Part 2 - Which patients do the standards apply to?

2.1 Do the targets include patients who are not referred through the Suspected Cancer Referral route?
The 31 day target applies to all new diagnoses of cancer regardless of the route of referral. For example this will include urgent GP referrals, urgent Consultant referrals, routine referrals and screening referrals.

The General Practitioner will ensure the urgent suspected cancer referral is sent within 24 hours of their consultation with the patient.

The 62 day target applies to patients who are referred through the urgent suspected cancer referral route. However, the standard applies to ALL patients referred through this route, irrespective of whether the referral was received within 24 hours.

2.2 Which patients should be included in the monitoring?
The Cancer Control Programme has set standards for all patients cared for under the HPSS in Northern Ireland and these patients should be monitored.

In the case where a patient is initially seen by the specialist privately but is then referred for first definitive treatment under the NHS, the patient should be included under the 31 day decision to treat to treatment target.

It is anticipated, the majority of definitive first treatments will be provided in secondary or tertiary care.

2.3 Do the treatment standards apply to patients receiving treatment for recurrence of cancer?

The standards only apply to patients with a newly diagnosed cancer. Some patients have metastases at presentation and so the treatment may be to the metastatic site rather than the primary site.

The standards do not apply to a patient receiving treatment for a recurrence of cancer. Clearly good clinical practice involves treating patients with recurrence as soon as possible on the basis of clinical priority.
When a patient is diagnosed with a second new cancer, which is not a recurrence, then the standards will apply to the treatment of this cancer (see part 6 for further details).

2.4 Do the treatment targets apply to patients who decline treatment?
Patients who decline any treatment should be excluded from the monitoring. However, even if there is no anti cancer treatment almost all patients will be offered a palliative intervention (e.g. stenting) or palliative care (e.g. symptom control) and these patients should be monitored.

2.5 Do the treatment targets apply to patients who die before treatment commences?
The targets concern waiting time to treatment. Hence patients who die before treatment commences should be excluded from the monitoring.

2.6 Are there any cases when the treatment time will exceed the standard time?

In a small number of cases there will be good clinical reasons for treatment time exceeding the target time. A generic example of this is where a patient is referred under the suspected cancer referral and there is diagnostic uncertainty as to whether they have cancer or not. These patients may require repeat diagnostic tests in order to reach a diagnosis.

- A patient who requires a particularly complex combination of scans and biopsies
- A patient for whom there is genuine clinical uncertainty about the diagnosis and the clinician elects to observe the patient over (say) a three-month period.

These patients will exceed the 62 day wait and this should be recorded on the cancer waits system. Detailed reasons on why these patients exceeded the target time should be recorded on the data collection process. It will not be appropriate to make adjustments in these cases.

The NI Cancer Network has endorsed the details of the thresholds allowed to take account of these clinical exceptions. These are based on the Healthcare Commission threasholds published in 2005. Examples of the suggested clinical exceptions are included in 4.23.

2.7 How do we monitor the following patient pathway? A patient is referred with a small breast lump which is fully assessed (e.g. by triple assessment, examination, imaging and needle biopsy) and is thought to be benign. The patient is reassured that the risk of this being cancer is low, but the clinician wants to check progress in 3 months. At that time it is clear that the lump is larger and a repeat biopsy shows cancer.

From the patient's perspective the interval between referral and diagnosis is clearly greater than 3 months. The waiting time reported should reflect this. We have always recognised that a small number of patients will breach for clinical reasons and this would be such a case.

2.8 At what point does a 'red flag' suspected cancer patient cease to be tracked as a potential 62 day wait patient?

A suspected cancer referral patient will cease to be tracked if a formal 'non-malignant' diagnosis is made (e.g. COPD). The patient comes off the 62 day monitoring. If the patient is subsequently diagnosed with cancer, they will enter the 31 day pathway from the date of decision to treat. This will include patients that are diagnosed with in-situ disease as these patients are not included in the cancer waits targets (except DCIS in breast care).

Where a suspected cancer referral patient is followed up due to diagnostic uncertainty (e.g. TRUS biopsy negative with a raised PSA), the patient remains on '62 day tracking', but will become a clinical exception as and when prostate cancer is diagnosed, if they are treated outside the 62 days.

It should be noted that where a GP has deemed a patient to be a 'red flag' suspected cancer they should be followed through on the cancer pathway and monitored as such. If a consultant assesses a patient to be urgent based on their triage of the referral letter or on their findings at initial hospital assessment they should be tracked in the same way.

Following this examination if the Consultant or Senior Clinical Grade Doctor considers the patient is not a suspected cancer patient, they can formally notify the GP within 24 hours of their decision and remove the patient from the 62 day pathway. The decision of the Consultant or Experienced Senior Clinical Grade Doctor must confirm in the patients notes that the "the patient has now been seen and the clinical opinion is that the patient does not have any evidence of a malignancy. In view of this, I am satisfied that this patient can be removed from the cancer 62 day tracking process". A suggested template to confirm this process is shown below. This formal recording is

necessary and will allow the decision to be audited at a later stage.

Consultants should not however ‘downgrade’ referrals deemed ‘red flag’ suspect cancers by a GP, without prior consultation with the referrer or face to face assessment with the patient by a Consultant or Experienced Senior Clinical Grade Doctor. Each Trust will need to identify the appropriate means to obtain consent for the consultation with the referrer, for each of the patient pathways.

The monitoring process allows for the separate identification of these different sources of referral and the analysis of the final outcome of the process. Suspected Breast Cancer Referrals are the exception to this guidance and where appropriate, these can be re-graded ‘downwards’ by a Consultant or Senior Clinical Grade Doctor.

DATE:

Highly Suspicious of Cancer GP Red Flag Referrals.

Patient: **Consultant:**

DOB: **Hosp No:**

This patient has undergone the investigations on the HSC suspected cancer pathway:

OPD Appt:	
Investigations:	

This patient is waiting for the following investigations outstanding:

- **..**
- **..**

This patient has an outpatient appointment with you on:

- ..
- ..

In order to update this patients suspected cancer patient pathway I would be grateful if you could confirm

• The patient has now received all **appropriate diagnostic tests** for this pathway and no malignancy has been identified. In view of this a formal non malignant diagnosis has been made and I am satisfied that this patient can be removed from the cancer 62 day PTL tracking process.	SIGN:	DATE:
• This patient has now been seen and the **clinical opinion** is that the patient does not have a malignancy. In view of this a formal non malignant diagnosis has been made and I am satisfied that this patient can be removed from the cancer 62 day PTL tracking process.	SIGN:	DATE:
• This patient is to be continued on the HSC pathway and should receive any further investigations/appointments within 1 week of request:	SIGN:	DATE:

Please fax this completed form to Cancer Services as a matter of urgency.
Thank you for your time
Fax Number: <please insert details>

2.9 Does the referral to treatment standard apply when a patient is referred on suspicion of one cancer but is diagnosed with another within the same care spell?

Yes, any patient who is referred as a suspected cancer and diagnosed with cancer within that care spell should be monitored under the 62-day target from urgent referral to treatment. To meet this target trusts will require effective handover arrangements between specialities where this situation can arise.
Examples of the tumour groups where this may occur include:
* Gynae/Colorectal (symptoms non-specific)
* Breast/Lymphoma (axillary lumps)
* Head and Neck/Lymphoma/Lung (neck lumps)
* Upper GI/Lower GI (symptoms non-specific)

Part 3 - How are the waiting times calculated in the regional database?

The table below refers to data items which will be fully explained in the core data items document. Database field names are in capitals

3.1 Reports: The regional monitoring process will provide reports for each of the waiting times standards. The table below specifies how the monitoring process will select records for a report and how the waiting time for each patient is calculated. *For the reporting period starting x and ending y*

For Target	Database will select records where	Calculation of waiting time:
Urgent referral to date first seen	DATE FIRST SEEN is between x and y **and** SOURCE OF REFERRAL FOR OUTPATIENTS = 03 or 92 **and** CANCER REFERRAL PRIORITY TYPE = 01	DATE FIRST SEEN **minus** CANCER REFERRAL RECEIVED DATE **minus** WAITING TIME ADJUSTMENT (FIRST SEEN)
Urgent referral to date of first definitive treatment	START DATE (first treatment) is between x and y **and** SOURCE OF REFERRAL FOR OUTPATIENTS = 03 or 92 **and** CANCER REFERRAL PRIORITY TYPE = 01 **and** PRIMARY DIAGNOSIS (ICD) is cancer+	START DATE (first treatment) **minus** CANCER REFERRAL RECEIVED DATE **minus** the sum of ~ WAITING TIME ADJUSTMENT (FIRST SEEN) ~ WAITING TIME ADJUSTMENT (DECISION TO TREAT) ~ WAITING TIME ADJUSTMENT (TREATMENT)
Decision to treat to first definitive treatment	START DATE (first treatment) is between x and y **and** PRIMARY DIAGNOSIS (ICD) is cancer+	START DATE (first treatment) **minus** DECISION TO TREAT DATE **minus** WAITING TIME ADJUSTMENT (TREATMENT)

See Appendix D of the Core Data definitions document

3.2 Performance Monitoring Process:

The performance monitoring process will be consistent with the other Service Delivery Unit workstream. See Section 7 which includes more information concerning the proposed process for monitoring cancer access standard.

3.3 For monitoring purposes, how many days is one month?

A month is taken to be 31 calendar days. Two months is 62 calendar days. Two weeks is 14 calendar days.

3.4 How do we count the days waited?

The date at the beginning of the waiting period is day 0. Hence is order to meet the 14 day standard if a patient is referred on 1st February the patient would need to be seen on or before 15th February.

For those patients referred as a suspected cancer patient, the first day is day 0, this would then mean that a patient referred on the 1st November the patient would need to have received their first definitive treatment on or before the 2nd January

Part 4 - FIRST DEFINITIVE TREATMENT

4.1 Several questions have been raised by Trusts regarding both the definition of “first definitive treatment” and the date which should be recorded. These issues have been considered nationally in England by the Cancer Waiting Times Implementation group and the National Cancer Director. Within Northern Ireland the guidance has been reviewed and endorsed by each of the NI Cancer Network Tumour Groups. The advice is given in the following paragraphs:

4.2 It may be useful to consider the various types of primary “treatment package” that different patients may receive:

- Many patients will receive a single treatment modality aimed at removing or eradicating the cancer completely or at reducing tumour bulk (e.g. surgery, radiotherapy or chemotherapy). In these cases the definition of “first definitive treatment” and the start date are usually straightforward.

- A second group of patients will receive a combination of treatments as their primary “treatment package” (e.g. surgery followed by radiotherapy followed by chemotherapy). In these cases the “first definitive treatment” is the first of these modalities to be delivered, and the date is the start date of this first treatment.

- A third group of patients require an intervention which does not itself affect the cancer to be undertaken prior to the delivery of the anticancer treatment(s) – to enable these treatments to be given safely. Such interventions might include formation of a colostomy for an obstructed bowel or insertion of an oesophageal stent. As these interventions form part of the planned “treatment package” for the patient it has been agreed that the start date of the enabling intervention should be taken as the date of first definitive treatment.

- A fourth group of patients undergo a clearly defined palliative intervention (e.g. a colostomy or a stent) but do not then receive any specific anticancer therapy. For these patients the start date of this intervention should be recorded as the date of first treatment.

- A fifth group of patients do not receive any anticancer treatments but are referred specifically to a specialist palliative care (SPC) team. For these patients the date of the first assessment by a member of the SPC team is to be taken as the date of the first “treatment”.

- A sixth group will receive both anticancer treatment (e.g. radiotherapy) and a specialist palliative care assessment. In this instance the date of the anticancer treatment is to be taken as date of first treatment.

- Finally, some patients do not receive any specific anticancer treatment/intervention and are not referred to a SPC team. Where the patient is receiving symptomatic support and is being monitored these patients should be classified as undergoing “Active Monitoring”. It is recognised that this is somewhat unsatisfactory as this group encompasses patients with early cancer (e.g. localised prostate cancer where serial monitoring of PSA is undertaken) and those with advanced cancers for which no immediate specific interventions are considered to be warranted. These patients may, of course, require general palliative care including symptom control – given under the care of GPs and/or oncologists. [NB At a later date revisions to the dataset will be considered but these cannot be made immediately]

4.3 The first definitive treatment is normally the first intervention which is intended to remove or shrink the tumour. Where there is no definitive anti cancer treatment almost all patients will be offered a palliative intervention (e.g. stenting) or palliative care (e.g. symptom control), which should be recorded for these purposes. In more detail:

First definitive treatment type	**Circumstances where this applies**
Surgery	♦ Complete excision of a tumour ♦ Partial excision/debulking of a tumour (but not just a biopsy for diagnostic or staging purposes) ♦ Palliative interventions (e.g. formation of a colostomy for a patient with an obstructing bowel cancer, insertion of an oesophageal stent or pleurodesis)
Drug treatment: Chemotherapy, *Biological therapy*[+] OR Hormone therapy	♦ Chemotherapy (including cases where this is being given prior to planned surgery or radiotherapy)
	♦ Biological therapy includes treatments targeted against a specific molecular abnormality in the cancer cell (e.g. rituximab, trastusumab, glivec) and treatments which target the immune system (e.g. interferon, interleukin 2, BCG).
	♦ Hormone Treatments should count as first definitive treatment in two circumstances (1) Where hormone treatment is being given as the sole treatment modal ity (2) Where the treatment plan specifies that a second treatment modality should only be given after a planned interval. This may for example be the case in patients with locally advanced breast or prostate cancer where hormone therapy is given for a planned period with the aim of shrinking the tumour before the patient receives surgery or radiotherapy.
Radiotherapy	♦ Given either to the primary site or to treat metastatic disease. This should include cases where radiotherapy is being given prior to planned surgery or chemotherapy.
Specialist Palliative Care (SPC)	♦ Given via hospital SPC teams ♦ Given via community SPC teams ♦ Given via hospices (if known by the Trust)
Active monitoring	♦ When none of the other defined treatment types apply and the patient is receiving symptomatic support and is being monitored. The date of commencement of active monitoring should be the consultation date on which this plan of care is agreed with the patient, including the intervals between assessments (e.g. serial PSA measurements for prostate patients). This treatment type may be used for any tumour site if appropriate. ♦ For the purposes of waiting times the field active monitoring should also be used to record patients with advanced cancer who require general palliative care.

[+]*Biological therapy – For the purposes of the performance monitoring Biological Therapy should be recorded as "chemotherapy" in the field PLANNED CANCER TREATMENT TYPE as defined in Core Data Definitions document.*

4.4 What is the date of treatment where treatment is self-administered?
The Start date of treatment is taken to be the date of the outpatient appointment where the patient is given the prescription.

4.5 Where should palliative procedures such as stenting be recorded?
To be consistent with the Cancer Dataset any procedure should be recorded under surgery. Section 7 of the cancer dataset is designed to collect all surgery and all other procedures and hence a palliative procedure such as stenting should be recorded under surgery. Of course the waiting dataset will not tell us whether the surgery is curative, palliative or what the intervention is. Trusts and networks may want to record the intention of the surgery or the OPCS 4 code of the procedure, but that is beyond what is required nationally to monitor waiting times.

4.6 How should we record supportive care drugs on the database?
Where a patient receives palliative care only they may of course be treated with supportive care drugs, but this is not recorded as first treatment. The first treatment should be recorded as one of the following:

i. Where the patient does not receive any anticancer treatments but is referred specifically to a specialist palliative care (SPC) team. For these patients the date of the first assessment by a member of the SPC team is to be taken as the date of the first “treatment”.

ii. Where the patient is not referred to an SPC team and is receiving symptomatic support and is being monitored these patients should be classified as undergoing “Active Monitoring”.

4.7 How should a patient who is diagnosed incidentally for cancer be monitored?

Some patients may be diagnosed for cancer during routine investigations or while being treated for another condition. This is why we have set targets from decision to treat to treatment, and once cancer is diagnosed the patient should be treated without delay. These patients should be monitored under the 31 day decision to treat to treatment target. Where the patient is treated immediately at point of diagnosis the decision to treat will be the same date as the date of the operation. (e.g. when a patient is unexpectedly found to have a cancer during surgery for a suspected benign condition).

4.8 Can a diagnostic procedure also be counted as treatment?
A purely diagnostic procedure (including biopsies) does not count as treatment unless the tumour is effectively removed by the procedure, examples of this would be a polypectomy during a Colonoscopy or an excision biopsy of a melanoma.
If an excision biopsy is therapeutic in intent (i.e. the intention is to remove the tumour) then clearly this will count as first treatment, irrespective of whether the margins were clear.

4.9 – How are patients who are treated for cancer under a clinical trial monitored?
The cancer waits standards apply to all patients treated under the NHS and so has to include patients treated under clinical trials. A suspension does not apply simply because a patient is participating in a clinical trial.

4.10 Are Carcinoid tumours reported for cancer waits?
Carcinoids of the appendix are coded as D37.3 and so are not reported for cancer waits, but carcinoids of any other site are coded to a C code in ICD10 and so are reported for cancer waits.

<u>Haematology</u>

4.11 If a patient has a blood transfusion would this count as first treatment?
If a patient is not planned to have active anticancer treatment (e.g. chemotherapy or radiotherapy) then a blood transfusion should count - as a palliative care treatment (e.g. for

chronic lymphocyte leukaemia).
In all other circumstances the blood transfusion would not count as first treatment.

4.12 Would anti-biotics be counted as first treatment for low grade gastric lymphomas?
Yes anti-biotics would count as start of treatment for low grade gastric lymphoma.

4.13 What counts as treatment for lymphoma?
The removal of a lymph node is a biopsy to establish diagnosis and would not count as start of treatment as there is disease throughout the body. Patients will be treated with chemotherapy, radiotherapy or observation depending on the biopsy diagnosis.

Breast

4.14 In the treatment of breast cancer what is the position when a patient has immediate reconstruction as part of the first definitive treatment?
When a patient has immediate reconstruction as part of the first definitive treatment this should be within a month of decision to treat where this can possibly be achieved. However if a patient is offered alternative definitive treatment within a month, i.e. Mastectomy without immediate reconstruction, but instead chooses to have the immediate reconstruction at a somewhat later date, the provider should not be penalised for this. Full details on these patients should be provided by the trust in the exception report.

4.15 Does Sentinel Node Biopsy count as start of treatment in breast cancer?
This does not count as start of treatment as this is a diagnostic procedure to determine whether cancer has spread to the lymph nodes.

Lung

4.16 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.

4.17 In lung cancer would the drainage of a pleural effusion count as treatment?
If a patient is not planned to have active anticancer treatment (e.g. chemotherapy) then this should count - as a palliative care treatment
In other circumstances it will not count.

4.18 In lung cancer would a mediastinoscopy count as first treatment?
No, this would not count as start of treatment

4.19 If a patient has a non small cell lung cancer and has to be stented can this be classed as a first treatment?
Yes this would be recorded as the start of cancer treatment.

Head and Neck

4.20 Would dental clearance count as start of treatment in oral cancer?
No, this would not count as start of treatment. 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 (see section 8.10).

4.21 Head & neck patients often require the insertion of a PEG (Percutaneous Endoscopic Gastrostomy) prior to surgery or radiotherapy, would this count as the start of a first treatment?

This procedure enables patients nutrition prior to the start of active treatment. In this case the

period they are unfit for the treatment should be an adjustment, but the insertion of the PEG is not the treatment itself. If a patient requires nutrition via a PEG to make them fit for active treatment a medical suspension may be recorded.

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

Urology

4.24 How do we monitor patients with bladder cancer?
Cancer registries do not record carcinoma in situ or pTa transitional cell carcinoma as 'cancer' as they are regarded as non invasive. Patients with these histological diagnoses are therefore not counted for the purposes of the 31 and 62 day targets. (Grade 3 pTa are registered in ICD10 as in-situ tumours (D09.0) and grade 1 and 2 as borderline (D41.4))

For bladder cancer diagnoses, the TURBT counts as the first definitive treatment provided it is carried out with the intention of debulking rather than just carrying out a biopsy of the cancer. TURBT remains the first definitive treatment even for patients who require further treatment such as cystectomy or radiotherapy.

A TUR biopsy of a bladder cancer or a biopsy of metastatic disease will not count as first definitive treatment.

If a patient has completed the standard investigations for haematuria (i.e. normal cystoscopy and normal upper tract imaging) and no malignancy has been identified then a 'benign' diagnosis can be made and these patients will not be included in the 62 day target. However if monitoring or further tests are planned (e.g. because of abnormal urine cytology or equivocal upper tract imaging) then monitoring for the 62 day target cannot be stopped until these are complete and a benign cause is diagnosed.

4.25 What counts as first definitive treatment for Upper Tract Transitional Cell Carcinoma (TCC)?
First definitive treatments include:-
• Radical surgery (e.g. nephroureterectomy)
• Local excision (open or endoscopic)
• Chemotherapy
• Palliative therapy
• Surveillance

4.26 How do we monitor patients with prostate cancer?
Patients with a raised PSA or clinically suspected prostate cancer who are referred via the suspected cancer referral will continue to be monitored until cancer is diagnosed and the first definitive treatment commenced or an unequivocal benign diagnosis is made. In practice there still remain some unclear areas.

If a patient has a raised PSA and the prostate biopsy shows benign tissue or PIN only, provided no immediate re-biopsy is planned then monitoring ceases. However, if the suspicion of cancer remains (e.g. a very high PSA, suspicious histology or inadequate tissue obtained at the first biopsy) and a further immediate biopsy is planned despite the benign first biopsy the patient continues to be monitored.

Once a patient has been told that the diagnosis is benign even if continued assessment of the PSA is recommended, the patient is no longer tracked as a potential 62 day patient whether they are discharged or not.

For patients who have locally advanced or metastatic disease, first definitive treatment will usually be hormone therapy or watchful waiting.
For patients who apparently have localised disease and are suitable for curative treatment a pelvic MR scan may be indicated (see para 8.10 for guidance on stopping the clock).
Once a patient is given a number of treatment options, they may ask for time to think before selecting their preference. The clock stops while the clinician is waiting for the patient to decide (this is generally regarded as good practice). However the clock continues while the patient is waiting to see various specialists to discuss the different options e.g. surgeon, radiotherapist or brachytherapist.

