CANCER WAITING TIMES
Inter-Provider Transfer Guidance
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1 Background and purpose

1.1 We know there is much more to do to maximise the scope to save lives, including improving patient outcomes for rarer cancers, preventing cancers developing in the first place, modernisation of cancer screening, early diagnosis of symptomatic cancers, improved access to treatment and better care for cancer patients and survivors. Work continues in all these areas, especially focusing on achieving cancer waiting times standards, particularly the 62 day referral to treatment standard that has recently been missed, and taking robust action when these are not met, such as NHS England setting up its cancer waiting times taskforce.

1.2 An inter-provider transfer (IPT) occurs when a patient follows a pathway of care that involves a referral between providers. This guidance has been developed to support IPTs of patients on cancer pathways within the East Midlands Strategic Clinical Network (EMSCN) and is based on guidance contained within the DH document Improving-outcomes-strategy-for-cancer.pdf (January 2011).

1.3 This guidance applies to IPTs in all tumour pathways where the patient’s pathway transfers from one provider to another for any reason (i.e. cancer diagnostics, staging, treatment, and follow-up from all initial referral sources including GPs, cancer screening programmes, and consultant upgrades onto the 62 day pathway).

1.4 The guidance applies to referrals to all tertiary providers in EMSCN, including referrals for treatment from providers outside the Network.

1.5 This guidance should be used to ensure a smooth transition for patients into tertiary centres and will aid transparency and ownership of the pathways. It should be noted that National Cancer Waiting Time Standards are mandated.

1.6 The aim of this guidance is to ensure the timely transfer of clinical and administrative information between providers when an IPT occurs so that:

- Patients receive appropriate assessment, diagnosis and treatment within the specified cancer waiting times standards
- The patient journey is appropriately monitored, with key events communicated between all providers involved in the patient pathway
- Problems are escalated appropriately and in a timely manner to the relevant staff so that remedial action can be taken
- Breach reasons are agreed and appropriately allocated between providers.

1.7 The 62 day cancer waiting standard is an aggregate target for all trust cancer pathways. It is recognised that the target is easier to deliver for some pathways, for example Skin and Breast. The Colorectal, Urology, and Lung cancer pathways are high volume pathways and are considered more challenging, but it is asserted nationally that it should be possible to ensure that the aggregate target is met so that 85% of all cancer patients are treated within this time.

1.8 The Expert Clinical Advisory Groups (ECAGs) have developed four timed pathways for the following tumour sites to support delivery of cancer waiting times. These pathways were developed as part of detailed pathway analysis and improvement work to streamline pathways for the benefit of the patient. The timed pathways for the following four tumour sites are given at Appendix 2:

- Colorectal
- Oesophageal and gastric cancer
At present these pathways are aspirational pathways and therefore should not be used to determine breach allocation currently. However, providers and commissioners should work together to agree a local commissioning and implementation plan to support delivery.

2 Minimum data set

2.1 An inter-provider transfer (i.e. where the patient’s pathway transfers from one provider to another for any reason) may not be recognised as a referral without receipt of the minimum data set, which consists of two parts:

Clinical dataset, including:
- The Specialist MDT (SMDT) Referral Form
- Imaging and Pathology (with accompanying reports) – or any pre-referral tests outlined within the pathways documentation in Appendix 2. These should be supplied by the secondary provider as specified in the SMDT referral form.

Cancer Waiting Times Dataset, transferred via the:
- Inter-Provider Transfer Form – mandatory fields completed as a minimum. This dataset includes the national cancer waiting times dataset plus the inter-provider referral date

2.2 Referrals to a Specialist Multi-Disciplinary Team (SMDT) Meeting shall include:
- Full Clinical dataset including reports
- Cancer Waiting Times dataset

2.3 In the case of referrals for diagnostics and treatment which do not require SMDT discussion the clinical referral letter should be accompanied by the Cancer Waiting Times dataset including date of diagnosis and basis of diagnosis where definitive diagnosis has been confirmed.

3 Inter-provider transfers

3.1 Inter-provider transfers (IPTs) from any initial referral source should be made in accordance with timescales and pathways as agreed by the East Midlands ECAGs and detailed in the corresponding Clinical Guidelines. Any specialist diagnostics or treatment requiring completion by a particular day is explicitly described in the pathway documentation.

