Vicki Graham
Cancer Services Co-ordinator
C/O Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

23 September 2022

Dear Madam,

Re: The Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust

Provision of a Section 21 Notice requiring the provision of evidence in the form of a written statement

I am writing to you in my capacity as Solicitor to the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust (the Urology Services Inquiry) which has been set up under the Inquiries Act 2005 ('the Act').

I enclose a copy of the Urology Services Inquiry's Terms of Reference for your information.

You will be aware that the Inquiry has commenced its investigations into the matters set out in its Terms of Reference. The Inquiry is continuing with the process of gathering all of the relevant documentation from relevant departments, organisations and individuals. In addition, the Inquiry has also now begun the process of requiring individuals who have been, or may have been, involved in the range of matters which come within the Inquiry's Terms of Reference to provide written evidence to the Inquiry panel.

The Urology Services Inquiry is now issuing to you a Statutory Notice (known as a Section 21 Notice) pursuant to its powers to compel the provision of evidence in the form of a written statement in relation to the matters falling within its Terms of Reference.

The Inquiry is aware that you have held posts relevant to the Inquiry's Terms of Reference. The Inquiry understands that you will have access to all of the relevant information required to provide the witness statement required now or at any stage

throughout the duration of this Inquiry. Should you consider that not to be the case, please advise us of that as soon as possible.

The Schedule to the enclosed Section 21 Notice provides full details as to the matters which should be covered in the written evidence which is required from you. As the text of the Section 21 Notice explains, you are required by law to comply with it.

Please bear in mind the fact that the witness statement required by the enclosed Notice is likely (in common with many other statements we will request) to be published by the Inquiry in due course. It should therefore ideally be written in a manner which is as accessible as possible in terms of public understanding.

You will note that certain questions raise issues regarding documentation. As you are aware the Trust has already responded to our earlier Section 21 Notice requesting documentation from the Trust as an organisation. However if you in your personal capacity hold any additional documentation which you consider is of relevance to our work and is not within the custody or power of the Trust and/or has not been provided to us to date, then we would ask that this is also provided with this response.

If it would assist you, I am happy to meet with you and/or the Trust's legal representative(s) to discuss what documents you have and whether they are covered by the Section 21 Notice.

You will also find attached to the Section 21 Notice a Guidance Note explaining the nature of a Section 21 Notice and the procedures that the Inquiry has adopted in relation to such a notice. In particular, you are asked to provide your evidence in the form of the template witness statement which is also enclosed with this correspondence. In addition, as referred to above, you will also find enclosed a copy of the Inquiry's Terms of Reference to assist you in understanding the scope of the Inquiry's work and therefore the ambit of the Section 21 Notice.

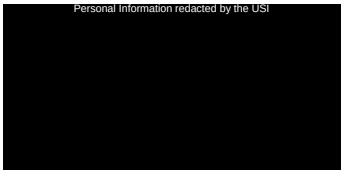
Given the tight time-frame within which the Inquiry must operate, the Chair of the Inquiry would be grateful if you would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance in the Notice itself.

If there is any difficulty in complying with this time limit you must make application to the Chair for an extension of time before the expiry of the time limit, and that application must provide full reasons in explanation of any difficulty.

Finally, I would be grateful if you could acknowledge receipt of this correspondence and the enclosed Notice by email to Personal Information redacted by the USI.

Please do not hesitate to contact me to discuss any matter arising.

Yours faithfully



Anne Donnelly
Solicitor to the Urology Services Inquiry

Tel: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

THE INDEPENDENT PUBLIC INQUIRY INTO
UROLOGY SERVICES IN THE
SOUTHERN HEALTH AND SOCIAL CARE TRUST

Chair's Notice

[No 80 of 2022]

Pursuant to Section 21(2) of the Inquiries Act 2005

WARNING

If, without reasonable excuse, you fail to comply with the requirements of this Notice you will be committing an offence under section 35 of the Inquiries Act 2005 and may be liable on conviction to a term of imprisonment and/or a fine.

Further, if you fail to comply with the requirements of this Notice, the Chair may certify the matter to the High Court of Justice in Northern Ireland under section 36 of the Inquiries Act 2005, where you may be held in contempt of court and may be imprisoned, fined or have your assets seized.

TO:

Vicki Graham
Cancer Services Co-ordinator
C/O Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.

2. The Notice requires you to do the acts set out in the body of the Notice.

3. You should read this Notice carefully and consult a solicitor as soon as possible about it.

4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.

5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by **noon on 21st October 2022.**

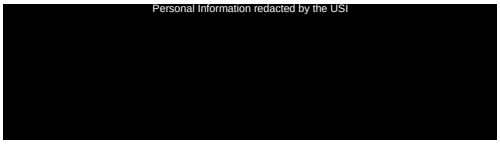
APPLICATION TO VARY OR REVOKE THE NOTICE

AND FURTHER TAKE NOTICE that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by **noon on 14th October 2022**.

Upon receipt of such a claim the Chair will then determine whether the Notice should be revoked or varied, including having regard to her obligations under section 21(5) of the Act, and you will be notified of her determination.

Dated this day 23rd September 2022

Signed: 

Christine Smith QC

Chair of Urology Services Inquiry

SCHEDULE
[No 80 of 2022]

SECTION 1 – GENERAL NARRATIVE

General

1. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with or by you, meetings you attended, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"). Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. Place any documents referred to in the body of your response as separate appendices set out in the order referred to in your answers. If you are in any doubt about document provision, please do not hesitate to contact the Trust's Solicitor, or in the alternative, the Inquiry Solicitor.

3. Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed and, as far as possible, to address your answers in a chronological format.

If there are questions that you do not know the answer to, or if you believe that someone else is better placed to answer a question, please explain and provide the name and role of that other person.

Your role

4. Please set out all roles held by you within the Southern Trust, including dates and a brief outline of duties and responsibilities in each post.

5. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for.

6. If your current role involves managing staff, please set out how you carry out this role, e.g. meetings, oral/written reports, assessments, appraisals, etc.

7. What systems were and are in place during your tenure to assure you that appropriate standards were being met by you and maintained by you in fulfilling your role?

8. Was your role subject to a performance review or appraisal? If so, please explain how and by whom this was carried out and provide any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

9. Where not covered by question 8 above, please set out any relevant policy and guidelines, both internal and external as applicable, governing your role. How, if at all, are you made aware of any updates on policy and guidance relevant to you?

10. What performance indicators, if any, are used to measure performance for your role?

11. How do you assure yourself that you adhere to the appropriate standards for your role? What systems were in place to assure you that appropriate standards were being met and maintained?

12. Have you experience of these systems being by-passed, whether by yourself or others? If yes, please explain in full, most particularly with reference to urology services.

13. What systems of governance do you use in fulfilling your role?

14. Have you been offered any support for quality improvement initiatives during your tenure? If yes, please explain and provide any supporting documentation.

15. During your tenure, who did you understand was responsible for overseeing the quality of services in urology?

16. In your experience, who oversaw the clinical governance arrangements of urology and, how was this done?

17. Did you feel able to provide the requisite service and support to urology services which your role required? If not, why not? Did you ever bring this to the attention of management and, if so, what, if anything, was done? What, if any, impact do you consider your inability to properly fulfill your role within urology had on patient care, governance or risk?

18. Did you feel supported by staff within urology in carrying out your role? Please explain your answer in full.

Urology services

19. Please explain those aspects of your role and responsibilities which are relevant to the operation, governance or clinical aspects of urology services.

20. With whom do you liaise directly about all aspects of your job relevant to urology? Do you have formal meetings? If so, please describe their frequency, attendance, how any agenda is decided and how the meetings are recorded. Please provide the minutes as appropriate. If meetings are informal, please provide examples.

21. In what way is your role relevant to the operational, clinical and/or governance aspects of urology services? How are these roles and responsibilities carried out on a day to day basis (or otherwise)?

22. What is your overall view of the efficiency and effectiveness of governance processes and procedures within urology as relevant to your role?

23. Through your role, did you inform or engage with performance metrics or have any other patient or system data input within urology? How did those systems help identify concerns, if at all?

24. Do you have any specific responsibility or input into any of the following areas within urology? If yes, please explain your role within that topic in full, including naming all others with whom you engaged:

    (i) Waiting times
    (ii) Triage/GP referral letters
    (iii) Letter and note dictation
    (iv) Patient care scheduling/Booking
    (v) Prescription of drugs

(vi) Administration of drugs
(vii) Private patient booking
(viii) Multi-disciplinary meetings (MDMs)/Attendance at MDMs
(ix) Following up on results/sign off of results
(x) Onward referral of patients for further care and treatment
(xi) Storage and management of health records
(xii) Operation of the Patient Administrative System (PAS)
(xiii) Staffing
(xiv) Clinical Nurse Specialists
(xv) Cancer Nurse Specialists
(xvi) Palliative Care Nurses
(xvii) Patient complaints/queries

Concerns

25. Please set out the procedure which you were expected to follow should you have a concern about an issue relevant to patient care and safety and governance.

26. Did you have any concerns arising from any of the issues set out at para 24, (i) – (xvii) above, *or any other matter* regarding urology services? If yes, please set out in full the nature of the concern, who, if anyone, you spoke to about it and what, if anything, happened next. You should include details of all meetings, contacts and outcomes. Was the concern resolved to your satisfaction? Please explain in full.

27. Did you have concerns regarding the practice of any practitioner in urology? If so, did you speak to anyone and what was the outcome? Please explain your answer in full, providing documentation as relevant. If you were aware of concerns but did not report them, please explain why not.

28. If you did have concerns regarding the practice of any practitioner in urology, what, in your view was the impact of the issue giving rise to concern on the provision, management and governance of urology services?

29. What steps were taken by you or others (if any) to risk assess the potential impact of the concerns once known?

30. Did you consider that the concern(s) raised presented a risk to patient safety and clinical care? If yes, please explain by reference to particular incidents/examples. Was the risk mitigated in any way?

31. Was it your experience that once concerns were raised, systems of oversight and monitoring were put in place? If yes, please explain in full.

32. In your experience, if concerns are raised by you or others, how, if at all, are the outcomes of any investigation relayed to staff to inform practice?

33. Did you have any concerns that governance, clinical care or issues around risk were not being identified, addressed and escalated as necessary within urology?

34. How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such Governance meeting minutes or notes, or in the Risk Register, whether at Departmental level or otherwise? Please provide any documents referred to.

35. What could improve the ways in which concerns are dealt with to enhance patient safety and experience and increase your effectiveness in carrying out your role?

Staff

36. As relevant, what was your view of the working relationships between urology staff and other Trust staff? Do you consider you had a good working relationship with those with whom you interacted within urology? If you had any concerns regarding staff relationships, did you speak to anyone and, if so, what was done?

37. In your experience, did medical (clinical) managers and non-medical (operational) managers in urology work well together? Whether your answer is yes or no, please explain with examples.

Learning

38. Are you now aware of governance concerns arising out of the provision of urology services which you were not previously aware of? Identify any governance concerns which fall into this category and state whether you could and should have been made aware of the issues at the time they arose and why.

39. Having had the opportunity to reflect on these governance concerns arising out of the provision of urology services, do you have an explanation as to what went wrong within urology services and why?

40. What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and, to the extent that you are aware, the concerns involving Mr. O'Brien in particular?

41. Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. Your answer may, for example, refer to an individual, a group or a particular level of staffing, or a particular discipline.

If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

42. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?

43. Do you think, overall, the governance arrangements were and are fit for purpose? Did you have concerns specifically about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?

44. If not specifically asked in this Notice, please provide any other information or views on the issues raised in this Notice. Alternatively, please take this opportunity to state anything you consider relevant to the Inquiry's Terms of Reference and which you consider may assist the Inquiry.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

UROLOGY SERVICES INQUIRY

Note: An addendum to this statement was received by the Inquiry on 5 May 2023 and can be found at WIT-94667 to WIT-94678. Annotated by the Urology Services Inquiry.

USI Ref: Section 21 Notice No. 80 of 2022

Date of Notice: 23 September 2022

Witness Statement of: Vicki Graham

I, Vicki Graham, will say as follows: -

SECTION 1 – GENERAL NARRATIVE

General

1. **Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with or by you, meetings you attended, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.**

1.1 My first role was as a Cancer Tracker MDT Co-Ordinator from 18.02.2009 – 05.10.2014. My main duties were to proactively track the progress of suspected cancer patients along their pathway from the point of referral to diagnosis and first treatment. I was responsible for the co-ordination of weekly MDT's (Multi-Disciplinary Team Meetings or MDMs as we referred to them). When I commenced this role, and from my recollection my first tumour site to track (suspect/confirmed) was Gynaecology (April 09 – August 09), followed by Lung (July 09 – Sept 09) and Haematology (July

09 – Sept 09). I also helped cover Head and Neck during these months, as I was training and covering/shadowing sites alongside other trackers. I started work on the Urology Tumour site in October 2009 until October14, when I went on secondment as Cancer Services Co-ordinator. During my time as Urology Cancer, I also helped to cover other tumour sites by tracking, prepping the MDTs, due to periods of annual leave or sick leave. It was my understanding that it was the intention of the Operational Support Lead, Wendy Clayton/Sharon Glenny and Cancer Services Co-ordinator, Angela Muldrew that all of the Cancer Trackers/MDT Co-ordinators were trained across multiple tumour sites at a time to allow for cross cover due to annual leave or absences due to sick leave. My role included attending these MDMs and recording relevant information such as the attendance list, taking brief notes of the topics discussed or any issues raised prior to the commencement of the meeting. I also recorded the management plan for each patient discussed at the MDM, which was to facilitate the timely provision of care for patients. I cannot recall raising any issues during my time in this role, other than those that I have referred to in my answer to Question 17 below, wherein I have referred to increased workload and pressure, and the tracking of patients not being able to be kept up to date. I cannot honestly recall raising a concern.

1.2 During my time as a Cancer Services Co-Ordinator Band 5 from 06.10.2014 to 09.08.2022 my main duties included supporting the Head of Services and OSL (Operational Support Leads), the performance management and commissioning functions within Cancer, the management of the Service and Budget Agreement (SBA) within Cancer Services and the management of the administrative staff within Cancer Services. I cannot recall raising any concerns while in this role as mentioned in the Terms of Reference.

1.3 I had left Cancer Service when the “lookback review” of patients took place so I am not aware of what this involved.

2. **Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"). Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. Place any documents referred to in the body of your response as separate appendices set out in the order referred to in your answers. If you are in any doubt about document provision, please do not hesitate to contact the Trust's Solicitor, or in the alternative, the Inquiry Solicitor.**

2.1 All relevant documents referenced in this statement can be located at S21 80 of 2022 – Attachments. Please see:

1. 20151412 Document 1 Cancer Performance Paper Nov 15

2. 20181609 Document 2 Downgraded from RF Report

3. 20112111 Document 3 Escalation Policy May 2011

4. 20112111 Document 3A (E) Escalation Policy May 2011 from AM

5. 20191209 Document 3B Cancer Pathway Escalation Policy Final August

6. 20191209 Document 3C (E) Escalation Policy 2019 sent to Trackers

7. 20162406 Document 4 KSF 2016

8. 20190602 Document 4A KSF Example sent to SMV

9. 20162001 Document 4B (E) List of outstanding KSF 2016 from WC

10. 20190602 Document 4C (E) KSF Example sent to SMV

11. 20153112 Document 4D List of outstanding KSF 2016 from HR

12. 20183101 Document 5 (E) Email re Bladder Cancer Guidance sent to Mr Haynes

13. 20183101 Document 5A Proposed Bladder Cancer Guidance Dec 2017

14. 20190208 Document 6 (E) Cancer Operational Meeting Tracking Change

15. 20191801 Document 6A (E) Cancer Operational Meeting Urgent Tracking Change – Sent to SG

16. 20140702 Document 7 ITT Protocol 2014

17. 20151204 Document 8 Tumour Specific Cancer Waiting Times Technical Guidance

18. 20142005 Document 8A (E) Review of Cancer Waiting Times Guidance

19. 20080201 Document 8B A Guide to Cancer Waiting Times January 2008

21. 20181609 Document 9 BSO Southern Trust Referrals Report with Practice Code

22. 20172108 Document 10 (E) DATIX Missed Referral General Surgery

23. 2190502 Document 10A (E) DATIX Late upgrade at triage OC Referral

24. 20190410 Document 10B (E) DATIX Delay with Review with Mr O'Brien

25. 20190509 Document 10C (E) DATIX Delay with referral to Belfast- Mr O'Brien

26. 20190110 Document 10D (E) DATIX Delay with referral to Belfast Mr O'Brien

27. 20190908 Document 10E (E) DATIX Delay with referral to Belfast Mr O'Brien

28. 20190509 Document 10F (E) DATIX Delay with referral to Belfast Mr O'Brien

29. 20190410 Document 11 (E) Alert to HoS & AD re tracking Cancer PTLs 31D & D85+

30. 20190410 Document 11A (E) Alert to Hos & AD re tracking Cancer PTLs 31D & D85+

31. 20190410 Document 11B (E) Alert to HoS & AD re tracking Cancer PTLs 31D & D85+

32. 20172509 Document 11C Tracking update sent to FR & SC

33. 20190407 Document 11D (E) Tracking update sent to SG

34. 20190407 Document 11F (E) Tracking escalation sent to SG

35. 20162801 Document 11G (E) Tracking update UGI & LGI sent to WC & AM

36. 20160102 Document 11H (E) Tracking update response from OSL (AM)

37. 20120908 Document 12 Urology MDM SOP August 2012

38. 20161118 Document 12A (E) Breast SOP SG

39. 20150505 Document 12B Tracking Gynae SOP 2015

40. 20161202 Document 12C Draft Urology SOP – MDM Administrative Process

41. 20162209 Document 14 (E) 1-1 with SG

42. 20160306 Document 15A (E) Workload Concerns sent to SG &AM

43. 20160510 Document 16 (E) Commencing work on updating SOPs

44. 20191801 Document 17 (E) Failsafe to ensure patients re-listed for MDM Discussion

45. 20191801 Document 17A Failsafe to ensure patients re-listed for MDM Discussion

46. 20172301 Document 18 (E) Escalation to HoS (MC) re breaching

47. 20152412 Document 18A (E) Escalation from HoS (MC) re risk of breaching

48. 20180803 Document 18B (E) Escalation response from Consultant (JOD) re risk of breaching

49. 20190609 Document 18C (E) Escalation responses from HoS (AN)

50. 20180902 Document 19 (E) Meeting with FR & SG

51. 20142305 Document 20 (E) Oncology Referral

52. 20152704 Document 21 Notes Meeting with RF Appointment Staff Monday 27Th April 2015

53. 20162303 Document 21A Notes Meeting with Trackers 23.03.16

54. 20120204 Document 21B Notes Meeting with Trackers 02.04.12

55. 20162704 Document 22 (E) Admin Managers Meeting Sent from WC

60. 20161902 Document 22A (E) Notes Admin Managers Meeting Sent from WC

61. 20140810 Document 23 Urology Tracking Tips for MDM 08.10.14

62. 20162801 Document 23 (E) Overtime for Tracking

63. 20140910 Document 24 Red Flag Pathway Process Urology

64. 20190309 Document 24 (E) Concerns re Tracking sent to SG

65. 20151805 Document 26 (E) Cancer Services SOP List WC

66. 20151805 Document 27 Cancer Services SOP List

67. 20120911 Document 28 Urology MDM SOP August 2012

3. **Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed and, as far as possible, to address your answers in a chronological format.**

   If there are questions that you do not know the answer to, or if you believe that someone else is better placed to answer a question, please explain and provide the name and role of that other person.

Your role

4. **Please set out all roles held by you within the Southern Trust, including dates and a brief outline of duties and responsibilities in each post.**

Job Title: Cancer Tracker MDT Co-ordinator Band 4 (Period 18.02.2009 – 05.10.2014)

4.1 The main duties and responsibilities were as listed below:

a) To proactively track the progress of suspected cancer patients along their pathway from the point of referral to diagnosis and first treatment.

b) Responsibility for the co-ordination of weekly MDTs (Multi-Disciplinary Team Meetings), relating to the tumour site I was tracking at that particular time. The tumour sites tracked in the Southern Trust are Gynaecology, Dermatology, Haematology, Breast Urology, Upper GI, Colorectal, Head, Neck, and Lung.

c) My role included attending the meeting for the Tumour site that I was tracking at the time and recording relevant information i.e. attendance record, brief notes of meeting and of any other discussions that took place and making a record of the management plan for each patient discussed to help facilitate the timely provision of care for patients.

d) To collect information relevant to each patient's clinical history from various systems i.e. NIPACS (Radiology System), NIECR (Northern Ireland Electronic Care Record), PAS (Patient Administration System) and to record this information into the CaPPs system (Cancer and Patient Pathway System) so that all relevant, and up to date information was available for discussion at the MDT.

Job Title: Cancer Services Co-Ordinator Band 5 (Period 06.10.2014 – 09.08.2020)

4.2 The main duties and responsibilities were as listed below:

a) To support the Head of Services and OSL. (Operational Support Leads)

b) The performance management and commissioning functions within Cancer Services. This involved me running regular PTLs (Primary Target Lists) for those patients who were to be seen in clinic under 9 weeks for Haematology and Palliative Care. If any patient was outside of this timeframe, I would have endeavoured to get the patient(s) rebooked to a different clinic, or if needed due to the volume of patients checked with the Head of Cancer Services to see if there was any funding available to run an extra clinic to facilitate these patients.

c) The management of the Service and Budget Agreement (SBA) within Cancer Services. This involved me keeping regular checks on the waiting lists for Haematology and Palliative Care to ensure no patient was going to breach the 9-week target. If any patient was getting close to the 9-week target, I tried to make all the necessary arrangements to try to facilitate them being seen on target. I also monitored clinic activity to check that what was agreed and commissioned in the Service and Budget Agreement (SBA) was being performed, and that there was no additional activity taking place.

d) The management of the administrative staff within Cancer Services. This included new staff inductions, three and six month probationary period reviews, ensuring that all of their mandatory training was up to date, carrying out annual KSFs (Knowledge and Skills Framework) and being a good support to all staff. My role also ensured that there was sufficient cover for each area, during times of annual leave, or set times i.e. Easter and Summer Holidays and Christmas. I kept all of the rotas up to date, including seating rotas. I would have reviewed departmental SOPs

(Standard Operating Procedures), which would have included me reading over the documents, checking with the relevant teams or staff members to ensure that all the steps included in the document were up to date, or if anything new needed to be added or removed. Once I was happy that the SOP was accurate and up to date I would have forwarded this onto my Line manager, Sharon Glenny for review, prior to circulation to staff members. This would also have applied to Urology. I was also a support mechanism for all staff members and if they were having any problems in work or their home life, ensuring I was supportive and understanding. I kept all annual leave records up to date for each staff member.

Job Title: Performance Officer Band 5 (Period 10.08.2020 – 31.07.2022)

4.3 The main duties and responsibilities were as listed below:

a) To support the Head of Performance, Lynn Lappin, in the management of the Performance Improvement Trajectories (PITs). An example of this would be Service Delivery. I linked in with each service area for each quarter, by sending out a template of what activity they were projecting (for new, review, virtual appointments) and then I would have updated their response onto a very detailed spreadsheet, capturing all of this information across all of the directorates/divisions. Once all projections were received, and if I noticed a variance in what they projected, against what they delivered I would have liaised with the relevant service area to get the narrative behind the variance i.e. staffing levels, accommodation issues etc. I would have used reports from the Trust SharePoint, uploaded by the Acute Information team. The findings and current position for Service Delivery was then reported by the Head of Performance, Lynn Lappin, to SPPG (Strategic Planning and Performance Group, previously HSCB).

b) I also acted on behalf of the Trust to support Operational Teams in the management of the PITs including analysis, interpretation and action planning to support achievement of the projected levels of performance.

Job Title: Contracts Officer Band 6 (Period 01.08.2022 – Present)

4.4 The main duties and responsibilities are as listed below:

a) The provision of best practice advice and guidance on contract management processes and procedures in line with both legislative and regional/local policy. This may also include the sourcing of specialist legal and procurement advice.

b) Managing relationships with a range of both internal and external stakeholders crucial to the contracting process e.g. Independent Sector Providers (ISP) DLS (Directorate of Legal Services), Pals (Procurement and Logistics Service).

c) To provide contract management activities in line with best practice guidance, proportionate to the value, risk and complexity identified within the contract and with the aim of achieving continuous improvement throughout the lifecycle of the contract.

d) To support the upstream contract management activities associated with planning/preparation for the contract award e.g. the development of business cases/assessments, service specifications, governance/quality assurance checks aligned to contractual awards, including for example review of indemnity, pharmaceutical assurances, environmental and qualifications/skill information, as applicable.

e) Responsible for developing and maintaining the contract documentation for the downstream contract activities over the lifecycle of the contract i.e. from contract award to contract end/contract termination e.g. copy of

contract, records of contract meetings, contract modifications and performance management documentation.

f) To ensure that key contract data is maintained in line with Trust contract minimum dataset requirements, with contract triggers identified, reviewed and responded to promptly as appropriate e.g. annual reviews and contract extensions.

g) To ensure that the necessary contract modifications are taken forward in line with the contract and agreements reached, evidencing a clear audit trail of decisions made/advice given e.g. benchmarking, contract variations, novations, contract extensions etc.

5. **Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for.**

5.1 During my time as a Cancer Tracker MDT Co-ordinator, Band 4 (Feb 09 – Oct 14) my direct line manager was Angela Muldrew, Cancer Services Co-ordinator. If Angela was unavailable I would have made contact with Wendy Clayton (Operational Support Lead) or Sharon Glenny (Operational Support Lead). I had no staff management while in this role.

5.2 During my time as Cancer Services Co-Ordinator, Band 5 (Oct 14 – August 20), my direct line manager was initially Wendy Clayton, Operational Support Lead (Oct 14 – April 16) and then Sharon Glenny, Operational Support Lead, as there was a change in which OSL covered what area i.e. IMWH (Integrated Maternity and Women's Health & Cancer Services, Medicine and Unscheduled Care and ATICs (Anaesthetics, Theatres and Intensive Care. If Sharon Glenny were unavailable, I would have either

reported to Angela Muldrew, RISOH Implementation Officer, or Fiona Reddick, Head of Cancer Services.

5.3 During my role as Cancer Services Co-Ordinator I was responsible for the staff members listed at 5.7 below and I have set out where they worked within Cancer Services. My responsibilities for all the staff members were to ensure that all areas were always staffed, to ensure that staff were adequately trained to carry out their daily duties, working out rotas etc. and to ensure that there was always enough cover to meet the needs of the service. I also ensured that all mandatory training (Corporate Induction (Once), Department Induction (Once), Fire Safety (Annually), Information Governance (every 3 years), Moving and Handling (every 3 years), Infection Prevention Control (every 2 years), was completed, and within the timeframe of the Mandatory Training schedule as stated in brackets. If any training was outstanding, I would have emailed the relevant staff members to advise them that this needed to be completed with an expected date of completion.

5.4 For new permanent staff members I would have completed their three and six month probationary review to discuss their progress, any areas of concern, and if an extension was needed, prior to confirming their permanent post.

5.5 I was responsible for the completion of the annual KSFs (Knowledge & Skills Framework) which is a useful tool to identify the knowledge, skills and learning and development to allow staff to do their job well. I admit that due to pressures within the service across most of the teams that these KSFs did not always happen when they were due, and unfortunately could have been a year behind. *Please see:*

8. 20190602 Document 4A KSF Example sent to SMV

10. 20190602 Document 4C (E) KSF Example sent to SMV

5.6 I would have held staff meetings. The staff meetings were scheduled, with no set frequency, or on an ad-hoc basis. I had an “open door” policy for all staff members, if they felt they needed to talk to me on a 1-1 basis. *Please see:*

52. 20152704 Document 21 Notes Meeting with RF Appointment Staff Monday 27Th April 2015

53. 20162303 Document 21A Notes Meeting with Trackers 23.03.16

54. 20120204 Document 21B Notes Meeting with Trackers 02.04.12

5.7 Staff members whom I had management responsibility for: -

a. Palliative Care Team, Alwyn Summerville, Band 4
b. Palliative Care Team, Rosemary Harland, Band 3
c. Mandeville Reception, Carol Glass, Band 3
d. Mandeville Reception, Michelle McCartney, Band 3
e. Mandeville Back Office, Beulah McArdle, Band 2
f. Mandeville Back Office, Joan McDermott, Band 2
g. Mandeville Back Office, Ryan Murphy, Band 2
h. Mandeville Back Office, Ronan McConaghy, Band 2
i. Breast Care Nurse Admin Support, Tracy McArdle, Band 3
j. Stoma Nurse Admin Support, Cheryl Bleakney, Band 3

5.8 For the Cancer Trackers, while there are tumour sites listed beside their names, this was their main site to track/co-ordinate MDMs, attend MDMs and complete after work. All trackers also helped to track other tumour sites if they had capacity and if there was sick leave or annual leave in the team.

a. Cancer Tracker, Marie Dabbous, Band 4 (Head & Neck, Urology, Haematology, Others, Sarcoma
b. Cancer Tracker, Wendy Kelly, Band 4 (Gynae, Haematology, Upper GI)
c. Cancer Tracker, Shauna McVeigh, (Urology) Band 4
d. Cancer Tracker, Hilda Shannon, Band 4 (Upper GI & Colorectal)
e. Cancer Tracker, Rachel McCartney, Band 4 (Breast)
f. Cancer Tracker, Ann Turkington, Band 4 (Lung)
g. Cancer Tracker, Griania White, Band 4 (Dermatology)
h. Cancer Tracker, Sinead Lee, Band 4 (Haematology, Colorectal)
i. Cancer Tracker, Sarah Moore, Band 4 (Covered all tumour sites - floating tracker to help add patients on for discussion, or cover MDMs in time of annual leave/sick leave.
j. Cancer Tracker, Catherine Glenny, Band 4 (Breast)
k. Admin Support to Cancer Tracker, Sarah McDonald, Band 2
l. Admin Support to Cancer Tracker, Andrew Overend, Band 2
m. Red Flag Appointment Team, Laura Berry, Band 3
n. Red Flag Appointment Team, Sharon McCann, Band 3
o. Red Flag Appointment Team, Ann Johnston, Band 3
p. Red Flag Appointment Team, Carol Ritchie, Band 3
q. Red Flag Appointment Team, Joseph McCaffrey, Band 3

r. Macmillan Admin Support, Stacy Leathem, Band 3
s. Macmillan Admin Support, Emma Hughes, Band 3
t. Orthoptics, Patricia Furphy, Band 3
u. Orthoptics, Danielle McConville, Band 3
v. Bowel Screening Admin Support, Marie Evans, Band 3

5.8 During my time as Performance Officer Band 5, (Period 10.08.2020–31.07.2022) my direct line manager was Julie Brodison, Band 7, and Performance Manager. If Julie were unavailable, I would have liaised with Elaine Murphy, Band 7, Performance Manager or Lynn Lappin, Band 8B, Head of Performance. I had no staff management while in this role.