First definitive treatment options include:-
• Radical surgery
• Radical radiotherapy
• Definitive treatment with new technology
• For those patients who have neo-adjuvant hormone therapy, the date of starting hormone therapy is taken as the first definitive treatment.
• Active monitoring
• Watchful waiting
If these options are chosen it is important to note the decision date clearly in the patient's case sheets for the monitoring team.

4.27 In prostate cancer would a TURP count as first treatment?
The guidance has been reviewed after further advice from urologists.
A TURP may be performed on known prostate cancer patients to palliate symptoms (where it could be regarded as de-bulking surgery).
In other patients a TURP may be carried out for benign disease and incidentally diagnose and treat prostate cancer. In both cases this will count a start of treatment.

4.28 How do we track a suspected cancer referral patient who refuses altogether to have a TRUS biopsy but the clinician continues to review?
The TRUS biopsy will potentially diagnose the patient and by refusing altogether to have a TRUS the patient has removed themselves from the 62 day pathway. If cancer is subsequently diagnosed then the patient will be monitored under the 31 day target.
Where a patient delays a TRUS biopsy an adjustment should be made, and tracking as a potential 62 day patient should continue.

4.29 What counts as first definitive treatment for kidney cancer?
First definitive treatments include;-
• Surveillance
• Radical surgery
• Local excision (nephron sparing surgery)
• Ablation using new technology
• Immunotherapy
• Palliative care

4.30 What counts as first definitive treatment for testis cancer?
First definitive treatments include
• Orchidectomy
• Chemotherapy
• Palliative care

4.31 What counts as first definitive treatment for penile cancer?
First definitive treatments include
• Debulking operation e.g. circumcision, excision biopsy
• Radical surgery e.g. amputation, excision inguinal lymph node metastases

• Radiotherapy
• Chemotherapy
• Palliative care

Carcinoma in situ is not classed as invasive and so is not included in cancer waiting times data

Gynae

4.19 What would count as the date of first treatment in Gynaecological Cancer?

- Date of admission for surgery (or date of admission as emergency if proceeds to surgery during that admission). A cone biopsy should count as first treatment in early cervical cancer as it is a curative / definitive treatment for stage 1a disease. A diagnostic loop biopsy in more advanced cases would not usually be called a "cone" biopsy.

- Open and Close surgery - Where a patient has a major laparotomy for (usually) ovarian cancer the intention is de-bulking (not diagnosis) and so will count as start of treatment.

- Date of first radiotherapy / chemotherapy where these are first treatments

- Date of first hormonal therapy where this is used as primary treatment (eg endometrial cancer in frail patients or very young patients with low grade disease)

- Date of “treatment enabling” intervention forming part of the planned “treatment package” (eg ureteric stenting for advanced cervical cancer)

- Date of palliative intervention (e.g. colostomy or stenting) where no specific anticancer therapy is planned

- Date of the first assessment by a member of the Specialist Palliative Care team for patients who do not receive any anticancer treatments. Diagnosis does not need to be confirmed by histology / cytology for inclusion into statistics.

- “Active Monitoring”: for patients who receive symptomatic support but who do not receive any specific anticancer treatment / intervention and are not referred to a SPC team – rare in gynae oncology

4.33 How do we record the wait for a patient with ovarian cancer who requires the drainage of Ascites prior to being fit for chemotherapy?
In this situation a medical suspension would apply for the period the patient is medically unfit for the chemotherapy.

Upper GI

4.34 Would the insertion of a pancreatic stent count as start of treatment for pancreatic cancer?
After discussions with national leads it has been agreed that the **previous guidance needs to be amended.**
If the planned first treatment is resection for pancreatic or related cancers (ampullary, duodenal and distal bile duct), but subsequently the patient requires a stent due to a delay to having the surgery then stenting will not count as start of treatment. Many clinicians agree that patients with mild obstructive jaundice (a serum bilirubin below 200 micromol/l) do not require bilary stenting before resection, if surgery and imaging are planned within 7-10 days. If this is the agreed clinical practice locally then stenting for these patients will not count as start of treatment.

If the planned first treatment is to insert a stent in order to resolve jaundice before the patient has a resection or the patient starts chemotherapy stenting will count as start of treatment.

4.35 Should gastrointestinal stromal tumours (GISTs) be recorded for cancer waits?
GISTs that are described as malignant, invasive or as having metastases are coded to the relevant C code for the part of GI tract involved and are thus included in the cancer waits. GISTs not otherwise specified are coded as borderline using the relevant D code and are not recorded for cancer waits.

4.36 Would a jejunostomy count as start of treatment?
The jejunostomy would not count as start of treatment as it is a procedure to insert a feeding tube. However if a patient is medically unfit while they recover from the procedure before start of treatment (e.g. chemotherapy) it is appropriate to make an adjustment and to suspend the patient for the period they are unfit.

Brain/CNS

4.21 When a patient with a Brain tumour is given Dexamethasone would this count as first treatment?
Dexamethasone will only count if the patient is only being cared for palliatively and no other anti-cancer treatment is offered.

4.38 Should treatment of Von Hippel-Lindau syndrome be recorded on cancer waits?
No, this is a benign condition and so is outside the monitoring of cancer waiting times.

4.39 Which grades of brain tumour do we report for cancer waiting times?
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 recorded for cancer waits

Skin

4.22 In skin cancer are Intraepidermal carcinomas, Lentigo malignas or bowen's disease included in the monitoring of cancer waiting times targets to treatment?

No. All these conditions are classified as carcinoma in-situ of the skin and so are outside the scope of diagnoses monitored for cancer waiting times. Full details of the diagnosis codes covered in cancer waiting times are available in the core data definitions document.

Complex pathways

4.23 What are the complex pathways/clinical exceptions and how should this be recorded?

For a very small number of patients, there will be good clinical reasons for their care pathway not to be completed within the 31/62 days. For reasons this will vary according to individual patients and the type of cancer. Such clinical exceptions should continue to be recorded on the cancer access database, and on waiting list, although they will end up breaching the standard times. It has been agreed by the Network Tumour Groups it is acceptable for these few cases to breach the standard.

For the 62 day pathway, patients may attend for diagnosis test which prove inconclusive, leaving uncertainty as to whether they have cancer or not. If is best practice for these patients to remain within the hospital system, as repeated tests over a period of time may be required before a definitive diagnosis can be made. However, the term ‘clinical exception’ cannot be applied simply because a patient requires a series of multiple diagnostic tests, for which there are long waiting times, thus a lung cancer patient who requires several staging tests is not a “clinical exception”.

The 31 day target does not cover the diagnostic phase of the pathway and so there are fewer reasons why a patient is likely to take longer than 31 days between decision to treat and the start of their treatment.

The following are a few examples of circumstances which might be categorized as clinical exceptions:

Gynaecology - There will be a few patients coming through less obvious pathway such as those presenting with a pleural effusion who turn out to have an ovarian carcinoma. Patients presenting with endometrial hyperplasia who require repeat biopsies, may also be clinical exceptions as there is diagnostic uncertainty.

Haematology - Patients with lymphoma who have solitary mediastinal (also see lung cancer) or abdominal lymph node disease.

Head and Neck - Patients with in-situ carcinoma and those presenting with an isolated lump in the neck from an unknown primary site.

Lower GI - Those patients presenting with a rectal or colonic polyp with a focus of invasive carcinoma.

Lung Cancer - Patients presenting with pulmonary nodules or shadowing of an uncertain nature that require follow-up prior to eventual diagnosis of lung cancer.

Upper GI - Patients presenting with high grade dysplasia or carcinoma in-situ.

Urology - An inconclusive trans-rectual ultrasound biopsy for suspected prostate cancer will be repeated, but there needs to be a time delay before the patient can be retested to allow the patient to recover.

The above is not intended to be an exhaustive list or clinical exceptions but instead to provide an indication of the type of patient that could be classified as such. It should be noted that the situation described above are such that the rules for adjustments and medical or social suspensions (stopping the clock) cannot be applied to them.

Part 5 - What is the “FIRST DIAGNOSTIC TEST”?

5.1 This section provides a list of first major diagnostic tests. The first major diagnostic test is the test which will move the level of suspicion of cancer from "possible/probable" (based on history, clinical examination or blood count) to "highly probable/certain". This list is not exhaustive and so should be used as a guide to help teams in recording this data.

Primary tumour type	**First major diagnostic test likely to be one of the following**
Breast	Mammogram, Ultrasound, Needle Biopsy
Lung	Bronchoscopy, CT scan or MRI
Colorectal	Barium Enema, Flexible Sigmoidoscopy, Rigid Sigmoidoscopy, Colonoscopy, biopsy, ultrasound for abdominal mass, CT, digital rectal exam, MRI
Upper GI	Barium Meal/Swallow or Gastroscopy
Urology	I.V.U., flexible cystoscopy, trans-rectal ultrasound. P.S.A., Ultrasound
Gynaecology	OVARY: Ultrasound Scan or Ca 125(usually), CT scan (in some cases) CERVIX: Biopsy VULVA: Biopsy, Vulvoscopy ENDOMETRIUM: Vaginal Ultrasound, Endometrium Assessment/Sampling, Hysteroscopy
Haematology	Full Blood Count, Bone Marrow, Node Biopsy or CT scan
Skin	Biopsy
Head and Neck	Upper airways endoscopy, biopsy, CT scan, MRI
Brain	CT or MRI scan

The date of the first diagnostic test is recorded in the field
CLINICAL INTERVENTION DATE (FIRST DIAGNOSTIC TEST)
The date of the first diagnostic test must be after the patient has been referred to secondary care.

Part 6 - When should a new record be created?

6.1 A new record is required for each new cancer care spell. This appendix provides definitions of a cancer care spell for breast, lung and skin cancers. The definitions of cancer care spells for other tumour types are being agreed through the development of the National Cancer Dataset and will be available in subsequent versions of the Dataset document (which will be made available on the Health and Social Care Information Centre website).

6.2 In general, recurrence of cancer at the same site is considered to be part of the same care spell (so it does not require a new record) but it would be the subject of a new care plan for its management. The treatment standards in the Cancer Control Programme only apply to first definitive treatment of newly diagnosed cancers.

6.3 Breast Cancer (see exceptions below)

A new Cancer Care Spell for breast cancer should be started for:

- different histology
- different laterality

So, simultaneous bilateral breast tumours with the same histology would result in two Cancer Care Spells, one for the right breast and one for the left breast.

Multi-focal tumours (i.e. discrete tumours apparently not in continuity with other primary cancers originating in the same site or tissue) would result in one Cancer Care Spell (unless they have different histology and/or different laterality).

6.4 Lung (see exceptions below)

A new Cancer Care Spell for lung cancer should be started for:

- Any tumour with a different histology, irrespective of ICD-10 code or laterality
- A tumour with a different three-character ICD-10 code, except in cases where this is considered to be recurrence of the original primary tumour
- A tumour with different laterality except in cases where this is considered to be recurrence of the original primary tumour

However, a single lesion of one histological type is considered a single primary (i.e. one Cancer Care Spell), even if the lesion crosses site boundaries above. Differences in histological type refer to differences in the first three digits of the morphology code.

So, simultaneous bilateral lung tumours with the same histology (excluding metastases) would result in two Cancer Care Spells, one for the right lung and one for the left lung.
Multi-focal tumours (i.e. discrete tumours apparently not in continuity with other primary cancers originating in the same site or tissue) would result in one Cancer Care Spell (unless they have different histology and/or different laterality) – unless these were considered to be metastatic from the primary tumour.

6.5 Skin Cancer

There are particular rules for recording skin cancers within the Cancer Dataset, which apply when collecting skin cancer data for monitoring of Cancer Waiting Times. For full details please see the Cancer Data Manual. **Please note that data on the treatment of basal cell carcinomas is not required for the cancer waiting system as they are not covered by the cancer waiting times targets to treatment (see core data definitions document for further details).**

For Squamous Cell Carcinoma – Most patients have a single lesion at presentation, but a significant number will get more primaries over a period of time. Only one cancer care spell (i.e. one record) should be recorded for all these Squamous Cell Carcinomas.

For Kaposi's sarcoma – A new cancer care spell should be started for each Kaposi sarcoma diagnosed.

Malignant Melanoma – A new cancer care spell should be started for each Malignant Melanoma diagnosed.

Cutaneous Lymphomas - A new cancer care spell should be started for each cutaneous lymphoma diagnosed.

6.6 Exceptions

The Cancer Waiting Times database works on the basis of a single dataset record for a given Cancer Referral Decision Date or a given Decision to Treat date. Hence there are rare occasions when the database cannot record both cancer care spells:

1. If a patient is referred by the GP for two different suspected cancers **on the same date,** only the first of these can be recorded.
2. If a patient is urgently referred for suspected cancer and is diagnosed with two separate cancers (which both relate to the **same Cancer Referral Decision Date),** only the cancer first treated can be recorded on this record. Where the decision to treat date for these cancers is different, treatment data for the second cancer should be recorded as a new record and information recorded from the date of decision to treat to date of first definitive treatment (start date).
3. If the decision to treat date **is the same date** for 2 separate cancers only the first of these cancers can recorded.

Part 7 – Data and the Database

There is currently no single system available regionally which will link the patients pathway across organisations. The aim in the mid to long term is to identify an IT system which is complimentary to all the existing IT systems within Northern Ireland and will enable the collection of information through a single data entry method. It is intended the collection of information to asses the timeliness of treatment should form part of the information collection process which is required to ensure effective clinical decision making and the audit of clinical outcomes.

It is recognised a number of Trusts have already established cancer patient databases which are used for the clinical decision making and audit for the cancer multi-disciplinary team. In the short term it is intended these should be developed by Trusts to allow the collection of the data items included in the core data definitions document.

A core data definitions document has been developed which lists all the information which is required to monitor the cancer patient access standard. Trust should ensure the databases are able to collect each of the listed information.

7.1 If the Trust does not have a database, what database is available?

The Cancer Registry has recognised the key forum for the collection of cancer patient treatment is the multi-disciplinary team and has developed a cancer patient database, including a cancer staging tool. A number of cancer multi-disciplinary team meetings are already using the Cancer Registry database to support the collection of cancer patient information and to facilitate timely decision-making. The Cancer Registry database will be made available to each Trust for local implementation.

7.2 What support is available for the database?

A training programme for the databases will be provided. Any supplementary IT support required will be provide from within Trust IT support staff. Any significant errors within the Cancer Registry database should be notified directly to the Clinical MDM Support Consultant, Dr Lisa Ranaghan Telephone 028 9063 2573

7.2 How will non-mandatory data recorded on the database be used?

Mandatory data on the database are required to monitor the cancer plan targets. In addition the database supports collection of a small number of additional data items that the Cancer Services Collaborative have shown are useful to support service improvement. All non mandatory data items will only be available for local use.

The core data definitions document clearly explains the data to be collected.

Only the trust(s) who manage the care of individual patients will be able to download patient identifiable information.

7.3 Will trusts be able to update data on patients for which there is an existing record on the database?

Yes. The database allows records to be automatically updated through the Cancer Multi-disciplinary Team meeting.

7.4 For which patients can we record CANCER REFERRAL DECISION DATE?

This may only be recorded on the database for Urgent Suspected Cancer Referrals from for suspected cancer. The Cancer Referral Decision Date and Health and Care Number together form the unique record identifier within the database for these records (see para 7.9).

7.5 Which data items within the database are required to monitor the Cancer plan Targets?

The table in Appendix A of the core data definitions document shows which data items are required for monitoring the Cancer Access Standards. The table splits up data required for the access standard and treatment data, as patients may be treated in a different organisation to where they are first seen.

"Trust where first seen if urgent GP referral for suspected cancer" - The M's show the data required for ALL suspected cancer referrals to allow reporting against the suspect cancer GP red flag referrals . i.e. A trust reporting the suspect cancer referrals must ensure all the M's are complete for each record. Other data is optional or not applicable.

"Trust where patient receives first definitive treatment for cancer following a referral other than an urgent GP referral for cancer" - The M's show the data required on all cancer patients who do not come through the suspect cancer red flag GP referral route for monitoring the one month diagnosis (decision to treat) to treatment target. The Trust who delivers the first definitive treatment must ensure this data is complete. Other data is optional or not applicable.

"Trust where patient receives first definitive treatment for cancer following an urgent GP referral for suspected cancer". The M's show the data required on all cancer patients who come through the 'red flag' GP suspect cancer rule to enable monitoring of the one month diagnosis (decision to treat) to treatment target and the two months urgent referral to treatment target. The Trust who delivers the first definitive treatment must ensure this data is complete. These patients will already have the data from the first column recorded on them within the database. Other data is optional or not applicable.

7.6 Why are some of the options on SOURCE OF REFERRAL FOR OUTPATIENTS not available on the database?

The source of referral relates to the initial referral into secondary care and so should relate to the DATE FIRST SEEN. Some of the options are not available on the database in order to protect the integrity of this data and to discourage trusts further down the pathway overwriting this data.

7.7 Which MDT discussion should be recorded on the database?

As stated in the Cancer Control Programme, the care of all patients should be formally reviewed by a specialist team. This will be either through direct assessment or through formal discussion with the team by the responsible clinician. This will help ensure that all patients have the benefit of the range of expert advice needed for high quality care.

In line with the manual of cancer services, the date of MDT meeting in which the patient's treatment plan is agreed should be recorded on the database.

(Standard 2A-136 " The Core MDT, at their regular meetings should agree and record individual patient's treatment plans. A record is made of the treatment plan … including the multidisciplinary planning decision".)

7.8 How should the new codes for cancer status be used?

Cancer Status codes and descriptions

1	Suspected cancer
3	No new cancer diagnosis identified by the Trust
5	Diagnosis of new cancer confirmed – treatment not yet planned
6	Diagnosis of new cancer confirmed - NHS treatment planned
7	Diagnosis of new cancer confirmed - no NHS treatment planned
8	First treatment commenced (NHS only)

The purpose of item is to identify those urgent referrals for suspected cancer who require data to be recorded on first definitive treatment.

1 Suspected cancer

3 No new cancer diagnosis identified by the Trust
Use when benign or normal diagnosis or when a patient is diagnosed with a recurrence (see below).

5 Diagnosis of new cancer confirmed - treatment not yet planned
Use for patients with a new diagnosis of cancer, but where treatment is not yet planned.

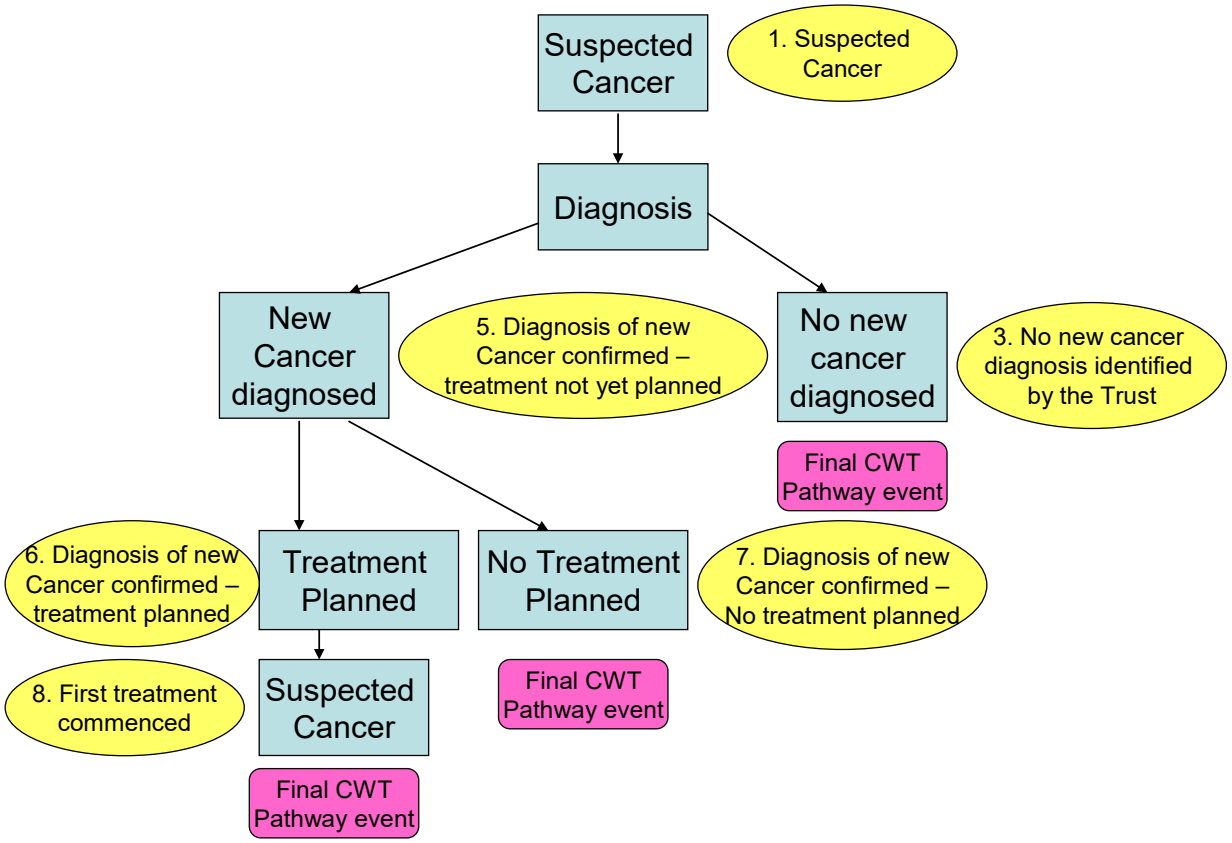
6 Diagnosis of new cancer confirmed - NHS treatment planned
Use for patients with a new diagnosis of cancer where NHS treatment is planned but has not yet commenced.

7 Diagnosis of new cancer confirmed - no NHS treatment planned
Use for patients with a new diagnosis of cancer where NHS treatment is not planned. Use this code when a patient dies before treatment, a patient refuses all treatment or a when a patient is first treated in an independent provider or the patient is first treated privately.

8 First treatment commenced (NHS only)
This code should be used when treatment under the NHS has commenced for a patient with a new diagnosis of cancer.

