

Trust Policy
Cancer Access Policy
Key Points

- The timescales within which cancer patients are treated is a vital quality measure and key indicator of the quality of cancer services offered at the Trust.
- This policy is based on the current National Cancer Waiting Times Guidance (version 9.0) and is designed to clarify the local actions where the national guidance is not explicit but excludes details of clinically agreed protocols.
- This policy describes how the Trust manages and reports performance relating to cancer waiting times and applies to all Frimley Health NHS Foundation Trust staff involved in the management of patients within the cancer pathways
- Cancer Services Teams based at each site will ensure that accurate and complete data on the Trust's performance against the National Cancer Waiting Times is recorded and reported to the National Cancer Waiting Times Portal (NHS Digital) within predetermined timescales

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Document Location

Document Type	Location
Electronic	Trust Intranet ('our place')
Paper	On request from Department or Stakeholders

Related Documents

Document Type	Document Name
National	National Cancer Waiting Times Guidance (version 9.0)
National	Addendum to the National Cancer Waiting Times Monitoring Dataset Guidance v9.0
Local	Local Standard operating procedures within Cancer Services & Specialties
National	National Quality Surveillance Specification – cancer services (site specific cancer)

Local	Quality Surveillance MDT site specific operational policy, annual report & work plan
National	Site specific Improving Outcomes Guidance (IOG)
National	NHS constitution & Associated handbook
Local	Site specific clinical referral pro-forma's (available on GP portal)
National & local	Tertiary Breach reallocation policies – national and local Strategic Clinical Networks
Local	Frimley Health Cancer Waiting Times Tertiary Referral SOP

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1. INTRODUCTION

- 1.1 The timescales within which cancer patients are treated is vital and a key indicator of the quality of cancer services offered at the Trust.
- 1.2 The best interest of the patient should be at the forefront of patient management decisions. This is of particular importance for children and vulnerable adults¹.
- 1.3 Frimley Health NHS Foundation Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

2. SCOPE OF THE POLICY

- 2.1 This policy is applicable to patients referred with either a suspected cancer or pre-existing diagnosis of cancer.
- 2.2 Patients excluded from this policy are those with:
 - i. Non-invasive cancer, i.e., carcinoma in situ (with the exception of breast)
 - ii. Suspected basal cell carcinoma
 - iii. Any other exceptions as per the National Cancer Waiting GuidanceOr who
 - iv. Die before treatment can begin
 - v. Are receiving diagnostic and/ or treatment privately²
 - vi. Refuse all reasonable offers of diagnostics or treatments, or opt to be treated outside of the NHS.

3. DEFINITIONS

- 3.1 **Primary Care** – referring General Medical Practitioners, General Dental Practitioners & Optometrists.
- 3.2 **Receiving Organisation** – Frimley Health NHS Foundation and neighbouring NHS Trusts
- 3.3 **Multi-Disciplinary Team Coordinators (MDTCs)** – members of Cancer Services Teams responsible for the tracking, co-ordination and escalation of concerns about individual patient pathways in support of specialty Multidisciplinary teams.
- 3.4 **Multi-Disciplinary Teams (MDT)** – comprise medical and non-medical professionals responsible for the cancer patient's care. It includes clinicians from a variety of disciplines. The exact constituent is defined for each tumour site as part of National Quality Surveillance requirements.
- 3.5 **MDT Clinical Lead** – the designated clinical lead with site specific specialist knowledge of treating cancer within a site specialist MDT

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

² unless the patient chooses to be seen privately but is then referred for treatment under the NHS or the patient is seen under the 2 wk standard chooses to have diagnostic tests privately but returns to the NHS for further treatment.