3.2 Discussion at MDT should not be delayed if the complete Clinical dataset is unavailable, however any resulting transfer of the patient to the tertiary provider must be accompanied by the complete minimum data set including Cancer Waiting Times together with date and basis of diagnosis as relevant.

3.3 Referral for diagnostics should follow the timescales specified by the pathways and be accompanied by the Cancer Waiting Times dataset. It need not be sent with an SMDT referral form unless being referred to the MDT first.

3.4 The referral to a specialist centre should be made no later than the EMSCN agreed IPT day of 42 days. If these timescales are not met the reason for the delay in referral needs to be explained to the specialist centre.

3.5 This guidance recommends an earlier referral day for oesophago-gastric and prostate cancer, where it is recommended the referral occurs no later than 21 days and 31 days respectively. These pathways are currently aspirational good-practice pathways to support delivery of Cancer Waiting Time Standards developed by the Expert Clinical Advisory Groups. Timescales and
planning for implementation of these pathways will be for local discussion between commissioners and providers.

3.6 The recommended day of referral for oesophago-gastric and prostate cancer is dependent on whether the patient is being referred for specialist diagnostics, staging or treatment. For example, the O-G pathway requires an early referral as all treatment decisions and some staging investigations (e.g. staging laparoscopy) are undertaken by the specialist MDT/specialist centre. In the prostate pathway, patients are diagnosed locally and only referred to the specialist MDT to be assessed for specialist treatments e.g. brachytherapy, hence a later referral date. Please refer to the timed pathways given in Appendix 2 to understand providers’ responsibilities prior to referral, i.e. what tests need to be completed and when discussions at MDT need to take place prior to referral. Recommended IPT referral days are shown in Figure 1 below:

<table>
<thead>
<tr>
<th>Tumour Site</th>
<th>Latest Referral</th>
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<tbody>
<tr>
<td>Breast</td>
<td>Day 42</td>
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<tr>
<td>Brain/CNS</td>
<td>Day 42</td>
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<tr>
<td>Brain/CNS Skull Base</td>
<td>Day 42</td>
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<tr>
<td>Brain/CNS Pituitary</td>
<td>Day 42</td>
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<tr>
<td>Colorectal Anal</td>
<td>Day 42</td>
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<tr>
<td>Colorectal Colon</td>
<td>Day 42</td>
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<tr>
<td>Colorectal Rectal</td>
<td>Day 42</td>
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<tr>
<td>Gynae Cervical</td>
<td>Day 42</td>
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<tr>
<td>Gynae Endometrial</td>
<td>Day 42</td>
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<tr>
<td>Gynae Vulva / Lower Vagina</td>
<td>Day 42</td>
</tr>
<tr>
<td>Gynae Ovarian &amp; Fallopian Tube</td>
<td>Day 42</td>
</tr>
<tr>
<td>Haematological Lymphoma, CML, Myeloma</td>
<td>Day 42</td>
</tr>
<tr>
<td>Head and Neck Thyroid</td>
<td>Day 42</td>
</tr>
<tr>
<td>HPB &amp; Hepatic HPB &amp; Pancreatic</td>
<td>Day 42</td>
</tr>
<tr>
<td>Lung</td>
<td>Day 42</td>
</tr>
<tr>
<td>Sarcoma</td>
<td>Day 42</td>
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<tr>
<td>Skin</td>
<td>Day 42</td>
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<tr>
<td>Upper GI Oesophageal and gastric cancer</td>
<td>Day 42</td>
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<tr>
<td>Urology Prostate</td>
<td>Day 42</td>
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</table>
4 Data Protection

4.1 Email accounts used for information transfer should only be accessible to relevant and appropriate personnel within each individual provider organisation. The email address must be an NHS.net address (email address with suffix @nhs.net) to allow secure transfer of encrypted information both for sending and receiving information.

4.2 In exceptional cases, for example where electronic transfer is not possible due to technical failure, paper information should be transferred via safe haven fax. Information transferred by post (for example hard copies of faxed paper information) should be clearly marked “Private and Confidential – To be opened by the addressee only”.

5 Patient Tracking

5.1 It is the responsibility of all providers to ensure that systems are in place for the effective tracking and navigation of all cancer patients.