Patients diagnosed with a recurrence
The standards only apply to patients with a newly diagnosed cancer. Some patients have metastases at presentation and so the treatment may be to the metastatic site rather than the primary site.
The standards do not apply to a patient receiving treatment for a recurrence of cancer. Clearly good clinical practice involves treating patients with recurrence as soon as possible on the basis of clinical priority.
When a patient is diagnosed with a second new cancer, which is not a recurrence, then the targets will apply to the treatment of this cancer.

Cancer Status and the patient care pathway



7.9 How is the primary key for a record in the CWT -db defined?

(Option 1) H&C Number + "Cancer Referral Decision Date" - If the patient is referred as an Urgent Referral for Suspected Cancer - Option 1 will be used and the trust where they are first seen has the responsibility to create the record on the system.

(Option 2) H&C Number + "Decision To Treat Date" - If the cancer patient is **NOT** an Urgent referral for Suspected Cancer, Option 2 will be used and the trust where they are **treated** has the responsibility to create the record on the system.

To add further information to a suspect cancer referral record (I.e. treatment data) it is necessary to include the "Cancer Referral Decision Date" (and the NHS Number) in any subsequent upload records. This information ensures the database will identify the correct record.

This means that there needs to be local mechanisms in place to ensure that the "Cancer Referral Decision Date" is passed along the pathway if the patient crosses trust boundaries:

7.10 What data should be recorded on patient admitted as an emergency?

Some cancer patients are admitted as emergencies and remain as an inpatient until they receive their first treatment. When a patient receives surgery as the first treatment the START DATE(SURGERY) is defined to be the date of admission. In this example the DECISION TO TREAT DATE may be after the date of admission and hence the interval between decision to treat and start date is negative. These dates will be accepted by the database.

7.11 In what circumstances should we use the code "4 – patient choice" in the field WAITING TIME ADJUSTMENT REASON (FIRST SEEN)?

This code should only be used if a patient referred by their GP as a suspected cancer makes it clear that they do not want an appointment within 14 days before an offer is made. The patient will be excluded from the reports generated on the CWT-db to monitor the Two Week Standard. However data on the patients waiting time should be uploaded onto the CWT-db, as this will be required for monitoring the Urgent Referral to treatment target if the patient is diagnosed with cancer.

Where a patient turns down an appointment offered within 14 days the code "2 – patient cancellation" should be used (for example the patient declines as they are on holiday on the date offered). The patient should be offered another appointment within 14 days of the cancelled appointment.

7.12 How do we record suspect cancer patients that are admitted as emergencies before they are seen?

When a suspected cancer patient is admitted as an emergency before they are seen. The emergency admission is the referral into the system and effectively supersedes the original referral. Where a patient is admitted for another condition the original suspected cancer referral still stands.

7.13 How do we record new cases of cancer cases where there is no pathology available?

It is well recognised that some patients with cancer never have microscopic verification (i.e. histology or cytology). This is particularly the case for internal cancers such as pancreatic and for elderly patients with lung cancer who are deemed unfit for bronchoscopy. In these cases diagnosis is made on non-microscopic information such as radiological investigations. For practical purposes if a patient has been told they have cancer and/or have received treatment for cancer the relevant primary diagnosis code should be used.

7.14 How should we record ICD10 code on Chronic Lymphocytic Leukaemia?

Chronic Lymphocytic Leukaemia should be reported using the 3-digit code C91. The CWT-db requires all acute leukaemia's to four digits in order to identify these cases separately to monitor the 2001 treatment target, but in other cases of leukaemia the ICD10 code is only required to 3 digits.

Decision to Treat

7.15 Why is “decision to treat date” used to monitor the 31 day target?

Date of diagnosis is already well defined for cancer registration purposes. In some cancers it is common for the diagnosis to take place AFTER first treatment. For example in testicular cancer, orchidectomy is counted as the first definitive treatment, although definitive diagnosis will be obtained from this operation. The start date for monitoring this target should be one that is meaningful for patients. The decision to treat date is the date of the consultation in which the patient and clinician agree the treatment plan for first treatment. If the first treatment requires an admission (e.g. Surgery) this date is recorded on hospital PAS systems, as the "Date of decision to admit" (used for calculation of waiting list statistics). A decision to treat is dependent on the agreement of the patient and so may not be on the day of the MDT meeting.

7.16 What is the date of decision to treat for chemotherapy or radiotherapy?

Oncologists have agreed that the "decision to treat date" is the date the oncologist sees the patient and agrees that the patient is suitable for treatment and that the patient agrees the treatment plan.

7.17 Can a decision to treat be made with a patient prior to completing all staging tests?

Normally staging tests are completed prior to making a decision to treat. As stated above if first treatment requires an admission (e.g. Surgery) this date is recorded as “Date of Decision to admit” on hospital PAS systems and is used for measuring elective inpatient waiting times and should also be used for cancer waiting times.

7.18 What date is the decision to treat for brachytherapy in prostate cancer?

In order to determine whether the prostate is suitable for brachytherapy a volume study has to be performed. The date of the decision to treat will be the date of the consultation where the treatment is agreed after the volume study has been completed.

Part 8 – Guidance on Adjustments for Cancer Waiting Times

8.1 There will be guidance issued which will explain the recording waiting times for the purposes of calculating inpatient waiting list and waiting time central returns.

8.2 This existing guidance also applies to the recording of waiting times in the cancer access standards database. This note provides some specific examples of adjustments in the cancer pathway.

8.3 In line with current guidance on waiting times an adjustment to the waiting time of a patient is applicable in the following circumstances.

- Patient cancelled an outpatient appointment
- Patient Did Not Attend (DNA) an outpatient appointment
- Patient defers an admission
- Suspension for patient reasons (often referred to as social suspension)
- Suspension for medical reasons

8.4 Patient cancelled an outpatient appointment

~ If this is the first outpatient appointment the clock restarts from the date the patient informs the Trust that they wished to cancel their appointment the adjustment is the number of days from date of decision to refer to date of appointment the patient refuses. (i.e. clock is reset)
For example if the referral is received on the 1 May and the appointment is offered for the 10th May, and the patient cancels it on the 5th May, this should take 5 days off your waiting time.

- If this is a follow-up appointment the adjustment is calculated as the number of days from the date the patient informs the Trust that they wished to refuse the appointment. Note: If the provider cancels the appointment then there is no affect on the waiting time.

8.5 Patient Did Not Attend (DNA) an outpatient appointment

~ If this is the first outpatient appointment the clock restarts from the date of the appointment the patient did not attend or the date on which they informed the Trust that they wished to cancel their appointment. The adjustment is the number of days from date of decision to refer to date of DNA. (i.e. clock is reset)

- If this is a follow-up appointment the adjustment is calculated as the number of days from the date the patient was last seen to the date of appointment the patient did not attend.

8.6 Patient defers admission

~ Patient is offered a reasonable date for admission but refuses. Provided the admission date was a reasonable one (i.e. there was a sufficient amount of notice and the provider took account of personal circumstances) this is described as a self-deferral. In such a case the waiting time is adjusted by the number of days from date of decision to treat to the date the admission was scheduled to take place.

Example

- A patient is contacted by the trust and offered an admission date for surgery to treat their breast cancer. At this time they declare that they are unable to attend on this date as they have booked a holiday. This is a patient deferral. In this case the period between the admission date they declined and the decision to treat date is to be removed by an adjustment.

Note: if the provider cancels the admission then there is no affect on the waiting time. (e.g. the 31 day target waiting times is calculated from the original decision to treat date)

8.7 Suspension for patient reasons (often referred as social suspensions)

The clock stops when

- When a patient has other commitments they wish to pursue prior to treatment or investigation (e.g. Holiday)
- When a patient requests a period of time to think (e.g. to decide on treatment options)
- When a patient requests a second opinion before making a decision on treatment. (The clock does not stop if the clinician requires a second opinion)
- **Suspensions must be clearly recorded in the patient notes**
- **The position of any patient suspended must be reviewed regularly.**

The clock does not stop

- When a patient chooses a treatment with a longer waiting time (e.g. radiotherapy rather than surgery)
- A patient should not be suspended once an admission date has been agreed, unless the date is later than normal due to the need to resolve other medical problems prior to treatment.

8.8 Examples of social suspensions

- A patient with cancer is seen by the oncologist and is suitable for a clinical trial. The patient is given the details and told he/she needs to make a choice about whether or not they wish to take part in the trial. This two-step process is good practice in terms of informed consent. Whilst taking the time to make the decision, the patient will be classed as suspended for patient reasons as he/she is technically unavailable for treatment. The clock starts again as soon as the patient has told the oncologist of their decision.

Note: Allowing patients time to consider treatment options is part of good clinical practice and is not confined to clinical trials.

- A young patient is advised that potentially curative treatment involves significant risk of serious side effects (which may include peri-operative death). The patient wishes to be referred for a second opinion to see if they might avoid these outcomes but yet still achieve cure. The patient is suspended for patient reasons as they have made themselves unavailable for treatment whilst seeking a second opinion.

- A patient is discussing their care-plan with a clinician and states (before any offer of an admission date is made) that they would like to take the holiday they have booked prior to treatment starting. As no offer of a TCI date had been made by the trust this can be classified as a suspension for patient reasons. The period which the patient has made themselves unavailable should be adjusted out of the calculated waiting time.

8.9 Suspension for medical reasons

The clock stops when

- When a patient is unavailable for admission for a period of time due to another medical condition that needs to be resolved
- When a patient is unavailable for a diagnostic or staging test or treatment due to another medical condition that needs to be resolved (e.g. reduce weight)
- **Suspensions must be clearly recorded in the patient notes**
- **The position of any patient suspended must be reviewed regularly.**

The clock does not stop

- When the trust is unable to offer treatment within the required timescales.
- For a patient who requires repeat biopsies or scans because of uncertainty the first time round.
- In patients for whom there is genuine clinical uncertainty about the diagnosis and the clinician elects to observe the patient over (say) a three month period.
- A patient should not be suspended once an admission date has been agreed, unless the date is later than normal due to the need to resolve other medical problems prior to treatment

8.10 Examples of suspension for medical reasons

 Some cancer patients will have co-morbidities, which will require investigation and/or treatment prior to administering cancer treatment. For example a cancer patient with angina may be referred for a cardiology opinion prior to treatment. In this case the clock will only stop if the cardiology opinion is that the patient is medically unfit for cancer treatment. If the opinion is that the patient is fit for cancer treatment then the clock does not stop. Hence the clock does not stop whilst an opinion on the co-morbidity is being sought. A similar example would be where a patient with mouth cancer requires dental extraction prior to ommencement of radiotherapy treatment – the clock would stop while the patient was not fit for treatment following the extraction, but not whilst they were waiting for the extraction.

 Patients with severe frailty/cachexia related to the cancer. A patient who requires intensive nutritional support (e.g. through intravenous feeding or through nasogastric feeding) before they are fit for surgery. The clock stops for the period the patient is medically unfit for surgery, with the start date of this period of suspension being defined as the date when a medical opinion as to their being unfit for treatment was received.

 A patient with cancer also has COPD. He/she is technically suitable for surgical resection but considered in need of a medical opinion (in this case usually a respiratory physician). The respiratory physician confirms the patient is medically unfit for the surgery at that time (clock stops at this point) (see above) and wishes to institute a changed therapeutic regime to optimise their respiratory function before surgery. The patient is suspended until medically fit for the surgery.

 In prostate cancer following a transrectal ultrasound-guided biopsy there may be swelling of the prostate gland. This makes interpretation of MRI scans unreliable. Many clinicians would advocate that there should be a planned interval of up to 4 weeks between biopsy and MRI, as the gland swelling means the patient is medically unfit for the scan and so a medical suspension is appropriate. Where this is agreed in local clinical protocols and if the clinician agrees this with the patient, then an adjustment can be made to the waiting time for the period that the patient is unfit to progress to the scan (i.e. where the MRI is requested after biopsy the clock can be stopped from date of MRI request until the date that is a maximum of 4 weeks after the biopsy). The patient notes need to make it clear that a medical suspension was necessary. Of course this must not be used to mask delays to MRI scans or subsequent delays to surgery.

 In the absence of conclusive research regarding the optimum time interval from TRUS biopsy to radical prostate surgery, it has been agreed through clinical consensus that there could

be a period of up to six weeks, depending on clinical judgement, between TRUS biopsy and radical prostate surgery. If this is agreed in local clinical protocols the patient should only be medically suspended for the period they are unfit (i.e. from the date it is agreed they will have radical surgery until the date 6 weeks after biopsy).

- If a cancer is found on barium enema a CT cannot be performed for up to 10 days as barium sulphate cannot be penetrated by X-Ray. A medical suspension may be recorded for the period the patient is unfit (following the decision that the patient requires a CT) if no other diagnostic activities can be carried out in this period and a CT scan was available within 10 days.

- Some patients diagnosed with primary liver cancer (Hepatoma) have an organ transplant as their first treatment. A patient should be suspended for the period that matched organs are not available.

8.11 Can we make an adjustment for radiographic investigations in menstruating females?
The Royal College issued guidance a few years ago indicating that, while the 28 day rule was satisfactory for most radiographic investigations, in menstruating females, the 10 day rule was safer for high dose investigations particularly barium enema and CT of the abdomen and pelvis (i.e. the procedure should be performed in the first 10 days of the menstrual cycle). Many departments also apply the 10 day rule for barium studies of the small bowel. Where this delays a patients investigation a medical suspension may be applied for the time the patient is unfit for the test.

8.12 How do we monitor a patient who agrees a treatment and then a week later changes their mind and wishes to receive a different treatment altogether?
The patient will have to agree a new decision to treat and hence the 31 day target clock is reset. For the 62 day target it is appropriate to remove the period from decision to treat to the date of cancellation and should be coded as a self-deferral.

8.13 How do we monitor a patient that refuses altogether the diagnostic test that may diagnose cancer but continues to be cared for by the trust?
In effect the patient, by refusing the diagnostic test, has taken them self off the 62 day pathway. The trust can not deliver on a patient who is not prepared to "be on the pathway". If the patient agrees at a later stage to have the test and is subsequently diagnosed with cancer, they should be monitored against the 31 day standard.

8.14 How do we monitor a patient that turns up for their diagnostic test but then refuses the test and has to be re-booked at a later date?
If the trust has done everything possible to avoid this happening (e.g. the patient is fully informed about what to expect) then the patient can be considered as having been self-deferred (or patient cancellation) and so an adjustment may be made.

8.15 How are adjustments to waiting times made?
There are three adjustment fields within the Cancer Waiting Times Database (CWT-Db) to record adjustment values depending on which point on the referral to treatment pathway the adjustment is appropriate.
WAITING TIMES ADJUSTMENT (FIRST SEEN) – To record adjustment (in days) between referral received date and date first seen.

WAITING TIMES ADJUSTMENT (DECISION TO TREAT) – To record adjustment (in days) between date first seen and date of decision to treat.

WAITING TIMES ADJUSTMENT (TREATMENT) – To record adjustment (in days) between date of decision to treat and start date of treatment.

If an adjustment is recorded a user is also required to give the reason for adjustment (using the fields WAITING TIME ADJUSTMENT REASON (FIRST SEEN), WAITING TIME ADJUSTMENT

REASON (DECISION TO TREAT), and WAITING TIME ADJUSTMENT REASON (TREATMENT)

Please Note: A comment in the delay reason comment field will **not** result in a patient's waiting time being adjusted. The system requires the adjustment fields above to be completed in order to calculate an adjusted waiting time.

8.16 Examples of adjusting a patients waiting time

Example A: The patient and surgeon agreed first definitive treatment of surgery on 01/11/2002. The date of admission for this surgery was 25/11/2002, but the patient defers treatment. The patient is then admitted on 09/12/2002 for the surgery.
DECISION TO TREAT DATE (SURGERY) = 01/11/2002
START DATE (SURGERY HOSPITAL PROVIDER SPELL) = 09/12/2002
WAITING TIME ADJUSTMENT (TREATMENT) = 25/11/2002 – 01/11/2002 = 24 days
The database will then calculate the waiting time for the decision to treat to treatment target which will be reported as 14 (START DATE (SURGERY HOSPITAL PROVIDER SPELL) - DECISION TO TREAT DATE (SURGERY) - WAITING TIME ADJUSTMENT (TREATMENT))

If however, the patient cancels on the 20/11/02 the waiting times will be adjusted and calculated as 20/02/02-01/02/07 = 11 days

Example B: A GP decides to refer a patient under the suspected cancer referral standard on 03/02/2003 and the referral is received on the 04/02/2003 and the patient is given an appointment for 11/02/2003. The patient cancels this appointment on the 07/02/2003 and is given another appointment for 18/02/2003, which the patient attends.
CANCER REFERRAL RECEIVED DATE = 04/02/2003
DATE FIRST SEEN = 18/02/2003
WAITING TIME ADJUSTMENT (FIRST SEEN) = 18/02/2003 – 04/02/2003 = 3 days
The database will calculate the waiting time from the above information and the reported waiting time will be 11 days (DATE FIRST SEEN - CANCER REFERRAL RECEIVED - WAITING TIME ADJUSTMENT (FIRST SEEN))

Example C: The patient above (who was first seen on 18/02/2003) cancels their follow-up appointment on 23/02/2003. This is an adjustment of 5 days from the date the patient cancels or DNAs. The patient is given another appointment for 04/03/2003, which the patient attends. The consultant and patient agree the first definitive treatment of surgery on 11/03/2003.
Date Last Seen = 18/02/2003
WAITING TIMES ADJUSTMENT (DECISION TO TREAT)
= Cancelled follow-up appointment – Date last seen
= 23/02/2003 – 18/02/2003 = 5 days

Example D: If the patient in examples B and C is admitted for the surgical treatment on 07/04/2003 then the waiting time from urgent referral to treatment is calculated as follows.
Waiting time from urgent referral to first treatment
= START DATE (SURGERY HOSPITAL PROVIDER SPELL) - CANCER REFERRAL RECEIVED DATE – WAITING TIME ADJUSTMENT (FIRST SEEN) - WAITING TIME ADJUSTMENT (DECISION TO TREAT) – WAITING TIME ADJUSTMENT (TREATMENT). This is when they cancel on the 25th Feb.
= 07/04/2003 – 04/02/2003 –(3 +7) – 10 = 52 days

References

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http://www. performance.doh.gov.uk/cancerwaits/

- Cancer Waiting Times Data

http://www. nhsia.nhs.uk/cancer/pages/waiting//documentation.asp

- The user manual for the Cancer Waiting Database (including CSV upload format for multiple records)
- System security document

http://www. nhsia.nhs.uk/nhais/pages/products/vaprod/openexe/

- User Access form for Cancer Waiting Times System

www. n hsia. n hs. u k/dscn

- DSCN 22/2002 – National Cancer Waiting Times Monitoring
- DSCN 31/2003 – Extension of Active Monitoring to all tumour sites
- DSCN 15/2004 – Cancer Waiting Times – First Definitive Treatment
- DSCN 27/2004 – Cancer Waiting Times - Cancer Status

www. nocancerwaits.org

- Information and slide packs from National Briefing and Cancer Waits executive delivery days
- Information on 27th June 2005 National Briefing
- **Materials for clinicians**
  - The ABC of Cancer Waits
  - The “one page guide” of key definitions for MDTs.
  - Power point slide pack

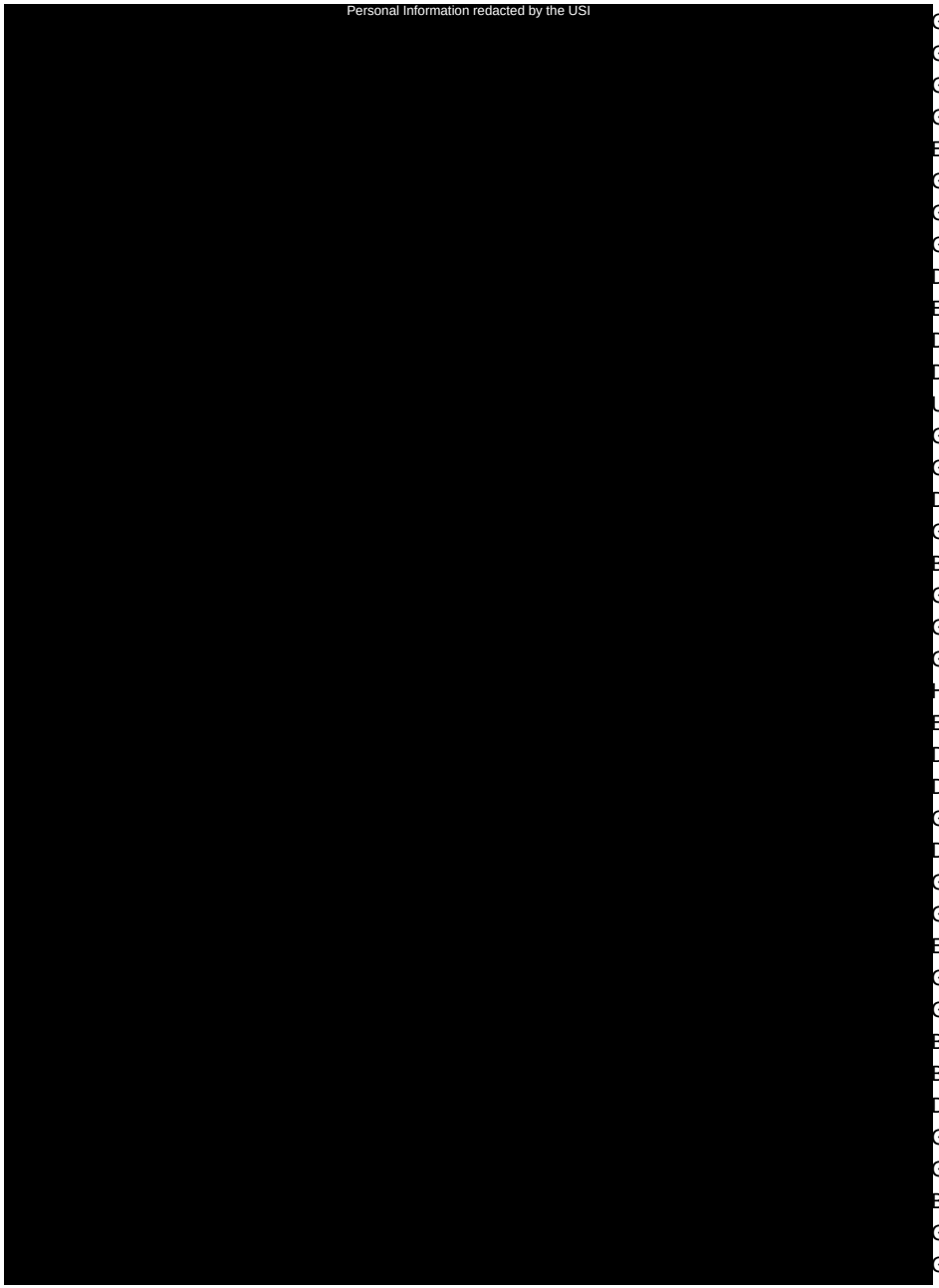
http://www.cancerimprovement.nhs.uk/scripts/default.asp?site_id=26&id=5620

