognised that the patient may never be fit for treatment, and that their fitness will need to reviewed after a fixed interval of at least 3 weeks to decide if it is appropriate to offer a treatment?
- Is the patient undergoing specific interventions other than standard exercise support, diet and advice – for example, are they being given any medicines, or interventions for substance dependency?

If the answers to any of the above are yes, then the patient is likely to be having more than standard prehabiliation and meets the criteria for active monitoring to be applied.

Active monitoring may also be applied to patients with prostate cancer who fall in the low or low-intermediate risk category – see section 3.10.5 of the Cancer Waiting Times guidance for more information. It is noted that the format of the information in the 'criteria' column of the table for the 'low-intermediate' grouping is difficult to interpret. Clinical colleagues have confirmed that the criteria for this group is as follows:

Gleason score 3+4=7 AND Stage T1-2 AND PSA <10

OR

Gleason score 3+3=6 AND Stage T1-2 AND PSA 10-20

This ensures there is no overlap between the different categories and each patient can be assigned to one group only. For help with calculating the Cambridge Prognostic Group (and thus the Cancer Waiting Times classification), a helpful tool can be found here: Cambridge Prognostic Group Calculator

3.4.3 Interval scanning

30. The Cancer Waiting Times Guidance (section 3.4.2) states: "In a case where a patient is ordered an interval scan or test, the 28 day FDS 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 '04 – Interval Scanning."

31. This also applies to the 62 day standard
32. 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."*
33. 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. Active monitoring cannot be used for thinking time with the exception of 'low' or 'low-intermediate' risk prostate cancer patients (see section 7 of this policy and section 3.10.5 of the national guidance).

34. The guidance states that it is important that patients having interval scans/tests are tracked and monitored to ensure the scan or test is completed when planned. One method to do so is to open a new 'dummy' upgrade pathway with a 'dummy' upgrade date set to the date the interval scan is due.
35. Patients should be upgraded to a new cancer pathway from the date that an abnormal result on such a scan/review means the patient requires further active investigation for suspected cancer (i.e. an outcome other than discharge or a further interval scan). Patients do not need to be placed on a cancer pathway if an abnormal result requires investigation for something that is not a suspected cancer (for example, an incidental finding of abdominal aortic aneurysm).
36. 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

3.4.4 Inter Trust referrals

37. 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.

38. 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.

39. 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.

40. 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.

41. 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'.

42. 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.

43. 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.

44. All MDT operational policies should state the clinical content, method of communication and timescales for the passing of clinical information for inter-provider transfer.

45. 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).

46. 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.

47. 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.

48. 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.

49. Appendix 4 sets out the agreed tracking and data for inter-trust referral forms.

50. In the case of missing inter-provider transfer forms, if a form has not been received before the decision to treat, the decision to treat will be the interprovider transfer date, even if the form is provided later than that date. This applies only with missing forms and not with critical clinical information required before treatment can safely proceed. It remains important that inter-provider transfer forms are provided in a timely way, as without a form the treating provider is 'blind' as to the correct target dates and cannot ensure the patient is prioritised fairly based on their waiting time. If frequent issues occur with inter-provider transfer forms not being provided in a timely way, Cancer Alliances should support the provider(s) concerned to develop processes to address this.

3.4.5 Performance allocation

51. Allocation of performance between providers will be undertaken in line with the national rules laid out in the Version 12.1 of the Cancer Waiting Times Guidance

52. 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.

53. 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.

54. 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

55. Providers will record all waiting times adjustments as part of the CWT Dataset.

56. 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

57. Data for the 28 day Faster Diagnosis Standard must be collected and submitted from April 2019.
58. 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.

59. 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 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.
60. 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.
61. In line with clinical coding rules, if a patient is told that cancer is 'probable' (or similar terms such as 'likely') it is acceptable to record this as the diagnosis. This communication would count as 'breaking bad news' and the patient would consider this the point being given a cancer diagnosis. Likewise, if a patient is given a 'probable' benign diagnosis it is acceptable to stop the pathway.
62. 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.
63. 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 62 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.
64. 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.

65. 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.
66. 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.
67. 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. Should the histology unexpectedly show a cancer, a senior manager should validate the sign-off to ensure it was appropriate and in line with the rules.
68. 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
69. There is currently an exclusion reason for the FDS standard entitled 'Repeated Did Not Attends (DNAs)/Patient triggered cancellations'. This creates a divergence from the rules for 62 day pathways, where removing a patient for any number of cancellations is not permitted. It has been confirmed by the National Cancer Programme that this exclusion reason will be revised to remove reference to cancellations and align the two standards. It will be some time before this revision to the wording is visible in the guidance, datasets and various instances of cancer management systems. From 1st May 2024 providers should use this exclusion reason only for patients who have DNA'd multiple times, not for cancellations.
70. 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 and with the regional performance monitoring team. 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.
71. 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.

72. 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.
73. 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

6. Diagnosis for brain and central nervous system cancers

The national guidance states that '*All malignant tumours (i.e. not just those which are WHO grade 3 and 4)'* are in scope of the waiting time rules. This change in scope (from only including grade 3 and 4 tumours) comes into place from 1st July 2023.

The Brain and Central Nervous System Cancer Clinical Advisory Group has confirmed that they would not consider any grade 1 or 2 brain/CNS tumour to be malignant and have not identified any exceptions to this. As such the clinical advice is that grade 1 and 2 tumours should be recorded as benign and would not be within the scope of the waiting time rules.

7. Prostate risk categorisation

Every prostate cancer patient should be assigned to a 'risk category' which is determined by a combination of the patient's PSA level, T stage, and Gleason score. The national guidance specifies exactly how to calculate the category using these three items of information. These categories align with the Cambridge Prognosis Group Classification.

In a small number of cases, one or more of the data items required to calculate the ‘risk category’ is not available as it cannot be clinically ascertained. When information is missing, the risk category should be assigned as follows:

- A patient with metastatic disease should be classified as high risk
- If any one of the three pieces of information is available and maps to one of the high risk categories, high risk should be assigned
- If any one or two of the three items are missing, the risk should be assigned based on the available items. Where these items map to more than one category, the higher of should be selected. For example, if a patient has a Gleason score of 3+4, a PSA of 12, and no T stage available, they would map to either category 2 or 3 depending on the T stage. Therefore category 3 should be selected.
- If none of the three items are available and the patient does not have metastatic disease, high risk should be assigned unless clinical information exists stating the patient has low risk disease (this scenario is extremely unlikely)

Appendix 1:

National Operational Standards

Measure	Operational Standard
Maximum 28 days from receipt of urgent referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), and receipt of urgent 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	75%
Maximum 31 days from Decision To Treat/Earliest Clinically Appropriate Date to Treatment of cancer	96%
Maximum 62 days from receipt of an urgent GP (or other referrer) referral for urgent suspected cancer or breast symptomatic referral, or urgent screening referral or consultant upgrade to First Definitive Treatment of cancer	85%

Appendix 2

Minimum Dataset for urgent suspected cancer

from GP/Dentist/Optician

- 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 an urgent suspected cancer referral proforma; however additional information (i.e. in the form of a clinic letter) may be included.
- Referrals should follow NICE guidance and any notes or advice on the relevant referral form

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 (62 day pathway type, 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@nbt.nhs.uk	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	shc-tr.salisbury-rapidreferralcentre@nhs.net	Always use generic account									
South Devon Healthcare	cancerservices.sdhcft@nhs.net										
Somerset	tsn-tr.CancerServices@nhs.net	Always use generic account									

UH Bristol and Weston (Bristol)	cancerservices@uhbw.nhs.uk	Always use generic account

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).