- 3.6 **Lead Cancer Clinician** – the designated Trust lead for cancer
- 3.7 **National Cancer Waiting Times Portal (NHS Digital)** – Cancer Waiting Times dataset submission
- 3.8 **Somerset Cancer Register (SCR)** – Cancer Database
- 3.9 **Cancer** – Malignant disease resulting from uncontrolled division of cells
- 3.10 **Cancer Waiting Times** – Standards which monitor the length of time that patients with cancer or suspected cancer wait to be seen and treated in England.
- 3.10 **Performance** – Measured against pre-determined operational standards as defined on pages 7-8 of National Cancer Waiting Times Monitoring Dataset Guidance – Version 9.0 <http://systems.digital.nhs.uk/ssd/cancerwaiting/cwtguide9.pdf>
- 3.11 **PTL** – Priority Target List – This is a report which is generated via the Somerset Cancer Register and confirms which patients are being monitored against the operational standards.
- 3.12 **DNA (Did not attend)** – When a patient does not attend an arranged appointment

4. PURPOSE OF THE POLICY

- 4.1 This policy describes how the Trust manages and reports performance relating to cancer waiting times and applies to all Frimley Health NHS Foundation Trust staff involved in the management of patients within the cancer pathways.
- 4.2 It excludes details of clinically agreed protocols including follow up arrangements and timescales.
- 4.3 For patients, it will make sure that people:
 - i. suspected to have cancer and/or with a confirmed cancer diagnosis receive treatment in accordance with the cancer standards relevant to their cancer pathway and according to their choice
 - ii. are treated according to clinical priority and those with the same clinical priority are treated in chronological order
- 4.4 For clinician and non-clinicians it will make sure that:
 - i. teams and individuals are aware of their responsibilities for moving patients along the agreed clinical pathway including how this impacts on the patient experience and Trust performance against national cancer access targets
 - ii. clinical support departments develop and monitor performance against agreed maximum waiting times for tests/investigations in their department.
- 4.5 For Cancer Services Teams based at each site it will ensure that data on the Trust's performance against the National Cancer Waiting Times is accurately and completely recorded and reported to the National Cancer Waiting Times Portal (NHS Digital) within predetermined timescales

5. THE POLICY

5.1 National Guidance

5.1.1 This policy is based on the National Cancer Waiting Times Guidance (version 9.0) and is designed to clarify local policies where the national guidance is not explicit

<http://systems.hscic.gov.uk/ssd/cancerwaiting/cwtguide9.pdf>)

5.1.2 Tertiary Referral Breach Reallocation

The reallocation of tertiary referral breaches between referring and receiving tertiary Trust / Trusts will be managed in accordance with:

i. National Guidance

<https://www.england.nhs.uk/wp-content/uploads/2016/03/cancr-brch-allocatn-guid-2016.pdf>

ii. Locally agreed Network Guidance available via strategic clinical networks

5.2 Directory of Services

5.2.1 Frimley Health NHS Foundation Trust works in partnership with the South East Coast and Thames Valley Strategic Clinical Networks, each of which holds Directory of Services.

5.3 Local Variations

5.3.1 There is operational variation in terms of the structures and processes around the receipt and administration, including booking of cancer referrals.

5.3.2 Details of these are included in standard operating procedures which are not listed in this policy but should be referred to.

5.4 Referral on to a 62 day pathway (as per National Cancer Performance Monitoring)

5.4.1 Two Week Wait (as per National Cancer Performance Monitoring)

5.4.1.1 Contact should be made with the referrer immediately if the required referral information / submitted pro-forma is incomplete. Referrals made via the E-RS platform must have the clinical referral added within 24 hours of submission. In instances where clinical information is not received within 24 hours, the pathway clock will be adjusted to the date the information is received.

5.4.1.2 A 2 week wait referral can only be withdrawn or downgraded by the referrer where the referral meets the NICE guidance for suspected cancer (NG12).

5.4.1.3 For new appointments, a minimum of two offers must be made up to and including within 14 days. Patients who are unavailable for an appointment within 14 days of referral should be deferred by the referrer (as per National CWT guidance). When this is not possible the Trust will defer the clock start until the patient is available, up to a period of 28 days from referral (please see 5.4.1.8).

5.4.1.4 All offers must be documented on the Patient Administration System with comments as to the reasons for patient declining the appointment recorded.

