# GM Cancer Access Policy

## Introduction and Overarching Principles

This section describes the required management of waiting times for patients with suspected and confirmed cancer, to ensure that such patients are diagnosed and treated as rapidly as possible and within the national waiting times standards. The Greater Manchester Cancer Access Policy section should be read in conjunction with the wider principles of the Elective Access Policy, the national Cancer Waiting Times (CWT) Guidance, the GM Inter-provider Transfer (IPT) policy, local SOPs and policy for cancer pathway management.

The national CWT guidance is the primary source of access information for the management of patients on cancer pathways. This section of the access policy is written in conjunction with V12.1. Future iterations of CWT will supersede the content of this policy.

As defined in the NHS Constitution, patients have the right to expect to be seen and treated within national operational standards ensuring timely diagnosis and treatment, equity of care and patient choice. Patients will, wherever possible, be offered dates for appointment or treatment in chronological order, based on the number of days remaining on their cancer pathway, unless there are identified clinical exceptions. Wherever possible, patients will be given reasonable notice and choice of appointments and treatment dates as defined within the policy.

The standards are:

* Faster Diagnosis Standard: a diagnosis or ruling out of cancer within 28 days of referral (set at 77% rising to 80% by 31.03.26)
* 31-day DTT RTT treatment standard: commence treatment within 62 days of being referred (set at 85%)

The 62 day RTT standard remains the primary target for delivery.

### 1.1.2 Purpose

The purpose of this policy is to ensure all patients requiring access are managed equitably and consistently in line with national waiting time standards and the [NHS Constitution](https://www.gov.uk/government/publications/the-nhs-constitution-for-england). As set out in the NHS Constitution, patients have the right to start consultant-led treatment within maximum waiting times. The policies and procedures comprising this policy adhere to national best practice and provide a framework to ensure that patients are treated transparently, fairly and reasonably.

This policy further describes the GM agreed approach to areas of the national CWT where ‘locally agreed policy’ is stipulated, or where there is perceived ambiguity. The policy does not aim to repeat the detail of the CWT.

This policy should be made available to all applicable staff, alongside suitable training.

### Scope

This policy applies to all patients referred on a suspected cancer pathway referred via a GMP / GDP / Optometrist, breast symptomatic pathway, via a national screening programme and patients added on to a suspected cancer pathway by way of a consultant upgrade based on clinical suspicion of a new cancer, cancer recurrence or disease progression.

1.1.4 Accountability and Governance

Each individual GM Trust Board is accountable for adherence to this policy, with delegated authority to the relevant committee for oversight.

The GM Cancer Board, with delegated authority to the GM Cancer Alliance are responsible for ensuring this policy adheres to national cancer requirements.

### Roles and responsibilities

All staff have a responsibility for ensuring that the principles outlined within this document are consistently applied. This policy applies to all members of staff who are involved in any aspect of delivering or reporting on cancer pathways. In addition to the generic responsibilities in the wider policy, the following are applicable to the management of cancer pathways.