5.9 Since I commenced my role as Contracts Officer, Band 6, my direct Line Manager is Pamela McCartney, Acute Contracts Manager. I have no staff management in this role.

6. **If your current role involves managing staff, please set out how you carry out this role, e.g. meetings, oral/written reports, assessments, appraisals, etc.**

6.1 In my current role as Contracts Officer (Band 6) I do not have any staff management.

7. **What systems were and are in place during your tenure to assure you that appropriate standards were being met by you and maintained by you in fulfilling your role?**

7.1 For the role of Cancer Tracker/MDT Co-ordinator (Band 4) as this was a permanent position, I was subject to a three and six-month probationary period. I met with Angela Muldrew (Cancer Services Co-ordinator) at three months, and then at six months to discuss my progress, training to date and any issues that had arisen. Thankfully, there were no issues and my permanent appointment was confirmed at my six-month review. I also had annual KSF's (Knowledge and Skills Framework), which took place as a group which all of the Cancer Trackers/MDT Co-ordinators attended together. The format of these was to say how we felt we all had performed over the last year. My objectives for the next year were listed, with examples being to continue to develop within my role and to gain as much experience while in my role and to keep my mandatory training up to date. Angela Muldrew would then have filled in her comments in relation to how she found my work. Angela Muldrew would also have checked that mandatory training was up to date, and if not a date for completion would have been agreed. We also had regular staff meetings. Angela Muldrew, Cancer Services Co-Ordinator, would have held these meetings either ad-hocly if something had changed or needed to change following advice from Wendy Clayton/ Sharon

Glenny, OSL (Operational Support Lead) to ensure that we were all aware of a change in practice. This guidance could also have come following Angela Muldrew's attendance at a Regional Cancer Operational Meeting at which all of the Trusts had collectively decided to change a process.

7.2 For the role of Cancer Services Co-ordinator (Band 5) I was seconded to this post for 1 year initially following an EOI (Expression of Interest) and successful interview. Angela Muldrew (RISOH implementation Officer- Band 6) oversaw my first KSF in this role from my recollection, and then Wendy Clayton/Sharon Glenny (Operational Support Lead Band 7) took over this responsibility, but I cannot recall if these always took place and if annually. I have checked with the Employee Engagement Department if they kept a record of my dates but unfortunately, they do not have a record. Due to the pressures within Cancer Services KSFs did not always happen as planned for me, as well as my staff members. In the absence of the KSFs staff members were emailed out to ensure that all mandatory e-learning and training was up to date, and if not, we had a timeline for when it had to be completed. *Please see:*

7. 20162406 Document 4 KSF 2016

7.4 I would also have met with my direct Line Manager, Wendy Clayton/Sharon Glenny (Operational Support Lead Band 7) in the form of a 1-1. These meetings were scheduled in our diary in Outlook Calendar on a weekly basis for 30 minutes, but these did not always take place if there were competing pressures in other areas, and if so, the meeting would have been cancelled. The 1-1 meetings gave me the chance to discuss all the areas for which I had management responsibility. During the 1-1 meetings, I would have discussed any issues or concerns with examples being (a) staffing levels in a certain area due to sick/annual leave and if there was enough cover to keep the service going, and if not, who could we take from another area to cover, and if they were trained.(b) Individual staff problems, which could have been anything from sickness records, family stresses, sick children or childcare arrangements, work like balance requests and requests

for a reduction in working hours, and how staff were performing and if there were any issues how was I addressing this, such as frequency for meeting with the staff members to discuss areas of concern, what the expectation was, checking if they feel they need more training in a certain area and a review plan. I always like staff to feel supported and that they could come to me if there was something that they were unhappy with and I would try my best to resolve, or try improving things. The 1-1meeting were not documented. Following discussion, if needed I linked in with Human Resources to ensure that I was providing the correct information to staff member (s) and took advice on how to best manage a particular situation. (c) How individual areas were performing, and if they were behind, how behind and what was the reason for this and what my solution was to try resolve this. I found these meetings reassuring as Wendy Clayton/Sharon Glenny would have provided feedback of how I handled each situation, and if there was anything I could have done differently, which was learning for me on how to manage each particular situation. I also used these meetings to say how I felt I was getting on and to identify if I was having difficulty in any areas that I was maybe struggling with. There were no notes kept of these 1-1 meetings. *Please see:*

41. 20162209 Document 14 (E) 1-1 with SG

7.5 Wendy Clayton/Sharon Glenny, Operational Support Lead Band 7, would also have had staff meetings for all of her Band 5 Admin staff. I cannot recall the frequency of these meetings but maybe two to three times a year. If there were other pressures in the service that needed urgent attention like a report that had to be completed for the Assistant Director (Ronan Carroll/Barry Conway), extra clinics to be set up, clinics to be covered by Consultant etc. the meetings could have been cancelled. These meetings gave us the opportunity to discuss any issues within our own areas, like staffing levels, vacancies, current pressures areas etc. Wendy Clayton/Sharon Glenny would have provided us with an update on Performance and Access Targets and what we needed to do across each

area. Wendy Clayton/Sharon Glenny would have provided an update on Finance/Budgets to keep us up to date. We would have discussed as a group if there were any operational issues, with an example being if the Standard Operating Procedures were being reviewed/updated. This was also a good forum for us to openly discuss things that had happened, with an example being staffing issues, and how they addressed it, what policy they used or did they need to speak to anyone to advise them, and if so who did they speak to. The individual staff member would have remained anonymous at all times but we could all learn and apply to our own areas if needed. *Please see:*

55. 20162704 Document 22 (E) Admin Managers Meeting Sent from WC

60. 20161902 Document 22A (E) Notes Admin Managers Meeting Sent from WC

65. 20151805 Document 26 (E) Cancer Services SOP List WC

66. 20151805 Document 27 Cancer Services SOP List

8. **Was your role subject to a performance review or appraisal? If so, please explain how and by whom this was carried out and provide any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.**

8.1 As Cancer Tracker/MDT Co-ordinator, Band 4, I was subject to a three and six-month probation period before my appointment was permanent. During these reviews with Angela Muldrew, Cancer Services Co-ordinator, my performance and progress to date was discussed, and how my training was going. Following my six-month review, and as no concerns were identified I was made a permanent staff member. I also had yearly KSFs which took place as a group, which all of the other Cancer Trackers/MDT Co-ordinators attended together. Angela Muldrew, Cancer Services Co-ordinator, Band 5, would have emailed out the template that needed

completed to each individual staff member. I then would have updated how I felt I had performed over the last year, what my objectives were, with examples being to continue to develop within my role and to gain as much experience while in my role, and to keep my mandatory training up to date etc. I also would have updated all my mandatory training dates. The objective section is where I would have added in if there were any upcoming training relevant to my role that I wanted to do. Due to funding issues there was an embargo on all spending, and from my recollection but I have been unable to verify the full period of embargo, but I think was from April 17 – November 17. All new posts and training were under scrutiny, and had to go through Scrutiny MDT for approval and sign off. Angela Muldrew would then have updated how she felt I had performed over the last year. Following the meeting, the KSF was signed. *Please see:*
7. 20162406 Document 4 KSF 2016

8.2 As Cancer Services Co-ordinator Band 5, it was the expectation that every staff member had yearly KSFs. Human Resources would have sent Wendy Clayton/Sharon Glenny a list of all staff members and when their last KSF was completed. This would have been emailed to me to work through. I would have had to provide assurance to Wendy Clayton/Sharon Glenny advising that these were work in progress. From my recollection, Angela Muldrew, RISOH Implementation Office Band 6, carried out my first KSF a year after I had commenced post, but I cannot recall the exact month. Due to pressures across all of the teams Sharon Glenny, Operational Support Lead Band 7, was not able to perform mine within the recommended timeframe (yearly). I always ensured that I kept my mandatory training up to date, even if my KSF did not take place. This also applied to the staff for which I had management responsibility. I kept track and monitored dates for mandatory training to ensure it was up to date, or as up to date as possible and if not, I would have emailed out asking for it to be completed by a certain date. Unfortunately, due to pressures, long-term sick leave, maternity leave etc. some mandatory training would not have been up to date for some staff. Examples of some of the mandatory training would be

Fire Training, Information Governance and Manual Handling. Mandatory training was completed online via the Trusts e-learning platform. It was recommended that staff try to attend face-to-face fire training, but if their role was not patient facing this could also be completed on line. *Please see:*
9. 20162001 Document 4B (E) List of outstanding KSF 2016 from WC

11. 20153112 Document 4D List of outstanding KSF 2016 from HR

9. **Where not covered by question 8 above, please set out any relevant policy and guidelines, both internal and external as applicable, governing your role. How, if at all, are you made aware of any updates on policy and guidance relevant to you?**

9.1 If there were any changes to guidance, with examples being the Escalation policy or NI Tumour specific Cancer Waiting Times (CWTs) Guidance, relevant to my role as Cancer Tracker/MDT Co-ordinator Band 4, Angela Muldrew, Cancer Services Co-Ordinator Band 5, would have called down into the trackers' office to advise of the change(s), which would then be followed up by an email, including any new guidance to follow. *Please see:*

3. 20112111 Document 3 Escalation Policy May 2011

4. 20112111 Document 3A (E) Escalation Policy May 2011 from AM

5. 20191209 Document 3B Cancer Pathway Escalation Policy Final August

16. 20140702 Document 7 ITT Protocol 2014

17. 20151204 Document 8 Tumour Specific Cancer Waiting Times Technical Guidance

18. 20142005 Document 8A (E) Review of Cancer Waiting Times Guidance

19. 20080201 Document 8B A Guide to Cancer Waiting Times January 2008

37. 20120908 Document 12 Urology MDM SOP August 2012

63. 20140910 Document 24 Red Flag Pathway Process Urology

67. 20120911 Document 28 Urology MDM SOP August 2012

9.2 As Cancer Services Co-ordinator, I also helped to develop some new SOPs (Standard Operating Procedures) in relation to tracking for each tumour site (Gynaecology, Haematology, Head & Neck, Urology etc.) and the MDM preparation and after work, during the Winter of 2016. I worked closely alongside each tracker, as they knew each pathway in detail so that there was guidance if someone was to help cover the site due to capacity, or if someone was off on leave or sick leave that they had clear direction as to what they were to do. The SOP for the tumour site would have been emailed to me by the Cancer Tracker/MDT Co-ordinator. I previewed the document and sent it onto my line manager, Sharon Glenny, Operational Support Lead, to review and for approval. Please see**:**

38. 20161118 Document 12A (E) Breast SOP SG

39. 20150505 Document 12B Tracking Gynae SOP 2015

40. 20161202 Document 12C Draft Urology SOP – MDM Administrative Process

43. 20160510 Document 16 (E) Commencing work on updating SOPs

44. 20191801 Document 17 (E) Failsafe to ensure patients re-listed for MDM Discussion

45. 20191801 Document 17A Failsafe to ensure patients re-listed for MDM Discussion

9.3 As a Cancer Service Co-ordinator, if any new guidance was agreed at the Regional Cancer Operational meeting I would have emailed the tracking team to advise of the changes and would also have called into the office to have an informal meeting to openly discuss changes and any implications that this would have to work loads. An example of this would be the change

to Bladder Cancers and that a TURBT (Transurethral Resection of Bladder Tumour) would no longer be counted as first definitive treatment for Bladder Cancers greater than Pt1 G3, this would be a diagnostic procedure. The patient was also to be referred to the Belfast Trust for radical surgery. I emailed Mr Haynes, Consultant Urologist to ask if this new process was to be discussed at Urology MDM to discuss progress. Shauna McVeigh, Cancer Tracker/MDT Co-ordinator advised of this change, with new guidance issued via email on 19.01.17, which was then subsequently followed. *Please see:*

5. 20191209 Document 3B Cancer Pathway Escalation Policy Final August

6. 20191209 Document 3C (E) Escalation Policy 2019 sent to Trackers

12. 20183101 Document 5 (E) Email re Bladder Cancer Guidance sent to Mr Haynes

13. 20183101 Document 5A Proposed Bladder Cancer Guidance Dec 2017

14. 20190208 Document 6 (E) Cancer Operational Meeting Tracking Change

15. 20191801 Document 6A (E) Cancer Operational Meeting Urgent Tracking Change – Sent to SG

9.4 I am aware that policies and procedures are available on the Trust Intranet, and would have checked these frequently, so that I was aware of any changes that might apply to me, or my staff. If I felt that staff would have needed to know of any changes to a policy, I would have circulated the new policy by email to alert them, following the same process that Angela Muldrew would have done, so that we were made aware of any changes. At times depending on what had been circulated both Angela Muldrew and I would have asked that once a document was read, due to its importance, that staff responded via email to state they had read it.

10. **What performance indicators, if any, are used to measure performance for your role?**

10.1 As Cancer Tracker/MDT Co-ordinator, Band 4, the Cancer Services Co-ordinator Band 5, Angela Muldrew, completed yearly KSFs in a group. This would have been the only tool that was used to measure performance from what I can recollect. The KSF templates were emailed to the Tracking team for us to complete how we felt we had performed over the last year, updating our objectives along with our mandatory training dates. We would then have met with Angela Muldrew, who would then have gone through these and added in her comments on how she felt each staff member had performed prior to sign off. Angela Muldrew also had an 'open door' policy that meant that she always made herself available if there was anything that I needed advice or guidance on. I also feel that these informal meetings were a measuring tool to see how we were all performing within our role. *Please see:*
7. 20162406 Document 4 KSF 2016

10.2 As Cancer Services Co-ordinator Band 5 there were yearly KSFs (but as previously mentioned these did not always happen yearly due to pressures). The KSFs would have been a tool used to measure performance. From my recollection, I also had regular 1-1 meetings with Sharon Glenny, Operational Support Lead Band 7, who also had an open door policy, which allowed me to have contact with my line manager if there was anything urgent that I needed to discuss or get advice on. By having these regular meetings with Sharon Glenny and openly discussing how I was finding my work and talking through any work related issues I felt that this was a good way for Sharon Glenny to measure performance whilst I was in this role. The 1-1 meetings were informal, so there were no formal minutes or notes taken from these. The meetings were scheduled for the same time each week in each of our diaries and were only cancelled if an urgent piece of work was ongoing. *Please see:*

41. 20162209 Document 14 (E) 1-1 with SG

42. 20160306 Document 15A (E) Workload Concerns sent to SG &AM

64. 20190309 Document 24 (E) Concerns re Tracking sent to SG.

11. **How do you assure yourself that you adhere to the appropriate standards for your role? What systems were in place to assure you that appropriate standards were being met and maintained?**

11.1 While I am in any role, I always work to the best of my ability, and follow all relevant policies (Work Life Balance Policy, Working Well Together Policy, Confidentiality Policy and Data Protection and IT Security) and procedures (Standard Operating Procedures as previously mentioned). For my own assurance, I link in with my line manager at 1-1s checking that I am doing everything that is expected and would openly ask how they feel I am doing, or if anything needs done differently. I always like to know what the expectations are for me in every role and openly ask questions if there is anything that I am unsure of, just so that I have the reassurance that I am doing everything correctly. I also feel that if any issues or concerns had been raised or noticed by my line manager or any other staff member that they would have been brought to my attention and discussed so that I could reflect, take note and learn to prevent any future episodes. *Please see:*
41. 20162209 Document 14 (E) 1-1 with SG

42. 20160306 Document 15A (E) Workload Concerns sent to SG &AM

50. 20180902 Document 19 (E) Meeting with FR & SG

12. **Have you experience of these systems being by-passed, whether by yourself or others? If yes, please explain in full, most particularly with reference to urology services.**

12.1 From my recollection my answer would be no. I have no experience of these systems being by-passed, by others or myself.

13. **What systems of governance do you use in fulfilling your role?**

13.1 To ensure that I am fulfilling my role I would follow and adhere to all relevant Trust policies and procedures and the relevant Standard Operating Procedures (SOPs). Examples of Trust Policies would be Work Life Balance, Working Well Together and Cancer Access Waiting Times, Records Management Policy, IT Security Policy and Escalation Policy. I would also have ensured that I kept up to date with all mandatory training (Fire Safety, Data Protection, Manual Handling and Record Management). I always ensure I lock my computer screen when I get up from my desk, and do not share passwords with any other staff member. *Please see:*

3. 20112111 Document 3 Escalation Policy May 2011

4. 20112111 Document 3A (E) Escalation Policy May 2011 from AM

5. 20191209 Document 3B Cancer Pathway Escalation Policy Final August

16. 20140702 Document 7 ITT Protocol 2014

17. 20151204 Document 8 Tumour Specific Cancer Waiting Times Technical Guidance

18. 20142005 Document 8A (E) Review of Cancer Waiting Times Guidance

13.2 As a Cancer Tracker/MDT Co-ordinator, I followed the Tumour Specific Cancer Waiting Times Guidance, which included targets that we were to meet, and if at any time in a patient's pathway I could see delays, or possible delays I referred to our local Escalation Policy, and made the necessary alerts to try to get patients through their pathway within agreed timescales. When referring to the Escalation Policy this provided a breakdown, of whom I was to email and at what point in the pathway. I would have provided a brief timeline of the patient's pathway to date, highlighting areas of concern i.e. surgery date and what the target date was, so that my line manager would have emailed the Head of Service to see if there was any sooner capacity. *Please see:*

3. 20112111 Document 3 Escalation Policy May 2011

4. 20112111 Document 3A (E) Escalation Policy May 2011 from AM

36. 20160102 Document 11H (E) Tracking update response from OSL (AM)

46. 20172301 Document 18 (E) Escalation to HoS (MC) re breaching

47. 20152412 Document 18A (E) Escalation from HoS (MC) re risk of breaching

48. 20180803 Document 18B (E) Escalation response from Consultant (JOD) re risk of breaching

49. 20190609 Document 18C (E) Escalation responses from HoS (AN)

13.3 As Cancer Services Co-ordinator my 1-1 meetings with my line manager, Wendy Clayton/Sharon Glenny, Operational Support Lead was a form of a governance meeting as they would have been checking all areas of my work and how I handled situations. Feedback was provided to advise if they would have done the same thing, or maybe handled things slightly different. Arranging staff meetings and attending these, as previously mentioned, was also a form of governance as this was keeping myself, and staff members up to date with any changes and I was being kept up to date on how areas were running. *Please see:*

41. 20162209 Document 14 (E) 1-1 with SG

42. 20160306 Document 15A (E) Workload Concerns sent to SG &AM

14. **Have you been offered any support for quality improvement initiatives during your tenure? If yes, please explain and provide any supporting documentation.**

14.1 No, I was not offered any support for quality improvement initiatives, but from my recollection, I did not put forward any quality improvement recommendations in either of my roles.

15. **During your tenure, who did you understand was responsible for overseeing the quality of services in urology?**

15.1 During my tenure in both roles, as Cancer Tracker/MDT Co-ordinator and Cancer Services Co-ordinator I felt that the overarching responsibility sat with multiple people, namely the Director of Acute Services (Esther Gishkori), the Assistant Director (Ronan Carroll) and the Head of Service (Martina Corrigan) to ensure that a good quality of service was consistently being delivered to every patient and that high standards of care were being met. I also feel that myself, along with all staff members working either in Urology or alongside the service were also partly responsible as all our work contributed in some way to the urology service and that we should all have done this to the best of our ability.

16. **In your experience, who oversaw the clinical governance arrangements of urology and, how was this done?**

16.1 In both my roles when working within Cancer Services I was not aware who oversaw the clinical governance arrangements of urology as I never heard this being discussed or who was responsible for this area of work. I had no part in this function of Urology.

17. **Did you feel able to provide the requisite service and support to urology services which your role required? If not, why not? Did you ever bring this to the attention of management and, if so, what, if anything, was done? What, if any, impact do you consider your inability to properly fulfill your role within urology had on patient care, governance or risk?**

17.1 Yes, I felt that during my time as Cancer Tracker/MDT Co-ordinator, Band 4, I was able to provide the requisite service and support the urology

service. My role supported the Urology Services as it was patient centred and the team could see the merit in having me working in this role. The urology team and I built up a great working relationship and we had developed our own processes that allowed communication to flow freely between themselves and me.

17.2 One example of this would have been for the Red Flag Prostate referral patients that attended the prostate clinic and had a prostate biopsy performed. Immediately after the clinic the Nurse Specialist (Kate O'Neill or Jenny McMahon) would have emailed a list of all of the patients. This list included their H&C Numbers so that I could list these patients on for MDM discussion the following week, which would have allowed time for reporting of pathology. This process helped mitigate the risk of a patient not being picked up via tracking, for maybe a few weeks, as the numbers of patients being tracked was on the increase. The increase in the number of patients tracked increased the workload, which meant that due to the rise in the volume of patients on the tracking list, it was not always possible to fully track the entire suspect and confirmed cancer patients on a weekly basis.

17.3 Angela Muldrew, Sharon Glenny, Fiona Reddick and Barry Conway were aware tracking was not always up to date, for the reasons as listed in point 17.2 i.e. due to increase in referrals, this had a direct impact on the volume of patients that needed to be tracked and numbers became unmanageable and tracking fell behind. In order to keep Angela, Sharon and Fiona up to date each Cancer Tracker/MDT Co-ordinator was to email through a tracking update on a weekly basis. This update included if a full track was able to be completed, or on average what percentage of patients had been tracked, and if this was behind a rough estimate i.e. 1 or 2 weeks, or in some cases longer. To try and help improve tracking, and so that the focus was on those patients who were due to have a diagnostic procedure done i.e. biopsy, CT, MRI or Flexible cystoscopy in case they needed listed for MDT discussion with results we used the notification alert function on CaPPs. This was a good failsafe if utilised and was kept up to date. By working this way it would mitigate the risk of a patient being overlooked with results. The way that this worked was if you knew a patient was going for a

CT scan you added in an alert to add a notification for 2 days following scan to allow time for reporting, then when tracking you worked from your notification list. This failsafe only worked if it was also kept up to date, which was not always possible for previously mentioned pressures with increased numbers to be tracked, which had an impact on the number of patients being listed for MDT discussion, and the MDT was the priority for the Cancer Tracker/MDT Co-ordinator. The impact if a patient was delayed being tracked was that they would not be listed for MDT discussion with results in a timely manner. Each patient had a target and this raised the risk of patients breaching their pathway. This delay would impact directly on the patient, as it would have delayed potential treatment. If a patient breached this would have affected the Trust's Performance, which would have been reported to the Board on a monthly basis - those patients who if a confirmed cancer completed treatment under target, or over target. If a patient breached their pathway, a breach report had to be completed by either the Cancer Tracker/MDT Co-ordinator or Cancer Services Co-ordinator, which provided a timeline for the patient and at what point the delays occurred. A short summary was collated at the top of the breach report identifying the main areas for delay. These breach reports were talked through at each Cancer Performance Meeting, to reflect over to see if the breach could have been prevented, and if so how, to try to have some learning. *Please see:*

29. 20190410 Document 11 (E) Alert to HoS & AD re tracking Cancer PTLs 31D & D85+

30. 20190410 Document 11A (E) Alert to Hos & AD re tracking Cancer PTLs 31D & D85+

31. 20190410 Document 11B (E) Alert to HoS & AD re tracking Cancer PTLs 31D & D85+

32. 20172509 Document 11C Tracking update sent to FR & SC

33. 20190407 Document 11D (E) Tracking update sent to SG

34. 20190407 Document 11F (E) Tracking escalation sent to SG

35. 20162801 Document 11G (E) Tracking update UGI & LGI sent to WC & AM

64. 20190309 Document 24 (E) Concerns re Tracking sent to SG

17.4 Another example would have been that the Urology theatre lists were emailed to me by individual Urology Secretaries. This was so that I knew in advance, what patients were to proceed to surgery, again allowing me to schedule the next MDM meeting to allow time for the reporting of pathology.

17.5 My role as Cancer Tracker/MDT Co-ordinator (Band 4), (the tumour site was not specified in the Job Description - Generic), was split between tracking the suspect/confirmed cancer patients and the co-ordinating the weekly MDM, as were all Cancer Trackers/MDT Co-ordinators. While I covered Urology, I was not solely aligned to this tumour site and could have been moved to another tumour site at any time. My job description was generic and did not specify a tumour site that I would be working on. This included updating all of the clinical information for each patient, which was very time consuming. We were always told by the Line Manager (Angela Muldrew, Band 5) that the meeting was the priority. At times due to the increased workload not all of the suspect/confirmed cancers could be fully tracked and therefore maybe missed being listed for MDM discussion for a week or two, which delayed their pathway. These concerns were raised with the Cancer Services Co-ordinator (Angela Muldrew, Band 5), Sharon Glenny (Operational Support Lead, Band 7) and Fiona Reddick (Head of Cancer Services, Band 8a or b). To try and prevent this from happening it was recommended that we work from the notification alert system on CaPPS, as mentioned in paragraph 17.3, so that patients were being listed as soon as possible if results were available. Theatre lists were also circulated in advance, which allowed me to schedule the patient for MDT discussion the following week, to allow time for pathology results to be available.

17.6 During my tenure as Cancer Services Co-Ordinator, Band 5, the Cancer Trackers/MDT Co-ordinators would have emailed me to advise of pressures, and that tracking was not always up to date, providing an update if a full track had been completed, and if not a percentage of what had been completed. The email would also have included their reason for tracking being behind. Delays in tracking was due to an increase in the number of Red Flag referrals received across all tumour sites, which increased workloads. I would have escalated this to my line manager Sharon Glenny (Band 7) and Fiona Reddick (Head of Service). As Cancer Services Co-ordinator I would have emailed out to the whole tracking team to see if anyone was in a position to help another tracker, and if they had capacity. While all tumour sites experienced an increase in the number of red flag referrals, and the number of patients to be tracked increased, ever tumour site would have had different volumes to track. I would also have checked with Sharon Glenny, Operational Support Lead, to see if overtime was available to try to get tracking up to date. If overtime was available, I asked that I be emailed by the tracker, in advance, to say that they were available and I would advise them what tumour site was mostly behind so that this was their focus. *Please see:*

32. 20172509 Document 11C Tracking update sent to FR & SC

33. 20190407 Document 11D (E) Tracking update sent to SG

34. 20190407 Document 11F (E) Tracking escalation sent to SG

35. 20162801 Document 11G (E) Tracking update UGI & LGI sent to WC & AM

36. 20160102 Document 11H (E) Tracking update response from OSL (AM)

62. 20162801 Document 23 (E) Overtime for Tracking

17.7 All of the Cancer Trackers would have raised the same concerns relating to increased workload and pressures, across all of the tumour sites,

including Urology. This was a risk to patient care. It was proposed that the trackers provided a weekly update to me to advise if their tumour site was up to date, or not, and if not how far was it behind and what was the reason, in relation to tracking. I would then have updated Sharon Glenny, Operational Support Lead, and Fiona Reddick, Head of Cancer Services of the up to date position with tracking. Delays in tracking patients with a diagnosis of cancer, or suspect cancer, for a week or two, or on occasion longer due to the volume of patients being tracked would have had a direct impact on patient care. This risk to individual patients was communicated via email to myself, or was raised at a Cancer Trackers meeting. The Cancer Services Co-ordinator Band 5 (this applied to Angela Muldrew and I as we covered the role at different times) would have emailed out to all of the other Cancer Trackers to see if anyone was in a position to help get tracking up to date. At times when overtime was available and depending on available funding, overtime was offered out to the whole tracking team, but they were under no obligation to accept or do overtime. If the overtime was accepted, the main focus was on the sites that were behind, which could have been urology, but the sites that were behind varied at different times, depending on size of MDM, annual leave and sick leave. Due to financial constraints overtime was not always available, and even when it was available overtime was not always done as staff were feeling tired and did not want to do this. *Please see:*

32. 20172509 Document 11C Tracking update sent to FR & SC

33. 20190407 Document 11D (E) Tracking update sent to SG

34. 20190407 Document 11F (E) Tracking escalation sent to SG

35. 20162801 Document 11G (E) Tracking update UGI & LGI sent to WC & AM

36. 20160102 Document 11H (E) Tracking update response from OSL (AM)

62. 20162801 Document 23 (E) Overtime for Tracking

17.8 Due to the direct risk to individual patients across all of the tumour sites, including Urology, if tracking was not kept up to date a Business Case was completed, which would have highlighted the areas that required more staff, and the risk to patients if these were not put in place. My contribution was to provide the staffing information i.e. how many full time equivalents I had in each team. I would also have made a comparison to the number of red flag referrals received at a given point in time, and then perhaps a year later to show the increase in activity. I would also have applied the same method to the Cancer Trackers/MDT Co-ordinators. From my recollection, we also worked out on average how long it would take to book a red flag appointment, including the whole process from receipt of referral, to appointment being booked. We also applied this methodology to tracking and worked out on average how long it takes to track each patient. The last Business Case paper that I can recollect was in November 2015 by Sharon Glenny, Operational Support Lead and Barry Conway, Assistant Director who completed this piece of work. When the Business Case was approved, and funding was agreed more Cancer Trackers and Red Flag Appointment staff were recruited to try to reduce the risk to patients. The increase in staffing levels was to cross all tumour sites, and was not specific to Urology. Sharon Glenny, Operational Support Lead, would have more details as to how many Business Cases were completed, dates approved and staffing levels agreed. *Please see:*

1. 20151412 Document 1 Cancer Performance Paper Nov 15

Did you feel supported by staff within urology in carrying out your role? Please explain your answer in full.