- 5.4.1.5 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 or cancellations resulting in referral back to the referrer.
- 5.4.1.6 If a patient does not attend their first appointment a second appointment should automatically be made and sent by whoever records the DNA.
- 5.4.1.7 If an adult patient does not attend their second appointment (without prior notification to the Trust) the provider will refer the patient back to their GP with a letter from the responsible clinician.
- 5.4.1.8 If a patient has declined or not booked an appointment within 28 days of first being contacted the provider may refer the patient back to their GP via a letter from the responsible clinician. The MDTC will contact the responsible MDT lead to trigger this process.
- 5.4.1.9 Patients should be able to cancel and re-book their first appointment. If cancellation is made on the day, this is classified as a DNA. The same applies if a patient does not follow the preparation for investigation procedures such as flexi-sigmoidoscopy, gastroscopy, colonoscopy or CT pneumocolon within 24 hours of procedure.
- 5.4.1.10 Patients that attend for a procedure then decline or decide not to proceed, will be classified as DNA.
- 5.4.1.11 Patients who cancel their second appointment may be referred back to their GP but only if this has been agreed with the patient in discussion with the consultant responsible³.
- 5.4.1.12 In all cases, prior to the patient being removed from the cancer pathway the patient and referrer will be informed in writing. The consultant will write to the GP within 5 working days to inform them of the action so that the patient can be followed up if needed within primary care. The patient will also receive a copy of this letter.

5.4.2 Consultant Upgrades

- 5.4.2.1 Hospital specialists have the right to ensure that patients who are not referred urgently as suspected cancer referrals but who have symptoms or signs indicating a high suspicion of cancer are managed on a 62 day pathway.
- 5.4.2.2 Any patient that is not already on a 62 day pathway, i.e., referred from a GP/GDP as an urgent suspicion of cancer referral or with breast symptoms (i.e., 2 week wait referral) and who is not referred through the screening programmes may be upgraded onto a 62 day pathway by the receiving specialty. The 62 day target starts on the date the upgrade decision is made. The upgrade referral should be made in writing/via email to the Cancer Unit confirming the upgrade and speciality concerned.
- 5.4.2.3 The points in the pathway where a referral may be upgraded are:
- i. On receipt or triage of referral where this may meet Improving Outcomes Guidance IOG criteria for suspicion of cancer

³ See CWT 3.1.23

- ii. During or following initial visit where there is a suspicion of cancer
- iii. During or following diagnostic procedures where imaging or histology/cytology indicate or confirm the presence of cancer
- iv. On or before the MDT meeting date

5.4.2.4 Upgrade to the 62 day pathway must occur before the decision to treat date. Patients not upgraded by this point will be measured against the 31 day decision to treat to first definitive treatment.

5.4.2.5 The upgrade will only be applicable for patients that have a suspicion of a new cancer not those who may be suspected of a recurrence as these patients are monitored under the 31 day subsequent treatment pathway.

5.4.3 **Incidental Findings**

Incidental findings of cancer, either via an emergency attendance or pathological and radiological findings, will be referred to the appropriate MDT for tracking and management

5.5 **Diagnosis & Staging**

5.5.1 Support services including radiology and pathology are required to develop and monitor KPIs in line with national clinical and college guidance (details of which are not included in this policy).

5.5.2 MDT membership includes representation from radiology and pathology, who are integral to ensuring that results of investigations are available in support of delivering cancer performance.

5.5.3 MDT co-ordinators are required to record all details of investigations on the Somerset Cancer Register (SCR), including date of request, date performed and outcome. Any delays should be escalated to the relevant clinical team/operational management and cancer services management. Cancer pathway investigations are to be completed and reported within 7 days from referral for 90% of cases.

5.5.4 The GP should be notified of confirmed new diagnosis via secure fax / e-mail within 1 working day of the diagnosis being discussed with the patient. The GP will also receive a copy of the consultation letter in all cases as a safeguard.

5.6 **Decision to Treat**

5.6.1 For newly diagnosed cancers all patients should be treated within 31 days of the decision to treat date (DTT) irrespective of the treatment modality.

5.6.2 For incidental findings from surgical treatments the DTT and treatment will be recorded as the same day

5.7 **Treatment**

5.7.1 **First Definitive Treatment**

This is recorded as the first intervention intended to remove or shrink the tumour.