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| **Chief Delivery Officer/ Chief Operating Officer** | Effective monitoring and adherence with the associated IPT policy and national CWT guidance.  To ensure appropriate PTL meetings are in place to facilitate patient being manged through their pathways in line with the CWT requirements.  To ensure robust SOP and operational policies are in place to deliver cancer pathways within 62 days.  To establish and maintain a fully functional Trust Cancer Board including locality representation.  To consult with GM Cancer Alliance on any proposed changes to cancer pathway flows in Greater Manchester. |
| **Chief Digital Information Officer** | Ensures compliance with mandated data submissions including but not limited to cancer waiting times, COSD, MINCAN, national and local audit. |
| **Trust/Divisional Medical Director(s) / Trust Lead Cancer Clinician** | To ensure formal harm reviews are undertaken for all patients treated beyond 104 days, and that breach RCAs are reviewed for all patients treated over 62 days.  That local and MDTs operate in accordance with the required standards in terms of membership and quoracy, that MDTs function throughout the year and are rearranged appropriately if they fall on a bank holiday or that provision is made to ensure a pathway is not delayed as a result.  Ensuring appropriate clinical representation at the Trust Cancer Board, and associated meetings including specialty patient tracking meetings. |
| **Divisional Directors** | That core services required for the timely and effective delivery of cancer pathways are maintained throughout the year, including bank holidays, and proactively plan for season variation in referrals and patient choice.  To ensure appropriate escalation processes are in place and adhered to. |
| **Divisional Management Teams/Operational Managers** | Ensure proactive management of capacity to maintain waiting times for all cancer pathway milestones in accordance with the national Best Practice Timed Pathway, and IPT policy requirements. |
| **Cancer Management Teams** | To act as the local expert in compliance with CWT standards and ensuring the appropriate escalation policies and operating procedures are in place throughout the Trust.  To act as the main conduit with GM Cancer Alliance in relation to adherence to and delivery of CWT, including points of clarification / escalation of concerns, data submission, predicted performance, audit.  Ensure effective communication with locality teams on referral quality, and compliance with MDS.  To ensure effective patient tracking / MDT processes (including meetings) to ensure patients are tracked adequately, and their pathways expedited to meet the CWT requirements.  To ensure the appropriate and accurate recording of all pathway data.  To ensure a process of audit is in place related to accurate clock stop / starts, 31 day/ consultant upgrade pathways and the use of active monitoring and patient adjustments as a minimum. |
| **The patient’s GP and/or referrer** | * To ensure that referrals are completed on the GM standard referral forms * Ensure that appropriate filter function tests are completed in accordance with the tumour specific referral forms * That patients referred on a LGI pathway have a FIT completed and a result of >10 before a referral is made * Optimise the use of the NSS pathway to avoid unnecessary investigations * To ensure that patients are told they are being referred on a suspected cancer pathway and are provided with the appropriate information on the pathway – including likely tests and expectations of attendance * Ensuring the patient letter and full referral information is added within 24 hours of the referral being made * Ensuring that NHS only telephone numbers are shared to facilitate referral discussions * Ensure a frequent check of the referral portal to ensure patients have converted their URBN and that their pathway is progressing |
| **ICB** | * To ensure sufficient capacity is commissioned to deliver the CWT standards |

## 2.0 Referral management

## Permitted refers of patients onto suspected cancer pathways are defined in the CWT guidance. There are no locally agreed additions / exceptions. However, for recording purposes CWT also describes pathways that should be recorded as a GP Suspected Cancer Referral (SCR) i.e. lung pathway where patient is retained after an abnormal chest xray. All organisations are expected to record pathways in accordance with these requirements.

CWT states certain pathways could be recorded as a GP Suspected Cancer Referral (SCR). There are no locally agreed additions. For the purpose of consistency, unless stipulated in CWT GM Trusts should report other patients through consultant upgrades. This includes patients suspected of cancer from a routine referral at triage / clinic / first attendance / follow up. Patients who attend though ED and require further investigation. Patients flagged as abnormal radiology, or histopathology should automatically be upgraded on to a consultant pathway.

Any consultant or permitted member of a consultant team can upgrade a patient onto a cancer pathway as a ‘consultant upgrade’.

Patients should meet the required NG12 criteria for referral into tumour specific pathways. Additionally, HRT and Breast Symptomatic pathways in place should be adhered to at all times.

GM commissioned non-site specific pathways are in place throughout GM. Patients not meeting a site-specific NG12 criteria but where there are vague, but concerning symptoms should be referred into this service.

The cancer clocks should start on the day the patient converts their UBRN or the day the referral is received into secondary care (not when letter uploaded). This should be classed as day 0 (zero) of the pathway.

## 2.1 Referral documentation

All GPs within GM should refer patients using the agreed GM pathway referral forms. These should be completed in full and with all filter function tests completed. All referrals should be made using E-RS

Trusts should have mechanisms outside of E-RS for receiving referrals from Community hubs, independent sector providers, GDP and Optometrists. All referrals should be accompanied by the same level of details as the agreed referral forms.