18.1 Yes, I always felt supported by all of the staff that I worked with within Urology during my time as a Cancer Tracker/ MDT Co-ordinator (Feb 2009 - Oct 2014). The staff members that I would have regularly interacted with during this period of time were Mrs Martina Corrigan (Head of Service), Mr Akhtar (Consultant Urologist), Mr Young (Consultant Urologist), Mr A O'Brien (Consultant Urologist) Mr J O'Donoghue (Consultant Urologist), Mr

A Pahuja (Consultant Urologist), Mr M Tyson, Mr T Glackin (Consultant Urologist) Mr M Haynes (Consultant Urologist), Jenny McMahon (Nurse Specialist), Kate O'Neill (Nurse Specialist), Leanne Hanvey (Secretary), Monica McCrory (Secretary), Liz Troughton (Secretary) and Dr G McClean (Consultant Pathologist).

18.2 When I commenced my role as the Urology Tracker (Oct 09 – Oct 14) it was a relatively new post so we were all learning together what my role was, and how it would help patients and the care that they would receive. I had regular informal meetings with the Nurse Specialists, to get some background and understanding of the Urology Service and the individual pathways for each tumour site i.e. Prostate, Renal, and Testicular, Bladder, Penile and kidney. These would be the tumour sites that I would be tracking so I needed to know as much about these as possible, for my own understanding and learning. My training, which commenced as soon as I started working as a Cancer Tracker/MDT Co-ordinator was mostly on the job training and learning, with me shadowing several staff members, who were Cancer Trackers, to see what their processes were and how they worked. I also would have checked with Angela Muldrew, Cancer Services Co-ordinator, who was my line manager, if I was unsure of anything relating to tracking or the MDTs. While settling into this role the whole team was supportive as this was all new to me, and they were able to take time out of their already very busy schedules to go over processes and pathways. I felt at any time if I had any queries at all that I could phone either Kate O'Neill or Jenny McMahon, drop them an email or call round and have a discussion face to face. All of the Consultant Urologists were also very helpful in answering any queries that I had regarding a patient's pathway, and the treatment that they were going to receive or had received and if this would be counted as first definitive treatment - my role as the tracker was to track each patient on the CaPPs system (Cancer and Patient Pathway System) either until they were proven to have no cancer, or if diagnosed with cancer, up until they received their first definitive treatment.

18.3 During the weekly Cancer MDMs, I was always made feel included and part of the team. If I had any question in relation to a patient's management plan, I felt confident in asking at any stage in the discussion, just for clarification, as it was my role to take a note of each patient's management plan following the discussion.

Urology services

19. **Please explain those aspects of your role and responsibilities which are relevant to the operation, governance or clinical aspects of urology services.**

19.1 During my time as Urology Cancer Tracker/MDT Co-ordinator, I always worked to a high standard, ensuring accuracy when adding patients on for discussion. It was my responsibility to prepare the information for each patient discussed at the MDM. I scheduled the patients for discussion from tracking or when I was advised to add a patient by email from a Consultant Urologist or Urology Nurse Specialist. From a governance perspective I checked and double checked that all information was correct and relevant by completing a cross check of their H&C on CaPPs (Cancer and Patient Pathway System), against the different various systems (Patient Administration System, NIPACS, NIECR etc.). This provided me with the reassurance that the information added was correct. I was aware of the need to apply great attention to detail and what the risk would be if information added in against a patient's record was incorrect.

20. **With whom do you liaise directly about all aspects of your job relevant to urology? Do you have formal meetings? If so, please describe their frequency, attendance, how any agenda is decided and how the meetings are recorded. Please provide the minutes as appropriate. If meetings are informal, please provide examples.**

20.1 As a Cancer Tracker/MDT Co-ordinator, Band 4, I would have liaised with multiple people, including staff members working in Cancer Services

and the Urology team itself. I would have attended the weekly Urology MDT. This would have been a formal meeting with me keeping the attendance record up to date, along with brief notes of items outside of the patient list being discussed. An example of an informal meeting, with no agenda, attendance record or minutes being recorded would have been if I called down into Angela Muldrew's, (Cancer Services Co-ordinator) office for advice regarding a patient or their management. On occasion, I would have had conversations with either individual or several staff members, with the most regular contact being with Kate O'Neill, Jenny McMahon, Mr O'Brien, Mr Haynes or Mr Glackin if I wanted clarity on a patient's pathway, or what was a first definitive treatment. These conversations were always informal with no record of them taking place.

20.2 If there was something in particular that I needed to speak to my line manager, Angela Muldrew, Cancer Services Co-ordinator, Band 5, no attendance would have been recorded, and there would not have been an agenda. No notes would have been recorded. An example of this would be if I needed advice regarding tracking, interpreting Guidance (Tumour Specific Cancer Waiting Times Technical Guidance) to ensure I was applying this correctly to my tracking to ensure that no patient was being removed from the CaPPs system inappropriately. I cannot recall what else I would have discussed with Angela Muldrew, but I do know no matter what I went down to discuss with her she always made time to discuss what I wanted to talk about and always endeavoured to answer my questions, and if not she done her best to get me an answer.

20.3 I would have scheduled, arranged and co-ordinated the weekly Urology MDM list, adding the names of the patients to be discussed by my weekly tracking on the CaPPs system, or by being advised of a patient to be listed by a Consultant Urologist. These were formal meetings that took place every Thursday at 2.15pm, unless there was an audit, M and M meeting or Bank Holiday on that day. There was no set agenda for these meetings as the purpose of these meetings was to discuss patients care and management plans. I circulated the list of patients who were for discussion prior to the meeting at an agreed time. This agreed time did change, by a

day or so but would always have been discussed at the MDT so that everyone was in agreement when it would be. From my recollection the meeting was on a Thursday afternoon, with the cut off point for patients being added for discussion being Tuesday at 2pm, with me circulating the patient preview list on a Wednesday morning to allow time for preparation for the Consultant Radiologist, Consultant Urologists, Consultant Pathologist and Consultant Oncologist attending the meetings. I kept an up to date record off all those who attended the meeting. The attendance list was noted in the brief notes, which were discussed after each MDM. Those in attendance were also recorded in the CaPPs system, which could be extracted into excel, which the clinicians used for their appraisals as they had a set number of MDMs to attend on a yearly basis. If it was noted that a Consultant Radiologist or a Consultant Oncologist was not attending on a regular basis, I would have escalated this to the Head of Cancer Services, Fiona Reddick, and it would have been tried to have this resolved at her level, or it would have been escalated further to Barry Conway, Assistant Director. I recorded the management plan for each patient listed for discussion. I then printed each individual outcome via CaPPs which was to be sent to the GP of the patient, and the chair of each MDM always read down through the MDM outcome to ensure all was correct before signing the letter, including that I had taken the management plan down correctly. Mr O'Brien always ensured that (MDM Outcomes, Oncology Referrals and GP letters) all clinical information included in the narrative was meaningful and that the management plan was correct before these would be signed and posted to the GP.

20.4 As Cancer Service Co-ordinator I would have liaised with multiple people, including staff members working in Cancer Services and the Urology team itself. The meetings that I would have attended that included Urology, but were not solely for Urology, were the monthly Cancer Performance Meetings, the Cancer Operational Meetings and staff meetings with the Red Flag Team and the Cancer Tracking Team.

20.5 For the monthly Cancer Performance Meetings I would have drafted up the Agenda, going by a previously agreed template that I updated on a

monthly basis depending if there were any other issues to be discussed. Examples of items added to the agenda would have been notes from a previous meeting, update on MDT benchmarking work, General position/update by tumour site/issues for escalation, other issues by exception and any other business. The Head of Cancer Services, Fiona Reddick, or any of the other Heads of Service, or Operational Support Leads would have notified me if they wanted to discuss a certain issue. This meeting would have been formal, with me recording the attendances as well as taking notes from the meeting. I also compiled the monthly Cancer Performance report, which covered all tumour sites, along with the performance break down. This breakdown would have included performance relating to Breast 2 week wait as a percentage, 31 Day patients performance as a percentage and 62 Day patients performance as a percentage. This would have been broken down further so that it provided site-specific information and how many patients completed treatment either under their target or over their target date. I would have provided a high-level summary of what tumour sites breached, taking this from the individual reports, that are previously mentioned in paragraph 17.3 so that they could see if there was a trend with the patients breaching i.e. delay with 1st Outpatient appointment, delay in diagnostics, delay in tracking etc. This would have highlighted areas of risk, with an example being limited capacity for 1st Outpatients, diagnostics, delays accessing Consultant review clinics post MDT. I drafted the notes from the Cancer Performance Meeting, and these would have been sent to the Head of Cancer Services, Fiona Reddick, to review and amend, if necessary, prior to circulation to the core members (Heads of Services, Operational Support Leads, Head of Performance, Cancer Services Co-ordinator) for their record.

20.6 The Regional Cancer Operational Meetings took place monthly. These would have been formal meetings. The schedule for the year was issued to those who attended the meetings in each Trust, along with who would chair each meeting. It was the responsibility of the Chair to draft the agenda, using a previously agreed template. The Chair would ask in advance if anything specific needed to be listed for discussion. When it was

the Southern Trust's turn to chair the meeting, I would have taken the notes. The Head of Cancer Services, Fiona Reddick, checked these notes prior to circulation. Urology would have been discussed at this forum, but more in relation to performance and any issues with capacity for example with first Outpatient appointments, diagnostics, Surgery etc. All Trusts provided the same type of information as mentioned above, including Inter Trust Transfers. New Guidance or processes would also have been discussed, or if any guidance was to be reviewed/amended, or if any particular issues were to be brought to a different type of meeting i.e. Steering Group. I was not involved in these meetings so I do not know the format of these.

21. **In what way is your role relevant to the operational, clinical and/or governance aspects of urology services? How are these roles and responsibilities carried out on a day to day basis (or otherwise)?**

21.1 During both my roles as Cancer Tracker/MDT Co-ordinator and Cancer Services Co-ordinator I worked within Cancer Services. While I worked in Cancer Services I worked alongside the Urology Team. While working as Urology Cancer Tracker/MDT Co-ordinator my responsibilities included the tracking for all suspect and confirmed Urology cancers, up to the point of being removed from pathway if they were found to have no cancer or benign, or if they were a confirmed cancer up to the point of their first definitive treatment. From a governance point, I ensured that I was following the most up to date guidance such as Tumour Specific Cancer Waiting Times Technical Guidance. I also ensured that when adding in any clinical information onto the CaPPs system for each patient that all information was correct. I worked from two computer screens, which allowed me to have the CaPPs system on one screen, and then the system that I was taking results from displayed on the other screen (NIPACS, NIECR, PAS and Lab Centre). By working in this way it allowed me to cross check the patient's Health and Care number (H&C) on CaPPS against the system displayed on the other screen. Double checking patients ensured that the results that I was adding onto CaPPs system matched. I was aware of the clinical risk and the impact that it could have had it I had copied over the

wrong information. This could have changed a patient's management plan and have had devastating consequences. Thankfully, this did not happen. *Please see:*

3. 20112111 Document 3 Escalation Policy May 2011

4. 20112111 Document 3A (E) Escalation Policy May 2011 from AM

16. 20140702 Document 7 ITT Protocol 2014

17. 20151204 Document 8 Tumour Specific Cancer Waiting Times Technical Guidance

18. 20142005 Document 8A (E) Review of Cancer Waiting Times Guidance

22. What is your overall view of the efficiency and effectiveness of governance processes and procedures within urology as relevant to your role?

22.1 As Urology Cancer Tracker/MDT Co-ordinator (Oct 09 – Oct 14) (Band 4), we followed the Cancer Access Waiting Times Guidance. This document provided information on each tumour site's pathway and the targets. The guidance also provided the breakdown as to what could be counted as first definitive treatment for each tumour site. First definitive treatment is the point to which we tracked the patients to and then removed from the CaPPs system. In order to meet these targets (31Day and 62 Day) patients had an escalation policy that we used as a reference. The Escalation policy ensured that each patient, if identified through tracking, as being at risk of delay in their pathway i.e. first OPD, diagnostics, surgery etc., was escalated as per the policy to try to expedite the patient to see if anything could be done to get the patient seen sooner. As the Cancer Tracker, this could have meant liaising with the Red Flag appointment team to see if any sooner appointments were available, liaising with the radiology department for diagnostics, or the Head of Service, Martina Corrigan, or Consultant Urologists to see if they had any sooner availability. This was done to try to

ensure that if patient was diagnosed as having cancer that they did not breach their target, which was in the best interest of the patient, and helped improve performance for the Urology Team. While having our own processes and escalation policy for cancer services I did not follow any ones that were specific to Urology so could not comment any further on this.

23. Through your role, did you inform or engage with performance metrics or have any other patient or system data input within urology? How did those systems help identify concerns, if at all?

23.1 As Cancer Tracker /MDT Co-ordinator (Band 4), there were targets that we were to follow, as per the Cancer Access Waiting Times. The targets that we were to meet were the 31 Day and 62 Day. Those on the 31 Day pathway would have been referred in as suspect cancer via any other way other than GP (Consultant to Consultant, Emergency Department, from results of pathology or Diagnostics). Those on the 62 Day pathway were those that would have been referred in as a suspect cancer (Red Flag) by a GP or had been referred in as Urgent or Routine and had been upgraded to Red Flag status following triage. In order for us to meet the target, depending on what pathway the patient was on we had to be very proactive while tracking, trying our best to get patients through their pathway as efficiently as possible so that there was enough time left on the pathway to commence treatment on target. I also followed the local Escalation policy to alert areas of risk at the earliest stage in their pathway. While it was the intention to get as many patients through their pathway as possible, and within target, sometimes this was not always possible due to circumstances beyond a Cancer Tracker's/MDT Co-ordinator's control. If a patient was escalated on the basis that they were at risk of breaching and if the escalation policy had been followed but nothing could be done to get the patient fitted in for a review appointment, diagnostics or surgery on target there was not much that we could do and the patient breached their pathway. For each patient that breached their pathway a breach report had

to be completed, which provided a timeline of the patient's pathway with the focus being on the delays. The breakdown of each breach report was discussed at the monthly cancer performance meetings, so this could be counted as performance as our work was always been reviewed by management. *Please see:*

4. 20112111 Document 3A (E) Escalation Policy May 2011 from AM

5. 20191209 Document 3B Cancer Pathway Escalation Policy Final August

16. 20140702 Document 7 ITT Protocol 2014

23.2 The computer system that I used to allow me to track each patient was Cancer Access and Patient Pathway System (CaPPs), which was a regionally agreed system. This system visibly displayed what day each patient was on in his or her pathway. The CaPPs system was also colour coded. Green (patient was on track and meeting target at that stage in their pathway i.e. 1st Outpatient appointment was booked by day 10). Amber (patient is at risk of breaching, which would alert you to check on this patient to see if anything could be updated i.e. clinic outcome, diagnostic or pathology report). Red (patient is very close to running out of time on their pathway – these would appear at the top of your tracking and would be your main focus as there was still time for the patient to complete on target, or be removed from CaPPs as no cancer or downgraded). Black (patient had breached their pathway). This system made it very easy to identify which patients were at risk of breaching their pathway (31 Day or 62 Day patient), and the patients further along their pathway. Amber and red were the main focus area for tracking, for the reason that these patients had not yet breached their target, and that there was still a chance to chase up on appointments, diagnostics or surgery dates. I would have followed the Escalation policy throughout the pathway and would escalated to the relevant people (Cancer Services Co-ordinator) as a patient could still

complete on target and there be no breach. That is the main purpose of a Cancer Tracker/MDT Co-ordinator to get patients through their pathway as effectively and efficiently as possible. This system was solely for the tracking of suspect/confirmed cancers, in urology as well as all the tumour sites tracked in the Southern Trust.

24. Do you have any specific responsibility or input into any of the following areas within urology? If yes, please explain your role within that topic in full, including naming all others with whom you engaged:

(i) **Waiting times**

24.1 During my time as Cancer Tracker/MDT Co-ordinator for Urology, I was responsible for all patients who were being actively tracked on the CaPPs system (Cancer and Patient Pathway System) for Urology (31 Day and 62 Day patients). If tracking and I identified a patient's first outpatient appointment was outside the target, (a patient should have their first appointment by Day 10, but by Day 14 at the latest), I would have emailed the Red Flag appointment team to see if they had any sooner availability. The Red Flag appointment team had responsibility for managing Red Flag clinics and would have checked capacity on a daily basis to see when the next available appointment would be for that specific tumour area. The Red Flag appointment team worked from a blank clinic template sheet. There was one sheet for each tumour site (Gynaecology, Haematology, Urology, Respiratory, Gastroenterology, Colorectal, and Dermatology). The clinic codes aligned to each specific tumour site were already on the template, and it was the responsibility of the Red Flag appointment team to keep this up to date and add on any new clinic codes. The Red Flag team, using the PAS system (Patient Administration System) checked when the next available appointment slot was. Each sheet was updated daily to ensure that there had been no cancellations etc. so that there was no lost capacity due to the demand for Red Flag appointments. If the Red Flag team responded to me that a first appointment was going to be outside Day 14, I would have escalated this to the Cancer Services Co-ordinator, as per the escalation policy, to see if we could get an appointment date sooner.

24.2 As Cancer Services Co-ordinator if there was no or very limited capacity available within 14 days from the date of referral received the Red Flag staff member would have escalated to me, by email, with a list of patients and what day they are booked to i.e. Day 17 indicating that this was the earliest date available. Following the escalation policy I, as Cancer Services Co-ordinator would have emailed the relevant OSL's(Operational Support Lead), aligned to that speciality indicating that the Red Flag Team was having issues with capacity for appointments, along with the relevant Head of Service, to see if there was any chance of any additionally to try and bring forward the appointment. This escalation was to see if it was possible to swap a less urgent patient's appointment to accommodate the red flag appointment. I did not always receive a response back with options, and from my recollection more so in the last few years of my time in this role (2018 – 2020) as there was nothing that could be done to expedite appointments i.e. additional clinics etc. *Please see:*

46. 20172301 Document 18 (E) Escalation to HoS (MC) re breaching

47. 20152412 Document 18A (E) Escalation from HoS (MC) re risk of breaching

48. 20180803 Document 18B (E) Escalation response from Consultant (JOD) re risk of breaching

49. 20190609 Document 18C (E) Escalation responses from HoS (AN)

24.3 The staff members that I would have liaised with were:

a) Carol Ritchie, Clerical Officer, Red Flag Appointment Team
b) Sinead Lee, Clerical Officer, Red Flag Appointment Team
c) Joseph McCaffrey, Clerical Officer, Red Flag Appointment Team

24.4 As Cancer Services Co-ordinator, I would have had management responsibility for the Red Flag Appointment Team and would have liaised with them on a regular, if not daily basis. During my tenure processes for the booking of appointments changed from 06.02.17, as we moved from paper triaging GP

referrals to electronic referrals, which was a phased approach, with different tumour sites starting at different times. The Red Flag appointment team would have changed their processes and updated their SOP (Standard Operating Procedure) to reflect changes, and I would have reviewed processes, ensuring that fail safes were in place, with one example being the check list that was sent through from BSO on a weekly basis, to me, which I forwarded onto the Red Flag appointment team. This report captured all the previous weeks' Red Flag referrals Health and Care Numbers so that the Red Flag Team would check that each patient was registered onto our system. By following this process, it mitigated the risk of Red Flag referrals being delayed in registration or missed altogether. For appointments booked for Urology I would have liaised with the Red Flag appointment team listed above in (i) waiting times.

ii) **Triage/GP referral letters**

24.5 As mentioned above the Red Flag appointment team (Carol Ritchie, Sinead Lee and Joseph McCaffrey) would have had responsibility for all of the suspect cancer referrals that were received into Cancer Services (Either from GP via CCG, 62 Day patients, or by handwritten referral from a Consultant to Consultant or Emergency Department, 31 Day patients). From my recollection if they printed off these referrals from CCG, they always ensured that if they printed 10 referrals, that 10 printed by cross-referencing with CCG. This process, and printing in smaller batches was a failsafe to ensure that no referrals were missed/delayed. Once an appointment was also booked by the Red Flag appointment team the CaPPs was updated to say that the 1st outpatient appointment had been booked, and then added in a notification reminder to help the Cancer Trackers when tracking as they worked from notifications. Each one of these referrals that was printed had their details added to a spreadsheet by the Red Flag Team, another way of keeping track of all referrals, and whom they had been brought to for triaging, across all of the different tumour sites, and depending on who was the named Consultant of the week for triage. This process also applied to Urology. The spreadsheet was updated when the referrals had been returned from triage, and what the

outcome of triage was, for example continue on Red Flag pathway, downgraded to Urgent or Routine. If these referrals did not return from triage, within 72 hours, the details of the outstanding referrals would have been escalated via email to me, Cancer Services Co-ordinator. This process of escalation if referrals were not returned within 72 hours also applied to Urology referrals. This escalation was in keeping with the Escalation policy and it would have been my responsibility to email the Head of Service over the area that the referrals were outstanding (Martina Corrigan in the case of Urology), or the Consultant directly who was triaging the referrals that week to advise that these were outstanding and to ask if they could be triaged. Depending on who the Consultant of the Week was these referrals could have remained outstanding and I had to chase these up again, or the referrals could have been triaged quickly. This happened across all tumour sites at times, and not just urology.

Please see:

2. 20181609 Document 2 Downgraded from RF Report

21. 20181609 Document 9 BSO Southern Trust Referrals Report with Practice Code

24.6 Once the change in process for referrals for Urology changed to electronic triaging the team would have been able to keep track on referrals via NIECR – Norther Ireland Electronic Care Record. The same principles applied in that if the Red Flag referrals were not triaged within 72 hours these would have been escalated to me and again, I would have escalated to the relevant Head of Service. This was the process for all Red Flag referrals, not just for urology.

iii) Letter and note dictation

24.7 Not applicable in my role as Cancer Tracker or Cancer Services Co-ordinator.

iv) Patient care scheduling/Booking

24.8 Not applicable in my role as Cancer Tracker or Cancer Services Co-ordinator.

v) Prescription of drugs – N/A

24.9 Not applicable in my role as Cancer Tracker or Cancer Services Co-ordinator.

vi) Administration of drugs

24.10 Not applicable in my role as Cancer Tracker or Cancer Services Co-ordinator.

vii) Private patient booking

24.11 Not applicable in my role as Cancer Tracker or Cancer Services Co-ordinator.

viii) Multi-disciplinary meetings (MDMs)/Attendance at MDMs

24.12 I attended these meetings on a weekly basis, as I was the Urology Cancer Tracker. It was my responsibility to compile the list of patients for discussion at the meeting, updating clinical information, Consultant, diagnostics to date, pathology results etc. I would have printed out paper copies for those in attendance. I updated this information into the CaPPs system, which I emailed out to the attendees of the meeting the day prior to the meeting to allow time for Consultant Urologists, Consultant Radiologists, Consultant Pathologists, and Consultant Oncologists to preview patients prior to discussion. I displayed the CaPPS System via a projector so that everyone who attended could clearly see what patient was being discussed. The Radiologist would also have been displaying radiology imaging relevant to that patient. I would have updated the management plan for each patient, during the MDM; this would have been a draft version, with the final version completed after the MDM, which was read over and checked by the chair or the MDM. Once the final version was signed by the Chair, I would have verified the letter on the CaPPs relating to that particular discussion (This process was completed by ticking a verified button aligned to each MDT discussion if there was more than one, as some patients would have had multiple MDT discussions). Once this letter was signed it was our governance check that the management plan was accurate. Once verified on CaPPs the letter would automatically upload onto NIECR making it instantly viewable by Consultants or GPs. The Cancer

Trackers Admin Support (Sarah McDonald or Ryan Murphy) filed a photocopy of the signed letter into the patient's medical notes. The Cancer Trackers Admin Support, (Sarah McDonald), posted the actual signed GP letter to the patient's GP to keep for their own records. It was my understanding that it would be the Consultant's responsibility to put the plan into effect.

24.13 I would also have kept an attendance list of everyone in attendance at the meeting. Attendances were also updated for each MDT into the CaPPs system, going by the attendance list. This information could then be extracted and imported to Excel for the use of Clinicians' annual appraisals. Brief notes, including the attendance record, which was recorded by me was circulated to the MDT circulation list. From my recollection the circulation list would have included Consultant Urologist, Consultant Pathologists, Consultant Radiologist, Secretaries, Cancer Trackers/MDT Co-Ordinators, Consultant Oncologists, Head of Cancer Services, Fiona Reddick and Barry Conway, Assistant Director. I also circulated an updated version of the patient preview list, which contained the management plan for each patient.

24.14 I would have engaged with Mr O'Brien, Consultant Urologist, Mr Glackin, Consultant Urologist, Mr Haynes, Consultant Urologist, Mr Pahuja, Consultant Urologist, Mr Young, Consultant Urologist (limited attendance), Dr M Williams, Radiologist, Dr M McClure, Radiologist, Dr G McClean, Pathologist, Dr R Shah Pathologist, Kate O'Neill, Nurse Specialist, Jenny McMahon, Nurse Specialist, Stephanie Reid, and the Palliative Care Nurse. The Oncologists would have linked in virtually when they were able to link into MDMs from Belfast, but this would not have been on a weekly basis.

ix) Following up on results/sign off of results

24.15 Prior to each MDM I would have updated any pathology (NIECR or Lab-centre) or radiology results (NIECR or Sectra RIS) for each patient that was being discussed. During each MDM, I would have drafted the management plan for each patient. The chair of the MDM, Consultant Urologist, would have provided the management plan directly to me, advising me word for word what to write for each patient. Following the MDM, I would have reviewed this and ensured there were no typos etc. Once I had this completed for each patient

discussed at MDM I would have printed off the GP Letter. When Mr O'Brien was chair of the MDM I would have phoned him on a Thursday evening to come down to my office, to review the plans and to sign letters, prior to these being posted to GPs for their record. Mr O'Brien also liked to get these all completed and signed off on the same day as the MDT. This also worked well because Mr O'Brien's post MDT review clinic for his patients to be informed of their management plan was the following day, which was on a Friday. This meant that Sarah McDonald, my admin support, was able to file the photocopy of the GP letter, along with the MDM outcome into the patient medical notes, prior to their appointment, which all ran very smoothly as the meeting had not taken place somewhat 24 hours prior. I was happy to work late on a Thursday evening (8.30pm) to get everything completed and all my outcomes done, letters signed, brief notes completed and circulated before I went home as this meant I could dedicate the whole of Friday to tracking. If Mr Glackin and or Mr Haynes were chairing the MDT, they would have signed these letters the next day. My clinical admin support (Sarah McDonald) would then have taken a photo copy of the signed letter and printed the MDM outcome sheet from CaPPs and kept this as a copy for the medical notes – this copy was kept for governance to show that a Consultant had signed management plan.

x) Onward referral of patients for further care and treatment

24.16 During my tenure as Cancer Tracker/MDT Co-ordinator (Urology), it was my responsibility to track a confirmed cancer patient up until they had received their first definitive treatment. This was in either the 31-Day pathway, or 62-Day pathway. If a patient did not have their first treatment in the Southern Trust, they would have been referred to another Trust for treatment. This transfer of care between Trusts is called an Inter Trust Transfer (ITT). If it had been decided at MDM that a patient was to be transferred to Belfast, and this was their first definitive treatment I would have generated an oncology referral letter via the CaPPs system for that patient. I then would have got the oncology letter signed by the Chair, after it had been checked to ensure the management plan was correct; the oncology letters had the same governance process which was followed for the GP Letters. The Oncology letter was emailed directly to the

relevant tracker in the Belfast Trust. My failsafe for this process was to highlight what patients required ITT to another Trust, by a highlighter pen and wrote ITT on the patient preview list. I then would have ticked that the referral had been sent, once I had emailed off the referral, and made a note of whom I had emailed, so that they were aware of the patient, as they would be tracking them from that point. The patient would then have been ITTd on the CaPPs system so that they were no longer for tracking in the Southern Trust. An onward oncology referral could have been generated in the form of a letter to the named Consultant Oncologist, but this was not normal practice, from my recollection. If a referral was done like this, without the ITT the Belfast Tracker would not have been aware of the patient, so would not have been able to chase up on appointments etc. *Please see:*

16. 20140702 Document 7 ITT Protocol 2014

51. 20142305 Document 20 (E) Oncology Referral

24.17 For patients who had already received their first definitive treatment and were closed off the CaPPs system as treatment complete, but were being referred to Oncology, an Oncology referral was not generated from the CaPPs system. The named Consultant would have generated a referral letter and sent this to the Oncologist. These patients would not have been actively tracked on the CaPPs system once first definitive treatment was completed.

24.18 I am sorry I do not have any copies of this process, as I have not been in this role from Oct 2014.

xi) Storage and management of health records

24.19 Not applicable in my role as Cancer Tracker or Cancer Services Co-ordinator.

xii) Operation of the Patient Administrative System (PAS)

24.20 During my tenure as Cancer Tracker/MDT Co-ordinator (Urology), I had a ‘look up’ function only for PAS, which I used for tracking purposes to see when

a patient had a hospital appointment, admission etc. I did not have any access to input information.