- ***Applying High Impact Changes to Cancer***
- ***The “How to” Guide: Achieving Cancer Waiting Times***

Discussion Forum

The discussion forum is designed to give the opportunity for those interested in cancer access standards information to discuss ideas or share good practice. This discussion forum is located on the <> web site<>?
To check out the discussion forum please visit:
www.dhsspsweb site

FORENAME	SURNAME	HCN	DOB	REFERRING GP	SPEC\HOSPITAL	DATE REFERRAL CREATED	DATE REFERRAL SUBMITTED
Personal Information redacted by the USI					GENERAL SURGERY - COLORECTAL\South Tyrone	11/09/2018 10:58	11/09/2018 10:58
					GASTROENTEROLOGY\Craigavon Area Hospital	10/09/2018 23:42	10/09/2018 23:42
					EAR, NOSE & THROAT\South Tyrone Hospital	10/09/2018 13:34	10/09/2018 13:34
					GASTROENTEROLOGY\South Tyrone Hospital	12/09/2018 13:11	12/09/2018 13:11
					EAR, NOSE & THROAT\South Tyrone Hospital	13/09/2018 11:46	13/09/2018 11:46
					HAEMATOLOGY\Craigavon Area Hospital	10/09/2018 08:59	10/09/2018 08:59
					DERMATOLOGY\South Tyrone Hospital	10/09/2018 12:05	10/09/2018 12:05
					GENERAL SURGERY - COLORECTAL\Craigavon Ar	12/09/2018 17:09	12/09/2018 17:09
					DERMATOLOGY\South Tyrone Hospital	12/09/2018 17:15	12/09/2018 17:15
					DERMATOLOGY\South Tyrone Hospital	13/09/2018 10:45	13/09/2018 10:45
					EAR, NOSE & THROAT\Craigavon Area Hospital	10/09/2018 09:33	10/09/2018 09:33
					GENERAL SURGERY - COLORECTAL\Craigavon Ar	11/09/2018 13:19	11/09/2018 13:19
					GENERAL SURGERY - UPPER GI\Craigavon Area H	12/09/2018 11:13	12/09/2018 11:13
					GENERAL SURGERY - UPPER GI\Craigavon Area H	14/09/2018 10:00	14/09/2018 10:00
					DERMATOLOGY\Craigavon Area Hospital	10/09/2018 16:07	10/09/2018 16:08
					GYNAECOLOGY - OTHER\Craigavon Area Hospita	11/09/2018 16:25	11/09/2018 16:25
					DERMATOLOGY\Craigavon Area Hospital	11/09/2018 16:00	11/09/2018 17:30
					DERMATOLOGY\Craigavon Area Hospital	11/09/2018 12:13	11/09/2018 12:13
					BREAST SURGERY\Craigavon Area Hospital	14/09/2018 09:02	14/09/2018 09:02
					EAR, NOSE & THROAT\Daisy Hill Hospital	12/09/2018 14:57	12/09/2018 14:57
					GENERAL SURGERY - UPPER GI\Craigavon Area H	10/09/2018 12:43	10/09/2018 12:43
					GENERAL SURGERY - UPPER GI\Craigavon Area H	10/09/2018 17:33	10/09/2018 17:33
					GENERAL SURGERY - UPPER GI\Craigavon Area H	14/09/2018 12:58	14/09/2018 12:58
					DERMATOLOGY\Daisy Hill Hospital	10/09/2018 09:20	10/09/2018 09:20
					GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	13/09/2018 23:07	13/09/2018 23:07
					GYNAECOLOGY - OTHER\Craigavon Area Hospita	14/09/2018 17:15	14/09/2018 17:15
					BREAST SURGERY\Craigavon Area Hospital	14/09/2018 17:18	14/09/2018 17:18
					UROLOGY\Craigavon Area Hospital	13/09/2018 14:37	13/09/2018 14:37
					DERMATOLOGY\Craigavon Area Hospital	14/09/2018 18:17	14/09/2018 18:17
					GYNAECOLOGY - OTHER\Craigavon Area Hospita	13/09/2018 13:10	13/09/2018 13:11
					GENERAL SURGERY - COLORECTAL\Craigavon Ar	11/09/2018 11:11	11/09/2018 11:11
					GASTROENTEROLOGY\Craigavon Area Hospital	14/09/2018 12:58	14/09/2018 13:15
					UROLOGY\Craigavon Area Hospital	14/09/2018 15:06	14/09/2018 15:06
					RESPIRATORY\Craigavon Area Hospital	14/09/2018 17:10	14/09/2018 17:10
					HAEMATOLOGY\Craigavon Area Hospital	10/09/2018 14:37	10/09/2018 14:37
					DERMATOLOGY\Craigavon Area Hospital	14/09/2018 11:27	14/09/2018 11:27
					GENERAL SURGERY - OTHER\Craigavon Area Hos	10/09/2018 09:30	10/09/2018 09:30
					GENERAL SURGERY - UPPER GI\Craigavon Area H	14/09/2018 10:48	14/09/2018 12:55
					GENERAL SURGERY - UPPER GI\Craigavon Area H	14/09/2018 17:06	14/09/2018 17:06



GASTROENTEROLOGY\Craigavon Area Hospital	13/09/2018 13:01	13/09/2018 13:01
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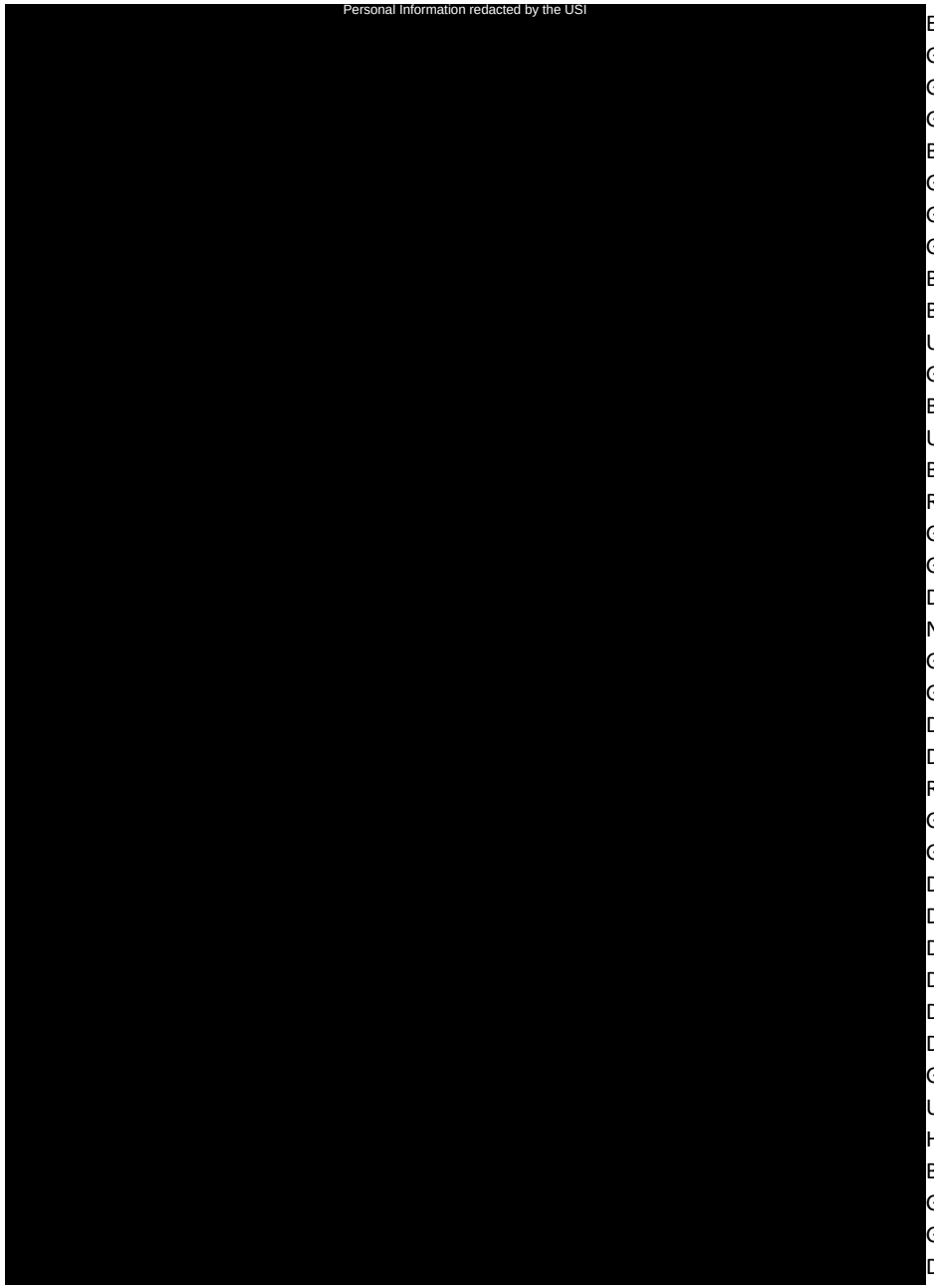
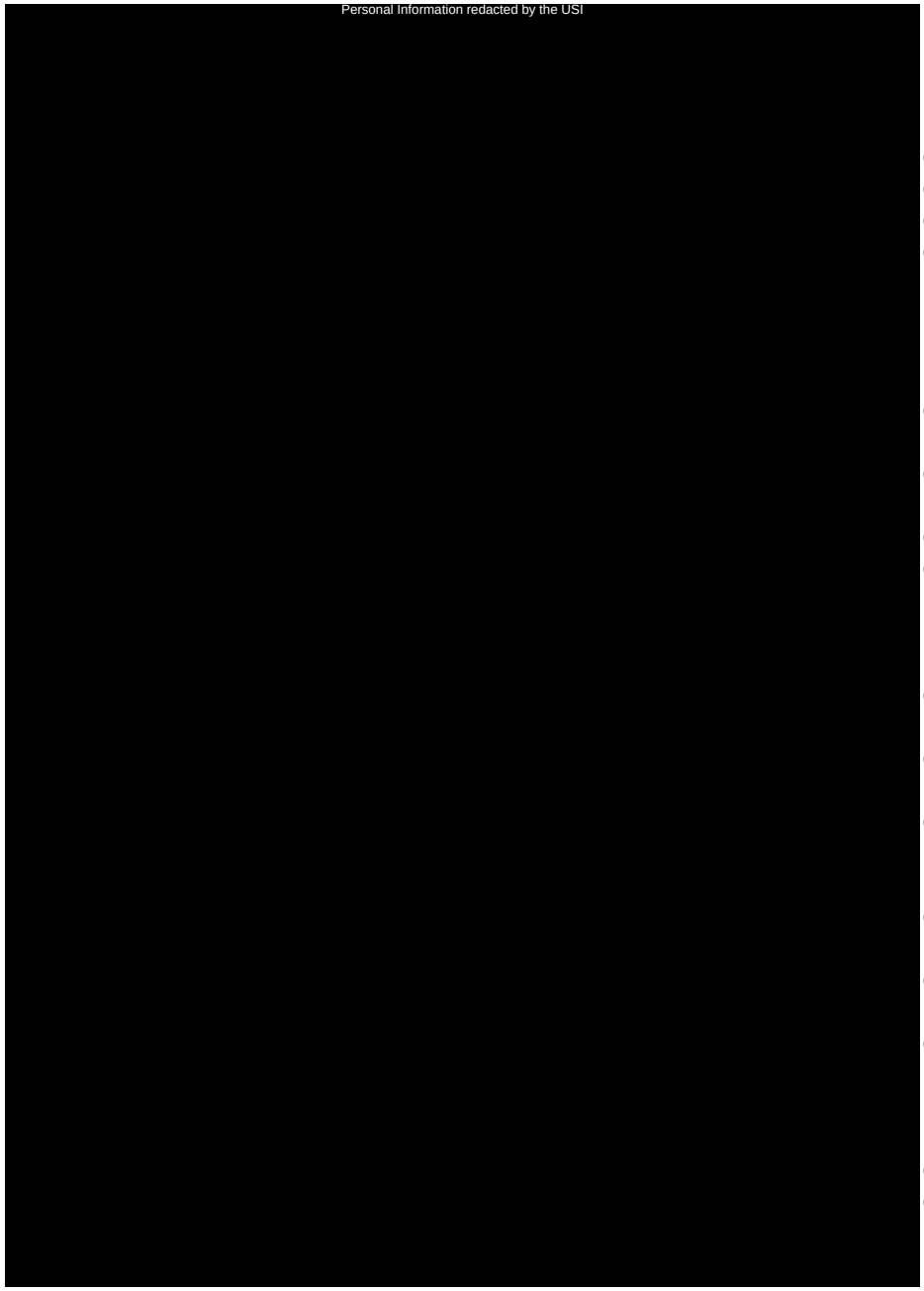
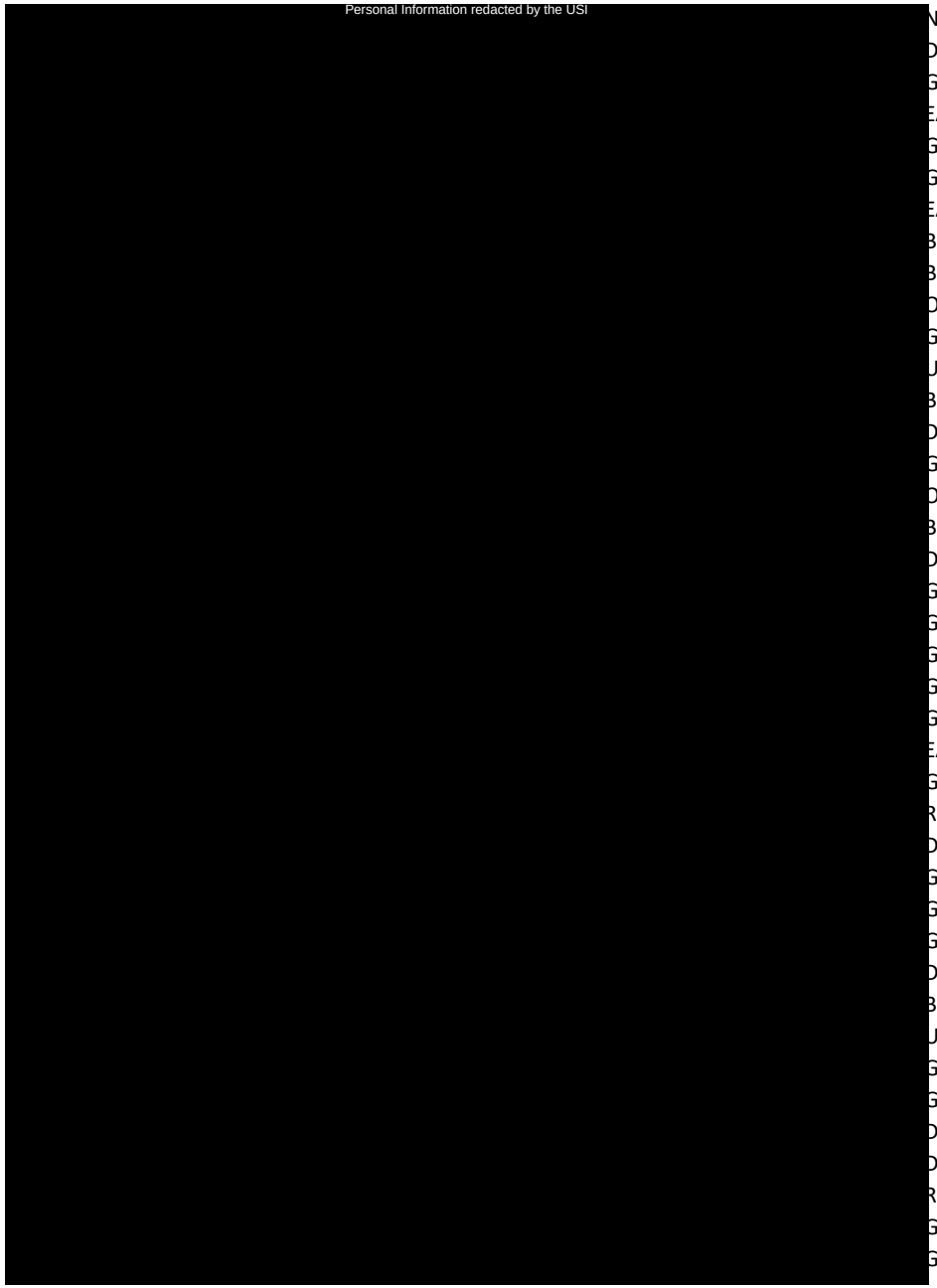
GENERAL SURGERY - COLORECTAL\Craigavon Ar	10/09/2018 12:50	10/09/2018 12:50
GASTROENTEROLOGY\Craigavon Area Hospital	12/09/2018 12:46	12/09/2018 12:46
EAR, NOSE & THROAT\Craigavon Area Hospital	12/09/2018 13:23	12/09/2018 13:24
GASTROENTEROLOGY\Craigavon Area Hospital	12/09/2018 13:29	12/09/2018 13:29
GENERAL SURGERY - OTHER\Craigavon Area Hos	11/09/2018 11:39	13/09/2018 17:44
GENERAL SURGERY - UPPER GI\Craigavon Area H	12/09/2018 14:14	12/09/2018 14:14
DERMATOLOGY\Craigavon Area Hospital	14/09/2018 17:42	14/09/2018 17:42
EAR, NOSE & THROAT\Craigavon Area Hospital	10/09/2018 10:29	10/09/2018 10:29
DERMATOLOGY\Craigavon Area Hospital	13/09/2018 17:19	13/09/2018 17:19
DERMATOLOGY\Craigavon Area Hospital	14/09/2018 13:46	14/09/2018 13:46
UROLOGY\Craigavon Area Hospital	11/09/2018 12:16	11/09/2018 12:16
GYNAECOLOGY - OTHER\Craigavon Area Hospita	13/09/2018 12:17	13/09/2018 12:17
GENERAL SURGERY - COLORECTAL\Craigavon Ar	13/09/2018 12:50	13/09/2018 12:50
DERMATOLOGY\Craigavon Area Hospital	10/09/2018 12:42	10/09/2018 12:42
GYNAECOLOGY - OTHER\Craigavon Area Hospita	12/09/2018 16:01	12/09/2018 16:01
BREAST SURGERY\Craigavon Area Hospital	13/09/2018 17:26	13/09/2018 17:26
GASTROENTEROLOGY\Craigavon Area Hospital	11/09/2018 12:24	11/09/2018 12:24
GENERAL SURGERY - OTHER\Craigavon Area Hos	09/09/2018 21:57	09/09/2018 21:57
GENERAL SURGERY - UPPER GI\Craigavon Area H	11/09/2018 17:38	11/09/2018 17:38
HAEMATOLOGY\Craigavon Area Hospital	11/09/2018 09:04	11/09/2018 09:04
EAR, NOSE & THROAT\Craigavon Area Hospital	11/09/2018 13:11	11/09/2018 13:11
DERMATOLOGY\Craigavon Area Hospital	10/09/2018 19:56	10/09/2018 19:56
DERMATOLOGY\Craigavon Area Hospital	12/09/2018 16:16	12/09/2018 16:16
GYNAECOLOGY - OTHER\Craigavon Area Hospita	09/09/2018 22:10	09/09/2018 22:10
DERMATOLOGY\Craigavon Area Hospital	14/09/2018 09:26	14/09/2018 09:26
GYNAECOLOGY - OTHER\Craigavon Area Hospita	10/09/2018 16:02	10/09/2018 16:02
GENERAL SURGERY - COLORECTAL\Craigavon Ar	10/09/2018 17:09	10/09/2018 17:09
EAR, NOSE & THROAT\Craigavon Area Hospital	10/09/2018 18:24	10/09/2018 18:24
GENERAL SURGERY - COLORECTAL\Craigavon Ar	10/09/2018 17:24	10/09/2018 17:25
GENERAL SURGERY - COLORECTAL\Craigavon Ar	11/09/2018 11:16	11/09/2018 11:17
BREAST SURGERY\Craigavon Area Hospital	14/09/2018 10:50	14/09/2018 10:50
BREAST SURGERY\Craigavon Area Hospital	10/09/2018 12:40	10/09/2018 12:41
DERMATOLOGY\Craigavon Area Hospital	14/09/2018 13:33	14/09/2018 13:33
GYNAECOLOGY - OTHER\Craigavon Area Hospita	11/09/2018 13:01	11/09/2018 13:02
GASTROENTEROLOGY\Craigavon Area Hospital	14/09/2018 11:16	14/09/2018 11:16
BREAST SURGERY\Craigavon Area Hospital	14/09/2018 13:27	14/09/2018 13:27
GASTROENTEROLOGY\Craigavon Area Hospital	13/09/2018 13:05	14/09/2018 17:39
GASTROENTEROLOGY\Craigavon Area Hospital	13/09/2018 13:09	13/09/2018 13:09