All patients being referred on a Lower GI suspected cancer pathway should have a FIT result of 10mg/ unless FIT is not indicated (rectal bleed etc as per GM FIT SOP (append). Patients with LGI symptoms with a FIT below 10 but where there is still clinical concern should be referred into a Non-Site Specific (NSS) pathway.

Appropriate audit at practice level should be in place to review compliance with referral documentation (filter function tests, adherence to alternative pathways – HRT, Breast symptomatic, and meeting NG12 criteria).

2.2 e-RS – Appointment Slot Issues (ASI)

If a referral is made to a Directly Bookable Service and there are insufficient slots available for the selected service at the time of attempting to book (or convert their Unique Booking Reference Number (UBRN), the patient will appear on the Appointment Slot Issue (ASI) work list. The cancer clock starts from the point at which the patient or referrer attempted to book.

Any referral deemed an ASI must be added to the appropriate waiting list for review and management within 24 hours.

All Trusts are required to review their suspected cancer pathway ASI list at least daily and ensure that where clock starts are not automated due to ASI that the correct clock is entered, and that sufficient audit process is in place to ensure data quality standards.

## e-RS – Advice and Guidance

Advice and guidance is not permitted on suspected cancer pathways. Patients meeting the NICE threshold for referral must be referred directly into a suspected cancer service.

Advice and guidance is permitted for Breast Symptomatic referrals (patients not initially suspected of cancer and may be managed pre-referral in line with a routine elective pathway.

The GM agreed approach to the management of Breast Symptomatic referrals is as follows:

TBC via Pathway Board and added.

Of note, although pre-referral management processes have recently altered (as above) if a patient is referred into secondary care pathway, the patient pathway should be treated in line with FDS and 62 day clock requirements and regular pathway management processed.

## Incomplete referrals

Referrals should not be rejected or returned because information is missing. Information should be requested from the GP but the default position should be to book and see the patient in the safest manner within the required timescales. There should be no pause or resetting of the pathway start date in line with the patients’ best interests. Incomplete referrals should form part of feedback between Trusts / localities, with GM Cancer providing oversight and escalation points.

If a referral is received that a consultant does not feel meets the NICE requirements for a SCR criteria, this may be discussed with the referrer. The referrer can then retract the referral or removed its SCR criteria after this discussion if appropriate. A SCR tag can only be removed prior to a first appointment in secondary care after discussion and agreement with the referring GP/GDP. If the patient has already attended secondary care, then they can only be removed from a cancer pathway by stopping the 28 day FDS clock as non-cancer.

Only, the referring GP/GDP has the ability to remove a SCR status. Patients cannot be ‘downgraded’ in secondary care under any circumstances.

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## Referrals From Private Practice

Patients can choose to re-enter an NHS pathway at any point in their diagnostic / treatment pathway. All Trusts should have mechanisms to receive referrals from private practice and apply cancer clocks in accordance with CWT guidelines

## Consultant Upgrades

A consultant or an authorised member of the consultant team can upgrade a patient if cancer is suspected. The date of the upgrade then starts the 62-day clock. This can happen at any point prior to the patient being listed on a Cancer MDT, and should be at the first suspicion of cancer. I.e.

* when triaging a routine referral
* after seeing the patient for the first time as a routine patient
* after a diagnostic test
* As a new requirement in CWT V12.1 When an abnormal radiology or histopathology report is generated

The patient and the GP should be informed of the upgrade at an appropriate point dependent on the mechanism of upgrade.