24.21 During my tenure as Cancer Services Co-ordinator I had more access to PAS, but this was to add additional clinics etc. for Urology or other tumour sites, so that the Red Flag appointment team could book appointments (as listed above). On the rare occasion, I would have booked some patients into appointment slots if the team was short staffed and slots needed filled urgently. I would not have engaged directly with staff members working in the urology services. 0

xiii) Staffing

24.22 Not applicable in my role as Cancer Tracker or Cancer Services Co-ordinator for Urology Services.

xiv) Clinical Nurse Specialists

24.23 I would have had regular contact with the Clinical Nurse Specialists (Kate O'Neill and Jenny McMahon) in Urology. This contact would have been either at the Urology MDM, or if I called round to discuss a certain patient or issue in clinic. I also would have had regular emails from Jenny McMahon and Kate O'Neill advising me of patients that had a procedure performed and needed listed for MDM discussion etc.

xv) Cancer Nurse Specialists

24.24 Not applicable in my role as Cancer Tracker or Cancer Services Co-ordinator.

xvi) Palliative Care Nurses

24.25 Not applicable in 0my role as Cancer Tracker or Cancer Services Co-ordinator.

xvii) Patient complaints/queries

24.26 During my time as Cancer Services Co-ordinator (Band 5) if I was made aware of a complaint that had been raised I would have been asked to start an investigation from the start of their pathway, and if any delays occurred at this

point how did this happen i.e. late upgrade, lost referral etc. Once I had compiled a comprehensive time line, I would have updated my line manager, Cancer Services Co-Ordinator, Sharon Glenny (Band 7) and Fiona Reddick, Head of Cancer Services. At this point, I would not have had to add to Datix, as they were made aware of the complaint/query. If the complaint/query related to a urology patient, I would have made Martina Corrigan (Head of Service) aware of my findings, and possibly Ronan Carrol, Assistant Director. *Please see:*

22. 20172108 Document 10 (E) DATIX Missed Referral General Surgery

23. 2190502 Document 10A (E) DATIX Late upgrade at triage OC Referral

24. 20190410 Document 10B (E) DATIX Delay with Review with Mr O'Brien

25. 20190509 Document 10C (E) DATIX Delay with referral to Belfast- Mr O'Brien

26. 20190110 Document 10D (E) DATIX Delay with referral to Belfast Mr O'Brien

27. 20190908 Document 10E (E) DATIX Delay with referral to Belfast Mr O'Brien

28. 20190509 Document 10F (E) DATIX Delay with referral to Belfast Mr O'Brien

Concerns

25. **Please set out the procedure which you were expected to follow should you have a concern about an issue relevant to patient care and safety and governance.**

25.1 As Cancer Tracker/MDT Co-ordinator if I had any concerns about an issue relevant to patient care and safety and governance I would have raised this with my line manager at the time, Angela Muldrew, Cancer Services Co-ordinator. From my recollection, this did not need to happen.

25.2 As Cancer Services Co-Ordinator (Band 5) if a member of staff raised their concerns regarding a specific patient, or possible delay with referral being triaged or being a late upgrade etc. I would have commenced my own investigation, speaking with the relevant team to try to obtain as much information as possible, to see what had happened and how this could have happened. I would have had access to the PAS (Patient Administration System), CaPPs (Cancer & Patient Pathway System), and NIECR (Northern Ireland Electronic Care Record) systems. Access to these systems would have allowed me to track a patient's referral from date of receipt in the Trust. If any delays were identified I would have drafted up a timeline of where the delays occurred, how they occurred and my steps taken to date i.e. I would have alerted my direct line manager, Sharon Glenny (Band 7) of the issue and spoken to her about my concerns and findings to date, either face to face or by telephone. The next step would have been to escalate my concerns and findings to the Head of Cancer Services (Fiona Reddick) and the relevant Head of Service, including Sharon Glenny into the email. If my concerns were deemed a risk to a patient, I would have raised a Datix so that the issue would have been investigated, across all relevant departments. I would also have checked with the relevant team to ensure that they were following the most up to date Standard Operating Procedure (SOPs). Teams were also aware that as they were the ones doing the job that if any procedures changed it was their responsibility to update the SOP to reflect this change. *Please see:*

22. 20172108 Document 10 (E) DATIX Missed Referral General Surgery

23. 2190502 Document 10A (E) DATIX Late upgrade at triage OC Referral

24. 20190410 Document 10B (E) DATIX Delay with Review with Mr O'Brien

25. 20190509 Document 10C (E) DATIX Delay with referral to Belfast- Mr O'Brien

26. 20190110 Document 10D (E) DATIX Delay with referral to Belfast Mr O'Brien

27. 20190908 Document 10E (E) DATIX Delay with referral to Belfast Mr O'Brien

28. 20190509 Document 10F (E) DATIX Delay with referral to Belfast Mr O'Brien

25.3 Following the outcome of my investigation, I would have met with the relevant team to discuss my findings and advise of the outcome to allow for reflective learning and to try to prevent/mitigate the risk of the same thing happening again. Many fail-safes were developed, with an example being that I as Cancer Services Co-ordinator received an emailed list, password protected, first thing on a Monday morning, from Business Services Organisations (BSO) that listed all of the patients that had been referred to the Southern Trust as a Red Flag Referral. I forwarded on this report to the Red Flag Appointment team, via email, for one of them to go through each patient on the list, cross-referencing that they were registered on our system PAS (Patient Administration System). While this process was time consuming it was reassuring to know that no referrals were overlooked, and had not been actioned/or registered on the system. Once the report was checked by the Red Flag team they responded to me by email to advise that the report had been checked. *Please see:*

21. 20181609 Document 9 BSO Southern Trust Referrals Report with Practice Code

25.4 Once referrals went to electronic triage via NIECR, I as Cancer Services Co-ordinator had permissions on NIECR to run a report for a specified time, normally weekly, to show all the Red Flag Referrals that had been received, and what the triage outcome was. If a referral was downgraded from Red Flag status a downgraded letter, stating the urgency (Urgent or Routine) was then posted to the GP advising them of the change in status, and to keep them up to date on their patient. Please see**:**

2. 20181609 Document 2 Downgraded from RF Report

26. **Did you have any concerns arising from any of the issues set out at para 24, (i) – (xvii) above, *or any other matter* regarding urology services? If yes, please set out in full the nature of the concern, who, if anyone, you spoke to about it and what, if anything, happened next. You should include details of all meetings, contacts and outcomes. Was the concern resolved to your satisfaction? Please explain in full.**

26.1 No, I do not recall having any concerns arising from any of the issues set out at para 24. I feel that I have answered how I managed the process for referrals that were delayed at triage. I was not concerned about these, but followed the guidance i.e. escalation policy and tried to keep escalating if these were outstanding. I do not recall attending any meetings regarding this

27. **Did you have concerns regarding the practice of any practitioner in urology? If so, did you speak to anyone and what was the outcome? Please explain your answer in full, providing documentation as relevant. If you were aware of concerns but did not report them, please explain why not.**

27.1 No, I did not have any concerns regarding the practice of any practitioner in Urology.

28. **If you did have concerns regarding the practice of any practitioner in urology, what, in your view was the impact of the issue giving rise to concern on the provision, management and governance of urology services?**

28.1 No response required to this question, as I did not have any concerns regarding the practice of any practitioner in urology.

29. **What steps were taken by you or others (if any) to risk assess the potential impact of the concerns once known?**

29.1 I am not aware of any steps taken by me or any others to risk assess the potential impact of the concerns once known as I was no longer working in Cancer Services and I was not aware of any concerns.

30. Did you consider that the concern(s) raised presented a risk to patient safety and clinical care? If yes, please explain by reference to particular incidents/examples. Was the risk mitigated in any way?

30.1 I feel I cannot answer this question as I am not aware of the concern(s) raised and if they presented a risk to patient safety and clinical care.

31. Was it your experience that once concerns were raised, systems of oversight and monitoring were put in place? If yes, please explain in full.

31.1 As I was no longer working in Cancer Services, and I was not aware of any concerns raised, I cannot answer this question. Sinead Lee (Cancer Services Co-ordinator Band 5) Sharon Glenny (Operational Support Lead Band 7), Angela Muldrew (RISOH Implementation Officer Band 6) and Fiona Reddick (Head of Cancer Services Band 8+) could perhaps provide you with details of systems of oversight and monitoring that were put in place.

32. **In your experience, if concerns are raised by you or others, how, if at all, are the outcomes of any investigation relayed to staff to inform practice?**

32.1 From my recollection if I, or others, while working as a Cancer Tracker/MDT Co-ordinator (Band 4), or as a Cancer Services Co-Ordinator (Band 5) raised any concerns that were identified as an SAI (Serious Adverse Incident), I do not recall being advised of the outcome of any investigation if it was logged onto the DATIX (Risk Management System). This was due to being a Band 4 or Band 5, and it was my understanding that we did not need to know. As a Band 5 and going by findings of my own investigation I would have updated the relevant team that a Datix had been raised. This was so that they were aware of what had happened, how it happened and what the learning was so that all relevant processes could be reviewed. By re-viewing, the processes this helped to identify what processes were maybe not fully followed, and if any fail-safes were to be developed to ensure that, the same thing did not happen. In some cases, from my recollection, we would only have been provided with limited information, due to my Banding (5). I would not have been privy to all information was my understanding. This information would have been shared with the higher banded staff, I think, but I cannot say with certainty that this happened.

33. Did you have any concerns that governance, clinical care or issues around risk were not being identified, addressed and escalated as necessary within urology?

33.1 No, I did not have any concerns that governance, clinical care or issues around risk were not being identified, addressed and escalated, as necessary while I worked in Cancer Services. I was not aware of any ongoing issues or concerns within Urology Services. I was aware that referral numbers were on the increase for Urology and for all of the tumour sites. I was also aware that there were problems with tracking, and that this was not always possible to be kept up to date, due to the increase in referrals across all of the tumour sites, as previously mentioned and capacity issues for appointments, diagnostics and surgery. These issues were discussed at

the local Cancer Performance, and Regional Cancer Operational Meetings. The Assistant Director (Barry Conway) and the Heads of Services, along with Operational Support Leads, Head of Performance (Lynn Lappin) and Service Administrators would have been in attendance in these meetings so would have been aware of ongoing issues.

34. How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such Governance meeting minutes or notes, or in the Risk Register, whether at Departmental level or otherwise? Please provide any documents referred to.

34.1 I cannot answer this question as I never attended any Governance meetings, and while I added some SAI (Serious Adverse Incidents), onto the Datix System, some relating to Urology patients and delays with referrals, not all of these SAIs were aligned to Urology. The DATIX system is a Risk Register for the Trust. I did not get feedback as to what the outcomes were following investigation. I am not sure who could help you answer this question. *Please see:*

22. 20172108 Document 10 (E) DATIX Missed Referral General Surgery

23. 2190502 Document 10A (E) DATIX Late upgrade at triage OC Referral

24. 20190410 Document 10B (E) DATIX Delay with Review with Mr O'Brien

25. 20190509 Document 10C (E) DATIX Delay with referral to Belfast- Mr O'Brien

26. 20190110 Document 10D (E) DATIX Delay with referral to Belfast Mr O'Brien

27. 20190908 Document 10E (E) DATIX Delay with referral to Belfast Mr O'Brien

28. 20190509 Document 10F (E) DATIX Delay with referral to Belfast Mr O'Brien

29. 20190410 Document 11 (E) Alert to HoS & AD re tracking Cancer PTLs 31D & D85+

34.2 An example of a Urology SAI was the delay with a patient. This patient was discussed at Uro-Oncology MDM 3/10/2019 and it would appear outcomes from previous Uro-Oncology MDM (27/06/2019) have not been actioned. The delay is not with the tracker but a delay in review with Mr O'Brien, and then once reviewed in clinic on 16.08.19 there has been no further movement or update on patient's management. Tracker (Shauna McVeigh) appears to have listed patient for MDM discussion on 03.10.19 to try to get an update on Management. Patient was informally discussed on 03.10.19 so there was no MDM outcome & then Datix was raised Ref Number – Personal Information redacted by the USI. Patient was initially discussed at MDM on 28.06.19 (31D Patient) then patient waited 49 days for review with Mr O'Brien on 16.08.19. Diary update on Capp's dates 09.08.19. Appointment was then booked with Mr O'Brien on 16.08.19 following Mr Haynes message to Mr O'Brien. *Please see:*

24. 20190410 Document 10B (E) DATIX Delay with Review with Mr O'Brien

25. 20190509 Document 10C (E) DATIX Delay with referral to Belfast- Mr O'Brien

26. 20190110 Document 10D (E) DATIX Delay with referral to Belfast Mr O'Brien

27. 20190908 Document 10E (E) DATIX Delay with referral to Belfast Mr O'Brien

28. 20190509 Document 10F (E) DATIX Delay with referral to Belfast Mr O'Brien

35. **What could improve the ways in which concerns are dealt with to enhance patient safety and experience and increase your effectiveness in carrying out your role?**

35.1 I no longer work in Cancer Services or alongside Urology (since July 20) so feel I cannot answer this question. Sinead Lee (Cancer Services Co-Ordinator Band 5) Angela Muldrew (RISOH Implementation Office Band 6), Sharon Glenny (Operational Support Lead Band 7) or Fiona Reddick (Head of Cancer Services (Band 8+) would maybe be able to answer this question. While I was working in Cancer Services, I felt things could have improved with communication and what information was shared among staff from the higher bands. I felt at times I was drip fed limited information to allow me to do my job, but that by having some more knowledge on certain things it would maybe have made it a bit easier to understand why some decisions had been made etc. I cannot provide an example of this; this is just how I felt.

Staff

36. **As relevant, what was your view of the working relationships between urology staff and other Trust staff? Do you consider you had a good working relationship with those with whom you interacted within urology? If you had any concerns regarding staff relationships, did you speak to anyone and, if so, what was done?**

36.1 In my opinion, and from my recollection, I felt that there was a good working relationship between urology staff and other Trust staff, but I can only comment on what I witnessed when I was attending the Urology MDM, and this was on a weekly basis.

36.2 During the MDMs there would have been various discussions regarding a patient's specific pathway and proposed treatments that perhaps not everyone was in full agreement with, in regards to certain diagnostics or treatment/review plans. This was the purpose of the MDM to come up with a collective treatment plan, and by the end of the discussion,

a collective agreement was always reached, and the Chair of the MDM would have signed off this management plan.

36.3 I would not have seen any other interactions with other staff members outside of the MDM setting, or the Urology Clinics that I would have gone to to get paperwork signed or had a particular question to ask so I could not comment on other working relationships.

36.4 Yes, I do consider that I had a good working relationship with everyone that I interacted with within urology, and that they were always very approachable, regardless of their seniority or role in urology. I always felt very comfortable in asking any questions and always felt that they were happy to give me their time. I really enjoyed my time working as Urology Cancer Tracker.

37. **In your experience, did medical (clinical) managers and non-medical (operational) managers in urology work well together? Whether your answer is yes or no, please explain with examples.**

37.1 Sorry I am not fully clear whom this question would be referring to, as I would not have heard staff being referred to as medical (Clinical) managers and non-medical (operational) managers. Mr Michael Young was the Clinical Lead in Urology. In my experience and from what I can recollect I would say yes, Martina Corrigan, Head of Service and Wendy Clayton, Operational Support Lead, worked well together. I do not recall being at a meeting when they would have all been present together (Mr Young, Martina and Wendy) I always found Mr Young very friendly and approachable and most helpful. My reason for thinking that Martina and Wendy worked well together was that if they were both present at a meeting such as the Cancer Performance Meetings, at which I attended and recorded the minutes, I could see they had a good working relationship, that they talked openly to each other and both responded to different types of questions which were asked at the meeting. They seemed comfortable in each other's company and talked freely prior to the meeting commencing. Because of these

responses, I felt that they worked well together, and had a clear understanding of the pressures, issues and futures plans/projects within Urology.

Learning

38. **Are you now aware of governance concerns arising out of the provision of urology services which you were not previously aware of? Identify any governance concerns which fall into this category and state whether you could and should have been made aware of the issues at the time they arose and why.**

38.1 To be honest I am not aware of what has happened to have instigated this Inquiry other than it relates to Mr O'Brien. I had left my job as Cancer Services Co-ordinator when the statement was released (24 November 2020) that there would be a public inquiry, so I feel I cannot comment on this question.

39. **Having had the opportunity to reflect on these governance concerns arising out of the provision of urology services, do you have an explanation as to what went wrong within urology services and why?**

39.1 As I have not had the opportunity to reflect on the governance concerns arising out of the provision of the urology service I cannot provide an explanation as to what I feel went wrong within urology services and why.

40. **What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and, to the extent that you are aware, the concerns involving Mr. O'Brien in particular?**

40.1 As previously mentioned I have no knowledge of the concerns within urology services, and very limited information in relation to the concerns involving Mr O'Brien in particular so I do not feel that I can honestly comment.

40.2 All that I can recall is that while Mr O'Brien was chair of the Urology MDM that he was so committed and dedicated to this role. Prior to Mr O'Brien taking on this role I, as Cancer Tracker, had to compile the clinical summary for each patient that was to be discussed. Mr O'Brien changed this so that each Clinician provided a more comprehensive clinical history. The reason for this change was that at times clinical information available for discussion was very limited, if I was not tracking these patients, so management plans could not always be made and patients would have been deferred to the next week. This change was a work around to stop this happening so that there was very clear and relevant information for discussion. Mr O'Brien provided me with a very clear and informative outcome plan for each patient. After each meeting, I would have commenced work immediately (5pm) on the outcomes for each patient, printing out each individual MDM plan for each patient discussed, along with a copy for the medical notes. Once I had these all printed out I would have telephoned/texted Mr O'Brien, who remained on hospital premises, to come down to my office to go through each outcome, along with all of the clinical information to ensure accuracy, so that these were all signed and verified on the CaPPs system before 8.30pm each Thursday night. The turnaround times for GP letters to be signed following MDM is 48 hours and Mr O'Brien always endeavoured to have these done immediately after the MDM.

41. **Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. Your answer may, for example, refer to an individual, a group or a particular level of staffing, or a particular discipline.**

41.1 I feel that I cannot answer this question, as I am unsure of the problems within urology services that the question is referring to.

If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

42. **Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?**

42.1 I am not aware of what concerns were identified and I feel I cannot answer this question as I do not know the detail behind the question that is being asked.

43. **Do you think, overall, the governance arrangements were and are fit for purpose? Did you have concerns specifically about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?**

43.1 I do not feel that I can answer this question, as I am not aware of the governance arrangements so could not comment if they were fit for purpose.

44. **If not specifically asked in this Notice, please provide any other information or views on the issues raised in this Notice. Alternatively, please take this opportunity to state anything you consider relevant**

to the Inquiry's Terms of Reference and which you consider may assist the Inquiry.

44.1 After reviewing all of my responses, I feel that I have nothing further that I would like to add to my statement that would further assist the Inquiry.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: Vicki Graham

Date: 20/10/2022

Section 21 Notice Number 80 of 2022

Witness Statement: Vicki Graham

Index

Attachment	Document
1	20151412 Document 1 Cancer Performance Paper Nov 15
2	20181609 Document 2 Downgraded from RF Report
3	20112111 Document 3 Escalation Policy May 2011
4	20112111 Document 3A (E) Escalation Policy May 2011 from AM
5	20191209 Document 3B Cancer Pathway Escalation Policy Final August
6	20191209 Document 3C (E) Escalation Policy 2019 sent to Trackers
7	20162406 Document 4 KSF 2016
8	20190602 Document 4A KSF Example sent to SMV
9	20162001 Document 4B (E) List of outstanding KSF 2016 from WC
10	20190602 Document 4C (E) KSF Example sent to SMV
11	20153112 Document 4D List of outstanding KSF 2016 from HR
12	20183101 Document 5 (E) Email re Bladder Cancer Guidance sent to Mr Haynes
13	20183101 Document 5A Proposed Bladder Cancer Guidance Dec 2017
14	20190208 Document 6 (E) Cancer Operational Meeting Tracking Change
15	20191801 Document 6A (E) Cancer Operational Meeting Urgent Tracking Change – Sent to SG
16	20140702 Document 7 ITT Protocol 2014
17	20151204 Document 8 Tumour Specific Cancer Waiting Times Technical Guidance
18	20142005 Document 8A (E) Review of Cancer Waiting Times Guidance
19	20080201 Document 8B A Guide to Cancer Waiting Times January 2008
21	20181609 Document 9 BSO Southern Trust Referrals Report with Practice Code
22	20172108 Document 10 (E) DATIX Missed Referral General Surgery
23	2190502 Document 10A (E) DATIX Late upgrade at triage OC Referral
24	20190410 Document 10B (E) DATIX Delay with Review with Mr O'Brien
25	20190509 Document 10C (E) DATIX Delay with referral to Belfast- Mr O'Brien
26	20190110 Document 10D (E) DATIX Delay with referral to Belfast Mr O'Brien
27	20190908 Document 10E (E) DATIX Delay with referral to Belfast Mr O'Brien
28	20190509 Document 10F (E) DATIX Delay with referral to Belfast Mr O'Brien
29	20190410 Document 11 (E) Alert to HoS & AD re tracking Cancer PTLs 31D & D85+
30	20190410 Document 11A (E) Alert to Hos & AD re tracking Cancer PTLs 31D & D85+
31	20190410 Document 11B (E) Alert to HoS & AD re tracking Cancer PTLs 31D & D85+
32	20172509 Document 11C Tracking update sent to FR & SC
33	20190407 Document 11D (E) Tracking update sent to SG
34	20190407 Document 11F (E) Tracking escalation sent to SG
35	20162801 Document 11G (E) Tracking update UGI & LGI sent to WC & AM
36	20160102 Document 11H (E) Tracking update response from OSL (AM)
37	20120908 Document 12 Urology MDM SOP August 2012
38	20161118 Document 12A (E) Breast SOP SG
39	20150505 Document 12B Tracking Gynae SOP 2015
40	20161202 Document 12C Draft Urology SOP – MDM Administrative Process
41	20162209 Document 14 (E) 1-1 with SG

42	20160306 Document 15A (E) Workload Concerns sent to SG &AM
43	20160510 Document 16 (E) Commencing work on updating SOPs
44	20191801 Document 17 (E) Failsafe to ensure patients re-listed for MDM Discussion
45	20191801 Document 17A Failsafe to ensure patients re-listed for MDM Discussion
46	20172301 Document 18 (E) Escalation to HoS (MC) re breaching
47	20152412 Document 18A (E) Escalation from HoS (MC) re risk of breaching
48	20180803 Document 18B (E) Escalation response from Consultant (JOD) re risk of breaching
49	20190609 Document 18C (E) Escalation responses from HoS (AN)
50	20180902 Document 19 (E) Meeting with FR & SG
51	20142305 Document 20 (E) Oncology Referral
52	20152704 Document 21 Notes Meeting with RF Appointment Staff Monday 27Th April 2015
53	20162303 Document 21A Notes Meeting with Trackers 23.03.16
54	20120204 Document 21B Notes Meeting with Trackers 02.04.12
55	20162704 Document 22 (E) Admin Managers Meeting Sent from WC
60	20161902 Document 22A (E) Notes Admin Managers Meeting Sent from WC
62	20162801 Document 23 (E) Overtime for Tracking
63	20140910 Document 24 Red Flag Pathway Process Urology
64	20190309 Document 24 (E) Concerns re Tracking sent to SG
65	20151805 Document 26 (E) Cancer Services SOP List WC
66	20151805 Document 27 Cancer Services SOP List
67	20120911 Document 28 Urology MDM SOP August 2012

CANCER PERFORMANCE BRIEFING PAPER
December 2015

Introduction

The cancer access waiting times standards were implemented by the Department of Health in September 2005. The purpose of the waiting times was to ensure that patients presenting to their GP with symptoms suggestive of cancer or diagnosed to have cancer as an incidental finding or through the screening programmes were dealt with within the secondary care system along regionally agreed specific pathways. The Southern Health and Social Care Trust (SHSCT) is responsible for achieving 3 cancer access PfA targets plus an intra-trust transfer time of 28 days for those patients who will receive their first definitive treatment from the Belfast Health & Social care Trust :

- Suspected Breast Cancer Referrals – 100% to be seen within 14 days (commenced 2001)
- By March 2008 75% of GP suspected cancer referrals to be diagnosed and commence treatment within 62 days – to increase to 95% by March 2009 (Appendix 1)
- By March 2008 98% of patients diagnosed with cancer should begin treatment within 31 days of the decision to treat date.

Cancer services within SHSCT are provided for patients across sites, primarily Craigavon Area Hospital and Daisy Hill Hospital. Patients may be referred to Consultants/Specialties for example Breast, Lung, ENT, Haematology, Radiology and others. Co-ordination and centralisation of patient pathways and processes is essential to achieve the ministerial targets. Central to the success of managing the patients along the pathways and achieving the cancer access targets is the tracking/administrative function. This remainder of this briefing paper describes the ongoing and increasing risks and challenges associated with achieving the required cancer targets from the tracking perspective.

Modes of Referral rates

Receipt of Red Flags

In order for the Trust to meet the cancer access targets suspected cancer referrals have been categorised as being 'red flags' (RF). There are 2 main ways in which the Trust receives RFs:

1. Suspected cancer referrals (Red flag) are referred by GPs using the NICaN referral guidelines. The referrals are to be faxed to the 'red flag' central access referral fax machines (based in Daisy Hill Hospital and Craigavon Hospital).
   - **CAH Red Flag fax number:** Personal Information redacted by USI
   - **DHH Red Flag fax number:** Personal Information redacted by USI

   Or alternatively, referrals are received electronically via CCG (Clinical Communication Gateway)

2. General referrals from GPs to the acute Trust services have been centralised to a single referral and booking centre based at the Craigavon Hospital site, which can be triaged and upgraded to a RF by secondary care consultant

In order to ensure that patients are appointed and move to investigations and treatment as quickly as possible, a designated Cancer Tracking Team has been established. This

incorporates both the tracking of suspect and confirmed cancers, and providing administrative support to the multi-disciplinary team meetings (MDT).

Triaging of RF referrals

The first crucial step in the patient's pathway is to ensure that the all referrals including RF are triaged (assessed and clinically vetted) appropriately and in a very timely manner (ideally same day triage for RF and 72hours for urgents and routine).

Those RF referrals which are triaged as appropriate are allocated to the relevant 1st appointment e.g. outpatient clinic, straight to test, and then proceed along the timed relevant pathway if clinically appropriate.

Table 1a below demonstrates the RF demand steadily increasing from the commencement of cancer access standards in 2008/9 of approximately 14% for 62 day patients and 12% for 31 day patients each year, with the exception of approximately 100% increase for both standards between 2008/9 and 2009/10. The admin manpower has not increased to compliment the increase in workload year on year, leading to a pressure on service, tracking not being 'live' and difficulty covering MDM's during periods of annual and sick leave.