5.2 The secondary provider will continue to track the patient once the notification of transfer has been sent to the tertiary provider, in order to monitor that the patient’s treatment is within cancer waiting time standards.

5.3 The tertiary provider will start to track the patient as soon as the inter-provider transfer has been received.

5.4 The Lead Cancer Manager/designated person at the secondary provider is responsible for ensuring that the Lead Cancer Manager/designated person at the tertiary provider is informed of any key events or changes to the target date for all patients at the designated centre that they are tracking.

5.5 The Lead Cancer Manager/designated person at the tertiary provider is responsible for ensuring that the inter-provider transfer form is updated to reflect treatment planning, key events and changes to target dates. They must ensure that this is electronically transferred to Lead Cancer Managers/designated person at the secondary provider on a weekly basis.

5.6 It is encouraged that the use of systems be reinforced by verbal updates between MDT co-ordinators.

6 Escalation of inter-provider transfers

6.1 Robust lines of communication, including verbal contact, should be established between all people who collect Cancer Waiting Times data, especially for inter-provider referrals that are a regular part of a patient pathway. Queries and anomalies, in particular potential breaches, should be highlighted and resolved as quickly as possible.

6.2 It is the responsibility of the secondary provider to ensure that the Lead Cancer Manager at the tertiary provider is notified immediately of any patient referred later than the day/s specified.

6.3 It is recommended good practice for all providers to ensure that there is an agreed protocol in place for the appropriate escalation of suspected and confirmed cancer patients. For assurance and consistency the EMSCN will ensure these meet expected standards on behalf of NHS England and Clinical Commissioning Groups.

An effective protocol would include:

- Clear procedures for action/further escalation at all levels of the organisation with identified roles for each level of escalation through to an executive lead (or equivalent)
- Clear escalation timescales e.g. how long the Cancer Pathway Coordinator/MDT
Coordinator/Service Manager has to resolve an issue before it is raised to the next level, through to the Executive Lead (or equivalent)

- Escalation trigger points linked to individual pathway timescales
- Escalation trigger points for any patient without a diagnosis by IPT agreed day
- Information about how the Priority Target Listing (PTL) will be monitored and used to proactively navigate patients through agreed, timed pathways.

7 Inter-provider breaches

7.1 This guidance has been developed to facilitate discussions about breach allocation between providers involved in an IPT breach. It provides a guide to breach allocation, but does not remove the need for discussion between providers to reach joint decisions about allocation.

7.2 Should providers agree that the full breach was the responsibility of an individual provider this will not affect Department of Health monitoring which will continue to apportion the breach equally between the ‘first seen provider’ and the ‘treating provider’.

7.3 A breach allocation to one individual provider will however enable providers to assess their performance in relation to their contribution to the breach, and facilitate discussions on performance between NHS Foundation Trusts, Monitor, Trust Development Agency and Clinical Commissioning Groups.

7.4 When a patient has been referred after the agreed inter-provider transfer day of the pathway a root cause analysis (RCA) to understand the cause of the late referral should be completed by the secondary provider. The RCA should include a timeline of the patient pathway so far to assist in pinpointing the cause in case of a future breach.

7.5 If a breach occurs, the tertiary provider should notify the secondary provider of the breach and a full root cause analysis be undertaken between providers and agreed and completed in time to inform local Exeter of notification that the breach has occurred. This should be made available on request to the Clinical Commissioning Groups.
### Table 1: Breach allocation guidance

<table>
<thead>
<tr>
<th>Conditions of Breach</th>
<th>Who takes breach</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Secondary Provider</td>
</tr>
<tr>
<td>Patients referred <strong>before agreed IPT referral day date</strong> as specified of the 62 day pathway</td>
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<tr>
<td>Due to factors within the control of the tertiary provider:</td>
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<tr>
<td>administration delays capacity issues</td>
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<tr>
<td>failure to submit minimum data set&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Due to factors outside control of the tertiary provider e.g. patient controlled delays and delays by both providers</td>
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</tr>
<tr>
<td>Patients referred <strong>after agreed IPT referral day</strong> or before day 62 of 62 day pathway:</td>
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<td>Due to factors within the control of the secondary provider:</td>
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<tr>
<td>administration delays capacity issues</td>
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<tr>
<td>failure to submit minimum data set&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Due to factors outside control of the secondary provider e.g. patient controlled delays and delays by both providers</td>
<td></td>
</tr>
<tr>
<td>Patients referred at any point in the pathway</td>
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</tr>
<tr>
<td>Complex pathway&lt;sup&gt;2&lt;/sup&gt;</td>
<td>As Agreed in Discussion</td>
</tr>
<tr>
<td>Pathways involving more than two providers</td>
<td>As Agreed in Discussion</td>
</tr>
<tr>
<td>Patient Choice</td>
<td>As Agreed in Discussion</td>
</tr>
<tr>
<td>Patients referred after day 62:</td>
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</tr>
<tr>
<td>Secondary provider takes breach for all patients referred after day 62 of pathway</td>
<td>As Agreed in Discussion</td>
</tr>
</tbody>
</table>