6. Duties /Organisational Structure

6.1 Primary Care

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

- i. Ensure that the patient meets the clinical criteria for a 2 week wait referral.
- ii. Ensure all relevant investigations and tests have been carried out, as specified on the referral pro-forma.
- iii. Ensure that the referral pro-forma is completed in full. If received incomplete the referral will be returned to the referrer.
- iv. Initiate the referral through the use of E-RS.
- v. Provide the national minimum core dataset when transferring care to another provider – as per tertiary referral policy (in process of development).
- vi. Respond quickly to queries raised by the receiving trust for more information.
- vii. Ensure the patient understands the urgent suspected cancer nature of the referral and the need for urgency and availability for investigations and appointments.
- viii. Provide relevant information in the form of the Trust Suspected Cancer Information Leaflet
- ix. Record that this information has been given to the patient and if not document the reason why this has not been possible. N.B. booking staff will assume that the patient has this understanding unless otherwise indicated⁴.
- x. Respond to patient concerns if they have become distressed following contact from the Trust offering an appointment on a suspected cancer pathway
- xi. Ensure the patient is eligible for NHS treatment.

6.1.2 If a patient cannot make themselves available for an appointment within two weeks, despite having been given appropriate information, it is technically possible for a GP (GMP, GDP or Optometrist) to defer making the referral until the patient is available for referral – a provider cannot refuse a referral however the GP should ensure that the patient is able and willing:

- i. to be seen within 2 weeks for first appointments
- ii. to be available for diagnostic tests and treatments within 62 days of referral

6.2 Patient Responsibilities

6.2.1 Patients also have a role to play as outlined in the NHS Constitution ⁵and the associated handbook⁶; these include:

- i. Attending their hospital appointment or ensuring that they contact the hospital to cancel it, giving as much notice as possible if they are unable to attend.
- ii. Managing their own health where possible
- iii. Use the part of the service appropriate for their needs
- iv. Be involved in the management of their treatment pathway
- v. Ensuring that they inform their healthcare provider of any changes in personal circumstances, particularly contact details and registered GP.

⁴ See CWT Guide 3.1.14.

⁵ <https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england>

⁶ <http://www.nhs.uk/choiceinthenhs/rightsandpledges/nhsconstitution/documents/2013/handbook-to-the-nhs-constitution.pdf>

Associated with this:

GPs have a responsibility for checking the patient's understanding of the suspected cancer nature of the referral and ensuring availability. (check box on site-specific referral proformas)

Clinical teams within the Trust also support patients in improving their understanding and compliance.

6.3 Receiving Organisation

6.3.1 Staff within the Trust have a responsibility to manage all cancer pathways to ensure that patients are treated within timescales that meet the cancer standards and in accordance with clinical priorities.

- i. Any problems or suspected / potential breaches must be escalated through the appropriate line management structure.
- ii. GPs will receive confirmation of receipt of referral

6.3.2 Clinicians and managers are accountable for

- i. Ensuring sufficient capacity to ensure patients are triaged, seen, diagnosed and, where needed, treated to meet demand and be compliant with waiting times targets
- ii. The implementation of effective monitoring systems with the clinical and diagnostic services to ensure compliance with national quality and access targets relevant to the clinical specialty
- iii. Avoidance of breaches of the targets.
- iv. Undertaking multidisciplinary root cause analysis of any breaches which do occur including the identification of actions agreed to mitigate future breaches.
- v. Implementing systems and processes that support audit, data quality. This includes validating data to ensure accurate reports are produced within agreed timescales.

6.3.3 Outpatient Booking and Reception staff and those staff designated to make outpatient appointments including for diagnostic tests and treatment

Staff are required to:

- i. Book all follow up appointments as per the relevant Cancer Standard, ensuring these meet clinical prioritisation and are within the expected stage of the specialty Cancer Pathway, i.e., does not exceed or risk compliance with the known breach date.
- ii. Ensure where possible that each patient leaves with the date of their next clinical or diagnostic appointment. If this is not possible, then contact should be made with the patient within 2 working days by phone with written appointment to follow
- iii. Escalate any concerns including a lack of capacity or patient delays to their relevant line manager

6.3.4 Medical Secretaries

- i. All clinical letters for diagnosed / suspected cancer patients to be typed and available within one working day. Any delays in being able to upload to ICE, e.g., clinician authorisation, must be escalated to the relevant specialty manager.

- ii. All appointment or treatment offers must be documented on the Patient Administration System with comments as to the reasons for patient declining any offers recorded.