Graph/Table 1 illustrates the referral pattern for all tumours per month

Table 1a
62 Day Suspect Referrals

	April	May	June	July	August	September	October	November	December	January	February	March	Total 62-day referrals	% increase
2008/09	8	15	17	34	44	261	577	412	378	373	536	437	**3,092**	
2009/10	550	604	653	555	577	515	583	550	472	507	573	485	**6,624**	114.2%
2010/11	587	594	728	622	662	746	667	646	473	670	728	599	**7,722**	16.6%
2011/12	677	649	740	630	632	751	669	645	547	681	737	655	**8,013**	3.8%
2012/13	635	733	684	700	778	770	865	814	621	823	801	861	**9,085**	13.4%
2013/14	766	865	856	874	815	874	944	905	821	967	829	1,079	**10,595**	16.6%
2014/15	844	925	1,080	1,000	922	1,068	1,067	1,013	944	1,027	1,193	1,019	**12,102**	14.2%
201516	1,096	1,022	1,333	1,204	1,080	1043							13556	12.0%

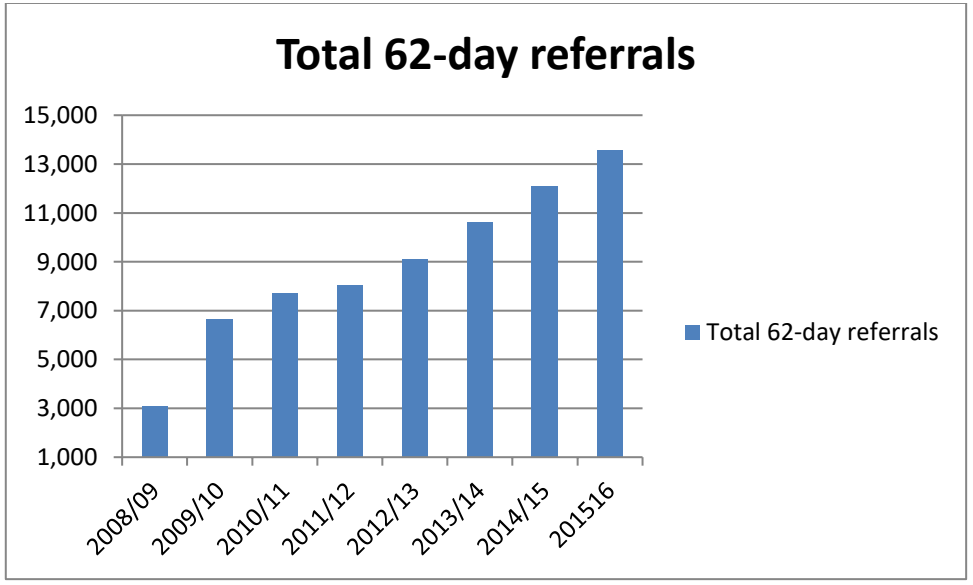
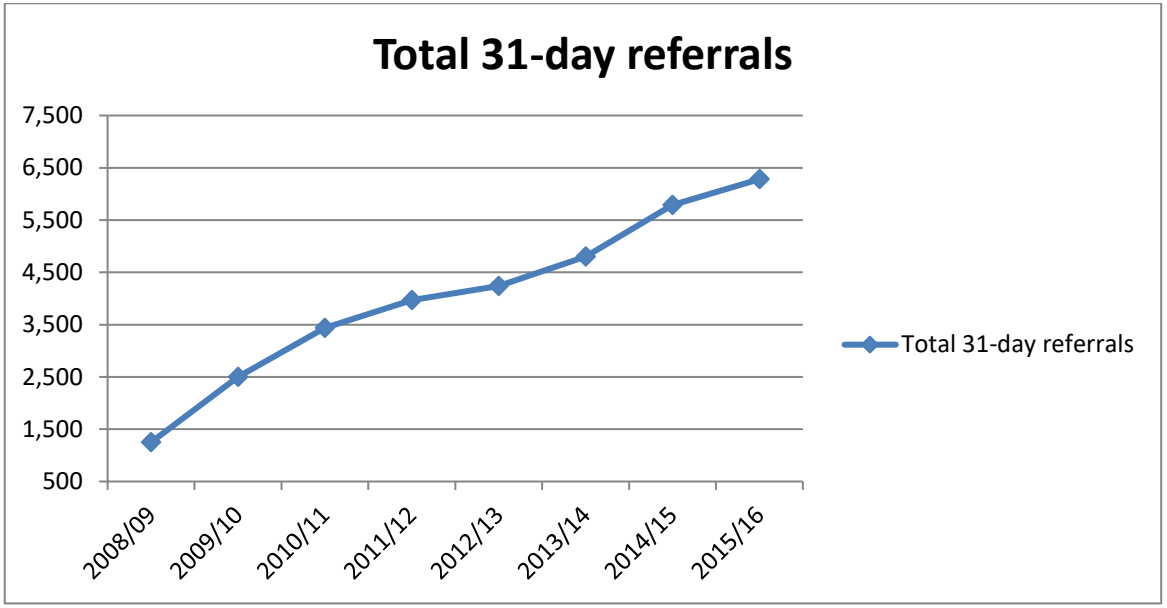


Table 1b
31 Day Suspect Referrals

	April	May	June	July	August	Sept	Oct	Nov	Dec	January	Feb	March	Total 31-day referrals	% increase
2008/09	12	26	32	44	43	70	142	169	140	185	204	183	1,250	
2009/10	147	159	223	161	221	254	265	227	211	225	225	179	2,497	99.8%
2010/11	265	238	281	285	245	305	306	309	261	300	342	298	3,435	37.6%
2011/12	290	325	350	297	311	359	324	337	318	338	342	381	3,972	15.6%
2012/13	309	454	358	338	329	376	334	316	306	381	349	387	4,237	6.7%
2013/14	343	383	395	398	396	387	456	412	413	393	376	448	4,800	13.3%
2014/15	392	436	478	520	399	523	553	494	459	489	548	498	5,789	20.6%
2015/16	543	479	609	491	521	498							6282	8.5%

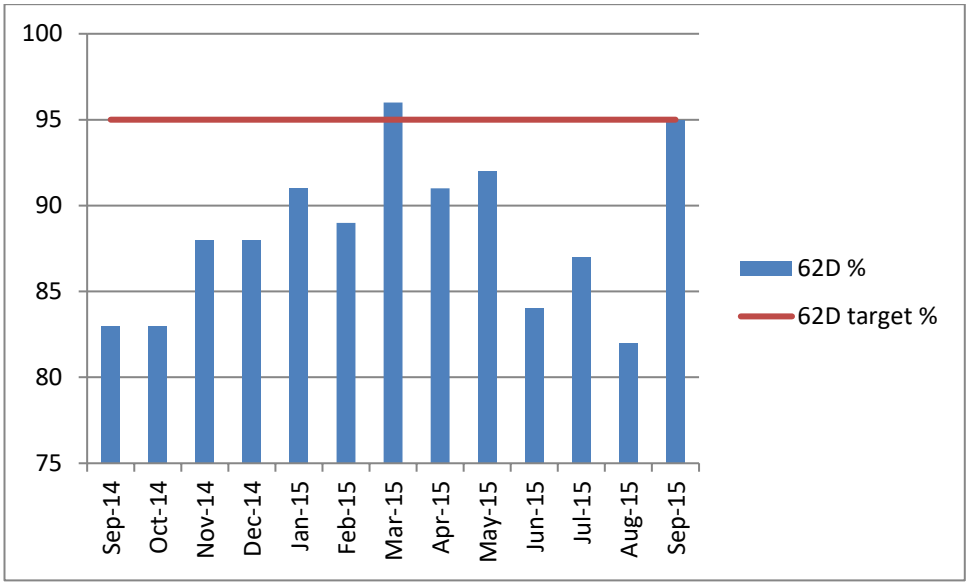


Cancer Performance.

It is important to highlight that the monthly cancer performance percentage for 62D & 31D are determined by the volume of confirmed cancers in that month against the number of cancers patients who breach the 62/31 day pathway also in that month. Therefore it is possible that with a low volume of patients diagnosed in any month (mean 45) the percentage could fall if the number of patients who breach the pathway remains the same. This is illustrated in table 2 and most not be underestimated as to a reason for a fall in the monthly performance.

TABLE 2a 62 day cancer performance

	No of confirmed cancers	No of cancer breachers	% Performance
Sept 14	59	9.5	83%
Oct 14	56	5.5	83%
Nov 14	57	5.5	88%
Dec 14	63	5.0	88%
Jan 15	63	5.0	91%
Feb 15	46	4.5	89%
March 15	45	1.5	96%
April 15	56	4.0	91%
May 15	52	4.0	92%
June 15	52	7.5	84%
July 15	49	6.0	87%
Aug 15	53	8.0	82%
Sept 15	65	3.0	95%



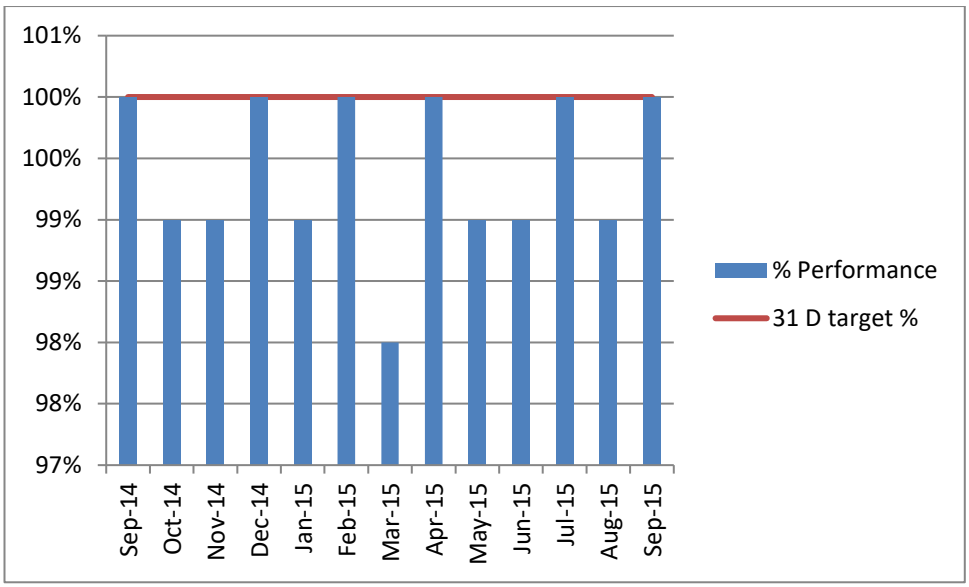
The 62D pathway has key milestones (appendix 1) which the cancer trackers work towards. These are:

- First outpatient appointment – D10
- Imaging & Diagnostics – D17-20
- Presentation at MDT – D20-21
- ITT (if required) D28

- By Day 31 all cancer patients must be at the point of 'date decision to treat' and management plan agreed
- First definitive treatment – D62

TABLE 2b 31 day cancer performance

	No of confirmed cancers	No of cancer breachers	% Performance
Sep-14	125	0	100%
Oct-14	125	1	99%
Nov-14	107	1	99%
Dec-14	111	0	100%
Jan-15	122	1	99%
Feb-15	85	0	100%
Mar-15	119	2	98%
Apr-15	109	0	100%
May-15	102	1	99%
Jun-15	114	1	99%
Jul-15	126	0	100%
Aug-15	101	1	99%
Sep-15	150	0	100%



Cancer Tracker / MDM Responsibilities

The Cancer Tracker has a pivotal role in ensuring the patients on the 31 and 62 day cancer pathways are fast tracked through all the above milestones, escalated and discussed at MDMs. Below is a list of the Cancer Tracker / MDM Co-ordinators core responsibilities:

- prospectively track all patients with cancer or suspected cancer in achieving the regional cancer access targets
- ensuring that all patients with cancer or suspected cancer have pre booked appointments and treatment in line with cancer access targets, and to raise delays with the MDT.
- ensuring all cancer patients are discussed at the MDT meeting
- ensuring all MDM management plans have been signed-off as being a correct record of the meeting's discussion. (This forms the main body of the MDT letter to GP)
- recording the MDT attendance for every meeting.
- adding any patient on the MDT list not discussed to the following week's list.
- For maintaining timely and accurate data collection, within CaPPs

.

The Cancer Tracking Team is currently made up of the following:

Cancer Team	Band / wte	Tumour Site	Frequency of MDT	Patients tracked on average	Average pts discussed at MDM	Average times a pt is discussed at MDM
Shauna McVeigh	1.0wte	Urology	Weekly	190	40	2
Ann Turkington	1.0wte	Lung Head & Neck Brain	Weekly Monthly Regional	200	Lung = 25 H&N (thyroid) = 15	2 1.5
Griania White	1.0wte	Upper & Lower GI	Weekly	500	UGI =10 LGI = 15	2 2
Wendy Kelly	1.0 wte	Gynae Haematology	Weekly Weekly	130	Gynae = 20 Haem = 6	2 2
Kelly George / Marie Dabbous	1.0wte (job share)	Breast Sarcoma	Weekly None	180	Breast = 37	2
Rachel McCartney	0.6wte	Skin	Weekly	150	Skin = 22	1

In total there are currently 5.5wte, however**, 1.6wte Trackers were recruited at risk** in November 2011

Band 3 Cancer appointment staff
There is currently 3.0 wte cancer appointment staff in post, of which 1.0wte recruited at risk in March 2012

Band 2 Cancer admin support
There is currently 2.0wte in post, of which **1.25wte recruited at risk** in February 2012

At risk posts:

- Band 4 – 1.6wte
- Band 3 – 1.0wte
- Band 2 – 1.25wte

Comparison of average number of patients discussed at each MDM

Cancer Team	Average pts discussed at MDM April to Oct 14	Average pts discussed at MDM April to Oct 15	Increase in pts discussed at MDM's each week	Average 50 MDM's per annual
Shauna McVeigh	Urology = 36	Urology = 40	Urology = +4	Urology = +200
Ann Turkington	Lung = 17 H&N (thyroid) = 15	Lung = 25 H&N (thyroid) = 15	Lung = +8 H&N (thyroid) = 0	Lung = +400 H&N (thyroid) = 0
Griania White	UGI =10 LGI = 14	UGI =10 LGI = 15	UGI =0 LGI = +1	UGI =0 LGI = +50
Wendy Kelly	Gynae = 14 Haem = 3	Gynae = 20 Haem = 6	Gynae = +6 Haem = +3	Gynae = +300 Haem = +150
Kelly George / Marie Dabbous	Breast = 31	Breast = 37	Breast = +6	Breast = +300
Rachel McCartney	Skin = 12	Skin = 22	Skin = +10	Skin = +500

Total number of an additional 1,900 more patients discussed at MDM's over the year comparison between April to Oct 14 and April to Oct 15 (7-months) – therefore, approximately an additional 3,257 pts discussed for the year

3,257 pts x 20minutes per patient to add to MDM and outcomes = 65,140 minutes / 50 weeks = 1,302.8 minutes per week = 21.7 hours per week (0.6wte). This does not include tracking of the patients

Each cancer pathway is complex and can vary dependent on the number of diagnostic tests that are required. The tumour sites which require multiple escalations from the Cancer Trackers to the HOS and AD due to lack of capacity, delay in reporting, delay in review etc are:

- Lung – escalated due to complex diagnostic pathway, patient requires CT, bronch, CT Biopsy, PET
- Urology – escalated due to radiology imaging and reported capacity
- Head & Neck – escalated due to CT biopsy capacity

The other tumours may still have escalations dependent on time of year (seasonal peaks, holiday season etc)

There is also 1.0wte band 2 support the Trackers in the below duties

- Printing MDM preview lists from CaPPs prior to the meeting (9 MDMs per week x 10 copies per MDM)
- filing the MDM outcome into the relevant notes (189 outcomes per week) and forwarding a copy to the oncology department of those patients who need to be referred to the oncologists
- posting a summary sheet or the pro forma to the referring General Practitioner within 24 hours of the MDT discussion taking place.
- Pull the breast packs (35 packs per week)

Admin Pressures

The core duty of the Cancer Tracker/MDM Co-ordinators is the live tracking of the suspect and confirmed cancer patient along their pathway. Tracking needs to be kept up-to-date in order to prevent breachers. The manpower the Cancer team has not changed since 2011 with an ongoing increase in demand of referrals:

	2010/11 referrals	**2015/16 referrals projected**	**Variance increase**	**% Increase**
62 Day	7722	13556	5834	75%
31 Day	3435	6282	2847	83%

The above significant increase has led to admin pressures in the Band 4 Cancer Tracker team, Band 3 Cancer appointment team and the Band 2 Admin support team

Proposals

In order to actively track the cancer patients, ensure the outcomes are forwarded to the GPs within 24 hours and filed in the hospital notes prior to the next review with 2-days the following additional admin staff are required.

Band 4 –

- 1.5wte to solely track and cover MDM's during periods of leave
- 1.6wte funding for at risk posts

Total: 3.1 wte

Band 3
1.0wte funding for at risk posts

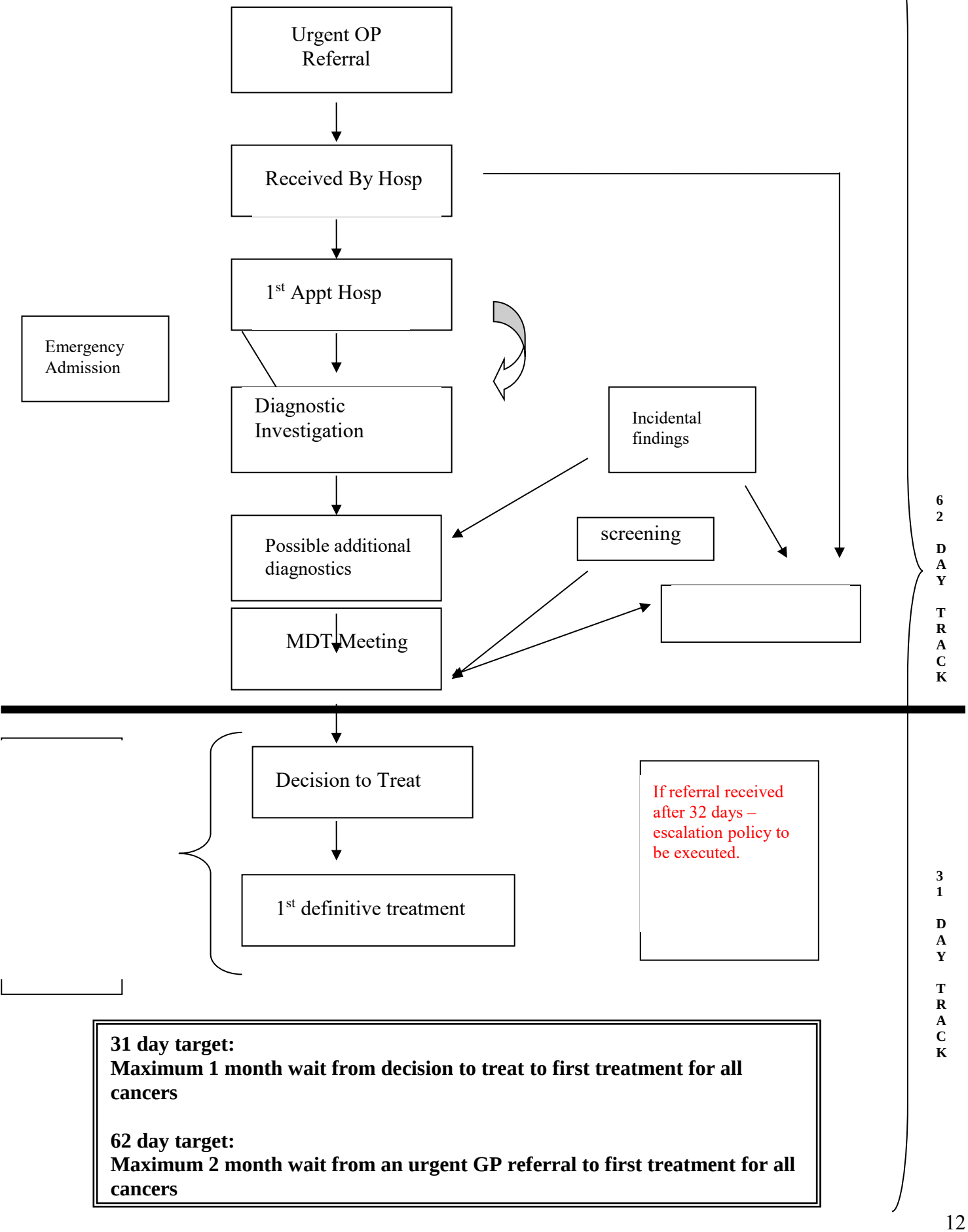
Band 2

- 1.0wte – to support the posting, printing and filing of the MDMs
- 1.25wte funding for at risk posts

Total 2.25wte

Appendix 1

CANCER PATIENT PATHWAY



31 day target:
Maximum 1 month wait from decision to treat to first treatment for all cancers

62 day target:
Maximum 2 month wait from an urgent GP referral to first treatment for all cancers

HCN	Surname	Forename	Specialty	GP Priority	Priority	PriorityChanged
Personal Information redacted by the USI			DERMATOLOGY	Red Flag	Urgent	DOWNGRADED
			GYNAECOLOGY - OTI	Red Flag	Routine	DOWNGRADED
			GYNAECOLOGY - OTI	Red Flag	Urgent	DOWNGRADED
			GYNAECOLOGY - OTI	Red Flag	Urgent	DOWNGRADED
			DERMATOLOGY	Red Flag	Urgent	DOWNGRADED
			GYNAECOLOGY - OTI	Red Flag	Urgent	DOWNGRADED
			DERMATOLOGY	Red Flag	Urgent	DOWNGRADED
			DERMATOLOGY	Red Flag	Urgent	DOWNGRADED
			GYNAECOLOGY - OTI	Red Flag	Routine	DOWNGRADED
			GYNAECOLOGY - OTI	Red Flag	Urgent	DOWNGRADED
			DERMATOLOGY	Red Flag	Urgent	DOWNGRADED
			GYNAECOLOGY - OTI	Red Flag	Urgent	DOWNGRADED
			GYNAECOLOGY - OTI	Red Flag	Urgent	DOWNGRADED
			GYNAECOLOGY - OTI	Red Flag	Urgent	DOWNGRADED
			GASTROENTEROLOG	Red Flag	Urgent	DOWNGRADED
			DERMATOLOGY	Red Flag	Urgent	DOWNGRADED
			GYNAECOLOGY - OTI	Red Flag	Urgent	DOWNGRADED
			DERMATOLOGY	Red Flag	Urgent	DOWNGRADED
			GYNAECOLOGY - OTI	Red Flag	Urgent	DOWNGRADED
			DERMATOLOGY	Red Flag	Urgent	DOWNGRADED
			GASTROENTEROLOG	Red Flag	Urgent	DOWNGRADED
			GYNAECOLOGY - OTI	Red Flag	Routine	DOWNGRADED
			GYNAECOLOGY - OTI	Red Flag	Urgent	DOWNGRADED
			GYNAECOLOGY - OTI	Red Flag	Urgent	DOWNGRADED
			UROLOGY	Red Flag	Urgent	DOWNGRADED
			GASTROENTEROLOG	Red Flag	Urgent	DOWNGRADED
			DERMATOLOGY	Red Flag	Urgent	DOWNGRADED
			GYNAECOLOGY - OTI	Red Flag	Urgent	DOWNGRADED
			DERMATOLOGY	Red Flag	Urgent	DOWNGRADED
			UROLOGY	Red Flag	Urgent	DOWNGRADED
			UROLOGY	Red Flag	Urgent	DOWNGRADED
			DERMATOLOGY	Red Flag	Urgent	DOWNGRADED

Personal Information redacted by the USI

Personal Information redacted by the USI

GYNAECOLOGY - OTI	Red Flag	Urgent	DOWNGRADED
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GYNAECOLOGY - OTI	Red Flag	Urgent	DOWNGRADED
GYNAECOLOGY - OTI	Red Flag	Urgent	DOWNGRADED
GYNAECOLOGY - OTI	Red Flag	Urgent	DOWNGRADED
GYNAECOLOGY - OTI	Red Flag	Urgent	DOWNGRADED
DERMATOLOGY	Red Flag	Urgent	DOWNGRADED
DERMATOLOGY	Red Flag	Urgent	DOWNGRADED
DERMATOLOGY	Red Flag	Urgent	DOWNGRADED
GYNAECOLOGY - OTI	Red Flag	Urgent	DOWNGRADED
GYNAECOLOGY - OTI	Red Flag	Urgent	DOWNGRADED
GENERAL SURGERY	Red Flag	Urgent	DOWNGRADED
GYNAECOLOGY - OTI	Red Flag	Urgent	DOWNGRADED
DERMATOLOGY	Red Flag	Urgent	DOWNGRADED
DERMATOLOGY	Red Flag	Urgent	DOWNGRADED
GENERAL SURGERY -	Red Flag	Urgent	DOWNGRADED

Personal Information redacted by the USI, 24.09.18

HCN	Full Name	Hospital	Specialty	GP Priority	Priority	PriorityChanged
Personal Information redacted by the USI		Craigavon Area Hospital	GYNAECOLOGY - OTHER	Red Flag	Urgent	DOWNGRADED
		Craigavon Area Hospital	GYNAECOLOGY - OTHER	Red Flag	Routine	DOWNGRADED
		Craigavon Area Hospital	DERMATOLOGY	Red Flag	Urgent	DOWNGRADED
		Daisy Hill Hospital	GENERAL SURGERY - COLORECTAL	Red Flag	Urgent	DOWNGRADED
		Craigavon Area Hospital	DERMATOLOGY	Red Flag	Urgent	DOWNGRADED
		Craigavon Area Hospital	GYNAECOLOGY - OTHER	Red Flag	Urgent	DOWNGRADED
		Craigavon Area Hospital	DERMATOLOGY	Red Flag	Urgent	DOWNGRADED
		Craigavon Area Hospital	DERMATOLOGY	Red Flag	Urgent	DOWNGRADED
		Daisy Hill Hospital	GENERAL SURGERY - COLORECTAL	Red Flag	Urgent	DOWNGRADED
		South Tyrone Hospital	DERMATOLOGY	Red Flag	Urgent	DOWNGRADED
		South Tyrone Hospital	DERMATOLOGY	Red Flag	Urgent	DOWNGRADED
		Daisy Hill Hospital	DERMATOLOGY	Red Flag	Urgent	DOWNGRADED
		Daisy Hill Hospital	GENERAL SURGERY - OTHER	Red Flag	Urgent	DOWNGRADED
		Daisy Hill Hospital	GENERAL SURGERY - COLORECTAL	Red Flag	Urgent	DOWNGRADED
		Daisy Hill Hospital	GENERAL SURGERY - COLORECTAL	Red Flag	Urgent	DOWNGRADED
		Craigavon Area Hospital	GASTROENTEROLOGY	Red Flag	Urgent	DOWNGRADED
		Armagh Community Hospital	GYNAECOLOGY - OTHER	Red Flag	Urgent	DOWNGRADED
		Armagh Community Hospital	DERMATOLOGY	Red Flag	Urgent	DOWNGRADED
		Daisy Hill Hospital	GYNAECOLOGY - OTHER	Red Flag	Urgent	DOWNGRADED
		Craigavon Area Hospital	GASTROENTEROLOGY	Red Flag	Urgent	DOWNGRADED
		Daisy Hill Hospital	DERMATOLOGY	Red Flag	Urgent	DOWNGRADED

Personal Information redacted by the USI 25.09.18

HCN	Full Name	Hospital	Specialty	Date of Referral	GP Priority	Priority
Personal Information redacted by the USI		Daisy Hill Hospital	DERMATOLOGY	20/09/2018 12:33	Red Flag	Urgent
		Craigavon Area Hospital	DERMATOLOGY	20/09/2018 10:48	Red Flag	Urgent
		Daisy Hill Hospital	GYNAECOLOGY - OTHER	20/09/2018 10:29	Red Flag	Urgent
		Craigavon Area Hospital	UROLOGY	18/09/2018 18:10	Red Flag	Urgent
		Daisy Hill Hospital	GENERAL SURGERY - COLO	18/09/2018 11:27	Red Flag	Urgent
		South Tyrone Hospital	DERMATOLOGY	18/09/2018 09:39	Red Flag	Urgent
		South Tyrone Hospital	GASTROENTEROLOGY	17/09/2018 17:15	Red Flag	Urgent
		Craigavon Area Hospital	DERMATOLOGY	17/09/2018 15:52	Red Flag	Urgent
		Daisy Hill Hospital	DERMATOLOGY	17/09/2018 14:33	Red Flag	Urgent
		Craigavon Area Hospital	GASTROENTEROLOGY	17/09/2018 12:27	Red Flag	Urgent
		Craigavon Area Hospital	GYNAECOLOGY - OTHER	14/09/2018 17:15	Red Flag	Urgent

Personal Information redacted by the USI

25.09.18

Southern Health and Social Care Trust

Cancer Target Escalation Policy

Background

This policy is to inform Tracker/MDT Co-ordinators, Clinicians and Divisional Management Teams of the escalation policy for Cancer Access targets.

The current cancer access standard waiting time targets are:
14 days – 100% for the 2 week wait breast symptomatic outpatient appointment
31 days – 98% date decision to treat to first definitive treatment
62 days – 95% date of receipt of referral to first definitive treatment

It is the purpose of this policy to illustrate the actions that will be required at specific points along the patient's pathway. These actions will be escalated from the first trigger point (illustrated in Table 1).

In order for the patient to progress along the pathway the Cancer Trackers have a central role to play in that they will start the tracking process and the initial escalation. The trackers have been given the authority to expedite referrals (either appointments/diagnostics) within their own level of responsibility.

In the event of delays in the patient pathway, as detailed in Appendix 1 the tracker will escalate to the Cancer Services Co-ordinator or in her absence the Operational Support lead, who will in turn advise the Cancer Head of Service, who will advise the relevant head of Service, of any actions taken or ongoing delays.

Table 1 Key points on the pathway for tracker escalation if not booked or completed

Key Point	Best date	Latest Acceptable
First appointment	By day 10	By day 14
Investigations/staging	By day 17	By day 20
MDM	By day 25	By day 26
ITT	By day 28	By day 28
Treatment	By day 31 or 62 (relevant to pathway)	Day 31 or 62

The Head of Service will escalate patients who go 'red' at key points prior to day 31 on the pathways to the relevant Assistant Directors and Clinical leads (where not already discussed at MDT).

Where patients have gone beyond day 21 with no first appointments, in addition to the above people, this will be escalated to the Director for Acute Services.

The tracker will raise all on going risks at the Multidisciplinary meeting, and communicate the outcome and any unresolved issues to the Cancer Services Co-ordinator who will, if required, escalate through a series of senior managers (see table 2) ultimately to the Executive Lead for Cancer, who will inform the Chief Executive in the event of failure to resolve this issue.

The table below illustrates the escalation chain. Each level will escalate to the next as required until the delay has been addressed.

Southern Health and Social Care Trust

Escalation reporting and actions taken will be noted by the tracker in the diary page of the Capps system.

Table 2

Person Responsible	Name & Contact	Timescale for escalation
Cancer Tracker/MDT Co-ordinator	Anne Turkington Personal Information redacted by the HSI Hilda Kerr Personal Information redacted by Sharon Reid Personal Information redacted by the HSI Wendy Kelly Information redacted by Vicki Graham Personal Information redacted by the HSI	Within 24 hours of noted point of breach
Cancer Services Co-ordinator + relevant service co-ordinator	Angela Montgomery	Within 24 hours of noted point of breach
Operational Support Lead + relevant services OSL	Wendy Clayton	Within 24 hours of noted point of breach
Head Of Cancer Services + relevant service HoS	Alison Porter	Within 24 hours of noted point of breach
Assistant Director for Cancer & Clinical Services + relevant Assistant Director for relevant specialty area & Relevant Clinical Lead	Ronan Carroll Relevant MDT Clinical Lead Heather Trouton Barry Conway Anne McVey	Next day
Executive Lead for Cancer	Gillian Rankin	Within 24 hours of noted point of breach
Director of Performance & Reform	Paula Clarke	Within 24 hours of noted point of breach
Chief Executive Officer	Mairead McAlinden	As appropriate

Note – these timescales are the longest periods expected. Earlier action may be necessary

Cancer Tracker/MDT Co-ordinator will be aware of their individual patient pathways and the reasonable timescales expected. A generic pathway is attached as Appendix 1, specific site pathways area are also available. Each step of the pathway is a potential weak link in the chain; and clear observation is required at all stages to ensure:

(a) patients appointments are booked
(b) patients attend these appointments
(c) the next appointment is booked
(d) treatment is started

General principles of escalation are

(a) the earlier the better. It is easier to stand people down once the problem is resolved than to catch up lost time
(b) try everything you know to resolve the problem
(c) recognise that you can't solve all of the problems – but by passing it on you will give others a chance to

Southern Health and Social Care Trust

(d) clearly record on the diary and pass on the steps you have taken
(e) take action in a timely manner – be clear of the timescale of escalation

Inter-Trust transfers
Where the potential or breach involves an inter trust transfer it is the responsibility of the Southern Trust's Executive Lead for Cancer to contact the Executive Lead for Cancer in the 'referred to' Trust to discuss delayed referrals (received after 28days) and breach situations in order to understand reasons for delay and to agree "shared breaches". The breach report mechanism exists to support this.

This policy must be followed by all members of staff, in every event. This policy is designed to ensure problems are resolved at the lowest level, but that an executive director is informed within 24 hours of any failure of the system that has not been resolved at lower organisational/divisional levels.