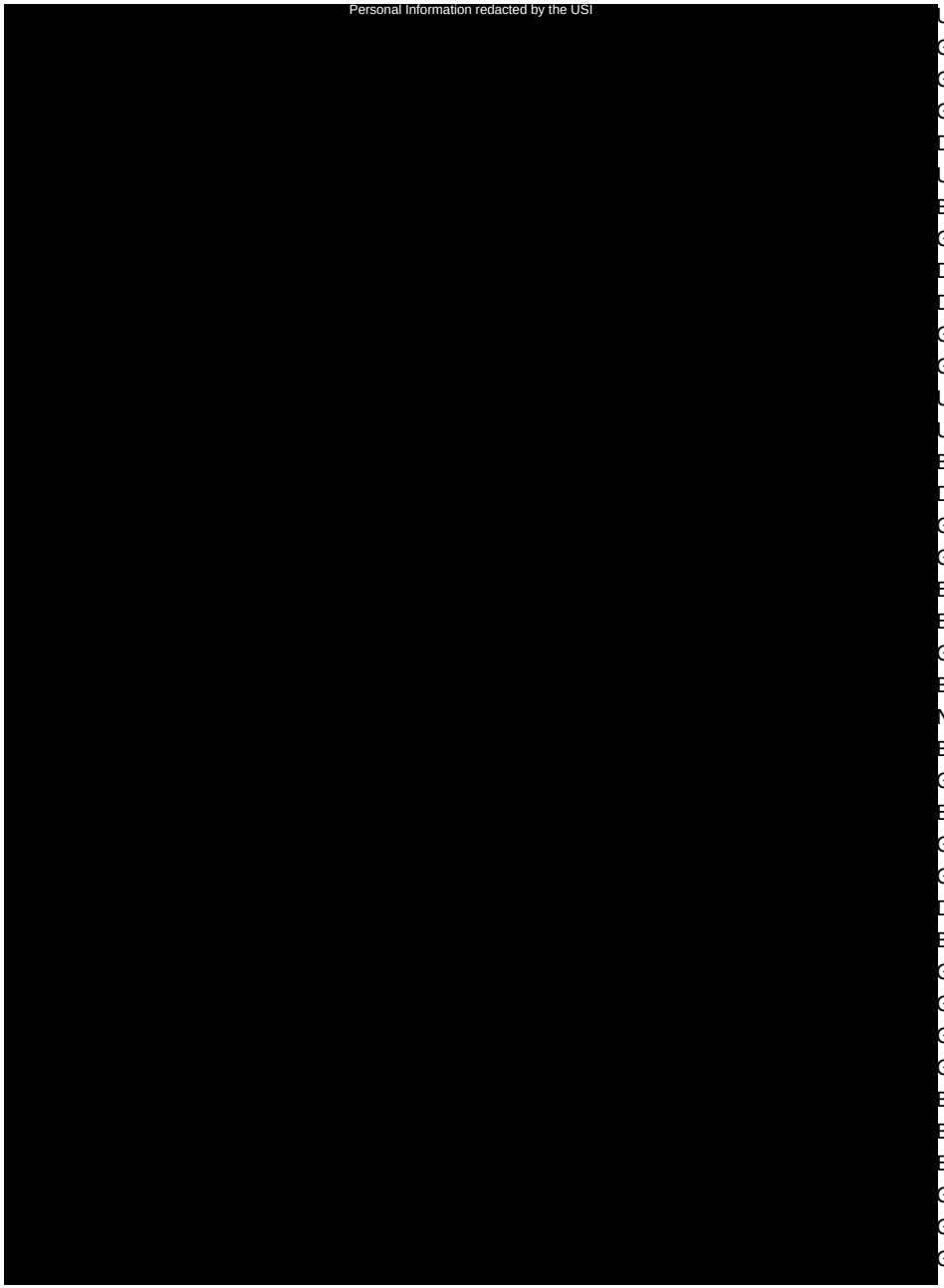
EAR, NOSE & THROAT\Craigavon Area Hospital	11/09/2018 10:51	11/09/2018 11:06
GENERAL SURGERY - COLORECTAL\Craigavon Ar	11/09/2018 12:38	11/09/2018 12:38
GENERAL SURGERY - OTHER\Craigavon Area Hos	10/09/2018 13:51	10/09/2018 13:51
GYNAECOLOGY - OTHER\Craigavon Area Hospita	10/09/2018 11:30	10/09/2018 11:30
BREAST SURGERY\Craigavon Area Hospital	10/09/2018 12:22	10/09/2018 12:23
GYNAECOLOGY - OTHER\Craigavon Area Hospita	10/09/2018 12:33	11/09/2018 16:46
GYNAECOLOGY - OTHER\Craigavon Area Hospita	10/09/2018 13:54	10/09/2018 13:55
GYNAECOLOGY - OTHER\Craigavon Area Hospita	12/09/2018 17:24	12/09/2018 17:24
BREAST SURGERY\Craigavon Area Hospital	12/09/2018 17:31	12/09/2018 17:31
BREAST SURGERY\Craigavon Area Hospital	14/09/2018 16:42	14/09/2018 16:42
UROLOGY\Craigavon Area Hospital	11/09/2018 08:31	11/09/2018 08:31
GENERAL SURGERY - COLORECTAL\Banbridge Po	11/09/2018 12:43	11/09/2018 12:43
BREAST SURGERY\Craigavon Area Hospital	14/09/2018 09:36	17/09/2018 08:38
UROLOGY\Craigavon Area Hospital	14/09/2018 09:51	14/09/2018 09:51
BREAST SURGERY\Craigavon Area Hospital	14/09/2018 10:07	14/09/2018 10:07
RESPIRATORY\Craigavon Area Hospital	14/09/2018 12:38	14/09/2018 12:38
GENERAL SURGERY - COLORECTAL\Craigavon Ar	12/09/2018 14:35	12/09/2018 14:35
GENERAL SURGERY - COLORECTAL\Craigavon Ar	14/09/2018 12:27	14/09/2018 12:27
DERMATOLOGY\Craigavon Area Hospital	10/09/2018 17:28	11/09/2018 09:25
NEUROLOGY\Craigavon Area Hospital	11/09/2018 13:05	11/09/2018 13:06
GASTROENTEROLOGY\Daisy Hill Hospital	11/09/2018 17:43	11/09/2018 17:43
GYNAECOLOGY - OTHER\Daisy Hill Hospital	12/09/2018 15:35	12/09/2018 15:35
DERMATOLOGY\Craigavon Area Hospital	14/09/2018 18:23	14/09/2018 18:23
DERMATOLOGY\Craigavon Area Hospital	13/09/2018 13:57	13/09/2018 13:57
RESPIRATORY\Craigavon Area Hospital	11/09/2018 10:15	11/09/2018 10:15
GYNAECOLOGY - OTHER\Craigavon Area Hospita	11/09/2018 12:14	11/09/2018 12:14
GENERAL SURGERY - COLORECTAL\Craigavon Ar	14/09/2018 09:20	14/09/2018 09:20
DERMATOLOGY\Craigavon Area Hospital	14/09/2018 09:04	14/09/2018 09:04
DERMATOLOGY\Craigavon Area Hospital	14/09/2018 17:17	14/09/2018 17:17
DERMATOLOGY\Craigavon Area Hospital	11/09/2018 10:03	11/09/2018 10:03
DERMATOLOGY\Craigavon Area Hospital	13/09/2018 15:02	13/09/2018 15:02
DERMATOLOGY\Craigavon Area Hospital	14/09/2018 14:33	14/09/2018 14:33
DERMATOLOGY\Craigavon Area Hospital	11/09/2018 12:46	11/09/2018 12:46
GENERAL SURGERY - COLORECTAL\Craigavon Ar	14/09/2018 14:31	14/09/2018 14:31
UROLOGY\Craigavon Area Hospital	14/09/2018 18:10	14/09/2018 18:10
HAEMATOLOGY\Craigavon Area Hospital	11/09/2018 13:32	11/09/2018 16:19
BREAST SURGERY\Craigavon Area Hospital	14/09/2018 15:10	14/09/2018 16:45
GENERAL SURGERY - COLORECTAL\Craigavon Ar	10/09/2018 18:26	11/09/2018 11:04
GYNAECOLOGY - OTHER\Craigavon Area Hospita	10/09/2018 12:56	10/09/2018 14:32
DERMATOLOGY\Craigavon Area Hospital	10/09/2018 18:34	11/09/2018 10:29



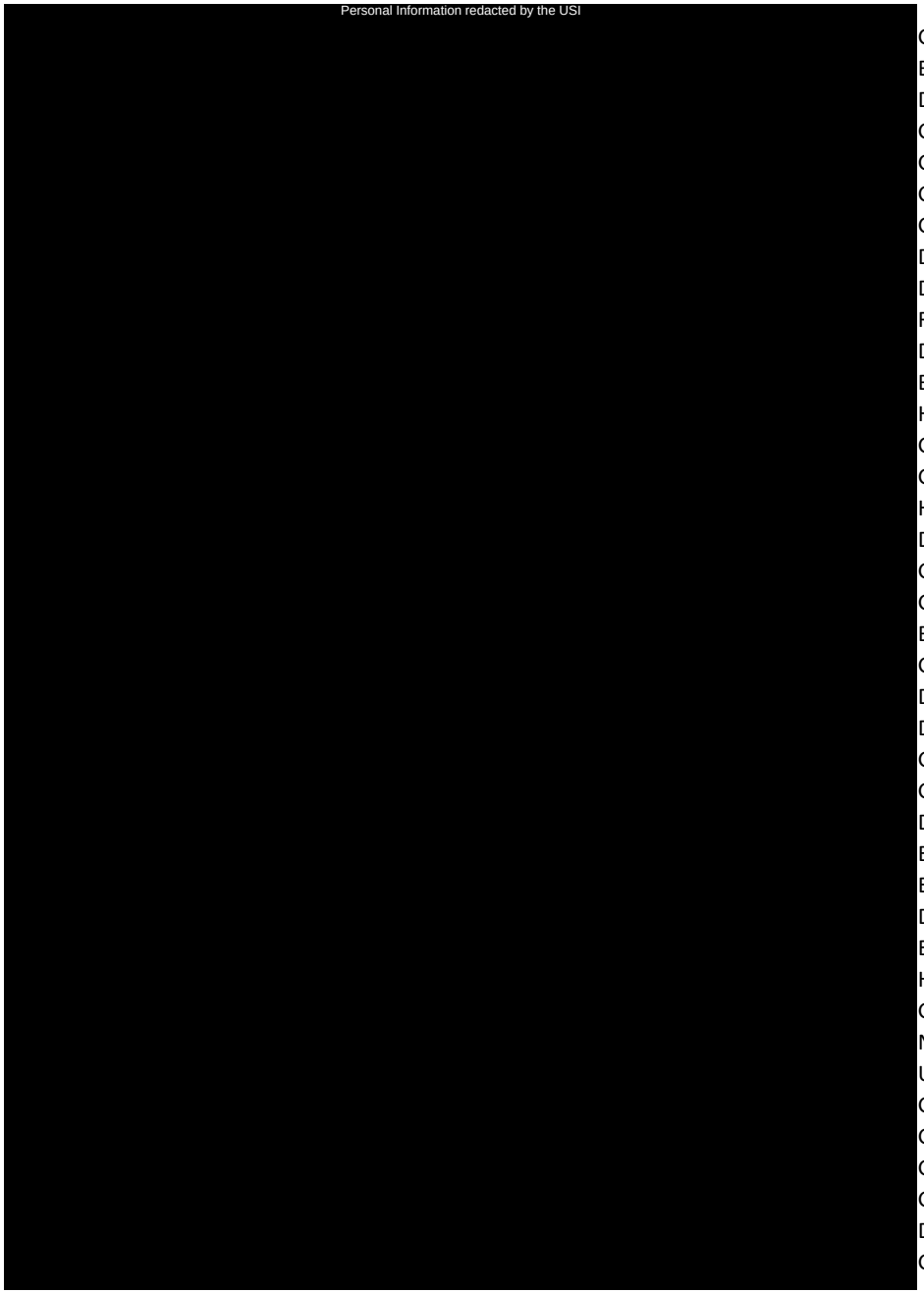
DERMATOLOGY\Craigavon Area Hospital	14/09/2018 17:16	17/09/2018 09:45
DERMATOLOGY\Craigavon Area Hospital	14/09/2018 18:06	17/09/2018 09:37
EAR, NOSE & THROAT\Craigavon Area Hospital	12/09/2018 14:50	12/09/2018 14:50
EAR, NOSE & THROAT\Craigavon Area Hospital	14/09/2018 13:16	14/09/2018 13:22
GENERAL SURGERY - COLORECTAL\Craigavon Ar	14/09/2018 15:06	14/09/2018 16:36
GENERAL SURGERY - COLORECTAL\Craigavon Ar	13/09/2018 12:35	13/09/2018 12:35
GENERAL SURGERY - COLORECTAL\Craigavon Ar	14/09/2018 10:05	14/09/2018 10:05
GENERAL SURGERY - OTHER\Craigavon Area Hos	10/09/2018 15:18	10/09/2018 15:18
BREAST SURGERY\Craigavon Area Hospital	10/09/2018 17:12	10/09/2018 17:12
BREAST SURGERY\Craigavon Area Hospital	12/09/2018 12:03	12/09/2018 12:11
RESPIRATORY\Craigavon Area Hospital	12/09/2018 15:15	12/09/2018 15:15
BREAST SURGERY\Craigavon Area Hospital	12/09/2018 17:24	12/09/2018 17:25
GENERAL SURGERY - COLORECTAL\Craigavon Ar	10/09/2018 16:53	10/09/2018 16:53
EAR, NOSE & THROAT\Craigavon Area Hospital	11/09/2018 10:55	11/09/2018 10:55
GENERAL SURGERY - COLORECTAL\Craigavon Ar	14/09/2018 16:08	14/09/2018 16:08
EAR, NOSE & THROAT\Craigavon Area Hospital	13/09/2018 18:37	13/09/2018 18:37
GYNAECOLOGY - OTHER\Craigavon Area Hospita	12/09/2018 17:53	12/09/2018 17:54
GYNAECOLOGY - OTHER\Craigavon Area Hospita	12/09/2018 16:34	12/09/2018 16:34
RESPIRATORY\Craigavon Area Hospital	14/09/2018 16:14	14/09/2018 16:14
RESPIRATORY\Craigavon Area Hospital	10/09/2018 17:45	10/09/2018 17:45
BREAST SURGERY\Craigavon Area Hospital	11/09/2018 17:39	11/09/2018 17:39
GENERAL SURGERY - UPPER GI\Craigavon Area H	10/09/2018 15:45	10/09/2018 15:45
DERMATOLOGY\South Tyrone Hospital	13/09/2018 09:50	13/09/2018 09:50
GENERAL SURGERY - COLORECTAL\Craigavon Ar	13/09/2018 18:02	13/09/2018 18:02
BREAST SURGERY\Craigavon Area Hospital	14/09/2018 18:08	14/09/2018 18:09
GENERAL SURGERY - COLORECTAL\South Tyrone	12/09/2018 15:32	12/09/2018 15:32
BREAST SURGERY\Craigavon Area Hospital	12/09/2018 13:12	12/09/2018 13:13
BREAST SURGERY\Craigavon Area Hospital	13/09/2018 17:16	13/09/2018 17:16
GENERAL SURGERY - UPPER GI\South Tyrone Ho	13/09/2018 15:47	13/09/2018 15:47
BREAST SURGERY\Craigavon Area Hospital	10/09/2018 15:56	10/09/2018 15:56
GASTROENTEROLOGY\South Tyrone Hospital	11/09/2018 10:58	11/09/2018 10:58
BREAST SURGERY\Craigavon Area Hospital	11/09/2018 10:08	11/09/2018 10:08
GYNAECOLOGY - OTHER\Craigavon Area Hospita	11/09/2018 12:19	11/09/2018 12:19
BREAST SURGERY\Craigavon Area Hospital	11/09/2018 16:05	11/09/2018 16:05
BREAST SURGERY\Craigavon Area Hospital	12/09/2018 11:32	12/09/2018 11:32
BREAST SURGERY\Craigavon Area Hospital	13/09/2018 10:24	13/09/2018 10:24
GYNAECOLOGY - OTHER\Craigavon Area Hospita	14/09/2018 15:07	14/09/2018 15:07
GENERAL SURGERY - UPPER GI\Craigavon Area H	10/09/2018 11:59	10/09/2018 11:59
DERMATOLOGY\Craigavon Area Hospital	12/09/2018 10:44	12/09/2018 10:44
DERMATOLOGY\Craigavon Area Hospital	13/09/2018 10:22	13/09/2018 10:22



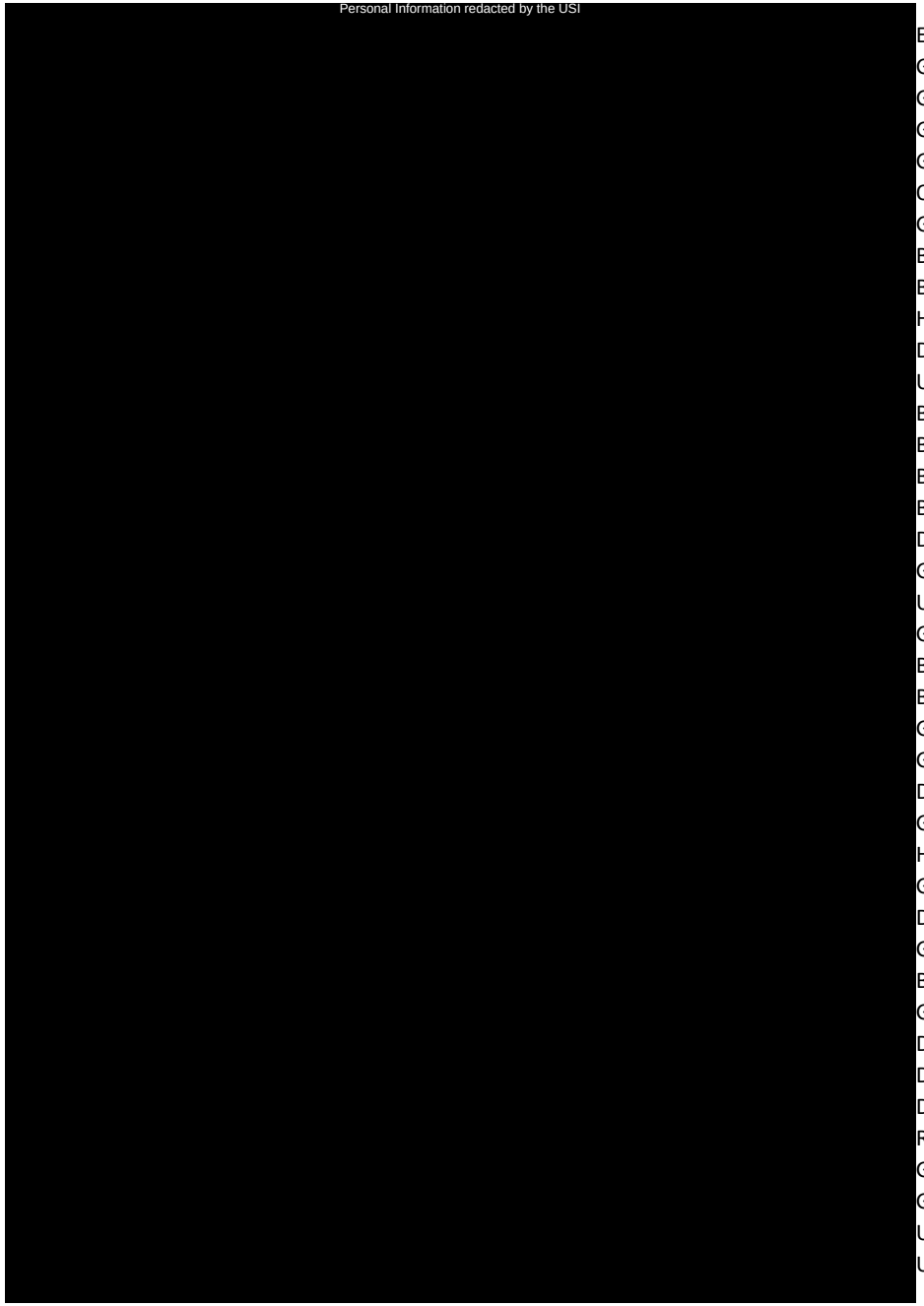
NEUROLOGY\Craigavon Area Hospital	14/09/2018 10:39	14/09/2018 10:39
DERMATOLOGY\Craigavon Area Hospital	10/09/2018 13:19	10/09/2018 13:20
GENERAL SURGERY - OTHER\Craigavon Area Hos	14/09/2018 10:20	14/09/2018 10:20
EAR, NOSE & THROAT\Armagh Community Hosp	13/09/2018 16:06	13/09/2018 16:06
GENERAL SURGERY - UPPER GI\South Tyrone Ho	10/09/2018 17:45	10/09/2018 17:45
GENERAL SURGERY - UPPER GI\Craigavon Area H	14/09/2018 13:37	14/09/2018 13:37
EAR, NOSE & THROAT\South Tyrone Hospital	12/09/2018 09:44	12/09/2018 09:44
BREAST SURGERY\Craigavon Area Hospital	14/09/2018 11:49	14/09/2018 11:49
BREAST SURGERY\Craigavon Area Hospital	13/09/2018 12:27	13/09/2018 12:27
ORAL SURGERY\Craigavon Area Hospital	11/09/2018 17:33	11/09/2018 17:33
GENERAL SURGERY - COLORECTAL\Craigavon Ar	11/09/2018 17:38	11/09/2018 17:38
UROLOGY\Craigavon Area Hospital	12/09/2018 10:39	12/09/2018 10:40
BREAST SURGERY\Craigavon Area Hospital	11/09/2018 11:15	12/09/2018 10:22
DERMATOLOGY\Armagh Community Hospital	12/09/2018 12:08	12/09/2018 17:25
GYNAECOLOGY - OTHER\Craigavon Area Hospita	11/09/2018 17:30	11/09/2018 17:32
ORAL SURGERY\Craigavon Area Hospital	13/09/2018 17:41	13/09/2018 17:42
BREAST SURGERY\Craigavon Area Hospital	14/09/2018 17:17	14/09/2018 17:17
DERMATOLOGY\Daisy Hill Hospital	10/09/2018 13:22	10/09/2018 13:22
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	13/09/2018 12:14	13/09/2018 12:14
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	13/09/2018 12:17	13/09/2018 12:17
GENERAL SURGERY - UPPER GI\Craigavon Area H	13/09/2018 16:35	13/09/2018 16:35
GENERAL SURGERY - UPPER GI\South Tyrone Ho	10/09/2018 09:49	10/09/2018 09:49
GENERAL SURGERY - COLORECTAL\Craigavon Ar	11/09/2018 09:20	11/09/2018 09:20
EAR, NOSE & THROAT\Craigavon Area Hospital	11/09/2018 17:45	11/09/2018 17:45
GYNAECOLOGY - OTHER\Craigavon Area Hospita	13/09/2018 08:38	13/09/2018 08:38
RESPIRATORY\Craigavon Area Hospital	13/09/2018 15:52	13/09/2018 15:52
DERMATOLOGY\Craigavon Area Hospital	11/09/2018 12:44	11/09/2018 12:44
GENERAL SURGERY - COLORECTAL\Craigavon Ar	14/09/2018 15:40	14/09/2018 15:40
GENERAL SURGERY - UPPER GI\Craigavon Area H	10/09/2018 12:25	10/09/2018 12:55
GYNAECOLOGY - OTHER\Craigavon Area Hospita	14/09/2018 17:41	14/09/2018 17:41
DERMATOLOGY\South Tyrone Hospital	10/09/2018 10:56	10/09/2018 10:56
BREAST SURGERY\Craigavon Area Hospital	14/09/2018 09:15	14/09/2018 09:15
UROLOGY\Craigavon Area Hospital	14/09/2018 11:39	14/09/2018 11:39
GENERAL SURGERY - COLORECTAL\South Tyrone	12/09/2018 17:03	12/09/2018 17:03
GENERAL SURGERY - COLORECTAL\Craigavon Ar	14/09/2018 12:10	14/09/2018 12:10
DERMATOLOGY\Armagh Community Hospital	14/09/2018 15:42	17/09/2018 08:31
DERMATOLOGY\Armagh Community Hospital	14/09/2018 11:12	14/09/2018 11:12
RESPIRATORY\Craigavon Area Hospital	14/09/2018 08:39	14/09/2018 08:39
GENERAL SURGERY - COLORECTAL\Craigavon Ar	12/09/2018 11:53	12/09/2018 11:53
GENERAL SURGERY - COLORECTAL\Craigavon Ar	13/09/2018 18:31	13/09/2018 18:32