<sup>1</sup> see section 2 for definition of dataset

<sup>2</sup> Examples of complex pathway:
- a patient where there is diagnostic uncertainty as to whether they have cancer or not who may require repeat diagnostic tests in order to reach a diagnosis
- a patient who requires a particularly complex combination of scans and biopsies
- a patient has other significant medical issues cancer unknown primary
- where a clinician elects to observe a patient over a period of time before carrying out further investigations (clinical uncertainty).

### 8 Referrals to a specialist MDT (SMDT)

8.1 Referrals to a specialist MDT should be completed in accordance with the Expert Clinical Advisory Group Guidelines between Local and Specialist Multi-Disciplinary Teams.
8.2 Referrals to a SMDT should be made within one working day of the decision to refer the patient (DTR). This applies to:
- Referrals from an LMDT to a SMDT
- Referrals to a SMDT or member of an SMDT made outside of an LMDT meeting e.g. consultant to SMDT referrals and radiotherapy referrals.

8.3 The DTR is not a data item in the Cancer Waiting Times (CWT) dataset, but should be a key trigger for referral to the SMDT. This will facilitate timely management of cancer patients and, regardless of place of treatment, will assist all organisations to comply with the CWT targets.

8.4 It is the responsibility of the secondary provider to put in place systems to ensure that all referrals are made within one working day of the decision to refer the patient and record the date of transfer accurately for Audit purposes.

8.5 It is the responsibility of the tertiary provider to ensure that there are systems in place to inform the SMDT Coordinator within one working day of receipt of the referral so that the patient can be included in the next SMDT meeting. A record of the date of referral receipt and notification to SMDT coordinator should be kept.

8.6 All SMDT referrals must specify the cancer waiting time’s target that applies to the referral and the date the referral was made.

9 Radiotherapy/Visiting Consultant referrals (not via SMDT)

9.1 It is the responsibility of the secondary provider to ensure that there are systems in place to inform the SMDT Coordinator/Patient Pathway Coordinator at the tertiary centre of radiotherapy or visiting consultant inter-provider referrals, within one working day of the referral, so that the patient can be tracked appropriately. This includes completion and sending of the notification of transfer form.

9.2 It is the responsibility of the tertiary provider to have systems in place to receive and track the referral and to ensure the notification of treatment planning is updated and returned to the secondary provider on a weekly basis. This process applies to both radiotherapy and visiting consultant referrals.

10 Document Management and Approval

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</tr>
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<td>East Midlands Cancer Clinical Network Steering Group</td>
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<td>East Midlands Cancer Strategic Clinical Network Tel</td>
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For comments / amendments to this guidance please contact Louise Walker, East Midlands Cancer Strategic Clinical Network Manager, on Louise.walker8@nhs.net

Disclaimer

It is your responsibility to check against the electronic library that this printed out copy is the most recent issue of this document.
# Appendix 1: Inter Provider Transfer Form

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Appendix 2: Agreed Timed Pathways

Oesophageal & Gastric Cancer Pathway

Day 0
- GP 2ww Referral Received and triaged daily by gastro-enterologist

Day 7
- Endoscopy with request for histology

Day 13
- Staging CT: chest / abdomen / pelvis

Day 14
- Combined local / sMDT with histology, staging CT, co-morbidities and performance status. (Local MDT to present patients with cancer diagnosis to sMDT)

Day 15
- Outpatient Clinic with consultant and CNS. Shared decision making on treatment options.
  - Patients with curative intent
  - Palliative patients follow palliative care pathway at local hospital