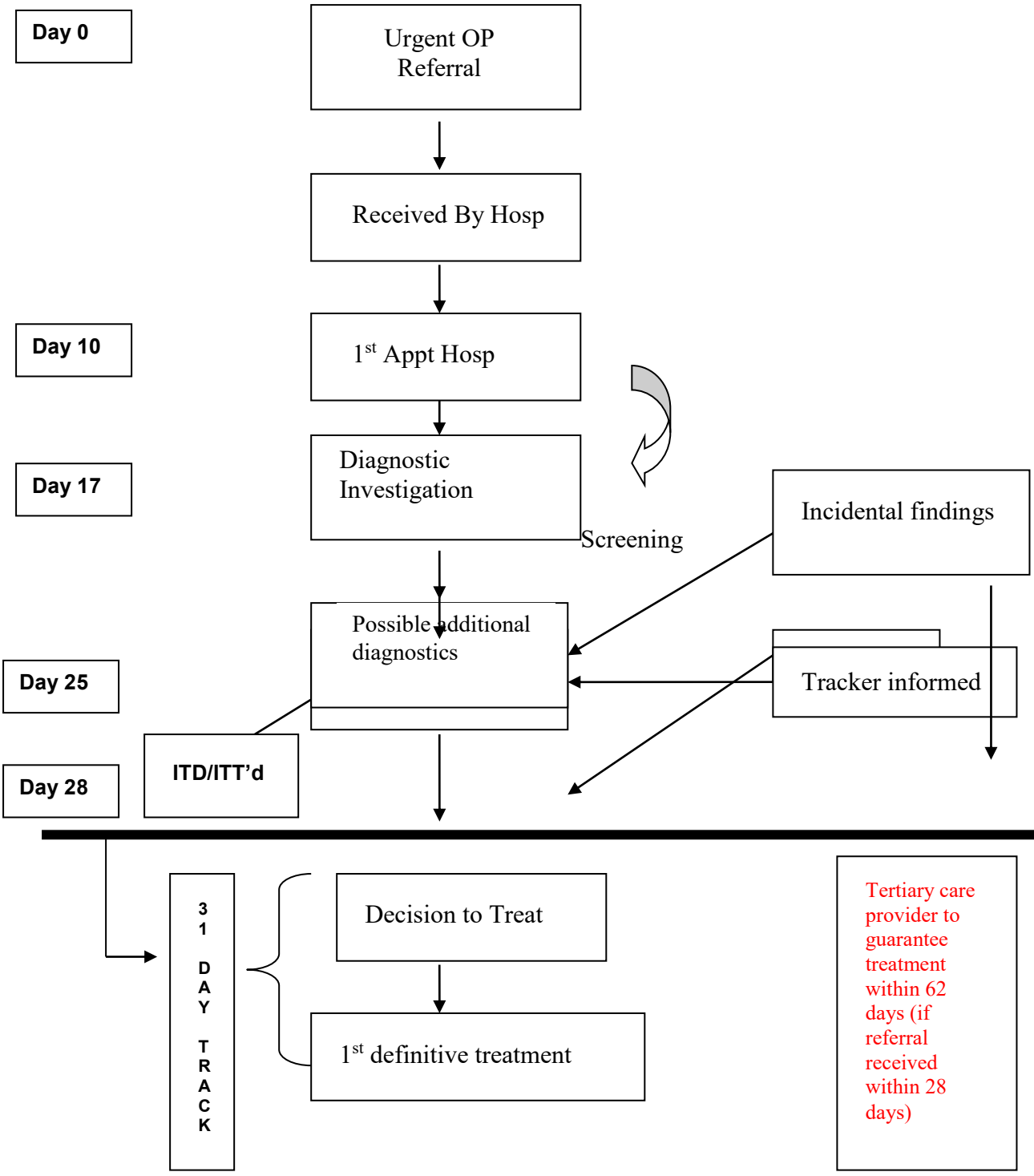
Breach Reports
Breach reports will be commenced by the trackers where patients breach the targets, i.e. 14 day for breast, 28 day for inter –trust transfers, day 31 and day 62 breaches.

A copy of the breach report will be forwarded to the relevant Assistant Director, and the teams Clinical lead for actions to be taken within agreed time frames.

Southern Health and Social Care Trust

Appendix 1(Key Timelines for Appointment)

PATIENT PATHWAY



31 day target:
Maximum 1 month wait from decision to treat to first treatment for all cancers

62 day target:
Maximum 2 month wait from an urgent GP referral to first treatment for all cancers

Graham, Vicki

From: Montgomery, Angela < Personal Information redacted by the USI >
Sent: 21 September 2011 13:50
To: Dabbous, Marie; Graham, Vicki; Kelly, Wendy; Kerr, Hilda; McDonald, Sarah; McVeigh, Shauna; Reid, Sharon; Turkington, Ann E
Subject: Escalation Policy
Attachments: Escalation Policy May 2011.doc

Hi

Please find attached new draft escalation policy can you please read this and let me know if you have any comments?

Thanks

Angela

Angela Montgomery
Cancer Services Co-Ordinator
Tel. No. (028) Personal Information

Cancer Pathway Escalation Policy

1.0 Background

This policy is to inform Cancer Tracker/ Multi-Disciplinary Team (MDT) Co-ordinators, Clinicians and Divisional Management Teams of the escalation policy for Cancer Access targets.

The current cancer access standard targets are:
14 days – 100% for the 2 week wait breast symptomatic outpatient appointment
31 days – 100% date decision to treat to first definitive treatment
62 days – 98% date of receipt of referral to first definitive treatment

The purpose of this policy to illustrate the actions that may be required at specific points along the patient's pathway. These actions will be escalated from the first trigger point. (Please see Table 1)

2.0 General Principles of Escalation

General principles of escalation are as follows:

(a) The earlier the better.
It is easier to stand people down once the problem is resolved than to catch up lost time
(b) Try everything you know to resolve the problem
(c) Recognise that you can't solve all of the problems – but by escalating it will give others a chance to help find a solution.
(d) Record on the escalation proforma the steps you have taken
(e) Take action in a timely manner
Be clear of the timescale of escalation
If a response is not received from Consultant/Clinician within outlined timescale for escalation the relevant Chair of the MDT is to be notified.

3.0 Trigger Points for Escalation

For a patient to progress along the pathway, the Cancer Trackers will start the tracking process and be responsible for escalations throughout the pathway. In order for the Trackers to track they have been given the authority to expedite referrals (either appointments/diagnostics) within their own level of responsibility. While the Red Flag Appointments Team will escalate patients outside of expected 1st appointment timescales, the tracker will track the full cancer pathway.

In the event of delays in the patient pathway, as detailed in Appendix 1, the tracker will escalate to the Cancer Services Co-ordinator (CSC) or in her absence the Operational Support lead (OSL), who will in turn advise the Head of Cancer Service. The CSC will advise the relevant Head of Service (HOS) /OSL for that specialty, of any actions required to be taken or ongoing delays.

The HOS/OSL for the specialty will escalate patients who trigger key points on the pathways to the relevant Assistant Directors and Clinical leads as required.

Table 1 - Key trigger points on the Cancer pathway for escalation if patient not booked or completed

Key Trigger	Trigger Point	Escalate To	Further Escalation Point	Also Escalate To
First appointment	By day 10	>Head of Service >OSL	By Day 21	>Assistant Director for the Specialty >Director for Acute Services
Investigations/ Diagnostics	By day 17	>Head of Service >OSL	Greater than 10 days for diagnostic investigation or reporting	>Head of Service for Radiology >Assistant Director for Cancer & Clinical Services
MDM	By day 25	>Head of Service >OSL		
ITT	By day 28	>Head of Service >OSL		
Treatment	By day 31 or 62 (relevant to pathway	>Head of Service >OSL	Breaches of 31 or 62 day pathway	>Assistant Director for the Specialty

**please note that red flag appointments will escalate 1st out-patient appointment, the tracker will be responsible for liaising with red flag team if patient is not booked or on red flag out-patient waiting list for appointment.*

3.4 Delayed Escalation Response:

If the Cancer Trackers are awaiting a response for longer than 1 week regarding a management plan for a patient on a cancer pathway, and all relevant steps have been taken as per escalation policy, the relevant Multi Disciplinary Meeting Chair will be notified to avoid any further delays for the patient and copied to HOS for the specialty.

3.5 MDT Meetings:

The tracker will raise all on going risks at the Multidisciplinary meeting which will be minuted, and communicate the outcome and any unresolved issues to the CSC. If no solution is found, the risk will be escalated through a series of senior managers (see table 2) ultimately to the Clinical Lead for Cancer, who will inform the Chief Executive in the event of failure to resolve this issue.

3.6 Deferment from MDT:

If a patient is deferred from MDT discussion, this must be escalated to the releveant specialty HOS and OSL. It is the HOS and OSL responsibility to ensure the patient is discussed the following week and this is highlighted to the Chair of the MDT.

3.7 Inter-Trust transfers:

It is recognised good practice that where a potential breach or confirmed breach requires an Inter Trust Transfer (ITT), it is the responsibility of the Southern Trust's Executive Lead for Cancer to contact the Executive Lead for Cancer in the 'referred to' Trust to discuss delayed referrals (received after 28 days) and breach situations in order to understand reasons for delay and to agree "shared breaches".

Unfortunately, as pathways for some tumour sites continue to come under increased pressure, it may not always be practical for this level of contact/discussion to take place. The Trust will continue to liaise closely with the 'referred to' Trust in these circumstances to ensure patients receive treatment and care as quickly as possible on the pathway

4.0 Escalation Chain

Table 2 – Escalation chain for trigger points throughout cancer pathway

Escalation Chain	Role Responsible for Escalating	Escalation Point	Timescale for escalation	Cumulative Timescale for escalation
1.	Red Flag Appointments Team/ Cancer Tracker/MDT Co-ordinator	Cancer Services Co-Ordinator	24 hours	24 hours
2.	Cancer Services Co-ordinator	Head of Service for the Specialty Head of Service for Cancer copied to relevant OSLs	24 hours	48 hours
3.	Head of Service for the Specialty	Assistant Director for the Specialty Assistant Director for Cancer Services *Copied to Head of Service for Cancer and Cancer Services Co-ordinator*	24 hours	3 days
4.	Assistant Director for the Specialty	Chair of MDM *Copied to Head of Service for Cancer and Cancer Services Co-ordinator*	24 hours	4 days
5.	Chair of MDM	Executive Lead for Cancer *Copied to Head of Service for Cancer and Cancer Services Co-ordinator*	24 hours	5 days
6.	Executive Lead for Cancer	Director of Acute Services *Copied to Head of Service for Cancer and Cancer Services Co-ordinator*	24 hours	6 days
7.	Director of Acute Services	Chief Executive Officer *Copied to Head of Service for Cancer and Cancer Services Co-ordinator*	24 hours	7 days

Note – these timescales are the longest periods expected.

Each Cancer Tracker/MDT Co-ordinator will be aware of individual patient pathways for each tumour site and the reasonable timescales expected. A generic pathway is attached as Appendix 1, specific site pathways are are also available.

Each step of the pathway is a potential weak link in the chain; and clear observation is required at all stages to ensure:

(a) patient appointment is booked
(b) patient attends appointment
(c) the next review appointment is booked
(d) treatment is commenced

The table above illustrates the escalation chain with each level escalating as required until the delay has been addressed.

Escalation reporting and actions taken will be noted by the tracker in the diary page of the Capps system.

Table 3 – Escalation Chain Roles and Contacts

Roles	Contact Name
Cancer Tracker/ MDT Co-Ordinator	Marie Dabbous Anne Turkington Hilda Shannon Wendy Kelly Shauna McVeigh Griania White Rachel McCartney Catherine Glenny Sinead Lee Sarah Moore
Cancer Services Co-Ordinator	Vicki Graham Angela Muldrew
Heads of Service	Fiona Reddick - Cancer Services Martina Corrigan - Urology/ENT Amie Nelson - UGI / LGI / Breast Kay Carroll – Derm / Lung Wendy Clarke – Gynaecology Louise Devlin - Gastroenterology
Operational Support Lead	Sharon Glenny – IMWH & CCS Wendy Clayton – SEC Lisa McAreavey - MUSC
Assistant Director	Barry Conway – IMWH & CCS Anne McVey – MUSC Ronan Carroll – SEC
Chair of MDM	Dr McCracken – Gynae Mr Neill – LGI Mr Glackin – Urology Dr Mathers – Breast Dr Convery – Lung Dr O'Hagan – Skin Dr Boyd – Haematology Dr McCaul – Head & Neck
Executive Lead for Cancer	Dr McCaul
Director of Acute Services	Esther Gishkori
Chief Executive Officer	Shane Devlin

5.0 Pathway Breaches

Breach reports will be commenced by the Cancer Tracker/MDT Co-ordinator where patients breach the targets, i.e. 14 day for breast, 28 day for inter–trust transfers, day 31 and day 62 breaches.

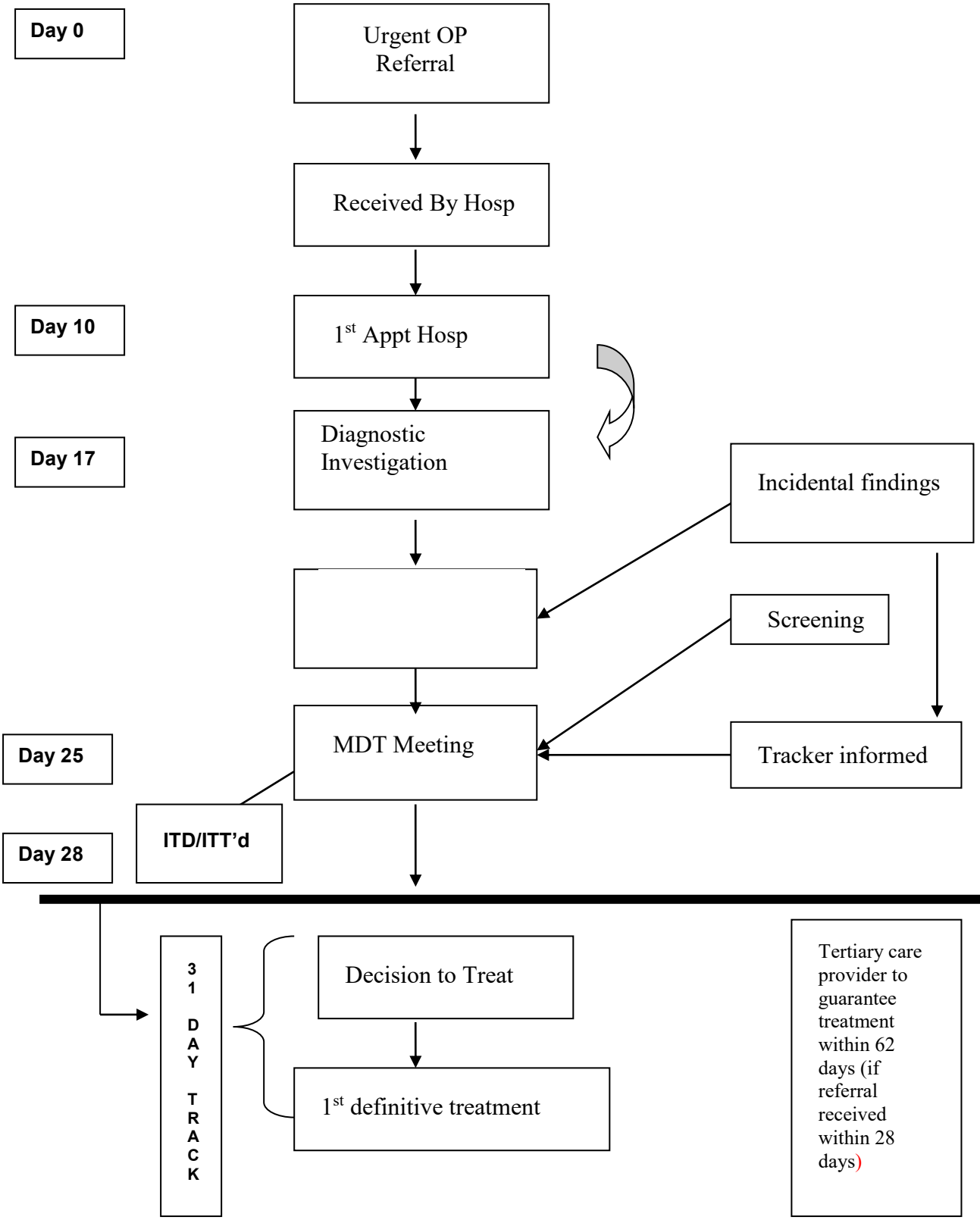
A copy of the breach report will be forwarded to the relevant Assistant Director, and the team's Clinical lead for action as appropriate.

Monthly breaches by tumour site will be discussed at the Cancer Monthly Performance Meeting and areas for improvement analysed.

This policy must be followed by all members of staff, in every event.
This policy is designed to ensure problems are resolved at the lowest level, but that an Executive Director is informed within 24 hours of any failure of the system that has not been resolved at lower organisational/divisional levels.

Appendix 1

PATIENT PATHWAY



31 day target:
Maximum 1 month wait from decision to treat to first treatment for all cancers

62 day target:
Maximum 2 month wait from an urgent GP referral to first treatment for all cancers

Graham, Vicki

From: Graham, Vicki <[redacted]>
Sent: 12 September 2019 12:42
To: Dabbous, Marie; Glenny, Catherine; Shannon, Hilda; Kelly, Wendy; Lee, Sinead; McVeigh, Shauna; Moore, SarahM; Shannon, Hilda; Turkington, Ann E; White, Griania
Cc: Glenny, Sharon
Subject: Cancer Pathway Escalation Policy Final August 2019 updated
Attachments: Cancer Pathway Escalation Policy Final Augut 2019 updated.doc

Importance: High

Afternoon,

Please see attached amended Escalation Policy that has been slightly amended. Could you please print this off so that you have the most up to date version of this close at hand to refer to?

**Just a reminder that is it the Red Flag Appointment team who are to escalate first appointments, but that it is the responsibility of the Tracker to track all patients that are on the 31D and 62D pathway for their own site(s). The Appointment team have all been reminded to add a notification and update CaPP's at time of booking, and now that the team is more settled this should become more evident. Please do contact that appointment team and include me into any emails if at any time when scrolling down your tracking page and there has been no recent activity for a particular patient so that not too much time lapses.

Also to keep you updated with regards to all the escalations that you have been all sending through as a team as per escalation policy – these are being audited as to how many responses/appointments/surgeries are able to be brought forward. Once this feedback has been received I will advise you all of the outcome.

Many thanks,

Vicki Graham
Cancer Services Co-ordinator
Office 10
Level 2
MEC
EXT [redacted]

Southern Health and Social Care Trust
Quality Care - for you, with you

Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title, Pay Band: Band 5 **Staff Number:** Personal Information redacted by the USI

Is Professional Registration up to date? _____

KEY ISSUES & OUTCOMES	COMMENTS
Have you read and understood your Post Outline? **Post Outlines can be accessed via Trust Intranet (KSF link)** **YES** [x] **NO** [ ] **Have Post Outline levels been achieved:** **YES** [x] **NO** [ ] **If no, record below what action to be taken:**	**Staff members comments on his/her performance over past year:** Personal Information redacted by the USI
Objectives for Next Year: Personal Information redacted by the USI	

Reviewee Staff Name (Print) VICKI GRAHAM Signature _____ Date 24/06/16

Reviewer Manager/Supervisor (Print) ANGELA MULDREW Signature _____ Date 24/6/16

Southern Health and Social Care Trust
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Part B

ANNUAL PERSONAL DEVELOPMENT PLAN

For training requirements specific to your staff group refer to Trust Intranet Training Link

Staff Number: Personal Information redacted by the USI

Training type	Identified learning need	Date Training Completed	Agreed Action
Corporate Mandatory Training ALL STAFF	Personal Information redacted by the USI		
Corporate Mandatory Training ROLE SPECIFIC			
Essential for Post			
Best practice/ Development (Coaching/Mentoring) (Relevant to current job role)			

Reviewee Staff Name (Print) VICKI GRAHAM Signature _____ Date 24/06/16

Reviewer Manager/Supervisor (Print) ANGELA MULDREW Signature _____ Date 24/06/16

PLEASE SEND COMPLETED PART B TO: KSF DEPARTMENT, HILL BUILDING, ST LUKES HOSPITAL, LOUGHGALL ROAD, ARMAGH BT61 7NQ

OR EMAIL TO: - Personal Information redacted by the USI

Graham, Vicki

From: Graham, Vicki <Personal Information redacted by the USI>
Sent: 06 February 2019 17:39
To: McVeigh, Shauna
Subject: 2019 PDR-SMcV
Attachments: 2019 PDR-SMcV.docx

Importance: High

Hi Shauna

That time again, well it's actually overdue so sorry, but could you please complete all your training and your comment on your performance, then we can schedule a date that suits to complete review?

If you have undertaken any other training or attended any course please let me know and I can list this on your report.

Many thanks,

Vicki Graham
Cancer Services Co-ordinator
Office 10
Level 2
MEC
EXT Personal Information redacted by

Graham, Vicki

From: Clayton, Wendy <Personal Information redacted by the USI>
Sent: 20 January 2016 13:49
To: Barron, Caroline; Graham, Vicki; McAlister, Linda; Meredith, Lorraine; Muldrew, Angela; Park, Denise; Reaney, Gillian
Subject: FW: KSF Report - Report detailing PDP's received from 1st December 2013 to the 31st December 2015 Inclusive
Attachments: December 2015 original.xlsx

Hi all

Can you advise on PDP compliance for your area please? How many are complete / to be complete by 31/3/16?

Thanks

Wendy Clayton
Operational Support Lead
Cancer & Clinical Services / ATICs
Tel: Personal Information redacted by the USI *Mob:* Personal Information redacted by the USI

From: Carroll, Ronan
Sent: 20 January 2016 11:21
To: McIlroy, Cathie; Magee, Brian; McGeough, Mary; Reddick, Fiona; Robinson, Jeanette; Clayton, Wendy
Subject: FW: KSF Report - Report detailing PDP's received from 1st December 2013 to the 31st December 2015 Inclusive

Well done – can we do better? (and don't reply yes we can!!!)

Ronan Carroll
Assistant Director Acute Services
Cancer & Clinical Services/ATICs
Personal Information redacted by the USI

From: Walker, Helen
Sent: 20 January 2016 11:17
To: Carroll, Anita; McVey, Anne; Conway, Barry; Gibson, Simon; Boyce, Tracey; Trouton, Heather; Carroll, Ronan
Subject: FW: KSF Report - Report detailing PDP's received from 1st December 2013 to the 31st December 2015 Inclusive

FYI and appropriate action.
H

From: Haddock, Noeleen
Sent: 19 January 2016 11:59
To: Donaghy, Kieran; Mallagh-Cassells, Heather; Heather Clyde; Toal, Vivienne; Forsythe, Anne; Patterson, Karyn; Anderson, Karen; King, Ray; Gordon, Lynda; Mallon, Maura; Walker, Helen; Campbell, Catriona; Johnston, Jenny; McElrath, Lindsay; Metcalfe, Alan
Cc: Davison, Tara; McCorry, Jenny; Irwin, Lynn; McCann, Ann; McGreevy, Carol
Subject: KSF Report - Report detailing PDP's received from 1st December 2013 to the 31st December 2015 Inclusive

Dear All,

Please find attached KSF / PDP report detailing receipt of PDPs received from 1st December 2013 to the 31st December 2015 Inclusive.

This report details the % of staff in each Directorate / Division who have completed their PDR / PDP Process. A breakdown of staff names within each division can be provided upon request if required.
Please note the VWAC Department have a number of staff who can be contacted to assist your department with any KSF queries, contact names can be found on the Intranet.

If you wish to speak to me in connection to the KSF report please do not hesitate to contact me.

Kind Regards

Noeleen Haddock
KSF Advisor / Lead
VWAC / KSF
Hill Building, St Luke's
Armagh
Personal Information redacted by the USI
Personal Information redacted by the USI

Southern Health and Social Care Trust
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Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title, Pay Band: Patient Tracker/MDT Co-Ordinator, Band 4 **Staff Number:** Personal Information redacted by the USI

Is Professional Registration up to date? _No_____

KEY ISSUES & OUTCOMES	COMMENTS
Have you read and understood your Post Outline? **Post Outlines can be accessed via Trust Intranet (KSF link)** **YES** ☐ **NO** ☐ **Have Post Outline levels been achieved:** **YES** ☑ **NO** ☐ **If no, record below what action to be taken:**	**Staff members comments on his/her performance over past year:** Personal Information redacted by the USI **Line Manager's Feedback on staff members performance over past year:**
Objectives for Next Year: Personal Information redacted by the USI	

Reviewee Staff Name (Print) _Shauna McVeigh_____ Signature _____ Date _____

Reviewer Manager/Supervisor (Print) _Vicki Graham_____ Signature _____ Date _____

Southern Health and Social Care Trust
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Part B

ANNUAL PERSONAL DEVELOPMENT PLAN

For training requirements specific to your staff group refer to Trust Intranet Training Link

Staff Number: Personal Information redacted by the USI _____

Training type	Identified learning need	Date Training Completed	Agreed Action
Corporate Mandatory Training ALL STAFF	Personal Information redacted by the USI		
Corporate Mandatory Training ROLE SPECIFIC			
Essential for Post			
Best practice/ Development (Coaching/Mentoring) (Relevant to current job role)			

Reviewee Staff Name (Print) __Shauna McVeigh _____ Signature _____ Date _____

Reviewer Manager/Supervisor (Print) Vicki Graham_____ Signature _____ Date _____

PLEASE SEND COMPLETED PART B TO: KSF DEPARTMENT, HILL BUILDING, ST LUKES HOSPITAL, LOUGHGALL ROAD, ARMAGH BT61 7NQ

OR EMAIL TO: - Personal Information redacted by the USI

Southern Health & Social Care Trust
Summary of Current Staff with PDPs by Directorate by Division
Prepared by HR Contact - Noeleen Haddock, KSF Advisor/ Lead
Date: 18.01.2016

Key: % Trained
0% - 59%
60% - 79%
80% - 100%

Notes:
This report is for KSF administration purposes only. Please do not share this information.
Staff with Multiple Posts are shown more than once in this report.

Staff on Maternity Leave are included in this report

THE STAFF LISTED BELOW HAVE BEEN EXCLUDED FROM THIS REPORT
1. Bank Staff
2. Staff on an Employment Break
3. Staff seconded out of Trust
4. All staff in personnell Areas Medical & Dental

		PDP's		
Directorate	**Division**	**Head Count**	**PDP Received**	**% PDP Received**
Acute Services	Cancer & Clinical Services Division	1000	437	44%
	Director's Office Division	2	0	0%
	Functional Support Services Division	983	422	43%
	General & Speciality Medicine Division	435	74	17%
	Integrated Maternity Services & Womens Health Division	395	251	64%
	Pharmacy Division	148	31	21%
	Surgery & Elective Division	449	97	22%
	Unscheduled Care Division	451	107	24%
Acute Services Total		**3863**	**1419**	**37%**
Chief Executive's Office	Chief Executive's Office Division	18	0	0%
	Communications Division	9	1	11%
Chief Executive's Office Total		**27**	**1**	**4%**
Children & Young People's Services	Corporate Parenting Division	231	88	38%
	Director's Office Division	7	3	43%
	Family Support & Safeguarding Division	560	88	16%
	Social Care Governance Division	5	5	100%
	Social Services Training Unit Division	19	10	53%
	Specialist Child Health & Disability Division	638	360	56%
Children & Young People's Services Total		**1460**	**554**	**38%**
Finance & Procurement	Director's Office Division	2	0	0%
	Financial Accounting Division	73	60	82%
	Financial Management Division	47	33	70%
Finance & Procurement Total		**122**	**93**	**76%**

HR & Organisational Development	Director's Office Division	10	5	50%
	Education Learning & Development Division	9	7	78%
	Employee Engagement & Relations Division	41	22	54%
	Equality Assurance Division	3	2	67%
	Estates Services Division	128	89	70%
	Health & Safety Division	5	4	80%
	Medical Staffing Unit Division	7	1	14%
	Occupational Health Division	15	15	100%
	Resourcing Division	21	15	71%
	Vocational Workforce Assessment Division	11	11	100%
	Workforce Information Division	17	0	0%
HR & Organisational Development Total		**267**	**171**	**64%**
Medical	Director's Office Division	10	6	60%
	Governance Division	13	9	69%
Medical Total		**23**	**15**	**65%**
Mental Health & Disability Services	Director's Office Division	67	33	49%
	Governance Division	25	19	76%
	Learning Disability Division	550	296	54%
	Medical Division	3	0	0%
	Mental Health Division	635	406	64%
	Physical Disability Division	203	84	41%
	Psychology Division	25	12	48%
Mental Health & Disability Services Total		**1508**	**850**	**56%**
Older People & Primary Care	Director's Office Division	7	3	43%
	Enhanced Services Division	563	372	66%
	Older People Division	1339	909	68%
	Primary Care Division	691	236	34%
	Promoting Wellbeing Division	69	49	71%
Older People & Primary Care Total		**2669**	**1569**	**59%**
Performance & Reform	Best Care Best Value Division	5	2	40%
	Corporate Planning Division	15	15	100%
	Director's Office Division	2	0	0%
	Informatics Division	118	68	58%
	Performance Improvement Division	14	4	29%
Performance & Reform Total		**154**	**89**	**58%**
Grand Total		**10093**	**4761**	**47%**
HR & Organisation Development	AFC & Staffside	13	3	23%

31st December 2015	Head Count	PDP Received	% PDP Received
Grand Total	10093	4761	47%

30th November 2015	Head Count	PDP Received	% PDP Received
Grand Total	9995	4683	47%

31st October 2015	Head Count	PDP Received	% PDP Received
Grand Total	9382	4479	48%

Graham, Vicki

From: Graham, Vicki <Personal Information redacted by the USI>
Sent: 31 January 2018 15:45
To: Haynes, Mark
Subject: Proposed Bladder Cancer Guidance Dec 2017 (3)
Attachments: Proposed Bladder Cancer Guidance Dec 2017 (3).docx

Importance: High

Hi Mark,

We discussed the proposed bladder cancer guidance today at the Regional Cancer OP meeting and all trackers are aware of this change in process. Would there be any chance that this could be discussed at the Urology MDM tomorrow just to finalise the process and so that Shauna can be part of this discussion as it will have quite a significant change to her current tracking process?