6.3.5 Multi-Disciplinary Team Coordinators (MDTCs) - are responsible for:

- i. Tracking patients on the Patient Tracking List (PTL) and monitoring the PTL to identify where investigations are not being planned within the appropriate timescale
- ii. Escalating (as per the escalation policy) to the relevant individual when alternative action needs to be taken to ensure that the patient's pathway continues to match the required standard
- iii. Providing the administrative management and to provide support for the functioning of the individual MDT meetings. This includes ensuring that patients are discussed in a timely manner at the relevant tumour site MDT meeting
- iv. Ensuring that all the necessary clinical and non-clinical information is available to allow the patient to be discussed holistically
- v. Providing the administrative support so that there is accurate, accessible and timely recording of the treatment plan agreed by the MDT
- vi. Planning communicating and interacting with clinicians and operational managers regarding issues relating to the patient pathway
- vii. Ensuring that referrals/appointments and planning of treatment for patients on the cancer pathway have been booked, escalating as required to relevant clinical and management teams
- viii. Capturing mandatory data sets to ensure compliance with local and national audits and enable monthly updates for validation by clinical leads.

6.3.6 Multi-Disciplinary Teams - Support the delivery of cancer standards by:

- i. Bringing together designated cancer specialists to discuss patient care and agree a treatment plan for individual patients.
- ii. Making sure care is planned according to national guidelines and in line with local and network clinically agreed pathways. With monitoring of compliance as part of a clinical governance framework.
- iii. Identifying and supporting entry of patients into clinical trials.
- iv. Monitoring attendance at MDT meetings to not only ensure compliance with core member quoracy but also ensure relevant decisions are made to achieve both good practice and cancer pathway compliance.
- v. Supporting the collection of good quality data relevant to clinical care and service improvement
- vi. Reviewing its performance in terms of achieving safe and timely care in line with good practice and cancer pathways standards
- vii. Taking responsibility for changing pathways as required and identified as a result of audit, data collection and performance information.
- viii. Developing and maintaining documentation required to demonstrate compliance with relevant Quality Surveillance requirements, including Operational Policy, Annual Report and progression against work plans.
- ix. Early escalation of risks to performance and compliance with Cancer Standards to relevant divisional clinical and managerial leads and work with them to identify and implement agreed remedial measures.

6.3.7 MDT Clinical Lead -

Each tumour site will be led by a clinician who has site specific specialist knowledge of treating cancer. The clinical lead will:

- i. Ensure that the objectives of MDT working (as laid out in Manual of Cancer Services) are met.
- ii. Ensure the MDT operates in accordance with recognised guidelines (including guidelines for onward referrals) with appropriate information being collected to inform clinical decision making and to support clinical governance / audit.
- iii. Implement and monitor mechanisms to support entry of eligible patients into clinical trials, subject to patients giving fully informed consent.
- iv. Take overall responsibility for ensuring that MDT meeting and team meet National Quality Surveillance requirements.
- v. Monitor and ensure attendance levels of core members are maintained, in line with quality measures.
- vi. Ensure that a target of 100% of cancer patients discussed at the MDT is met and recorded.
- vii. Provide the link to network and other relevant speciality groups, either by attendance at meetings or by nominating another MDT member to attend.
- viii. Lead on, or nominate a lead for, service improvement.
- ix. Organise and chair quarterly business and an annual meeting, to examine the functioning of the team and review operational policies and collate any activities that are required to ensure optimal functioning of the team (for example training for team members).
- x. Ensure MDT's activities are audited and results documented.
- xi. Ensure that the outcomes of the meeting are clearly recorded and clinically validated and that appropriate data collection is supported.
- xii. Ensure target of communicating MDT outcomes to primary care is met.
- xiii. Ensure that Root Cause Analysis (RCA) is undertaken in the event of a breach with recommendations actioned and monitored. To include:
 - i. Completion of a serious harm review for patients breaching beyond 104 days on pathway
 - ii. Where requested, a review of the last ten patient breaches and near misses (defined as patients who came within 48 hours of breaching) with the development of an MDT Improvement plan where the specialty does not meet the current standards as defined in the Trust 8 point Cancer Recovery Plan.