UROLOGY\Craigavon Area Hospital	10/09/2018 16:30	10/09/2018 16:30
GENERAL SURGERY - UPPER GI\Craigavon Area H	10/09/2018 10:47	10/09/2018 10:48
GENERAL SURGERY - COLORECTAL\Armagh Com	10/09/2018 12:27	10/09/2018 12:27
GENERAL SURGERY - COLORECTAL\Armagh Com	12/09/2018 12:14	12/09/2018 12:14
DERMATOLOGY\Craigavon Area Hospital	12/09/2018 12:57	12/09/2018 12:57
UROLOGY\Craigavon Area Hospital	12/09/2018 10:16	12/09/2018 10:16
BREAST SURGERY\Craigavon Area Hospital	14/09/2018 14:41	14/09/2018 14:41
GENERAL SURGERY - COLORECTAL\Craigavon Ar	11/09/2018 12:20	11/09/2018 12:20
DERMATOLOGY\Armagh Community Hospital	12/09/2018 11:20	12/09/2018 11:20
DERMATOLOGY\Armagh Community Hospital	14/09/2018 11:21	14/09/2018 11:21
GENERAL SURGERY - COLORECTAL\Craigavon Ar	14/09/2018 11:27	14/09/2018 11:27
GYNAECOLOGY - OTHER\South Tyrone Hospital	10/09/2018 16:03	10/09/2018 16:03
UROLOGY\Craigavon Area Hospital	11/09/2018 09:09	11/09/2018 09:09
UROLOGY\Craigavon Area Hospital	14/09/2018 11:55	14/09/2018 11:55
BREAST SURGERY\Craigavon Area Hospital	11/09/2018 16:06	11/09/2018 16:06
DERMATOLOGY\Daisy Hill Hospital	10/09/2018 10:27	10/09/2018 10:27
GENERAL SURGERY - RED FLAG NON GI\Daisy Hil	10/09/2018 15:17	10/09/2018 15:17
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	11/09/2018 10:33	11/09/2018 10:33
EAR, NOSE & THROAT\Daisy Hill Hospital	11/09/2018 09:57	11/09/2018 09:57
EAR, NOSE & THROAT\Daisy Hill Hospital	13/09/2018 17:01	13/09/2018 17:01
GYNAECOLOGY - OTHER\Daisy Hill Hospital	14/09/2018 17:22	14/09/2018 17:22
BREAST SURGERY\Craigavon Area Hospital	10/09/2018 18:12	10/09/2018 18:12
NEUROLOGY\Craigavon Area Hospital	14/09/2018 11:55	14/09/2018 11:55
BREAST SURGERY\Craigavon Area Hospital	10/09/2018 11:04	10/09/2018 11:04
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	10/09/2018 11:15	10/09/2018 11:15
EAR, NOSE & THROAT\Daisy Hill Hospital	08/09/2018 18:33	08/09/2018 18:33
GYNAECOLOGY - OTHER\Daisy Hill Hospital	10/09/2018 12:30	10/09/2018 12:30
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	08/09/2018 17:39	08/09/2018 17:39
DERMATOLOGY\Daisy Hill Hospital	10/09/2018 12:35	10/09/2018 12:35
BREAST SURGERY\Craigavon Area Hospital	12/09/2018 16:41	12/09/2018 16:41
GYNAECOLOGY - OTHER\Daisy Hill Hospital	10/09/2018 11:02	10/09/2018 11:02
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	11/09/2018 12:06	11/09/2018 12:06
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	13/09/2018 10:30	13/09/2018 10:30
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	14/09/2018 20:43	14/09/2018 20:43
BREAST SURGERY\Craigavon Area Hospital	13/09/2018 13:49	13/09/2018 13:49
BREAST SURGERY\Craigavon Area Hospital	14/09/2018 15:54	14/09/2018 15:54
EAR, NOSE & THROAT\Daisy Hill Hospital	13/09/2018 13:43	13/09/2018 13:43
GASTROENTEROLOGY\Daisy Hill Hospital	10/09/2018 15:48	10/09/2018 15:48
GYNAECOLOGY - OTHER\Daisy Hill Hospital	12/09/2018 14:34	12/09/2018 14:34
GASTROENTEROLOGY\Daisy Hill Hospital	13/09/2018 16:21	13/09/2018 16:21



GASTROENTEROLOGY\Daisy Hill Hospital	13/09/2018 09:46	13/09/2018 09:46
BREAST SURGERY\Craigavon Area Hospital	13/09/2018 14:39	13/09/2018 14:39
DERMATOLOGY\Daisy Hill Hospital	10/09/2018 09:56	10/09/2018 09:56
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	10/09/2018 12:58	10/09/2018 14:04
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	13/09/2018 16:36	13/09/2018 16:36
GENERAL SURGERY - OTHER\Daisy Hill Hospital	13/09/2018 13:27	13/09/2018 13:27
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	09/09/2018 20:36	09/09/2018 20:36
DERMATOLOGY\Daisy Hill Hospital	09/09/2018 20:47	09/09/2018 20:47
DERMATOLOGY\Daisy Hill Hospital	09/09/2018 13:49	09/09/2018 13:49
RESPIRATORY\Daisy Hill Hospital	13/09/2018 00:27	13/09/2018 00:27
DERMATOLOGY\Craigavon Area Hospital	14/09/2018 11:56	14/09/2018 14:08
BREAST SURGERY\Craigavon Area Hospital	09/09/2018 13:21	09/09/2018 13:21
HAEMATOLOGY\Daisy Hill Hospital	14/09/2018 11:30	14/09/2018 11:31
GYNAECOLOGY - OTHER\Daisy Hill Hospital	11/09/2018 10:47	11/09/2018 10:48
GYNAECOLOGY - OTHER\Daisy Hill Hospital	11/09/2018 17:21	11/09/2018 17:21
HAEMATURIA\Daisy Hill Hospital	12/09/2018 09:41	12/09/2018 09:41
DERMATOLOGY\Daisy Hill Hospital	11/09/2018 10:38	11/09/2018 10:38
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	11/09/2018 14:58	11/09/2018 14:58
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	12/09/2018 12:42	12/09/2018 12:42
BREAST SURGERY\Craigavon Area Hospital	11/09/2018 09:52	11/09/2018 09:52
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	13/09/2018 09:20	13/09/2018 09:20
DERMATOLOGY\Daisy Hill Hospital	13/09/2018 14:17	13/09/2018 14:17
DERMATOLOGY\Daisy Hill Hospital	13/09/2018 16:00	13/09/2018 16:00
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	14/09/2018 09:12	14/09/2018 09:12
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	14/09/2018 11:20	14/09/2018 11:20
DERMATOLOGY\Daisy Hill Hospital	10/09/2018 18:39	10/09/2018 18:40
EAR, NOSE & THROAT\Daisy Hill Hospital	12/09/2018 17:27	12/09/2018 17:27
EAR, NOSE & THROAT\Daisy Hill Hospital	12/09/2018 17:44	12/09/2018 17:45
DERMATOLOGY\Craigavon Area Hospital	13/09/2018 17:17	13/09/2018 17:17
EAR, NOSE & THROAT\Daisy Hill Hospital	11/09/2018 18:04	11/09/2018 18:05
HAEMATURIA\Daisy Hill Hospital	10/09/2018 17:26	10/09/2018 17:26
GASTROENTEROLOGY\Daisy Hill Hospital	11/09/2018 14:33	11/09/2018 14:33
NEUROLOGY\Daisy Hill Hospital	12/09/2018 17:45	12/09/2018 17:45
UROLOGY\Craigavon Area Hospital	11/09/2018 12:26	11/09/2018 12:27
GENERAL SURGERY - UPPER GI\Daisy Hill Hospita	13/09/2018 16:56	13/09/2018 16:56
GYNAECOLOGY - OTHER\Daisy Hill Hospital	13/09/2018 13:27	13/09/2018 13:28
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	13/09/2018 12:17	13/09/2018 12:17
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	14/09/2018 13:22	14/09/2018 13:22
DERMATOLOGY\Daisy Hill Hospital	13/09/2018 17:41	13/09/2018 17:41
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	14/09/2018 09:41	14/09/2018 09:41



EAR, NOSE & THROAT\Daisy Hill Hospital	10/09/2018 16:40	10/09/2018 16:40
GENERAL SURGERY - UPPER GI\Daisy Hill Hospita	10/09/2018 14:52	10/09/2018 14:52
GYNAECOLOGY - OTHER\Daisy Hill Hospital	14/09/2018 16:07	14/09/2018 16:07
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	13/09/2018 16:08	13/09/2018 16:08
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	14/09/2018 14:57	14/09/2018 14:58
ORAL SURGERY\Daisy Hill Hospital	11/09/2018 12:37	11/09/2018 12:37
GASTROENTEROLOGY\Daisy Hill Hospital	12/09/2018 17:58	12/09/2018 17:58
BREAST SURGERY\Craigavon Area Hospital	10/09/2018 15:31	10/09/2018 15:31
BREAST SURGERY\Craigavon Area Hospital	12/09/2018 12:33	12/09/2018 12:33
HAEMATURIA\Daisy Hill Hospital	13/09/2018 12:33	13/09/2018 12:33
DERMATOLOGY\Daisy Hill Hospital	11/09/2018 12:27	11/09/2018 12:27
UROLOGY\Daisy Hill Hospital	13/09/2018 12:36	13/09/2018 12:36
BREAST SURGERY\Craigavon Area Hospital	10/09/2018 09:39	10/09/2018 09:39
BREAST SURGERY\Craigavon Area Hospital	11/09/2018 09:38	11/09/2018 09:38
BREAST SURGERY\Craigavon Area Hospital	12/09/2018 13:18	12/09/2018 13:18
BREAST SURGERY\Craigavon Area Hospital	14/09/2018 16:38	14/09/2018 16:38
DERMATOLOGY\Daisy Hill Hospital	11/09/2018 15:36	11/09/2018 15:36
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	11/09/2018 16:58	11/09/2018 16:58
UROLOGY - MALE LUTS\Craigavon Area Hospital	10/09/2018 15:56	11/09/2018 14:12
GASTROENTEROLOGY\Daisy Hill Hospital	14/09/2018 11:39	14/09/2018 11:40
BREAST SURGERY\Craigavon Area Hospital	11/09/2018 16:48	11/09/2018 16:48
BREAST SURGERY\Craigavon Area Hospital	10/09/2018 18:17	10/09/2018 18:17
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	14/09/2018 09:38	14/09/2018 09:38
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	12/09/2018 14:40	12/09/2018 14:40
DERMATOLOGY\Daisy Hill Hospital	13/09/2018 10:07	13/09/2018 10:08
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	11/09/2018 16:29	11/09/2018 16:29
HAEMATOLOGY\Craigavon Area Hospital	12/09/2018 13:45	12/09/2018 13:45
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	10/09/2018 15:11	10/09/2018 15:11
DERMATOLOGY\Daisy Hill Hospital	14/09/2018 10:12	14/09/2018 10:12
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	13/09/2018 09:55	13/09/2018 09:55
BREAST SURGERY\Craigavon Area Hospital	11/09/2018 09:33	11/09/2018 09:33
GENERAL SURGERY - COLORECTAL\Daisy Hill Hos	11/09/2018 17:21	11/09/2018 17:21
DERMATOLOGY\Daisy Hill Hospital	12/09/2018 16:34	12/09/2018 16:34
DERMATOLOGY\Daisy Hill Hospital	13/09/2018 09:36	13/09/2018 09:36
DERMATOLOGY\Daisy Hill Hospital	10/09/2018 15:58	10/09/2018 15:58
RESPIRATORY\Daisy Hill Hospital	13/09/2018 17:00	13/09/2018 17:00
GASTROENTEROLOGY\Daisy Hill Hospital	10/09/2018 21:35	10/09/2018 21:35
GENERAL SURGERY - UPPER GI\Craigavon Area H	12/09/2018 11:41	13/09/2018 22:30
UROLOGY - MALE LUTS\Craigavon Area Hospital	12/09/2018 10:34	12/09/2018 10:34
UROLOGY\Craigavon Area Hospital	10/09/2018 11:56	10/09/2018 11:58

Personal Information redacted by the USI	UROLOGY\Craigavon Area Hospital	14/09/2018 17:14	17/09/2018 12:27
	UROLOGY\Craigavon Area Hospital	13/09/2018 11:49	13/09/2018 11:49
	UROLOGY\Craigavon Area Hospital	13/09/2018 22:00	13/09/2018 22:00
	BREAST SURGERY\Craigavon Area Hospital	10/09/2018 17:34	10/09/2018 17:34
	UROLOGY\Craigavon Area Hospital	11/09/2018 15:03	11/09/2018 15:03

Graham, Vicki

From: Graham, Vicki <Personal Information redacted by the USI>
Sent: 21 August 2017 11:58
To: Glenny, Sharon; Clayton, Wendy
Cc: Reddick, Fiona
Subject: RE: Missed Referral - Now booked to D37 (General Surgery)

Importance: High

Hi,

I have now completed the Datix for the below incident No: W Irrelevant redacted by the USI

Regards,

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)*

From: Glenny, Sharon
Sent: 21 August 2017 10:00
To: Graham, Vicki; Clayton, Wendy
Cc: Reddick, Fiona
Subject: RE: Missed Referral - Now booked to D37 (General Surgery)

Hi Vicki

We will have to keep a close watch on this patient to ensure pathway is not further delayed, however, I think this also warrants a IR1 – maybe you have already completed this?

Sharon

From: Graham, Vicki
Sent: 18 August 2017 14:29
To: Clayton, Wendy; Glenny, Sharon
Subject: Missed Referral - Now booked to D37 (General Surgery)
Importance: High

HI Wendy/Sharon,

Lynn from the RBC phoned me to say that a Dr had phoned up regarding a RF General Surgery referral and was wondering when the appointment would be. This unfortunately was not OP Reg'd on our system. On checking our weekly reports of all RF referrals that are sent in via CCG this was ticked, but unfortunately was not registered on the system so this was ticked in error. Looking back at this what I believe has happened is that when John was

completing he seen that an OP Reg had been opened for Haematology, which was sent in a few days after the Red Flag referral and thought that this represented the Lower GI Episode. I have spoken with John regarding this, and have highlighted the importance and the need for attention to detail when completing these reports, and have highlighted what the implications would have been if the GP did not phone up to check on referral. John is fully aware of the severity of this and for his own peace of mind he is checking over all other patients on that report to ensure that no one else was missed. This would have impacted significantly on patients pathway as patients at present are being seen on Day 10 – 12 from date of referral.

Site : Lower GI
Name : Personal Information redacted by the USI
Casenote : Personal Information redacted by the USI
HCN Personal Information redacted by the USI

Day	Date	Event
0	17/07/2017	Suspect Cancer 'Red Flag' referral from GP referred to Craigavon
32	18/08/2017	1st apt 23/08/2017. Day 37. Referral not ORE'd. Escalated to HOS.
37	**23/08/2017**	**1st OPD**

Regards,

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)*

Graham, Vicki

From: Graham, Vicki <Personal Information redacted by the USI>
Sent: 05 February 2019 10:37
To: Cardwell, David; McAloran, Paula
Subject: RE: Datix Incident Report Number Irrelevant information redacted by the USI

Thanks David,

Regards,

PACS Adminstrator
Telephone: Personal Information redacted by the USI

-----Original Message-----
From: Cardwell, David
Sent: 05 February 2019 09:14
To: Graham, Vicki; McAloran, Paula
Subject: RE: Datix Incident Report Number Irrelevant information redacted by the USI

Hi, Vicki, access granted.

Kind Regards
David Cardwell

Senior Governance Officer | Acute Services Clinical and Social Care Governance Team | The Maples | Craigavon Area Hospital | 68 Lurgan Road | Portadown BT63 5QQ |
Tel: Personal Information redacted by the USI | Email: Personal Information redacted by the USI

-----Original Message-----
From: Graham, Vicki
Sent: 04 February 2019 17:09
To: McAloran, Paula
Cc: Cardwell, David
Subject: RE: Datix Incident Report Number Irrelevant information redacted by the USI
Importance: High

Hi Paula

Sorry I tried to log on and amend the below incidents but a message ' You do not have necessary permissions to view the record' came up.

David - Could I my access please be amended so that I can view and update records, if necessary?

Many thanks,

Vicki Graham
Cancer Services Co-ordinator
Office 10
Level 2
MEC

EXT [redacted]

-----Original Message-----
From: McAloran, Paula
Sent: 04 February 2019 16:42
To: Graham, Vicki
Subject: FW: Datix Incident Report Number [redacted]

Vicki

I note a few datix regarding RF referrals. They are not being populated with the correct people to investigate

Kind Regards
Paula

Paula McAloran
Senior Governance Officer
Admin Floor Craigavon Area Hospital, Craigavon BT63 5QQ.
Extension [redacted]
External Number [redacted]

-----Original Message-----
From: datix [redacted] [redacted]]
Sent: 23 January 2019 16:38
To: McAloran, Paula
Subject: Datix Incident Report Number [redacted]

An incident report has been submitted via the DATIX web form.

The details are:

Form number: [redacted]

Description:

Received email from RF team advising of late upgraded OC referral. Details below.

OC referral from Cardiology to Gastroenterology
Date letter dictated: 02.01.19
Date Typed: 04.01.19
Date triage by Dr Hussain: 09.01.19
Date received in RF Office: 22.01.1
Appointment booked for 28.01.19 - Day 26

5 Day delay with referral being triaged, then further 13 day delay from it being triaged to being received in RF Office.

Please go to [redacted] to view and approve it.

Graham, Vicki

From: Graham, Vicki <Personal Information redacted by the USI>
Sent: 04 October 2019 11:50
To: Clayton, Wendy
Cc: Carroll, Ronan; Haynes, Mark
Subject: RE: Datix Incident Report Number Personal Information redacted by the USI

Importance: High

Hi Wendy,

Yes review date with Mr O'Brien was arranged for 16.08.19 (This was booked onto PAS on 09.08.19 following Mr Hayne's email I believe)
The outcome from clinic on 16.08.19 was then not able to be obtained.

Dates highlighted below are correct.

Regards,

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

From: Clayton, Wendy
Sent: 04 October 2019 11:36
To: Graham, Vicki
Cc: Carroll, Ronan; Haynes, Mark
Subject: RE: Datix Incident Report Number Personal Information redacted by the USI

Vicki – can you double check below dates please?

Regards

Wendy

Wendy Clayton
Operational Support Lead
ATI CS/SEC
Tel: Personal Information redacted by the USI
Mob: Personal Information redacted by the USI

From: Haynes, Mark
Sent: 04 October 2019 11:33
To: Carroll, Ronan
Cc: Corrigan, Martina; Clayton, Wendy; Young, Michael
Subject: RE: Datix Incident Report Number Personal Information redacted by the USI

It's significance is uncertain but there is an apparent delay in the patients cancer care pathway, and without investigating we cannot draw a conclusion as it is possible that he has done something but simply not communicated to anyone. A date in the time line is wrong, I have highlighted / corrected below.

Mark

From: Carroll, Ronan
Sent: 04 October 2019 11:08
To: Haynes, Mark; Young, Michael
Cc: Clayton, Wendy; Corrigan, Martina
Subject: FW: Datix Incident Report Number Personal Information redacted by the USI
Importance: High

Mark/Michael
Can I look to you both for guidance on the significance of this IR1 and the delay recorded
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery/Elective Care
Mob Personal Information redacted by USI

From: Clayton, Wendy
Sent: 04 October 2019 11:07
To: Carroll, Ronan
Subject: RE: Datix Incident Report Number Personal Information redacted by the USI

I've just been on with Vicki to investigate.

Patient 112 – 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 patients management. Tracker appears to have listed patient for MDM discussion on 03.10.19 to try and get an update on Management. Patient was informally discussed on 03.10.19 so there was no MDM outcome & then Datix was raised today.

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 Hayne's message to Mr O'Brien.