Many thanks,

Vicki Graham
Cancer Services Co-ordinator
Red Flag Appointment Office
Tel. No. Personal Information redacted by the USI
Internal Ext: Personal Information redacted by *(Note: if dialling from the old system please dial* Personal Information redacted by *in front of the extension)*

Proposed Bladder Cancer Guidance, December 2017

Does TURBT count as first treatment for bladder cancer?
If a patient has non muscle invasive bladder, transurethral resection of the bladder tumour (TURBT) counts as first treatment. This applies to patients staged as pT1G3 and below.

If a patient has muscle invasive bladder cancer (patients staged as pT2 and above), the initial TURBT should be classified as a diagnostic staging procedure. First definitive treatment for patients with muscle-invasive disease will be their subsequent treatment such as cystectomy, radiotherapy or neo-adjuvant chemotherapy.

The differentiation between muscle invasive and non muscle invasive will be made from the pathology following the TURBT. Some patients may be upstaged from non muscle invasive bladder cancer to muscle invasive at MDM. If this happens, the MDT coordinator must be notified so they can ensure the patient is tracked in the appropriate way.

Graham, Vicki

From: Graham, Vicki <Personal Information redacted by the USI>
Sent: 02 August 2019 11:58
To: Reddick, Fiona; Glenny, Sharon
Cc: Muldrew, Angela
Subject: Cancer Operational Meeting

Importance: High

Hi Fiona/Sharon,

Just following up on a topic that was discussed at this week's Cancer Operational Meeting, and that most other Trusts are now working closely with Consultants and Clinical teams in that they are actually documenting in clinic outcome letters/clinic outcome sheets that the patient can come off red flag pathway/or no longer needs to be tracked as a Red Flag. Do you know since the introduction of the new Escalation Policy, and due to the increased volume of patients being tracked if this request has been communicated out to local clinical team asking that they clearly state in clinic outcome letter that patient can be removed from RF Pathway? I feel this would help the tracking team considerably and would hopefully cut down on the emails that are currently sent to Consultant's or that are escalated if we are unsure of management plan?

Many thanks,

Vicki Graham
Cancer Services Co-ordinator
Office 10
Level 2
MEC
EXT Personal Information redacted by

Graham, Vicki

From: Graham, Vicki < Personal Information redacted by the USI >
Sent: 18 January 2019 15:41
To: Glenny, Sharon
Subject: Trackers *URGENT*

Importance: High

Hi Sharon,

Would you be able to give me a ring regarding the proposed changes to tracking following yesterday's meeting in that the trackers have now to keep patients open until advised by Clinicians. I passed this information onto the trackers, and it has caused a lot of confusion among the tracking team, most of which I can understand. The main issues of concern are listed below

- Do they need the clinicians to instruct them to take off each patient on the pathway (either by email of clinic outcome) if so what about all of the patients currently being tracked at the minute ? Griania gave me an example in that if a skin biopsy was benign – do they still need to check with Consultant.
- Staff members were happy to come in over weekend and look at tracking as we have Personal Information redacted by the USI & Ann is off on annual leave – They longer feel that they are unable to do this as they will not be able to take any patients off tracking.
- They are now querying their Band 4 role, as this is what distinguishes the difference between Sarah , who is a Band 3 and the trackers who are Band 4 is the tracking. It is that they had been using their knowledge and experience to take patients off tracking, and were checking with Consultant if they were unsure at any point – do they still need to continue to do this way of tracking.
- Is there a SOP on tracking, and if not will there be one made available.

- **Sharon raised the tracking issue i.e. Close off of episodes, as had been raised at previous meeting noting that Davinia as Regional lead will feed up to Cara. Sharon noted the issue of trackers closing down episodes on CAPPS on the presumption that it was the right action to take based on findings, however, the Trust felt that this should not be happening. Sharon advised that one other Trust has also stopped this and that we were contemplating the same.**

  Cara said from a governance perspective it was better to have patients opened incorrectly and retrospectively closed off - Lisa felt that this was too much risk for the trackers - Sharon confirmed that following this meeting she was advised the trackers not to close off until formal direction to close by the Clinician.

Many thanks,

Vicki Graham
Cancer Services Co-ordinator
Office 10
Level 2

MEC
EXT Personal Information redacted by

Title:	**Procedure for Tracking Cancer Patients Transferring Between HSC Trusts on Cancer Waiting Time Pathways**		
Author(s)	Davinia Lee, General Manager Cancer Services, BHSCT (previously Sarah Williamson) Fiona Reddick, Head of Cancer Services, SHSCT Wendy Clayton, Operational Support Lead, Cancer & Clinical Services, SHSCT		
Ownership:	Cancer Services Operational Meeting		
Approval by:	Cancer Services Operational Meeting	**Approval date:**	5th February 2014
Operational Date:	February 2014	**Next Review:**	February 2015
Version No.	V 1.0	Final draft issued across Trusts 5th February 2014	

1.0 Introduction and Purpose

This procedure is written to inform the Trust Cancer Patient Navigation teams of the process for tracking patients transferring between Trusts on 31 & 62 day pathways.

The responsibility for patient care and for ensuring timely and appropriate patient care ultimately lies with the clinician/s responsible for the patient's care, however in line with the relevant cancer access targets there is a role for patient trackers in expediting patients in line with the agreed waiting time targets as stipulated in DHSSPS guidance. Appendix 1 outlines the ITT guidelines for CaPPs (taken from NI Guidance, 2009)

Policy definitions

ITT- Intertrust transfer (for treatment)

ITD- Intertrust for discussion at an MDM or for diagnostics (Appendix 2)

It is the clear intention of this document to ensure that any likely difficulties of patients meeting the targets are reported at **the earliest opportunity** to a senior member of staff, who, if unable to resolve the issue, will make sure that the reason for the breach is understood and any required remedial action taken. This includes ongoing negotiation with the HSCB regarding additional capacity in a range of specialities.

2.0 Roles and Responsibilities

It is the responsibility of all those involved in the transfer of patients between HSC Trusts on cancer waiting time pathways to familiarise themselves with the content of this procedure.

3.0 Key Policy Principles

3.1 Responsibility of referring Trust prior to ITT

Patients should be diagnosed and staged in line with the NICaN agreed care pathways and/or NICE guidelines and patients should be transferred to the treating Trust at the appropriate point in the agreed tumour specific cancer pathway.

If a patient requires further investigations at a referring unit following regional MDT discussion, ITT cannot be initiated until all investigations have been carried out and the patient has been re-discussed at the regional MDT and/or the patient accepted for treatment. The patient must also be made aware of their diagnosis and onward referral for treatment. It is the responsibility of the referring Trust to ensure this is carried out immediately to avoid delay.

When a patient has been ITT-ed on CaPPs an e-mail should be sent to the relevant Tracker for notification. A written referral letter should be sent either by email/post within 24 hours of the CaPPs ITT.

3.2 Responsibility when a patient is ITD-ed

3.2.1 ITD for investigations

See Appendix 2 for details. When a patient is referred for investigations in another Trust, the patient record should be ITD-ed on CaPPs immediately. It is the responsibility of the Cancer Patient Navigator in the referring Trust to ensure the test has been booked in a timely manner. This should be escalated to the Trust where patient has been transferred if the patient is booked outwith the cancer pathway. It should then be escalated by the Tracking team upwards immediately if this cannot be accommodated.

3.2.2 ITD for MDM discussion at a specialist MDM

When a patient is referred for discussion at an MDT in another Trust, the patient record should be ITD-ed on CaPPs by the agreed cut-off time prior to MDM with full clinical detail and reason for discussion. An e-mail and MDM referral, if appropriate, should be sent to the relevant MDT co-ordinator with notification of ITD for MDM. It is the responsibility of the MDT Co-ordinator in the centre to ensure discussion takes place at the next MDM. If the patient is not discussed for some reason this should be fed back to the referring Trust. Following MDT discussion, the MDT Coordinator in the referring trust should email the MDM report to the referring clinician, their secretary and relevant tracker for action. If an ITT is required, it is the responsibility of MDT Co-ordinators in the referring Trust to check MDT outcomes and ensure ITTs are sent through to the treating Trust following MDT along with the appropriate referral information and letter.

3.3 Responsibility of Treating Trust

To refer a patient on a cancer waiting times pathway to another Trust following MDM discussion the patient record should be ITT-ed on CaPPs to the treating Trust with full clinical information on CaPPs. A referral letter should be sent and when received and accepted by the treating Trust clinician, the patient is now the responsibility of the treating Trust. The Navigator in the treating Trust should check on follow up actions. Responsibility for scheduling is the responsibility of the treating Trust.

If the patient is to receive treatment locally e.g. chemotherapy, the patient is not ITT-ed back to the unit[1]. If any local intervention such as chemotherapy requires escalation back at the referring Trust, this should be carried out by the central tracking team. The Oncology navigators in Belfast and local navigators should

[1] With the exception of the Western Trust. If the patient is to receive treatment locally in the Western Trust, the patient should be ITT'd back to the referring Trust by the central tracking team, with an email notification to the local tracker.

liaise if this cannot be booked within target; Once ITT is complete to Belfast, local Trust to email/phone Tracker.

4.0 Implementation of Procedure

For circulation to all patient navigator/MDT coordinator staff, their team leaders and cancer managers across Northern Ireland. Cancer managers and team leaders to raise awareness locally with regards to the implementation of the guidelines.

5.0 Monitoring

Adherence to this procedure should be monitored by each Trust and escalations made to the relevant cancer manager or team leader where there is non compliance.

Appendix 1: Guidelines for CaPPS – ITT Rules – from the NI Guidance, 2009

Scenario 1

Organisation First Seen	DTT	Organisation First Treated
Booking and Facilities from Trust B	Consultant from Trust A	Treatment provided at Trust A facilities
Consultant from Trust A		Consultant from Trust A
Breach Sharing 0.5 Trust B		Breach Sharing 0.5 Trust A

Scenario 2

Organisation First Seen	DTT	Organisation First Treated
Booking and Facilities from Trust B	Consultant from Trust A	Treatment provided at Trust B facilities
Consultant from Trust A		Consultant from Trust A
Breach Sharing 0.5 Trust B		Breach Sharing 0.5 Trust B

Scenario 3

Organisation First Seen	DTT	Organisation First Treated
Booking and Facilities from Trust A	Joint Appointment Consultant from Trust A and B	Treatment provided at Trust B facilities
Joint Appointment Consultant from Trust A and Trust B		Joint Appointment Consultant from Trust A and Trust B
Breach Sharing 0.5 Trust A		Breach Sharing 0.5 Trust B

Scenario 4

Organisation First Seen	DTT	Organisation First Treated
Booking completed by Trust A and using facilities from Trust B	Consultant from Trust A	Treatment provided at Trust B facilities
Consultant from Trust A		
Breach Sharing 0.5 Trust B		Breach Sharing 0.5 Trust B

Scenario 5

Organisation First Seen	DTT	Organisation First Treated
Booking completed by Trust A and using facilities from Trust B	Consultant from Trust A	Treatment provided at Trust A facilities
Consultant from Trust A		
Breach Sharing 0.5 Trust B		Breach Sharing 0.5 Trust A

Scenario 6

Organisation First Seen	DTT	Organisation First Treated
Booking completed by Trust A and using facilities from Trust B	Consultant from Trust B	Treatment provided at Trust B facilities
Consultant from Trust B		
Breach Sharing 0.5 Trust B		Breach Sharing 0.5 Trust B

Revised: ITT Meeting 6 January 2009

Appendix 2 – ITDs (updated March 2013)

Investigation	Provider Trust	Trust Referring to Provider Trust					Tracking responsibility
		Northern	Western	Southern	South-East	Belfast	
Pleural Biopsy (Lung)	Belfast	√	√	√	√	N/A	Shared between both Trusts but scheduled by Belfast
Microlaryngoscopy (H&N)	Belfast				√	N/A	Shared between both Trusts but scheduled by Belfast
Ureteroscopy (Urology)	Belfast				√	N/A	Shared between both Trusts but scheduled by Belfast
Gynae MRI	Belfast	√				N/A	Shared between both Trusts and scheduled by Belfast
EUS	Belfast /Western/ Southern/	√	√	√	√	√	Scheduled by provider Trust, trackingretained by referring Trust.
Ocreotide Scans	Belfast	√	√	√	√	N/A	Scheduled by Belfast, provided by Belfast
Staging laparoscopy and peritoneal washing/cytology	Belfast/SE Trust?	√	√	√	√	N/A	Scheduled by Belfast and tracked in Belfast

NI Tumour specific Cancer Waiting Times (CWTs) Guidance

Status: Draft

Version History
2nd Consultation: 1st April – 30th April 2015
1st Consultation: 21st November 2014 – 4th January 2015

Purpose:
This guidance provides supplementary tumour specific information to sections 4.11 – 4.26 of the NI Cancer Access Standards – A Guide, DHSSPS, 2008

Related Guidance:
This technical guidance should be viewed as supplementary guidance to the following document

- **HSCB PAS Technical Guidance for Recording Cancer Related Information issued March 2015**

Contents

1. Cancers of the Brain & Central Nervous System (CNS)

Patients included in / excluded from cancer waits

What Brain & CNS cancers are included in/excluded from the cancer waits standards?

In Scope:

WHO Grade 3 & 4 tumours (generally considered malignant)
ICD10 codes C47, C69-72[1]

.

Out of Scope:

. WHO Grade 1 & 2 tumours (generally considered benign)
. Von Hippel-Landau syndrome – a benign condition

:

What grades of brain tumour do we report for cancer waits?

Grade 3 and 4 tumours are considered malignant and should be reported for cancer waits. Grade 1 and 2 tumours are benign and so should not be reported for cancer waits

A tumour was WHO grade 2 on de-bulking and radiotherapy was given. The patient then had a WHO Grade 3 tumour in the same area. Is this classed as recurrence or a new primary?

For cancer waits the Grade 3 tumour should be reported as a new primary as the Grade 2 tumour was outside the scope of cancer waits.

Treatments/Subsequent Treatments

.

What cannot be classified as a first definitive treatment for Brain & CNS cancers (ie. cannot end the 62 day pathway)

- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment)
- surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure)
- Dexamethasone (unless described as palliative care with no other anti-cancer treatment being planned)

Metastases

Where would patients with metastatic brain cancer usually present to help us identify those that need to be on cancer waits pathways?

If patients have a previous known primary would generally present either by early return to an oncology clinic or with symptoms such as headaches, neurological symptoms or fits at an A&E department.

[1] http://www.who.int/classifications/icd/adaptations/oncology/en/

2. Breast cancer

Patients included in / excluded from cancer waits

What breast cancers are included in/excluded from the cancer waits standards?

In Scope:
. ICD10 code C50
. ICD10 code D05 (ie breast cancer in situ)
. *Paget's disease of nipple/breast* - clinical coders and cancer registries code this condition as ICD10 Code C50

Out of Scope:
. Atypical Ductal Hypoplasia (ADH)

Are in-situ breast cancers included within the cancer waits standards?

Yes. Both ductal carcinoma in situ (DCIS) and lobular carcinoma in situ (LCIS) come under the remit of the cancer waits standards (ICD10 code D05)

What patients are included in/ excluded from the symptomatic breast two week wait standard (where cancer is not suspected?)

Included:
. a patient with any breast symptom(s) (not covered in the NICE referral guidelines for suspected cancer) that a healthcare professional believes need to be seen by a specialist.

Excluded:
. referrals to family history clinics;
. referrals for cosmetic breast surgery (such as enlargement or reduction).

Screening
How are patients coming through the Breast Screening Programme managed for cancer waits?

Non-GP referrals of symptomatic patients including screening are not on 62 day Pathway, they are on a 31 day pathway

Treatments/Subsequent Treatments

What cannot be classed as first treatment for breast cancers (ie. cannot end the 62 day pathway)

- Surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure)
- Sentinel Lymph Node Biopsy – this is a diagnostic staging procedure to determine whether the cancer has spread to the lymph nodes
  Tamoxifen – hormone treatment can only be classed as FDT if it is to be the sole treatment modality or the treatment plan specifies that a second treatment modality should only be given after a planned interval. For example, unless the MDT has recommended that neoadjuvant therapy is necessary Tamoxifen prior to surgery would not be first treatment. In this case surgery should be reported as the first treatment rather than the start of tamoxifen even if it is necessary to wait to assess a response to tamoxifen

- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment)

A clinical trial protocol requires breast cancer patients to have two weeks hormone treatment proper to planned surgery? Would these hormones count as first treatment?

If a patient has agreed to enter a clinical trial then the trial protocol will determine which treatments are classed as first or subsequent treatme respectively and they will be assigned as such under cancer waits standards.

A patient is offered a mastectomy followed by a reconstruction at a later date (ie) the two procedures cannot be offered together due to capacity constraints). The patient elects to have the two procedures together at the later date – how is this handled for cancer waits?

A patient should have the choice of having reconstruction at the time of the mastectomy if this is clinically appropriate. If they choose this option and it cannot be delivered within local capacity then the patient would breach the standard.
This group of patients are accounted for within the operational standard.

If a patient has chosen to have mastectomy with immediate reconstruction and then changes her mind and wishes to have mastectomy only can the 'Decision to Treat' (DTT) date be updated?

In this scenario the patient is agreeing to a different treatment plan ie. mastectomy without immediate reconstruction therefore the DTT would be revised to when they agree to this revised care plan.

If a patient is diagnosed with 2 different foci of breast cancer - one in the upper inner quadrant (C50.2) and one in the lower outer quadrant (C50.5) of the same breast, would we just record one of these or both bearing in mind that the treatment would most likely be a mastectomy treating both at the same time?

If there were 2 breast referrals leading to the diagnosis of two primary cancers then you could have separate records one for each of the primaries and they would both end on the same day ie. with the same operation. However, it is more likely that this was a single referral that has resulted in cancer being found in 2 sites. It is not possible to record two ICD10 codes so , for this rare occurrence, you will need to either pick one of these sites and record it, or code it as breast cancer with site unspecified – your Cancer Registry could advise you on the local policy.

A patient goes to A&E with breast symptoms (they do not already have a two week referral in the system for this), they are seen by a breast surgeon, discharged and booked into a breast clinic – how is this managed for cancer waits?

Treated as a 31 day – suspect, under 'other' section

A patient previously treated for cancer in the left breast has attended a follow up appointment and there is suspicion of cancer in the right breast. If cancer is confirmed, how is this managed for cancer waits?

If a patient is being followed up in secondary care and a new primary cancer is diagnosed then this would be an incidental finding and would be covered by the 31 day standards only

A patient was referred via two week wait with a breast lump. A triple assessment did not diagnose cancer. Due to the nature of the lump the clinician decided to review the patient after 6 weeks and at that review decided to excise the lump. Histology confirmed cancer. How is this recorded for cancer waits?

Episode would be closed and re-opened as a 31 day on basis of histological findings

Are symptomatic breast two week wait patients on a 62 day pathway if they are diagnosed with cancer?

Yes. A patient referred via a symptomatic breast two week wait referral should be on a 62 day period if cancer is confirmed. .
Non-GP referrals of symptomatic patients (i.e. via screening / ED /Action Cancer) are not on 62 day Pathway, they are on a 31 day pathway

3. Gynaecological Cancers

Patients included in / excluded from cancer waits
What cancers are included in/excluded from the cancer waits standards?

In Scope:
. ICD10 codes C51-58

Out of Scope:
. Colposcopy referrals from cervical screening programme (other than those for moderate or severe dyskaryiosis, invasive or glandular neoplasia)
.

Do we track BCC's for Gynae if BCCs for skin cancer are excluded?

Yes. The only BCCs excluded from cancer waits are those coded as C44 (skin). All other BCCs are to be reported as per DSCN 20/2008.

Is cervical CIN3 included in cancer waits?

The CWT-Db will not accept ICD10 D codes for gynaecological conditions – a patient referred from the screening service with suspected CIN3 would be on the 62 day pathway as a possible cancer but if CIN3 is confirmed they will not be recorded for cancer waits after date first seen.

Is Borderline Ovarian Histology in the remit of cancer waits?

It depends if the patient has a confirmed diagnosis (ICD-10) with a C code or not. C codes are within the scope of cancer waits standards. D codes are not (except breast in situ). Borderline ovarian histology is generally coded as either C56 or D39.1 – the former would be within the remit of cancer waits and the latter would not.

How are patients coming through the Cervical Screening Programme managed for cancer waits?
Non-GP referrals of symptomatic patients including screening are not on 62 day Pathway, they are on a 31 day pathway

Treatments/Subsequent Treatment

What cannot be classed as first treatments for gynae cancers (ie. cannot end the 62 day pathway)

- cone or loop or LLETZ biopsy/hysteroscopy/colposcopy/vulvoscopy if diagnostic in intent only – however, if therapeutic in intent (i.e. if the intention of the procedure was to remove the tumour) then these would count as first treatment irrespective of whether the margins were clear. If the intention was diagnostic but the tissue was found to be malignant the procedure could count as first treatment if the tumour had effectively been removed by the excision. **Only the Specialist MDM can determine that a LLETZ biopsy can be recorded as first definitive treatment**
- removal of polyps for diagnostic purposes – however, if the tissue was found to be malignant the procedure could count as first treatment if the tumour had effectively been removed by the excision.
- removal of para-aortic nodes before a patient starts radiotherapy or chemotherapy - this is not classed as a therapeutic procedure unless clinically involved nodes are

having to be de-bulkeded prior to radiotherapy and MDM deems as necessary conditioning

- ileal conduit urinary diversion surgery to treat a bladder problem prior to active treatment eg chemoradiation – unless MDM deems as required conditioning
- removal/draining of ascites prior to chemotherapy (unless no other active treatment is planned) - unless MDM deems as required conditioning
- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment)

Is open and close surgery (usually for ovarian cancer) classed as first treatment?

Where the initial intention of the surgery had been to remove the tumour but it is not found to be possible at the time of surgery then this open and close surgery would still be classed as first treatment.

Is ureteric stenting for advanced cancer of the cervix allowed as first treatment?

Yes – this accepted as a first treatment under the previous waiting times rules (see section 3.9 in cancer waits guidance v7.0)

Is removal of pelvic lymph nodes considered a first treatment for cervical cancer?

Removal of pelvic lymph nodes as part of a two part operation to treat cervical cancer can be classed as first treatment. The second stage treatment (determined by the status of the nodes) would be covered by the 31 day subsequent treatment standard.

Is it acceptable to refer a gynae patient back to the GP if they are not yet fit enough for diagnostic tests eg. a 70 year old lady with post menopausal bleeding who cannot have a hysteroscopy until surgery for an aortic valve replacement has taken place.

Suspension rule would be applied.

.

After a LLETZ cone or formal cone biopsy the time taken for infection to subside and the cervix to heal is approximately six weeks and it is therefore inappropriate to undertake radical surgery before this time – how can this be managed for cancer waits?

It is recognised that some patients will not be able to be treated within 62 days and the 62 day operational standard takes account of this.

Are any adjustments possible if a patient's diagnostic tests/ treatments have to be delayed due to the menstrual cycle, pregnancy or a recent termination of pregnancy?

Adjustments are not possible for menstrual cycle.
Suspensions relating to pregnancy or termination to be agreed by MDM.

4. Haematological Cancers

Patients included in / excluded from cancer waits
What haematologicial cancers are included in/excluded from the cancer waits standards?

In Scope:
• ICD10 codes C81-C97 including: **expand codes**
chronic lymphocytic leukaemia
chronic myelomonocytic leukaemia (CMML) - for the purposes of cancer this is classed as a form of leukaemia rather than a form of myelodysplastic syndrome although it is noted that many are not clinically urgent
B-cell chronic lymphocytic leukaemia (CLL)
Small Lymphocytic Lymphoma (SLL)
all cases of acute leukaemia

Out of Scope:
. Myeloid dysplastic syndrome,(D464 or D46)

Treatments/Subsequent Treatments
What cannot be classed as first treatment for haematological cancers (ie. ending the 62 day pathway)

- Removal of Lymph Nodes – this will be a biopsy to establish a diagnosis of Lymphoma and there is likely to be additional disease throughout the body that will need active treatment.
- blood transfusions – unless a patient has no other active treatment planned, in this case the transfusions would be classed as palliative treatment
- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment)

Are antibiotics a valid first treatment for low grade gastric lymphomas?

Yes. Anti-biotics would count as start of treatment for low grade gastric lymphoma.
.
A patient with a haematological cancer is given steroids to manage chest symptoms for a few months prior to chemotherapy starting. Can the steroids be classed as a first treatment?

The operational standards take into account that some patients may not be clinically fit to receive treatment within a 62 day period.
.

Can total body radiation prior to BMT be classed as first treatment?

For a patient who is having a bone marrow transplant and is admitted before for conditioning e.g. whole body radiotherapy then the admission date would stop the clock assuming that the BMT itself took place within the same episode of care.

If a patient is diagnosed with one haematological condition that transforms to a different type, how is this managed in cancer waits?
For cancer waits, if the initial haematological condition had been within the remit of cancer waits and transforms then it would be classed as a recurrence. However, if the initial condition was not within the remit of cancer waits and then transforms then the new condition would be classed as a new primary. For example: follicular lymphoma transforming into a diffuse large B cell lymphoma or AML transforming to CML or CLL transforming to Hodgkin's) - would be classed as a recurrence as the initial conditions in each case had been covered by the cancer waits standards myeloid dysplastic syndrome transforming into AML - the AML would be classed as a new primary as MDS is not within the scope of cancer waits . Recurrences are not tracked as part of cancer waits.

A patient previously diagnosed with lymphoma in 2008 agreed to be put on active monitoring. In 2009, he is referred back by his GP due to swelling in lymph nodes in his groin. After investigation the patient is offered radiotherapy. He rejects this and active monitoring is continued. Is this active monitoring a new subsequent treatment or a continuation of the first?

Active monitoring is not tracked as part of cancer waits
If this had come in as a new referral episode would be closed as treatment declined.

A patient was referred to clinical team outside of Haematology (eg sarcoma, Head and Neck) and went on to have surgery. After surgery the patient was diagnosed with a haematological cancer. Would the surgery be counted as the first treatment?

The answer depends on the scenario. For example:

- if a patient had a lump which was a suspected sarcoma and there was surgery to remove it and this showed that it was actually a lymphoma then this would still be the first treatment; *close as sarcoma but open as 31 day incidental for lymphoma*
- if a patient had a lump which was a suspected sarcoma and there was surgery to remove it and this showed that it was actually a metastases then the surgery would be a first treatment of a metastases of unknown origin with all haematological cancer treatments t; *close haematology; open and track as a 31 day if known primary, close if unknown primary*
- if a patient had a lump which was a suspected sarcoma and there was surgery to remove it and it turned out to be something benign but at the time blood tests or something else showed up an incidental haematological cancer then the first treatment for the haematological cancer would be the first treatment as the surgery treated a non-cancerous condition. *Close 62 day; open as a 31 day incidental finding*

5. Head & Neck Cancers (incl. thyroid cancer)

Patients included in / excluded from cancer waits
What cancers are included in/excluded from the cancer waits standards?

In Scope:
. ICD10 Codes: C00 – C14, C30 – C32, C73, C77.0

Out of Scope:
. Barrett's oesophagus

Treatments/Subsequent Treatments
What cannot be classed as first treatment for head, neck or thyroid cancers (ie. cannot end the 62 day pathway)

Head & neck
- surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure)
- dental clearance eg. prior to radiotherapy An adjustment to the waiting time can be made if the dental clearance means the patient is unfit for radiotherapy and so the radiotherapy treatment is delayed.
- insertion of a PEG (percutaneous endoscopic gastrostomy) for nutrition to make patient fit for active treatment prior to radiotherapy – unless MDM deem necessary for patient conditioning
- insertion of a PEG prior to surgery (unless the PEG is carried out within the same episode of care as surgery – ie. if the patient is admitted for the PEG and is not discharged prior to the main surgery then the admission date for the PEG ends the cancer waits pathway).
- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment)

Thyroid
- surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure)
- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment)

Can tonsillectomy be considered first treatment when a patient goes on to have chemoradiotherapy?

If the tonsillectomy excised or de-bulked the tumour with therapeutic intent then it would count as first treatment even if the margins were not clear

A patient was referred by a GP via an urgent referral for a suspected head & neck cancer, which was subsequently confirmed. An oesophageal cancer was also found incidentally. The first treatment for the head & neck cancer also treats the oesophageal cancer - how should this be recorded?

The same treatment can be used to end both the 62 day pathway for the head and neck cancer and the 31 day pathway for the incidental oesophageal cancer that was found. Tracking teams need to open and close episodes for both tumour sites.

A patient had a two week referral with suspected head & neck cancer and required a biopsy. The patient is already having chemotherapy for lung cancer and has informed the Admissions Dept that he will contact them when he has completed treatment and is fit enough to proceed with the head & neck diagnostics. How should this be handled for cancer waits?

If patient not fit enough then suspension rule to be applied.
If the clinician thinks the patient is fit enough for the biopsy but the patient does not feel well enough the clock would still continue as they are not refusing to have the diagnostics they are wanting to defer until they are feeling better - this is their choice and the operational standard allows for a proportion of patients to choose to wait longer than the standard time.

Thyroid
What treatment modality should radioactive iodine be recorded as?

Radioiodine is a radioisotope therapy and should be classified as Code 18 'other treatments' in the cancer treatment modality field.

A patient is required to prepare for treatment by having injections of recombinant human TSH in addition to withdrawal of hormone treatment in order to obtain higher potential uptake at treatment. Would these injections be the start of treatment?