6.3.8 The Trust Lead Cancer Clinician – and their deputies are responsible for:

- i. Ensuring high quality cancer services are delivered and effectively coordinated
- ii. Ensuring adequate clinical and non-clinical support
- iii. Supervising arrangements for audit and supporting delivery of uniform standards
- iv. Supporting the development and implementation of protocols and pathways to ensure an effective network of high standard care for cancer patients within the cancer standards
- v. Reviewing and monitoring of completed 104 day Serious Harm RCA's with MDT Clinical Leads

7 Tertiary Referral Breach Reallocation

- 7.1 The reallocation of tertiary referral breaches between referring and receiving tertiary Trust / Trusts will be managed in accordance with:
- i. National Guidance
<https://www.england.nhs.uk/wp-content/uploads/2016/03/cancr-brch-allocatn-guid-2016.pdf>
 - ii. Locally agreed Network Guidance available via strategic clinical networks

8. Raising Awareness / Implementation / Training

- 8.1 In line with NHS England Publications Gateway Reference: 03614
http://www.ruh.nhs.uk/about/trustboard/2015_07/documents/13.4.pdf
- 8.1.1 The Trust Board has a named Executive Director responsible for delivering the national cancer waiting time standards.
- 8.1.2 The Board receives 62 day cancer wait performance reports for each individual cancer tumour pathway, not an all pathway average.
- 8.1.3 The Trust maintains a valid cancer specific PTL and carries out a weekly review for all cancer tumour pathways, tracking patients and reviewing data for accuracy and performance to inform and support the development of and compliance against timed clinical pathways.
- 8.1.4 As requested by Trust Lead Cancer Clinician, root cause breach analysis is to be carried out for each pathway not meeting current standards, with a review of the last ten patient breaches and near misses (defined as patients who came within 48hours of breaching).
- 8.1.5 Capacity and demand analysis will be undertaken for key elements of the pathway not meeting the standard with improvement plans developed based on:
- i. Breach analysis
 - ii. Capacity and demand modelling,
 - iii. Timetabled recovery trajectory
- 8.2 Local operational policies provide a framework for the induction, training and day to day management within each of the two Cancer Services Teams (Frimley North – Heatherwood & Wexham Park and Frimley South – Frimley) These include the approach to auditing data quality and accuracy, to ensure MDT coordinators are effectively supported, and have sufficient dedicated capacity to fulfil the function effectively.

9. Monitoring Compliance of Policy

- 9.1 Compliance will be monitored and reported internally via the Trust Performance management framework and in accordance with National Cancer Waiting Times Guidance CWT Guidance reported externally through the Cancer Waiting Times Portal (NHS Digital).
<http://systems.hscic.gov.uk/ssd/cancerwaiting/cwtguide9.pdf>
- 9.2 Additional monitoring of compliance will be via the HWPH and FPH Cancer Unit Steering Group (CUSG) and Cancer Board Meetings held monthly and quarterly respectively

10 REFERENCES

- 10.1 Cancer Waiting Times a Guide (version 9.0) and is designed to clarify local policies where the national guidance is not explicit
<http://systems.hscic.gov.uk/ssd/cancerwaiting/cwtguide9.pdf>
- 10.2 NHS Constitution
<https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england>
- 10.3 NHS Constitution associated handbook
<http://www.nhs.uk/choiceinthenhs/rightsandpledges/nhsconstitution/documents/2013/handbook-to-the-nhs-constitution.pdf>
- 10.4 NHS England Publications Gateway Reference: 03614
http://www.ruh.nhs.uk/about/trustboard/2015_07/documents/13.4.pdf
- 10.5 Tertiary Breach Reallocation 2016
<https://www.england.nhs.uk/wp-content/uploads/2016/03/cancr-brch-allocatn-guid-2016.pdf>
- 10.6 NICE Guidance for Recognition and Referral of Suspected Cancer (NG12)
<https://www.nice.org.uk/guidance/ng12/chapter/1-Recommendations-organised-by-site-of-cancer>
- 10.7 Addendum to the National Cancer Waiting Times Monitoring Dataset Guidance v9.0
<https://digital.nhs.uk/services/systems-and-service-delivery/screening-services/cancer-waiting-times>