## Pathway Management

Patients suspected with or following a cancer diagnosis should have expedited diagnostic and treatment pathways.  Waiting times should reflect the national Best Practice Timed pathways, aligning to delivery of 28-day Faster Diagnosis Standard (FDS), 62 day RTT and 31 day DTT standards.  The milestones for each pathway test can be found : [NHS England » Rapid cancer diagnostic and assessment pathways](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.england.nhs.uk%2Fpublication%2Frapid-cancer-diagnostic-and-assessment-pathways%2F&data=05%7C02%7Candy.mcallister2%40nhs.net%7C5d60145cc90e4b840ec808dd622ae818%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638774658596553372%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=ELVPoiJk9VB%2F4Dqdopu3VcaBSlIJA8mcTc6O6%2FbGoMc%3D&reserved=0)  Cancer pathways are recorded in calendar days, not working days, with Day 0 being the day the referral is received.  Providers of local and specialist diagnostics (including staging) should be able to report on their wait times for request to test and test to report for all diagnostics. Trusts should be able to distinguish between active pathways, and post treatment follow up pathways where timely tests are essential, but not at the level required for patients suspected of a new cancer or recurrence.

## Reasonable offer guidance for patients on cancer pathways

The local definition of reasonable notice for patients on a cancer pathway is any appointment, test, treatment date offered with greater than 24 hours’ notice, and communicated directly with the patient (i.e. by telephone or booking the next attendance at an appointment). Patients may not wish to attend at very short notice. Patients’ right to choice must be observed.

Patient adjustments would be solely in line with CWT guidance, and should only be applied by Cancer Management teams.

* 1. Communication with patients on cancer pathways

Patients must be told they are being placed on a suspected cancer pathway at the point of referral, or when being upgraded. It is good practice to check their understanding / reiterate at their first appointment.

Patients should have their contact details updated / checked at each attendance to aid good communication. Were patient apps / portals exist and patients agree this as their preferred form of communication instead of by letter patients should be advised to check the portal daily.

It should be standard practice that all appointments are agreed with patients. This includes diagnostics and treatment bookings as well as appointments. The use of app / portal does not replace the requirement to agree appointments, and for this telephone / face to face booking of the next pathway step would be the primary methods unless explicitly requested otherwise by the patient.

Every effort should be made to agree appointments with patients. Where the CWT describes this as several / multiple times, locally through this access policy this is defined as 3 times, at least one of these must be after 6pm in the evening, and calls must not be from a withheld number.

3.3 Patient Cancellations/Missed Appointments

Patients may cancel appointments, fail to attend for appointments or make themselves unavailable. Patient pathways must be managed with the patients best interest in mind.

Where a patient does not attend (DNA’s) their first attendance (appointment or test) the clock MAY be re-started, in line with explicit CWT guidance if the appointment had been agreed with the patient. All initial DNAs, even when agreed MUST be rebooked.

If a patient misses (DNAs) their first appointment twice, and both have been agreed with the patient their case should be reviewed by a clinician to decide on the best course of action for the patient, this may mean referring back to the GP but, only when this is deemed to be in their best clinical interest.

Such decisions should be made by the responsible clinician on an individual patient basis. A provider will need to demonstrate that they have made every reasonable effort to communicate the appointments before discharging the patient. If a patient cannot be contacted at all by telephone, it should allow 7 days for a letter from the date posted, or 48 hours for messaging via a portal / app to be deemed ‘reasonable efforts to communicate. The referrer should be contacted to aid in reaching the patient.

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## Delays/Unavailability

Where patients repeatedly delay their diagnosis and treatment, and the responsible clinician believes it to be in the patients’ best clinical interest, then they may be discharged back to the care of their GP and taken off the 62-day pathway. This also applies when patients explicitly refuse all offers of diagnosis and/or treatment. Prior to such a decision, a Trust must be able to demonstrate that all appropriate steps have been followed, with contact from navigator / administrator, nurse and clinician to ensure the patient fully understands, with appropriate support if the patient requires support or does not have capacity.

If a provider receives a referral and the patient is unable to attend 4 reasonable appointments within 3 weeks, their referral will be sent for a clinical review to ensure there is no clinical detriment to the patient. The patient will be encouraged to accept an earlier appointment but if the patient refuses to accept an earlier date, then the appointment should still be booked, and the clock continues from the original referral date.