If these 'preparations' are to mitigate the effects of the treatment once it starts then they are NOT counted as part of the treatment. However, if they are integral to the treatment itself ie. to facilitate the effectiveness of the treatment then they could be classed as the start of the treatment i.e conditioning. If this is in effect a combined treatment ie. treatments of different modalities combined in a way that they must be scheduled to take place together (as described in section 3.9 of the cancer waits guidance version 7.0) then the injections would be the start of the treatment.

Would a hemi-thyroidectomy count as start of treatment in patients diagnosed with Thyroid cancer?
Yes, hemi-thyroidectomy is considered as start of treatment.

6. Lower-Gastrointestinal Cancers – LGI (colon, rectal, anal)

Patients included in /excluded from cancer waits
What LGI cancers are included in/excluded from the cancer waits standards?

In Scope:
. ICD10 Codes: C17 – C21, C26

Out of Scope:
- Tis (carcinoma in situ) found in polyps excised at colonoscopy - Tis includes cancer cells confined within the glandular basement membrane (intraepithelial) or lamina propria (intramucosal) with no extension through muscularis mucosae into submucosa.
- Carcinoids of the appendix (coded as ICD10 D37.3)

Screening
How are patients coming through the Bowel Screening Programme managed against the cancer waits standards?
Non-GP referrals of symptomatic patients including screening are not on 62 day Pathway, they are on a 31 day pathway

Treatments/Subsequent Treatments
What cannot be classed as first treatment for LGI cancers (ie. ending the 62 day pathway)

- surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure)
- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment)

Can stenting be classed as a first treatment?
Stenting can be classed as first treatment when
- used as a palliative procedure in patients unfit for surgery or where no active treatment is planned.

Should MDM deem it necessary conditioning in preparation for surgery or active treatment then an adjustment/suspension could be applied.
.
Why can't a colostomy to prevent a bowel obstruction prior to some other kind of treatment such as chemo-radiotherapy being classed as first treatment?

A colostomy should only be classed as first treatment if;
- it's the only procedure/treatment being given and would be palliative
- it's an emergency procedure following an A & E admittance with actual bowel obstruction.

When it's performed as a preventative enabling treatment then it shouldn't count as first treatment as the care plan is for something more curative and that curative treatment should be classed as the first treatment. Should MDM deem it necessary conditioning then an adjustment/suspension could be applied.

A patient is referred to the LGI team with suspicion of rectal cancer – this is confirmed along with a bladder cancer. The bladder cancer was treated first. How should this be managed for cancer waits?

If there was only one urgent GP referral for suspected cancer there will be only one 62 day pathway and it would end with the treatment of the bladder cancer as this was treated first. The bowel cancer treatment would be covered by the 31 day period only as a first treatment for a different primary.

A patient had a date for an outpatient appointment following an urgent GP referral for suspected cancer, she DNA'd the first appointment as she was admitted as an emergency. During the emergency admission a CT scan revealed a possible colorectal cancer and she was then seen by one of the cancer MDTs. How should this be managed for cancer waits?

Suspension/adjustment for DNA but continue to track patient on 62 day pathway 

7. Lung

Patients included in / excluded from cancer waits
What lung cancers are included in the cancer waits standards?

ICD10 Codes: C33 – C39, C45 (C78 for secondary after unknown primary)
All carcinoid tumours of lung must be tracked

Treatments/Subsequent Treatments
What cannot be classed as first treatments (ie. cannot end the 62 day pathway)

Lung cancer

- drainage of a pleural effusion if further anti-cancer treatment is planned.
- pleurodesis if further anti-cancer treatment is planned
- mediastinoscopy - unless the excised tissue was found to be malignant and the tumour had effectively been removed by the excision irrespective of whether the margins were clear – this is unlikely.
- Stenting of the airway or superior vena cava (SVC) if further anti-cancer treatment is planned
- Laser treatment of major airways obstruction if further anti-cancer treatment is planned
- VATS biopsy (Video Assisted Thoracic Surgery) for diagnostic purposes unless procedure could be considered as de-bulking the tumour
- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment)
- surgery or radiotherapy for brain metastases - treatment of metastases cannot be classed as first treatment unless it is for metastases of primary of unknown origin.

Mesothelioma

- drainage of a pleural effusion if further anti-cancer treatment is planned.
- pleurodesis if further anti-cancer treatment is planned
- interventional analgesia (eg nerve block or cordotomy) if further anti-cancer treatment is planned
- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment)

If brain metastases need to be treated first, how is this managed for cancer waits?
Suspension rule would be applied.

Does talc pleurodesis count as first definitive treatment for lung cancer?
If it is palliative treatment and there is no planned active treatment.

A lung patient who has chemotherapy occasionally needs to take oral vitamin supplements for 7 days prior to treatment. Does this stop the clock as treatment start date?
It would depend on the purpose of the oral vitamin supplement. If they are to get the patient into better shape for the treatment then no - this would be considered as conditioning and an adjustment could be made.

Some lung cancer patients need to have Vitamin B12 injections for one week prior to the start of the chemotherapy. Is the Treatment Start Date the date of the Vitamin B12 injections or the date the chemotherapy drugs are given?
If they are to get the patient into better shape for the treatment then no - this would be considered as conditioning and an adjustment could be made. Treatment start date would be date of chemotherapy administration.

How should management of ascites covered by cancer waits standards?
Managing ascites could only be classed as first treatment if no further anti-cancer treatment is planned.

How should we record late stage lung cancer patients who have palliative symptom control whilst considering their treatment options?
Palliative symptom control would only be classed as first treatment if no active cancer treatment is planned.
If treatment options are still being considered and an active treatment is decided on then that treatment would be the first treatment not the previous symptom control

If a lung cancer patient dies between palliative symptom control and any planned anti-cancer treatment, how is this managed for cancer waits?
Record as patient deceased.

Would open and close lung surgery count?
A small number of patients will undergo open and close surgery on the lung which does not resect the lung. Although this does not remove the tumour this should still be counted as it is a treatment procedure, although the outcome is unsuccessful.

8. Sarcoma

Patients included in / excludes from cancer waits
What cancers are included in/excluded from the cancer waits standards?

In Scope:

- ICD10 C40-41,46, 48-49 &,79.5 (secondary with unknown primary)
- Kaposi sarcoma (malignant tumour arising from blood vessels in the skin) - rare in the western world except for patients with Aids.
- Fibrosarcoma

Out of Scope

- Fibromatosis

Treatments/Subsequent Treatments
What cannot be classed as first treatment for sarcomas (ie. ending the 62 day pathway)

- Surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure)
- Palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment)

9. Skin

Patients included in / excluded from cancer waits
What cancers are included in/excluded from the cancer waits standards?

In scope:
ICD10 Codes: C43 – C44 including:

- Malignant Melanomas
- Merkel Cell Carcinoma
- Squamous Cell Carcinoma (SCC) – all now included (not just the first)
- excluding the following conditions classified under C44:
- Basal Cell Carcinoma
- Multicentric Basal Cell Carcinoma
- Basal Cell Carcinoma, Morphoea
- Basal Cell Carcinoma, Fibroepithelial
- Basosquamous Carcinoma
- Metatypical Carcinoma
- Pilomatrix Carcinoma
- Kaposi's Sarcoma
- Cutaneous lymphomas

Out of Scope:

- Lentigo Malignas (considered Carcinoma In Situ)
- Bowen's Disease (considered Carcinoma In Situ)
- Intraepidermal Carcinomas (considered Carcinoma In Situ)
- Keratoacanthoma - benign condition not malignant

Is malignant melanoma in-situ within the remit of cancer waits?
No. Carcinoma in situ is excluded from cancer waits (with the exception of D05 – carcinoma in situ of breast).

Is Superficial Spreading Malignant Melanoma within the remit of cancer waits?
It depends. If it is specified as being 'in-situ' then it is not within the scope of cancer waits. However, if it is coded as C43 then it would be within the remit of cancer waits. This would be a local clinical decision – seek advice from your local clinical coding staff.

Do we only track the first skin SCC a patient has?
No. Each SCC in different locations on the body is covered by the cancer waits standards not just the first.

Treatments/Subsequent Treatments

What cannot be classed as first treatment for skin cancers (ie. cannot end the 62 day pathway)

- surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure)
- Sentinel Node Biopsy – this is a diagnostic staging procedure to determine whether the cancer has spread to the lymph nodes
- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment)

Can a patient cease to be tracked as a potential 62 day wait patient if, following clinical examination, a consultant thinks a skin cancer diagnosis is unlikely?

If the consultant has any degree of suspicion that a cancer may be present then the patient should continue to be tracked until histology is received:

- if histology confirms the patient does not have malignant melanoma (MM) or SCC the patient is removed from tracking;
- if histology shows MM or SCC the patient continues on a 62 day pathway.

Clinicians can take a view that a patient is highly unlikely to have skin cancer on the basis and may downgrade patient so they will be closed from the 62day pathway

If the patient is informed that the Consultant has no further suspicion of cancer, and is given a formal diagnosis of a benign condition or a BCC and this is documented in the notes:

- the patient is removed from tracking;
- the patient episode would be complete if no further treatment was required or alternatively the patient is put on a routine pathway for treatment of a benign condition;
- if the lesion later turned out to be a skin cancer the patient would only be on the 31 day pathway for treatment.

A GP makes a two week wait referral for a suspected skin cancer but states on the referral that the patient has a BCC (which is outside the remit of cancer waits) – how is this managed?

At consultant triage the clinician can downgrade if assess suspect additional BCC if further investigation is required patient is on 62 day pathway.

A GP makes a two week wait referral for a suspected skin cancer. A consultant see the patient and writes '?BCC' in the notes and wants to see the patient in 12 weeks for excision as he wants it to grow. Do we keep the patient on cancer waiting time tracking even though BCCs are not in the remit of cancer waits? Downgrade

At consultant triage the clinician can downgrade if assess suspect additional BCC if further investigation is required patient is on 62 day pathway.

10. Upper gastro-intestinal cancers (oesophageal, stomach, pancreatic, liver)

Patients included in / excluded from cancer waits
What cancers are included in/excluded from the cancer waits standards?

In Scope:

- ICD10 Codes: C17 – C16, C22 – C25
- Gastrointestinal stromal tumours (GISTs) that are described as malignant, invasive or as having metastases coded to the relevant ICD10 'C' code for the part of the gastro intestinal tract involved.

Out of Scope:

- GISTs not specified as above, coded as borderline using the relevant 'D' code

Could a moderately differentiated pancreatic endocrine neoplasm (insulinoma T2 G2 Mx) 'D' coded as a borderline malignancy be uploaded for CWT?
No. This would not be included under cancer waits if it was classified as 'in situ' (D coded)within ICD-10.
.
How should rare neuroendocrine tumours be coded – the diagnosis is not always specific to pancreatic origin?
Code as per Carcinoid Guidance (GIST)

Treatments/Subsequent Treatments

What cannot be classed as first treatment for upper GI cancers (ie. cannot end the 62 day pathway)

Pancreatic cancer

- surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure) If local practice adjustment
- Insertion of pancreatic/biliary stent - for patients with mild obstructive jaundice (a serum bilirubin below 200 micromol/l) if local practice is that they do not require biliary stenting before resection if surgery and imaging are planned within 7-10 days.
- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment)

Gastric/oesophagogastric cancer

- surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure)
- Jejunostomy to insert a feeding tube
- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment)

When can a pancreatic stent be classed as first treatment?
It could be classed as a first treatment if planned to resolve jaundice before a patient has a resection or starts chemotherapy. However, many clinicians agree that patients with mild obstructive jaundice (a serum bilirubin below 200 micromol/l) do not require biliary stenting before resection if surgery and imaging are planned within 7-10 days. If this is the agreed clinical practice locally then stenting these patients will not count as first treatment but an adjustment would be made under patient conditioning.

Is duodenal stenting prior to starting palliative chemotherapy classed as a first treatment?
The general rule is that a stent can only be classed as first treatment where the patient is unfit for other treatment. In this scenario the patient is having palliative chemotherapy and the stent is being classed as part of palliation.

A patient received an urgent GP referral to a gastroenterology clinic for suspected cancer and was found to have two gastric ulcers at endoscopy. Biopsies have shown a type of gastric lymphoma related to Helicobacter Pylori infection in the stomach. The patient has started standard eradication therapy – is this classed as first treatment?
No - a suspension would be applied.

Can Proton Pump Inhibitor (PPI) treatment be classed as a first treatment for an Upper GI cancer?
A proton pump inhibitor reduces the amount of acid made by the stomach and may be used alongside some cancer treatments such as imatinib and dasatinib to limit side effects. This would warrant a medical suspension.

Miscellaneous
Liver

How are liver transplants managed under the cancer waits standards?
When the agreed treatment for a cancer is a transplant the DECISION TO TREAT would be when the patient agrees the care plan that includes the transplant and the TREATMENT START DATE (CANCER) would be the date the patient is added to the transplant list. For the purposes of monitoring the 62-day standards a transplant should only be considered first treatment if no other active anti-cancer treatment is given in the interim.

UGI patient has an unknown primary cancer with liver and peritoneal metastases. The patient had an appendectomy which removed his appendix and surrounding fat which contained Squamous Cell Carcinoma. Can the appendectomy count as first treatment?
Yes - if you gave a first treatment not knowing what the primary was then that treatment is for metastases of unknown primary and would end a 62 day period.

Pancreas
What cancer treatment modality does APC Argon Plasma Coagulation come under?
Other Treatment

A GP made an urgent referral of a patient for a suspected Head & Neck cancer. This was confirmed and an oesophageal cancer was also found incidentally. First treatment for the head & neck cancer also treated the oesophageal cancer - how should this be recorded?

The treatment event can be used to end both the 62 day pathway for the head and neck cancer and the 31 day pathway for the incidental oesophageal cancer that was found.

11. Urological cancers (bladder, prostate, renal, testicular, upper tract transitional cell)

Patients included in /excluded from cancer waits
What cancers are included in/excluded from the cancer waits standards?

In Scope:

- ICD10 Codes: C66-C67 [Bladder]
- ICD10 Code: C61 [Prostate]
- ICD10 Codes: C64-C65 [Renal/Kidney]
- ICD10 Code: C60 [Penile]
- ICD10 Code: C62 [Testicular]
- ICD10 Code: C65-66 [Upper tract transitional cell carcinoma (renal pelvis or ureter)]

Out of Scope:

- pTa – transitional call carcinoma as regarded as non invasive [Bladder]

Treatments/Subsequent Treatments
What cannot be classed as first treatment for urological cancers (ie. ending the 62 day pathway)

- surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure)
- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment)

Bladder
Can Transurethral resection (TUR) biopsy of a bladder be classed as first treatment?
Not unless the excised tissue was found to be malignant and the tumour had effectively been removed by the excision irrespective of whether the margins were clear

Prostate
Can PSA monitoring prior to diagnosis of prostate cancer be counted as first treatment?
In this scenario the patient has not received a confirmed diagnosis of cancer so active monitoring via PSA monitoring would not be a treatment option.

Prostate
Would TURP (TransUrethral Resection of the Prostate) be classed as a first treatment?
TURP can be classed as first treatment if performed to de-bulk a tumour or if carried out for benign disease and cancer is found incidentally and has, in effect, been treated by the TURP.

Could PSA monitoring prior to diagnosis of prostate cancer be counted as first treatment? repeat
No. If a patient has yet to have a prostate cancer diagnosis but is having repeat PSA then this is a case of clinical uncertainty and the PSA testing does not end a 62 day pathway.

When can active surveillance/monitoring be classed as a first treatment for prostate cancer?

Active Monitoring (Surveillance) in terms of cancer waits is where a diagnosis has been reached but it is not appropriate to give any active treatment at that point in time but an active treatment is still intended. The patient is therefore monitored until a point in time when they are fit to receive or it is appropriate to give an active treatment. It is not to be used while waiting for a diagnosis to be confirmed or staging to be completed. Nor is it to be used to allow for thinking time or to address capacity issues that mean the proposed active treatment would not be available in 31/62 days. For example:

- If suspected prostate cancer is not yet confirmed and a patient needs repeat PSAs this is not active monitoring
- if a diagnosed prostate patient is offered a range of treatments and wants to take a couple of weeks to think about the options this is not active monitoring. Suspension rule applys
- if a diagnosed prostate patient is offered a range of treatments, selects brachytherapy and has to wait for this procedure it is not appropriate to say the patient is on active monitoring.

However, if a prostate patient has a tumour that is not causing any significant problems and they decide that they don't want to pursue active treatment immediately but have the cancer kept under check by repeat PSA etc this would be active monitoring.

Some prostate patients receive zoledronic acid prior to radiotherapy. Is this classed as a first treatment for cancer waits?
If the Zoledronic Acid is prescribed as palliative care with no other anti-cancer treatment planned then it could be classed as the FDT. If it is prescribed prior to radiotherapy is is not a first treatment.

Is radiotherapy to a male patient to prevent or reduce breast growth and tenderness caused by prostate cancer treatment reportable as a first treatment?

This is not in itself a cancer treatment. This cannot therefore be classed as the FDT.

Renal
Can a renal stent be classed as first treatment? Apply same rules as per palliative
The general rule is that a stent can only be classed as first treatment where:

- the patient is unfit for other treatment.
- the patient remained an in-patient between the date of admission for the stent and main surgery ie. if it is the same episode of care and surgery is the proposed treatment.

Would a 'nephrostomy' be counted as a first treatment?
A nephrostomy is an operation similar to a colostomy but for the collection of urine. If this is the only 'treatment' the patient is to receive ie. as palliative care with no other active treatment planned it can be classed as a first treatment and, although it is palliative in intent it would be recorded as surgery. If any other active treatment is planned it is not a first treatment.

Miscellaneous
Bladder
Patient referred urgently for suspected bladder cancer by their GP but nothing is found. A PSA is taken prompting further investigations for prostate cancer. Could the original referral for suspected bladder cancer be closed and a new non-urgent referral opened for the prostate cancer?

No, the investigations are part of the same pathway of care. If prostate cancer is diagnosed this would need to be treated within 62 days of receipt of the referral for suspected bladder cancer.

Prostate

The delay needed between TRUS biopsy and MRI makes the 62 day pathway difficult to achieve for prostate cancer – how should this be managed?

Many Providers allow a set period of time (often around 6 weeks) between the TRUS prostate biopsy and the staging MRI scan to reduce the incidence of equivocal scans or false positives.

This gives a “”, suspension rules apply which has been factored into the national operational standards. It is one of the reasons (along with patient thinking time) why it is anticipated 62 day performance for urological cancers is likely to be lower than the overall achievement against the 62 day standard. The operational standard is set for all tumours taken together and it is anticipated that some tumour groups such as urological will not achieve that level in their own right while others such as breast and skin cancer are likely to exceed it.

If a patient refuses to have a TRUS/biopsy and the consultant therefore decides to repeat a PSA at some point in the future would the patient remain on 62 day tracking until cancer is diagnosed or ruled out? Suspend until 2nd PSA if requested and within specified time period – 4 weeks reasonable delay, any more than 4 weeks it would be closed and re-opened as new referral

No. If a patient refuses a TRUS, they have refused a test that may potentially diagnose cancer and are therefore removed from tracking for 62 day. If the clinician continues to monitor via PSA and subsequently diagnoses the patient with cancer they will be tracked against the 31 day standard only.

In some circumstances GPs are referring patients on the two week wait pathway after only one moderately high PSA when they should repeat the test again. What action should we take?

Inappropriate referrals should be addressed locally ie. a consultant could speak to the 'offending' GP(s) or you could notifiy the commissioner or SHA if you have significant concerns about inappropriate GP referrals more generally.

If a patient has come in with only one moderately high PSA, the consultant will usually repeat the PSA test in 8 weeks time unless it is extremely obvious it is prostate cancer. The consultant leaves eight weeks between tests to ensure that the patient does not have any infection that can lead to the PSA rising. How is this managed under cancer waits?

Once the clock has started it is not possible to adjust it because the patient needs to wait (for clinical reasons) between tests. The operational standards take into account that a proportion of patients will not be clinically fit enough to be seen and treated within the cancer waits timescales.

If, after a second PSA test, a consultant cannot categorically say that the patient does or does not have cancer, what would you advise? Stay on pathway

If there is diagnostic uncertainty the patient stays on cancer waits tracking. The patient would only come off tracking if they were informed that they did not have cancer. This would be a clinical decision ie. is the consultant prepared to tell a patient that they do not have cancer. The operational standards take into account that a proportion of patients will not be clinically fit enough to be seen and treated within the cancer waits timescales.

Patients require a Volume Study prior to implantation of low-dose Radiotherapy seeds for brachytherapy – how does the volume study relate to cancer waits?
The volume study is part of the preparation and the DTT would be the date of the consultation where treatment is agreed to proceed **after** the volume study has been completed. The admission date for the implantation of the seeds would be the start of the treatment thus ending the 31 and/or 62 day pathway.

For patients who require 3 months of hormones prior to radiotherapy, we have been working out their treatment date and ensuring r/t planning is commenced prior to this date (i.e not waiting until the end of 3mths then planning). The cancer waits guidance says if pts are fit for r/t planning this would be hormone as first definitive treatment , however in our scenario pts are being prepared for their treatment but can't start until the end of 3 months. Please can you clarify how to manage this?
In this scenario Hormone is recorded as first treatment

Quite high numbers of suspected prostate cancer patients are referred in with an elevated PSA (only one test) that have a urinary tract infection (UTI), and thus need antibiotics to treat the infection prior to having the prostate biopsied. The period realistically before these patients could be biopsied would be 2-4 weeks. Could the patient be recorded as having no cancer diagnosed and the GP informed to treat with antibiotics prior to re-referring if PSA is still raised?
Suspension for duration of course of antibiotics

NICE guidelines set out when watchful waiting and active surveillance are appropriate treatment options for men with localised prostate cancer. How does this fit with active monitoring in cancer waits?
Follow agreed NICAN urology pathway definitions.

Graham, Vicki

From: Graham, Vicki [Personal Information redacted by the USI] >
Sent: 20 May 2014 12:44
To: Abogunrin, Funso; Brown, Lesley-Ann; Brown, Robin; Campbell, Dolores; Carser, Judith; connolly, maureen; Cummings, Ursula; Dabbous, Marie; Dignam, Paulette; Elliott, Noleen; Fionnuala Houghton; Glackin, Anthony; Graham, Vicki; Hamill, Joe; Hann, Gemma; Hanvey, Leanne; Kelly, Wendy; Larkin, Bronagh; McCartney, Rachel; McClean, Gareth; McClure, Mark; McConville, Richard; McCorry, Monica; McCreesh, Kate; McMahon, Jenny; Muldrew, Angela; Murphy, Linda; ONeill, Kate; Pahuja, Ajay; Paula McCloskey; Reid, Stephanie; Shah, Rajeev; Shannon, Hilda; Sheridan, Patrick; Suresh, Ram; Topping, Christina; Troughton, Elizabeth; Turkington, Ann E; White, Deborah; Williams, Marc
Subject: FW: Review of Cancer Waiting Times Guidance
Attachments: A guide to cancer waiting times - January 2008.doc

Please see attached document.

Regards,

Vicki

From: McDonald, Colm [Personal Information redacted by the USI]
Sent: 19 May 2014 14:50
To: Alexander, JulieA; Burgess, Elizabeth; Cantley, Hazel; Carson, Kevin; Claire Cassels; Clayton, Alison; Corcoran, Bernie; Cunningham, Wendy; Eakin, Ruth; Gray, Moyra; Grey, Arthur; Hagan, Chris; Harney, Jacqui; Harvey, Barbara; Hegarty, Shauna; Hennell, Claire; hetherington, Stacey; houghton, fionnuala; Hurwitz, Jane; Hynds, Sharon; Jain, Suneil; John McKnight; Johnston, Karen; Johnston, Margaret; Keane, Patrick; 'Laffan, Anna'; Lindsay, Richard; Lyons, CiaraA; McAleese, Jonathan; McCloskey, Paulam; McEvoy, Teresa; McGuigan, Jim; McKenna, Karen; McLaughlin, Michelle; McPhee, Wendy; Milligan, Gail; Mills, Karen; Mitchell, Darren; Morgan, Sharon; Morrow, Michelle; Mort, Paula; Napier, Hazel; 'Neville.dugan[Personal Information redacted by the USI]'; Norwood, Gillian; O'kane, Hugh; ORourke, Declan; O'Sullivan, Joe; Parkinson, Melanie; Hegarty, Shauna; 'Patricia Thompson'; 'Peter Ball'; Rooney, Keith; Shum, Lin; Smyth, Helen; Stephen Hamilton; Stewart, David; Thompson, SamanthaE; Thwaini, Ali; Vallely, Stephen; Venney, Cara; Graham, Vicki; Walker, Jennifer; Warren, Pamela; Wilson, Brian; Wlosinski, Marie
Cc: Lee, Davinia
Subject: FW: Review of Cancer Waiting Times Guidance

Dear all,

The Trust currently track all cancer patients in line with the cancer waiting times guidance which was issued in 2008 (see attached). The HSCB are planning to review this guidance over the next few months and have asked us to discuss any potential tumour specific queries/gaps/proposed changes with our clinical teams so we can present these for consideration to the review team.

As part of this process, I would be grateful if you would flag up any current issues or queries you may have with the current waiting times guidance and any gaps there are for your tumour area. There is some tumour specific guidance in the attached (pgs 12-18) but it is by no means comprehensive and does not include all tumour sites.

If you could return any initial comments back by 30th May it would be much appreciated.

Many Thanks
Davinia

Davinia Lee

General Manager, Cancer Services
2nd floor, Old Generator House
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Direct Line: Personal Information redacted by the USI
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DRAFT 10 – 2 January 2008

Department of Health, Social Services and Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí
www.dhsspsni.gov.uk

NORTHERN IRELAND CANCER ACCESS STANDARDS – A GUIDE

CONTENTS

Introduction

1. The NI Cancer Control Programme was published in November 2006. Within the Strategy there is a commitment to ensuring the timeliness of referral, diagnosis and treatment for suspected cancer patients. This document provides answers to some frequently asked questions about cancer access standards

- **2007/08 - '98% of patients diagnosed with cancer (decision to treat) should begin their treatment within a maximum of 31 days'**

- **2007/08 - '75% of patients urgently referred with a suspected cancer should begin their first definitive treatment within a maximum of 62 days. Where the performance of a tumour group currently exceeds this standard, performance should be sustained or improved against current levels'**

- **2008/09 - '95% of patients urgently referred as a suspected cancer should begin their first definitive treatment within a maximum of 62 days'.**

In addition there is also the existing two week waiting time standard for breast cancer patients:

- Maximum two week wait for referral for suspected breast cancer to date first seen from 1st August 2000.

This has been reinforced in Priorities for Action 2007/08.

- **"All breast referrals deemed urgent according to regionally agreed guidelines for suspected breast cancer should be seen within two weeks of the receipt of the GP referral"**

2. All these targets are being monitored through a regional cancer waiting times database tool offered to Trusts. The core data requirements will be circulated during December 2006.

Part 1- Who is responsible for meeting the targets and returning data?

1.1 Who is responsible for meeting the standards and returning data for Cancer Access Standards?

There is shared responsibility for the patients in the 62 day target between the First Seen Trust and the Treating Trust. This includes all records, i.e. the patients achieving the target and those breaching the target. The responsibility lies with the First Seen Trust to refer the patient in a timely manner allowing the Treating Trust adequate time to plan the treatment and deliver the diagnostic investigations in an appropriate timeframe to enable the target to be met.

Any breaches of the target will count half for both the Trust to which the patient was first referred and half to the Trust where the patient was treated. Accurate data needs to be communicated proactively to minimise delays in the patient pathway and ensure robust data quality.

This gives the Treating Trust enough time to properly plan the treatment within the target time and not delay the start of first definitive treatment. Any other Trust who may be involved in a patient's care (but not the treating trust or initially referred trust), must also expedite the processes through to 'first treatment'.

Where a 62 day breach occurs a discussion **must** take place between the referring and treating Trusts and agreement reached as to the reason for the breach, prior to identifying it on the database.
The trust where a patient is first seen following an urgent suspected cancer referral for returning data on these patients up to the date first seen.

1.2 Who is responsible for meeting the targets and returning data on the 31 day decision to treat to treatment target / 62 day referral for suspected cancer to first treatment target?

The trust administering the first definitive treatment is responsible for providing the information to support the targets on time to first treatment. See 1.2 regarding the shared responsibility for breaches of the target. They are also responsible for returning data on these patients to monitor the targets and for explaining breaches on existing standards (see below). The referring Trust will be responsible for ensuring the data items are transferred to the treating Trust.

Some patients on the 62 day pathway are first seen under the Cancer Access standard at one trust and are then referred on to another trust for treatment. The independent Regulation and Quality Improvement Authority (RQIA) may decide as part of its future work to assess the performance of all trusts in the care pathway in achieving the 62 day standard, from the end of 2008. So, in this case both trusts are responsible for ensuring that the 62 day waiting time target is met.

The new Health and Social Care Authority (HSCA) is responsible for commissioning services in line with the 31 and 62 day targets for their patients and should track waiting times for their managed population through the collection of cancer waiting times.

1.3 What information is required on breaches?

Detailed reports on breaches are required on all patients that wait longer than the target time and should include how long the patient waited, reason for the breach in the target and action put in place to prevent further breaches. The reasons for the breach should still be recorded for patients where there are good clinical reasons that a patient has waited longer than the target time (see para 2.6).

1.4 How does the database support the work of Service Improvement?

The collection of data has been designed to support the focus of service improvement by the Service Delivery Unit and the Northern Ireland Cancer Network. It allows the collection of a number of additional data items on cancer patients along the patient pathway, which the best evidence has shown are useful to service improvement.

1.5 Whose activity is it? Who is responsible for recording it?

Some questions have been raised about which trust code to record when a patient receives treatment. In general this is straightforward, but there are circumstances where you will need to consider the commissioning route for the care.

Some questions elsewhere in the UK have been raised about which trust code to record when a patient receives treatment. In Northern Ireland this is straightforward and there is no need to consider the commissioning route for the care.