Day 21
- Staging and O/P assessment
  - Pre-operative assessment
  - Anaesthetic assessment
  - Dietetic assessment
  - Holistic needs assessment

Day 28
- PET CT (non-gastric cancer)
- Staging laparoscopy for gastric cancers (selected patients)
- Diagnostic EUS (non-gastric cancer)

Day 31
- MDT Staging Review

Day 35
- Outpatient Clinic (Oncology)
- Outpatient Clinic (Surgery)

Day 62
- Treatment commences
  - Surgery / Neoadjuvant Chemotherapy / Endoscopic resection
Cancer Centre

Prostate Cancer Referral to Treatment Pathways

Start of the process

GP Decision to Refer (2ww)

GP 2ww Referral Received

Patient attends 1st OPA Probability / Risk assessed

Low Probability
PSA <10
DRE: Normal feeling prostate

PSA Monitoring
- Mildly elevated age specific PSA
- Repeat PSA / % fPSA
(e.g. confirmed or suspected UTI)
- Patient choice

Prostate Biopsies
- High clinical suspicion
- Family history of prostate cancer or BRACA gene
- Patient choice
(Consider mpMRI prior to biopsies)

Patient remains on 2ww tracking.
Re-review in 4-6 weeks & discharge or transfer to main pathway as appropriate

High Probability
PSA >10 +/-
DRE: Firm/Hard Prostate

Suitable for Radical treatments considering
- Age & life expectancy
- PSA
- Co-morbidities
- Good Performance Status

Unsuitable for Radical treatments considering
- PSA > 100
- Suspected metastases
- CT4 on DRE
- Severe co-morbidities
- Poor performance status

No Suspicion

Remove from Cancer pathway

MDT Discussion if Cancer is confirmed
- Assign risk category in men with localised prostate cancer and discuss treatment options for Localised, Locally advanced & Metastatic Prostate cancer (NICE CG175)

By Day 21
(Day 28 if with Bone Scan results)

Patient attends 2nd OPA (Counselling Clinic)
Diagnosis Treatment & Trials options discussed.
If appropriate & agreed start *AS,WW or ADT
Referral to specialist MDT as appropriate
Arrange Bone scan if necessary

+/- Oncology OPA for discussion re:
IMRT / Brachytherapy / Trial enrolment

+/- Tertiary referral for Brachytherapy if no local service available (patient’s choice)

Treatment & Trials discussed, Consent Obtained & Treatment scheduled

Treatment delivered

End of the process

* AS: Active surveillance; WW: Watchful waiting
ADT: Androgen Deprivation Therapy
*RAUS MDT (Multi-disciplinary Team) Guidance for Managing Prostate Cancer (September 2013) **NICE NICE CG175 2014 pages 39-47

Bone Scan
if PSA > 20
Cancels biopsy

MRI / mpMRI prior to biopsies

Cancer is not confirmed
Continue to monitor PSA. +/- further biopsies as clinically appropriate (NICE CG175)

Tertiary Referral
Referral from another centre OR Referral from another Speciality MDT to MDT referral

Specialist MDT

By Day 31

By Day 48

By Day 62

**NICE CG175 2014 pages 39-47

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NHS
LUNG Cancer Referral to Treatment Pathway

Route of presentation

GP Decision to refer (2ww)

Consultant / Emergency

GP 2ww Referral Received

CT lower neck, chest and upper abdomen

Pre Clinic / diagnostic MDT / Triage system

Outpatient Clinic (PM)

No Cancer

Further investigations

MDT decision based on available diagnosis, staging and fitness

Diagnosis, staging and fitness assessment according to patient preferences*

Interval CT

MDT

Further analysis (EGFR & ALK)

Outpatient Clinic (Surgery)

Outpatient Clinic (Oncology)

Best supportive care

Pre Op Clinic

Surgery

Chemotherapy

Radiotherapy

MDT discussion post treatment

Additional treatment / monitoring as appropriate

Holistic Assessment and follow-up / additional treatment / palliative treatment

Day 0

Day 7

Day 13

Day 14

Day 28

Day 35

Day 42

Day 60

*Patient preferences include, but are not limited to, their age, comorbidities, and personal values.