Edit	09-8-2019	Personal Information	Secretary advised - am not sure what is happening with this patient. Please see message below from Mr Haynes to Mr O'Brien regarding the most recent referral. Morning Aidan This man was discussed at MDM on 27th June regarding a renal lesion and the outcome was that your were going to organise a renal biopsy (with Factor VIII). A further referral has come in about his renal lesion which I am triaging as nil extra needed. Have you the biopsy in hand

No further update or clinic outcome was available from clinic on 16.08.19 – Mr O'Brien had been contacted regarding management updated.

Edit	04-10-2019	Personal Information	This man was discussed informally at MDM - time is passing for this patient and not sure what plan is in place for him. Mr Haynes to review in clinic. Chart not where it is tracked to. Have escalated to Vicki.	09-10-2019	No	Complete
Edit	03-10-2019	Personal Information	Have relisted this man for MDM as unsure as to what is happening with him, delays in his pathway.		Yes	Complete
Edit	25-9-2019	Personal Information	No reviews booked, no biopsy requested, clinic letter still not available	01-10-2019	Yes	Complete
Edit	19-9-2019	Personal Information	Response awaited from Mr O'Brien regarding this man - no biopsy has been requested, clinic letter not avialable	25-9-2019	Yes	Complete

Edit	13-9-2019	Personal Information	Response awaited from Mr O'Brien regarding this man - no biopsy has been requested.	17-9-2019	Yes	Complete
Edit	06-9-2019	Personal Information	Clinic letter not dictated, don't see that a biopsy has been requested for this man. Will check with Mr O'Brien.	13-9-2019	Yes	Complete
Edit	09-8-2019	Personal Information	Secretary advised - Mr O'Brien is seeing this patient at his clinic on Friday the 16th of August 2019.	20-8-2019	Yes	

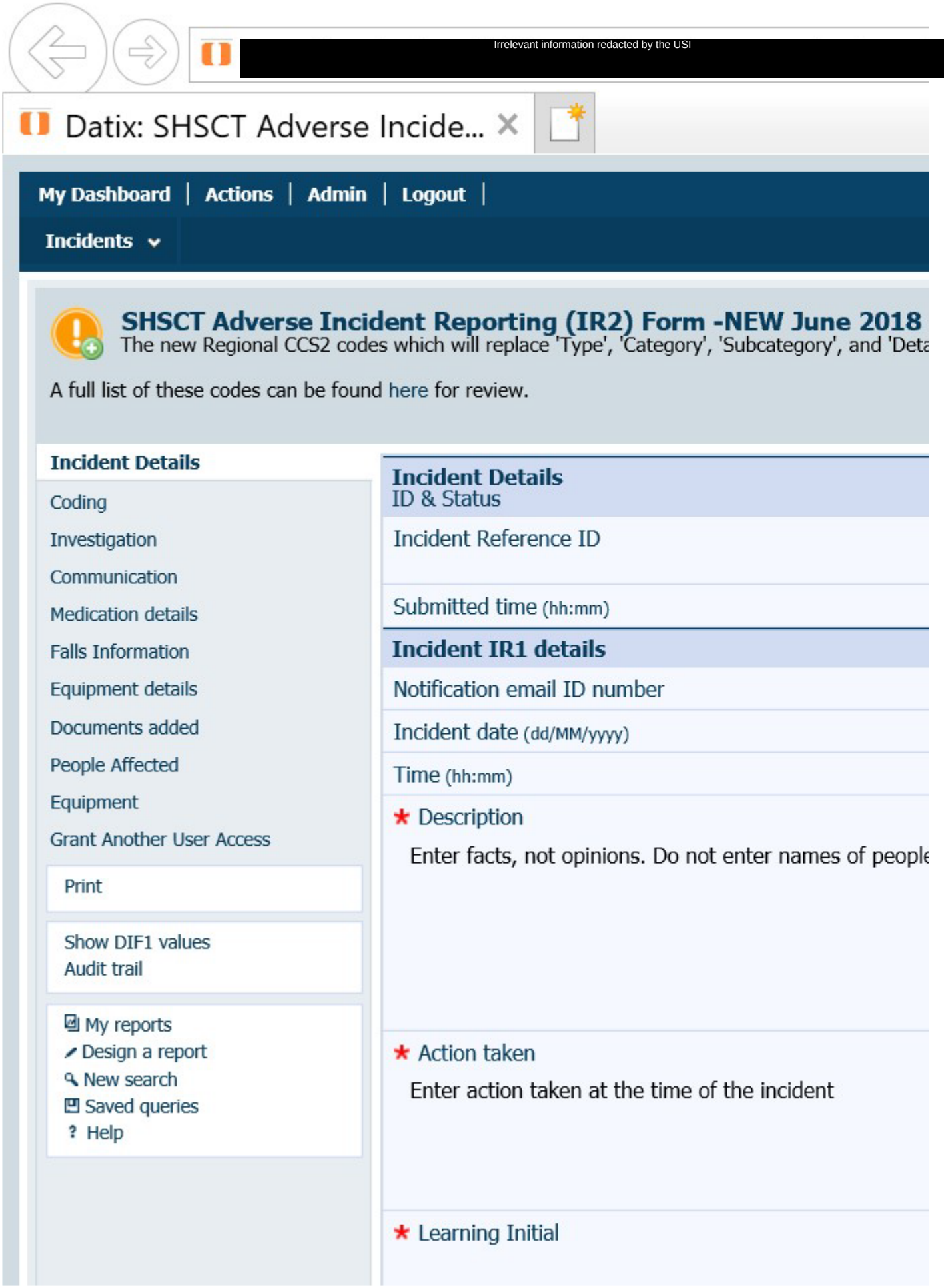
Regards

Wendy

Wendy Clayton
Operational Support Lead
ATI CS/SEC
Tel: Personal Information redacted by the USI
Mob: Personal Information redacted by the USI

From: Carroll, Ronan
Sent: 04 October 2019 10:25
To: Clayton, Wendy
Subject: FW: Datix Incident Report Number Personal Information redacted by the USI

Tracker issue?
Patient 112



Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery/Elective Care
Mob Personal Information redacted by the USI

-----Original Message-----
From: datix Personal Information redacted by the USI [Personal Information redacted by the USI]
Sent: 03 October 2019 16:26
To: Carroll, Ronan
Subject: Datix Incident Report Number Personal Information redacted by the USI

An incident report has been submitted via the DATIX web form.

The details are:

Form number: Personal Information redacted by the USI

Description:

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.

Please go to Irrelevant information redacted by the USI to view and approve it.

Graham, Vicki

From: Graham, Vicki Personal Information redacted by USI
Sent: 04 October 2019 11:02
To: Clayton, Wendy
Subject: FW: Patient 2 * POSSIBLE DATIX ** H&C Personal Information redacted by USI
Attachments: FW: Testicular MDM 26th Sept 19 (21.5 KB)

Importance: High

Hi Wendy,

Please see further patient that Shauna had brought to my attention due to a delay with this patients management as there is a good chance that another Datix could be raised as Belfast had queried the time delay with this patient.

Patient 2 Personal Information redacted by USI - Treatment was completed following surgery which was performed on 10.07.19 (Testicular Cancer) patient was discussed at MDM on 26.07.19 and was to be reviewed by Mr O'Brien which did take place on 23.08.19 but patient was not relisted for MDM discussion, nor was an outcome provided so Shauna. Shauna then listed the patient to be discussed at MDM on 26.09.19 as she was conscious of how much time had passed and patient had not been referred for chemotherapy. I have attached Shauna's emails that she sent to Mr O'Brien during the period of time.

Clinic outcome from 23.08.19 (Mr O'Brien) was dictated on 25.09.19 & typed on 26.09.19 – This was a referral to Oncology.

Patient was seen by Oncology on 01.10.19. Outcome not yet available on NIECR.

Edit	01-10-2019	Personal Information redacted by the USI	BCH had queried the time delay with this patient - Mr Glackin was emailed by BCH.		No	Complete
Edit	01-10-2019	Personal Information redacted by the USI	Discussed at Urology MDM 26.09.19. To be referred to Oncology for consideration of adjuvant chemotherapy.		No	Complete
Edit	05-9-2019	Personal Information redacted by the USI	This man was reviewed 23.08.19 clinic letter awaited, will list for testicular MDM.		No	Complete
Edit	14-8-2019	Personal Information redacted by the USI	Patient awaiting review slot, no response with regards to testicular MDM	19-8-2019	Yes	Complete
Edit	09-8-2019	Personal Information redacted by the USI	Have asked Mr O'Brien does he want this man listed for testicular MDM patient awaiting review slot.	13-8-2019	Yes	Complete
Edit	02-8-2019	Personal Information redacted by the USI	Review is to be booked post MDM - he needs listed for testicular MDM.	07-8-2019	Yes	Complete
Edit	26-7-2019	Personal Information redacted by the USI	Discussed at Urology MDM 25.07.19. Patient 2 orchidectomy pathology shows a T1 classical seminoma with invasion of the rete testes. His CT shows no evidence of metastases and his tumour markers were normal pre-surgery. Mr O'Brien to review in outpatients and refer to oncology and the testes MDM.	01-8-2019	Yes	Complete

Edit	18-7-2019	Personal Information redacted by the USI	Pathology advised path wouldn't be ready for MDM 18.07.19.		Yes	Complete
Edit	17-7-2019	Personal Information redacted by the USI	Add for MDM 25.07.19 - Clinical summary provided by AOB on 16/07/19	26-7-2019	Yes	Complete
Edit	11-7-2019	Personal Information redacted by the USI	For MDM 18/07/19 as per AOB re: pathology.	18-7-2019	Yes	Complete

Happy to discuss further if more information is required.

Regards,

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

From: McVeigh, Shauna
Sent: 01 October 2019 15:02
To: Graham, Vicki
Subject: RE: Testicular MDM 26th Sept 19

Thanks Vicki

Mr Glackin has advised to bring any cases that are being delayed in their pathway back to MDT for an update on progress and reason for delay so this might help with some of the patients.

Thanks
Shauna

From: Graham, Vicki
Sent: 01 October 2019 14:52
To: McVeigh, Shauna
Subject: RE: Testicular MDM 26th Sept 19

Thanks Shauna for the heads up with this one – definitely a long time for patient being listed to be discussed, and you tried and tried to speed things up. Good you have these emails.

Talk soon,

Vicki

From: McVeigh, Shauna
Sent: 01 October 2019 12:34
To: Graham, Vicki
Subject: FW: Testicular MDM 26th Sept 19

Hi Vicki

Just to keep you in the loop if this man is made aware to you at some stage.

Thanks

Shauna

From: McVeigh, Shauna
Sent: 01 October 2019 12:34
To: Glackin, Anthony
Subject: RE: Testicular MDM 26th Sept 19

Hi Mr Glackin,

With regards to this patient I have attached the emails that I had sent to Mr O'Brien about this man.

I used my own discretion and listed this man for the testicular MDM as I knew time was moving on and he was being delayed.

Thanks
Shauna

From: Campbell, Kirsty [mailto:Personal Information redacted by the USI]
Sent: 30 September 2019 14:32
To: McVeigh, Shauna
Subject: FW: Testicular MDM 26th Sept 19

Hi Shauna

Please see below for your info.

Kirsty

From: Mitchell, Darren Personal Information redacted by the USI
Sent: 30 September 2019 14:20
To: Glackin, Anthony (Personal Information redacted by the USI)
<Personal Information redacted by the USI>
Cc: Campbell, Kirsty <Personal Information redacted by the USI>; Oladipo, Bode
<Personal Information redacted by the USI>
Subject: Testicular MDM 26th Sept 19

Patient 2 Personal Information redacted by the USI

Tony – we had a look at this chaps case to see if we could have shortened the timeline for him at our end. He was referred to the regional MDM on 10/9/19 but the MDM list had closed and he was added to the next meeting (26/9/19). Apologies that we hadn't picked up the overall time to adjuvant chemo from surgery as 12weeks or we'd have marked as an urgent add on to the 12th.

I wonder if you might want to look at the timeline from surgery 10/7/19 to the referral 10/9/19 and see if there is anything we can learn from the whole picture and reduce the risk of similar cases missing the adjuvant chemo window.

Thanks

DMM

Graham, Vicki

From: McVeigh, Shauna <Personal Information redacted by the USI>
Sent: 01 October 2019 12:34
To: Graham, Vicki
Subject: FW: Testicular MDM 26th Sept 19
Attachments: Patient 2 Personal Information redacted by the USI - Testicular MDM (5.49 KB); Update for MDM - Patient 2 Personal Information (2.94 KB)

Hi Vicki

Just to keep you in the loop if this man is made aware to you at some stage.

Thanks
Shauna

From: McVeigh, Shauna
Sent: 01 October 2019 12:34
To: Glackin, Anthony
Subject: RE: Testicular MDM 26th Sept 19

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With regards to this patient I have attached the emails that I had sent to Mr O'Brien about this man.

I used my own discretion and listed this man for the testicular MDM as I knew time was moving on and he was being delayed.

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Sent: 30 September 2019 14:32
To: McVeigh, Shauna
Subject: FW: Testicular MDM 26th Sept 19

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Please see below for your info.

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From: Mitchell, Darren <Personal Information redacted by the USI>
Sent: 30 September 2019 14:20
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Cc: Campbell, Kirsty <Personal Information redacted by the USI>; Oladipo, Bode <Personal Information redacted by the USI>
Subject: Testicular MDM 26th Sept 19

Patient 2 Personal Information redacted by the USI

Tony – we had a look at this chaps case to see if we could have shortened the timeline for him at our end. He was referred to the regional MDM on 10/9/19 but the MDM list had closed and he was added to the next meeting (26/9/19). Apologies that we hadn't picked up the overall time to adjuvant chemo from surgery as 12weeks or we'd have marked as an urgent add on to the 12th.

I wonder if you might want to look at the timeline from surgery 10/7/19 to the referral 10/9/19 and see if there is anything we can learn from the whole picture and reduce the risk of similar cases missing the adjuvant chemo window.

Thanks

DMM

Graham, Vicki

From: McVeigh, Shauna <Personal Information redacted by the USI>
Sent: 09 August 2019 15:45
To: O'Brien, Aidan
Subject: Patient 2 Personal Information redacted by the USI - Testicular MDM

Hi Mr O'Brien,

With regards to reviews post MDM, I don't think you have many slots to book these patients into.

This man was discussed at MDM on 25 July 2019 and needs referred to the testicular MDM, would you like me to list him? he does not need any staging as he has had his CT completed.

Thanks
Shauna

Shauna Mcveigh
Cancer Tracker / MDT Co-ordinator
Ext Personal Information redacted by the

Graham, Vicki

From: McVeigh, Shauna <Personal Information redacted by the USI>
Sent: 05 September 2019 10:07
To: O'Brien, Aidan
Subject: Update for MDM - Patient 2 Personal Information redacted by the USI

Hi Mr O'Brien,

I have added Patient 2 to the testicular MDM, which I think is next week. Would you like to provide an outcome, you had reviewed him on 23 August 2019.

Thanks
Shauna

Shauna Mcveigh
Cancer Tracker / MDT Co-ordinator
Ext Personal Information

Graham, Vicki

From: Graham, Vicki <[redacted]>
Sent: 04 October 2019 17:49
To: Carroll, Kay; Carroll, Ronan; Clarke, Wendy; Clayton, Wendy; Conway, Barry; Conway, Maria; Corrigan, Martina; Devlin, Louise; Glenny, Sharon; Lappin, Lynn; Leeman, Lesley; McAreavey, Lisa; McVey, Anne; Murphy, Elaine; Reddick, Fiona; Scott, Jane M
Subject: Cancer PTL's 31D & D85+
Attachments: D85+ PTL's as of 04.10.19.xlsx; 31D PTL's as of 04.10.19.xlsx

Importance: High

Hi,

Please see attached Cancer PTL's for patients who are currently on Day 85+ of their pathway. I have highlighted the breaches red, the ones at risk of breaching amber, the ones that require a management update/clinic outcome/surgery date in yellow and the ones that will complete on target in green. Any assistance progressing the ones highlighted in yellow would be greatly appreciated if it is within your area.

Tracking is not fully up to date across a few of the sites (Haematology, LGI & UGI) due to further sick leave within the Tracking Team.

If you would like an individual update on any of these patients please let me know.

Individual escalations will continue to be sent.

Many thanks,

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

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

Primary Casenote	Hcn	Confirmed or Suspect	Suspect Tumour Site - Description	Pathway	Current wait	62 Day Breach (Y/N)	Date of Referral	Date First seen	Date Decision to Treat	Target date	Date treatment planned	Treatment Planned Y\N	Planned 1st treatment type	Last Diary Comments
Personal Information redacted by the USI		Confirmed	Urological Cancer	62	158	Y	29/04/2019	28/05/2019		30/06/2019		N		This man needs his urinary symptoms addressed before definitive plan for treatment can be made. Update from Mr O'Brien - So this man will not be making a definitive decision regarding the future management of his prostatic carcinoma until his lower urinary tract symptomatic status has been optimised, followed by appropriate referral, and I do not know when that will be.
		Confirmed	Urological Cancer	62	144	Y	13/05/2019	22/07/2019		14/07/2019		N		For review with Mr O'Donoghue. Attended review on 02.10.19 - no hormones appear to have been commenced. Discussed at Urology MDM 26.09.19. Mr Howe has high risk prostate cancer with possible pelvic lymph node disease including a node at the left common iliac artery identified on review of imaging at MDT. For review by Mr O'Donoghue to commence ADT and refer to Oncology for further management.
		Suspect	Urological Cancer	62	138	Y	25/02/2019	16/04/2019		20/07/2019		N		No response on date for this man's TURP - patient has been escalated to OSL. still awaiting response from Mr O'Brien
		Suspect	Lower Gastrointestinal Cancer	62	137	Y	16/04/2019	13/05/2019		21/07/2019		N		CT remains approved as URGENT and has not been upgraded to RF as per request of OSL. Patient to proceed to CT Scan - this was requested as urgent, but Sharon is to request that this is to be upgraded to RF's Sharon has emailed radiology service administrator to request this status is upgraded.
		Suspect	Lower Gastrointestinal Cancer	62	128	Y	28/05/2019	19/07/2019		30/07/2019		N		CT Colonography booked for 08/10/19 in STH.
		Suspect	Lower Gastrointestinal Cancer	62	127	Y	30/05/2019	23/07/2019		31/07/2019		N		Seen at clinic 26/09/19. For red flag Colonoscopy & biopsy on Consultant list - 21.10.19 - CSC escalated to OSL
		Suspect	Lower Gastrointestinal Cancer	62	125	Y	15/05/2019	15/07/2019		02/08/2019		N		CSC escalated to OS. LTCI - 05/10/19 - Day 126. Escalated to CSC.
		Suspect	Haematological Cancers	62	123	Y	03/06/2019	27/09/2019		04/08/2019		N		Await clinic letter from 27/09/19, emailed secretary to enquire, await letter and response
		Suspect	Urological Cancer	62	123	Y	03/06/2019	01/07/2019		04/08/2019		N	Surgery	This man has been preadmitted for surgery for 11.10.19 - will schedule for MDM with pathology, patient has been escalated as he will be a breach.

Personal Information redacted by the USI		Suspect	Urological Cancer	62	121	Y	05/06/2019	13/08/2019		06/08/2019		N		Kate has forwarded MRI scan to reg who saw the patient further management has not been planned - await response.Have sent MRI scan to Kate and Mr Solts secretary -nothing on PAS and no letters on NIECR.
		Suspect	Lower Gastrointestinal Cancer	62	120	Y	17/05/2019	27/06/2019		07/08/2019		N		CT Colonography booked for 24/09/19.
		Suspect	Urological Cancer	62	120	Y	24/05/2019	21/08/2019		07/08/2019		N		For MDM 10.10.19 with pathology from TRUSB. TRUSB 30.09.19.
		Confirmed	Urological Cancer	62	120	Y	06/06/2019	02/09/2019		07/08/2019		N		Bone scan remains booked for 16.10.19. Patient has been escalated for MDM 24.10.19
		Suspect	Lower Gastrointestinal Cancer	62	120	Y	28/05/2019	23/07/2019		07/08/2019		N		Update from 352 - CTC appointed for 27.09.19.
		Suspect	Lower Gastrointestinal Cancer	62	120	Y	06/06/2019	01/08/2019		07/08/2019		N		Appointment with Mr McArdle 03/10/19.
		Suspect	Lower Gastrointestinal Cancer	62	120	Y	06/06/2019	02/08/2019		07/08/2019		N		9 MRI Pelvis booked for 26/09/19.
		Confirmed	Haematological Cancers	62	119	Y	07/06/2019	20/09/2019		08/08/2019		N		Still awaiting clinic letter. Await outcome from MDM 27.09.19. Most likely surveillence
		Suspect	Haematological Cancers	62	119	Y	07/06/2019	27/09/2019		08/08/2019		N		Bloods taken, nothing further on labs, RF CT CAP requested on Sectra.
		Suspect	Lower Gastrointestinal Cancer	62	119	Y	07/06/2019	24/07/2019		08/08/2019		N		CSC escalated to OSL TCI - 10/10/19 - Day 125. Escalated to CSC.
		Confirmed	Lower Gastrointestinal Cancer	62	115	Y	11/06/2019	03/08/2019	18/09/2019	12/08/2019	08/10/2019	Y	Surgery	Discussed at Colorectal MDM 19/09/19. Surgery 08/10/19 & rediscuss

Personal Information redacted by the USI		Confirmed	Urological Cancer	62	115	Y	11/06/2019	02/08/2019		12/08/2019		N		Clinic letter awaited and update awaited, no response on this man's further management. Patient has been escalated. CSC escalated patient to HoS, AD's & OLS's. HoS emailed Consultant directly and asked if he could provide an update on this patients management.
		Suspect	Lower Gastrointestinal Cancer	62	114	Y	12/06/2019	03/08/2019		13/08/2019		N		Clinic outcome as per NIECR - For CT AP. CT AP planned for 25/09/19.
		Suspect	Lower Gastrointestinal Cancer	62	114	Y	21/05/2019	29/07/2019		13/08/2019		N		CSC escalated to OSL .TCI - 25/09/19 - Day 105. Escalated to CSC.
		Suspect	Lower Gastrointestinal Cancer	62	114	Y	12/06/2019	03/08/2019		13/08/2019		N		OGD showed no malignancy. Colonoscopy revealed a 1.5cm flat lesion. Emailed schedulers to rebook colonoscopy as per colonoscopy report.
		Confirmed	Urological Cancer	62	113	Y	13/06/2019	05/08/2019		14/08/2019		N		For MDM 03.10.19 with pathology. Biopsies booked for 30/09/19.
		Suspect	Lower Gastrointestinal Cancer	62	113	Y	13/06/2019	08/08/2019		14/08/2019		N		Pathology shows tubulovillous adenoma exhibiting low-grade dysplasia. Await Flexi Sig 25/09/19.
		Confirmed	Lower Gastrointestinal Cancer	62	113	Y	13/06/2019	03/08/2019		14/08/2019		N	Surgery	Discussed at Colorectal MDM 19/09/19. Check PSA then surgery & rediscuss.
		Suspect	Haematological Cancers	62	112	Y	30/05/2019	15/07/2019		15/08/2019		N		Awaiting clinic letter CSC escalated to OSL
		Confirmed	Urological Cancer	62	112	Y	14/06/2019	22/07/2019		15/08/2019		N		Clinic outcome not available on NIECR - staging scans were to be requested. Nothing on Sectra.
		Suspect	Lower Gastrointestinal Cancer	62	109	Y	17/06/2019	20/08/2019		18/08/2019		N		Flexi sig booked for 14/10/19 in DHH
		Suspect	Lower Gastrointestinal Cancer	62	109	Y	17/06/2019	15/08/2019		18/08/2019		N		CTC appointed for 27.09.19.
		Confirmed	Urological Cancer	62	109	Y	17/06/2019	05/08/2019		18/08/2019		N		Review is to be booked post MDM - secretary waiting on slots.

Personal Information redacted by the USI		Suspect	Lower Gastrointestinal Cancer	62	109	Y	17/06/2019	21/08/2019		18/08/2019		N		CSC escalated to OSL.TCI - 24/09/19 - Day 99. Escalated to CSC.
		Suspect	Urological Cancer	62	108	Y	18/06/2019	09/09/2019		19/08/2019		N		MRI has been requested, will escalate this man to OSL. Date to be defined.
		Suspect	Urological Cancer	62	108	Y	18/06/2019	09/09/2019		19/08/2019		N		TRUSB 01.10.19 - For MDM with results.
		Suspect	Lower Gastrointestinal Cancer	62	107	Y	19/06/2019	22/08/2019		20/08/2019		N		Colonoscopy rebooked for 03/10/19 in STH.
		Suspect	Lower Gastrointestinal Cancer	62	106	Y	20/06/2019	17/08/2019		21/08/2019		N		Colonoscopy rebooked for 07/10/19 in CAH - Day 109.
		Suspect	Haematological Cancers	62	106	Y	20/06/2019	29/08/2019		21/08/2019		N		No response to query, no further requests on SECTRA, further apt 31/10/19
		Suspect	Lower Gastrointestinal Cancer	62	105	Y	21/06/2019	04/09/2019		22/08/2019		N		CSC escalated to OSL TCI - 02/10/19. Day 103. Escalated to CSC.
		Suspect	Lower Gastrointestinal Cancer	62	104	Y	29/04/2019	28/05/2019		23/08/2019		N		CTC appointed for 01.10.19.
		Suspect	Lower Gastrointestinal Cancer	62	103	Y	09/04/2019	14/05/2019		24/08/2019		N		Dr Hillemand sent letter to patient offering plain CT - Awaiting patient response.
		Suspect	Lower Gastrointestinal Cancer	62	102	Y	20/06/2019	17/08/2019		25/08/2019		N		Colonoscopy booked for 24/09/19 in STH.
		Suspect	Lower Gastrointestinal Cancer	62	102	Y	24/06/2019	27/08/2019		25/08/2019		N		CSC escalated to OSL OGD & Colonoscopy planned for 24/09/19 - Day 91. Escalated to CSC.
		Suspect	Lower Gastrointestinal Cancer	62	102	Y	24/06/2019	30/08/2019		25/08/2019		N		For RF OGD & Colonoscopy as per MYO clinic 30.08.19. TCI - 27.09.19. Day 95. Escalated to CSC.
		Suspect	Haematological Cancers	62	101	Y	25/06/2019	27/09/2019		26/08/2019		N		No pathology on labs/SECTRA, bloods done. Awaiting clinic letter

Personal Information redacted by the USI		Suspect	Urological Cancer	62	100	Y	20/05/2019	01/08/2019		27/08/2019		N		No response on this lady she has been discharged on PAS as normal - await outcome.
		Suspect	Lower Gastrointestinal Cancer	62	99	Y	27/06/2019	27/08/2019		28/08/2019		N		TCI - 23/09/19 - Day 88. Escalated to CSC.
		Suspect	Haematological Cancers	62	99	Y	27/06/2019	25/09/2019		28/08/2019		N		Free light chain - Lambda -74.6 & kappa- 40.3. CXR & US ABD & PEL requested to be done within 6wks, await clinic lette
		Suspect	Lower Gastrointestinal Cancer	62	99	Y	31/05/2019	24/07/2019		28/08/2019		N		CT Colonography booked for 24/09/19 in DHH.
		Suspect	Lower Gastrointestinal Cancer	62	98	Y	28/06/2019	31/08/2019		29/08/2019		N		MDM 10.10.19 - Has been escalated.
		Suspect	Lower Gastrointestinal Cancer	62	98	Y	28/06/2019	27/08/2019		29/08/2019		N		Colonoscopy rebooked for 10/10/19 in CAH.
		Suspect	Urological Cancer	62	98	Y	28/06/2019	12/08/2019		29/08/2019		N		The above patient was offered an appointment for Thursday 3rd October but he cannot attend as he is in England.I have sent him out another appointment for Wednesday 9th October.
		Suspect	Upper Gastrointestinal Cancer	62	96	Y	28/05/2019	23/07/2019		31/08/2019		N		Still for Colonoscopy 15/10/19, has been escalated
		Suspect	Urological Cancer	62	96	Y	24/06/2019	10/09/2019		31/08/2019		N		Patient listed for MDM discussion 17.10.19 - biopsy planned for 08.10.19.
		Confirmed	Urological Cancer	62	95	Y	29/05/2019	30/07/2019		01/09/2019		N		TRUSB booked for 24.09.19 patient has been listed for MDM discussion 03.10.19.
		Suspect	Lower Gastrointestinal Cancer	62	95	Y	01/07/2019	24/08/2019		01/09/2019		N		CTC appointed for 01.10.19.
		Suspect	Lower Gastrointestinal Cancer	62	94	Y	02/07/2019	20/08/2019		02/09/2019		N		CT Colonography booked for 03/10/19 in Kingsbridge.
		Suspect	Lower Gastrointestinal Cancer	62	94	Y	06/06/2019	06/08/2019		02/09/2019		N		CSC escalated to OSL Patient cancelled scope on 02/09/19 - rebooked for 28/09/19. Adjustment added. Escalated to CSC.

Personal Information redacted by the USI		Suspect	Lower Gastrointestinal Cancer	62	94	Y	02/07/2019	24/08/2019		02/09/2019		N		Colonoscopy has shown a ulcerating lesion in caecum. Staging CT booked for 07/10/19. Emailed radiology to try and get CT brought forward so patient can be discussed at MDM 03/10/19. Escalated to CSC.
		Suspect	Haematological Cancers	62	94	Y	07/03/2019	28/03/2019		02/09/2019		N		Awaiting clinic letter CSC escalated to OSL
		Suspect	Haematological Cancers	62	94	Y	02/07/2019	28/08/2019		02/09/2019		N		Review planned for 10/10/19, awaiting clinic letter 28/08/19 CSC escalated to OSL
		Suspect	Urological Cancer	62	94	Y	02/07/2019	23/09/2019		02/09/2019		N		Await outcome US normal most likely discharged but await letter.
		Suspect	Gynae Cancers	62	94	Y	02/07/2019	16/07/2019		02/09/2019	30/09/2019	Y	Surgery	Surgery was performed 30/09/19 - pathology awaited. Will be a breach if ca is confirmed & has already been escalated.
		Suspect	Lower Gastrointestinal Cancer	62	94	Y	02/07/2019	24/08/2019		02/09/2019		N		CT Colonography booked for 01/10/19 in STH.
		Suspect	Urological Cancer	62	94	Y	29/05/2019	06/08/2019		02/09/2019		N		TRUSB booked for 08.10.19 - will list for MDM with pathology.
		Suspect	Urological Cancer	62	94	Y	02/07/2019	19/09/2019		02/09/2019		N		Discussed at Urology MDM 26.09.19. Mr Buchanan requires an up to date MRI scan of his prostate to be reviewed at MDT
		Suspect	Lower Gastrointestinal Cancer	62	93	Y	03/07/2019	24/08/2019		03/09/2019		N		CSC has escalated to HoS. Schedulers asked to keep patient in mind for cancellation.No malignancy found on CT. Now for red flag OGD & Colonoscopy 14/10/19 in STH - Day 103. Escalated to CSC.
		Suspect	Lower Gastrointestinal Cancer	62	93	Y	03/07/2019	27/08/2019		03/09/2019		N		Booked for Colonoscopy & biopsy 23/09/19 (D82). Escalated
		Confirmed	Lower Gastrointestinal Cancer	62	93	Y	03/07/2019	24/08/2019	30/09/2019	03/09/2019	07/10/2019	Y	Surgery	Left Hemicolectomy +/- Oophorectomy booked for 07/10/19.

Personal Information redacted by the USI		Suspect	Lower Gastrointestinal Cancer	62	92	Y	04/07/2019	24/08/2019		04/09/2019		N		CSC escalated to HoS, AD's & OSL's. CSC also emailed to Radiology SA - Radiology SA emailed to see if date could be provided as to when CTC will be appointed. Response received - I have checked the diary and the CTC waiting list and anticipate this patient will most likely be offered an appointment at end of October/first week of November.
		Suspect	Urological Cancer	62	92	Y	04/07/2019	16/09/2019		04/09/2019		N		MRI reported - No radiological evidence of a significant prostate tumour.PSAD of 0.22. have advised Mr Haynes of report.
		Suspect	Lower Gastrointestinal Cancer	62	92	Y	04/07/2019	24/08/2019		04/09/2019		N		Update from OSL -- Mr Kumar's list was not able to be done yesterday as there was an issue with the theatre - all patients to be rebooked to 11/10/19. Will escalate to Hos & AD's.
		Suspect	Urological Cancer	62	91	Y	05/07/2019	23/09/2019		05/09/2019		N		Have sent MRI scan to Mr O'Donoghue decision to be made about scan.
		Confirmed	Gynae Cancers	62	91	Y	05/07/2019	17/07/2019	11/09/2019	05/09/2019	14/10/2019	Y	Surgery	Had US Guided biopsy 01/10/19 & MRI 03/10/19 - listed for MDM 08/10/19 - Still for surgery 14/10/19.
		Suspect	Urological Cancer	62	91	Y	05/07/2019	22/08/2019		05/09/2019	11/10/2019	Y	Surgery	This man will breach his pathway surgery booked for 11.10.19 - the soonest he could be offered.
		Suspect	Urological Cancer	62	91	Y	05/07/2019	25/09/2019		05/09/2019		N		MRI appointed for 03.10.19. Will escalate this man to OSL as he could be a breach if cancer is confirmed.

Personal Information redacted by the USI		Confirmed	Haematological Cancers	62	91	Y	11/03/2019	27/03/2019		05/09/2019		N	Chemotherapy	Review booked for 07/10/19, await patient decision/clinic letter Day 94. Escalated to CSC.
		Suspect	Lower Gastrointestinal Cancer	62	91	Y	20/05/2019	17/07/2019		05/09/2019		N		CSC escalated to OSL SAppt planned for 30/09/19 - Day 87. Escalated to CSC.
		Suspect	Upper Gastrointestinal Cancer	62	91	Y	05/07/2019	21/08/2019		05/09/2019		N		Awaiting date for CTC, has been escalated. Radiology have been trying to contact patient but no answer, message has been left. Still to be checked if patient has script
		Suspect	Lower Gastrointestinal Cancer	62	91	Y	05/07/2019	24/08/2019		05/09/2019		N		Update from OSL -- Mr Kumar's list was not able to be done yesterday as there was an issue with the theatre - all patients to be rebooked to 11/10/19. Will escalate to Hos & AD's
		Suspect	Lower Gastrointestinal Cancer	62	91	Y	05/07/2019	24/08/2019		05/09/2019		N		CT Colonography 23/09/19 - Awaiting report.
		Suspect	Lower Gastrointestinal Cancer	62	91	Y	05/07/2019	24/08/2019		05/09/2019		N		10/09/2019 CSC escalated to OSL Sinead Langley 06/09/2019 For RF Colonoscopy as per Mr McArdle's clinic 05.09.19. TCI - 24.09.19. Day 81. Escalated to CSC. Sinead Langley
		Suspect	Lower Gastrointestinal Cancer	62	88	Y	08/07/2019	24/08/2019		08/09/2019		N		Seen at clinic 11/09/19. For red flag OGD & Colonoscopy 09/10/19 in DHH - Day 93. Escalated to CSC.
		Suspect	Lower Gastrointestinal Cancer	62	88	Y	08/07/2019	24/08/2019		08/09/2019		N		OGD & Colonoscopy booked for 24/09/19 in STH - Day 78. Escalated to CSC.
		Suspect	Lower Gastrointestinal Cancer	62	88	Y	08/07/2019	31/08/2019		08/09/2019		N		Staging CT booked for 10/10/19. Emailed to see if CT could be brought forward.

Personal Information redacted by the USI		Suspect	Urological Cancer	62	88	Y	08/07/2019	25/09/2019		08/09/2019		N		PSA has come down slightly - await management from Mr Glackin.
		Suspect	Haematological Cancers	62	88	Y	08/07/2019	27/09/2019		08/09/2019		N		US Abd booked for 21/10/19, further apt 14/11/19. Awaiting clinic letter 27/09/19
		Suspect	Lower Gastrointestinal Cancer	62	88	Y	03/06/2019	15/07/2019		08/09/2019		N		CTC planned for 23/09/19 - Day 77. Escalated to CSC.
		Suspect	Lower Gastrointestinal Cancer	62	88	Y	08/07/2019	31/08/2019		08/09/2019		N		CTC appointed for 15.10.19 - Colonoscopy abandoned due to excessive looping and patient discomfort. Normal to point of insertion. Red flag CT Colonography requested - awaiting date. Escalated to CSC.
		Suspect	Lower Gastrointestinal Cancer	62	87	Y	14/06/2019	08/08/2019		09/09/2019		N		Patient was unwell on day of scope 03.09.19 - Rebooked for 06/10/19. Day 89. Escalated to CSC.
		Suspect	Lower Gastrointestinal Cancer	62	87	Y	01/07/2019	31/08/2019		09/09/2019		N		OGD & Flexi Sig booked for 01/10/19 in CAH. Hi
		Suspect	Lower Gastrointestinal Cancer	62	87	Y	03/06/2019	20/07/2019		09/09/2019		N		Scopes performed on 27/08/19 - OGD normal. Colonoscopy shows diverticulosis and benign colonic polyps. Pathology reports hyperplastic polyp. CT CAP planned for 08/10/19.
		Suspect	Urological Cancer	62	87	Y	09/07/2019	23/09/2019		09/09/2019		N		Have checked with secretary for clinic outcome from 23.09.19.
		Suspect	Urological Cancer	62	87	Y	09/07/2019	30/09/2019		09/09/2019		N		PSA is elevated, have advised the reg decision to be made. S
		Suspect	Lower Gastrointestinal Cancer	62	86	Y	10/07/2019	02/09/2019		10/09/2019		N		TCI - 24.09.19 - Day 76. for colonoscopy. Escalated to CSC Sinead Langley

Personal Information redacted by the USI		Suspect	Lower Gastrointestinal Cancer	62	86	Y	24/06/2019	30/08/2019		10/09/2019		N		Theatre list cancelled for 21/09/19. Patient was rebooked for 20/09/19. Patient cancelled as unsuitable. Colonoscopy rebooked for 14/10/19 in DHH.
		Suspect	Upper Gastrointestinal Cancer	62	86	Y	10/07/2019	09/09/2019		10/09/2019		N		Still for OGD & Colonoscopy 09/10/19, has been escalated
		Suspect	Haematological Cancers	62	86	Y	10/07/2019	02/10/2019		10/09/2019		N		1st OPD 02.10.19 - Day 82 - Clinic outcome awaited.
		Suspect	Urological Cancer	62	86	Y	10/07/2019	30/09/2019		10/09/2019		N		MRI requested and appointed for 10.10.19 - PSa 8.4 8/7/19PSA 7.58 14/6/19malignant feeling prostate right lobe on Pers very fit for his age. Will escalate to OSL
		Suspect	Urological Cancer	62	86	Y	10/07/2019	30/09/2019		10/09/2019		N		Await repeat PSA. Clinic outcome - The plan would be for him to repeat his PSA given that he has only a single reading of PSA and if that remains high then we may consider proceeding to an MRI of his prostate Shauna McVeigh
		Suspect	Lower Gastrointestinal Cancer	62	86	Y	05/07/2019	24/08/2019		10/09/2019		N		Patient on holidays 11/10/19 - 16/10/19.
		Suspect	Lower Gastrointestinal Cancer	62	86	Y	10/07/2019	02/09/2019		10/09/2019		N		TCI - 27/09/19 - Day 79 for RF OGD & Colonoscopy. Escalated to CSC
		Confirmed	Urological Cancer	62	85	Y	11/07/2019	27/08/2019	16/09/2019	11/09/2019	18/10/2019	Y	Surgery	Referred to Gynae - left nephro-ureterectomy on 18th Oct. Ms Hutchinson left renal biopsy indicates malignancy. For review by Mr Glackin to recommend a left nephroureterectomy.
		Suspect	Lower Gastrointestinal Cancer	62	85	Y	11/07/2019	04/09/2019		11/09/2019		N		OGD & Colonoscopy booked for 05/10/19 in STH - Day 86. Escalated to CSC.
		Suspect	Lower Gastrointestinal Cancer	62	85	Y	11/07/2019	04/09/2019		11/09/2019		N		OGD & Colonoscopy booked for 01/10/19 in STH - Day 82. Escalated to CSC.
		Suspect	Haematological Cancers	62	85	Y	11/07/2019			11/09/2019		N		First appt planned for 09/10/19 - Day 90. Escalated to CSC.

Personal Information redacted by the USI		Suspect	Lower Gastrointestinal Cancer	62	85	Y	11/07/2019	04/09/2019		11/09/2019		N		Colonoscopy booked for 05/10/19 in STH - Day 86. Escalated to CSC.
		Suspect	Lower Gastrointestinal Cancer	62	85	Y	11/07/2019	03/09/2019		11/09/2019		N		Colonoscopy booked for 01/10/19 in DHH - Day 82. Escalated to CSC.
		Suspect	Lower Gastrointestinal Cancer	62	85	Y	11/07/2019	03/09/2019		11/09/2019		N		OGD & Colonoscopy booked for 01/10/19 in DHH - Day 82. Escalated to CSC.
		Suspect	Upper Gastrointestinal Cancer	62	85	Y	11/07/2019	23/08/2019		11/09/2019		N		CT 25/09/19 - No overt malignancy or recurrent identified. (Report only transcribed, AWAIT AUTHORISED). Still for Colonoscopy 16/10/19 (D97), has been escalated

Primary Casenote	HCN	Confirmed or Suspect	Suspect Tumour Site - Description	Primary Referral Date	Current wait	31 Day Breach (Y/N)	Date of Referral	Date First seen	Date Decision to Treat	Target date	Date Treatment Planned	Treatment Planned Y\\N	Planned 1st treatment type	Last Diary Comments
Personal Information redacted by the USI		Confirmed	Gynae Cancers	12/08/2019	37	Y	12/08/2019	14/08/2019	28/08/2019	28/09/2019	07/10/2019	Y	Surgery	Still for surgery 07/10/19 (D40) - breach has already been escalated. L
		Confirmed	Gynae Cancers	19/08/2019	30	N	19/08/2019	04/09/2019	04/09/2019	05/10/2019	10/09/2019	Y	Surgery	Still for surgery 10/10/19 - breach has already been escalated.
		Confirmed	Haematological Cancers	30/08/2019	18	N	30/08/2019	16/09/2019	16/09/2019	17/10/2019	04/10/2019	Y	Chemotherapy	Clinic apt 16/09/19 - Patient is to have egg harvesting 01/10/19 before having chemo starting. Chemo ABVD due to start 04/10/19. Await confirmation chemo started
														Right Hemicolectomy booked for 02/10/19 in CAH
		Confirmed	Gynae Cancers	26/08/2019	16	N	26/08/2019	09/09/2019	18/09/2019	19/10/2019		N	Surgery	Await surgery date, schedulers aware & has been escalated as a likely confirmed breach
														Review 30/09/19 cancelled , new apt 04/10/19. Await clinic letter to advise patients treatment. No medication on
		Confirmed	Lower Gastrointestinal Cancer	10/09/2019	14	N	10/09/2019	10/09/2019	20/09/2019	21/10/2019	01/10/2019	Y	Surgery	9 Discussed at Colorectal MDM 26/09/19. Extended Right Hemicolectomy 01/10/19.
														Booked for surgery 28/10/19, breach, has already been escalated.
		Confirmed	Gynae Cancers	02/09/2019	9	N	02/09/2019	11/09/2019	25/09/2019	26/10/2019		N	Surgery	Await surgery date, schedulers aware, has been escalated as likely confirmed breach
														Patient attended review on 01.10.19 and gave consent for surgery - provisional date of 03.10.19.
		Confirmed	Gynae Cancers	05/08/2019	2	N	05/08/2019	23/08/2019	02/10/2019	02/11/2019		N	Surgery	Added to W/L for TAH & BSO, emailed scheduler. Emailed target to scheduler: 02/11/19
														Reviewed 02.10.19 - Date awaited for surgery.

Graham, Vicki

From: Glenny, Sharon <Personal Information redacted by the USI>
Sent: 25 September 2017 15:47
To: Graham, Vicki; Reddick, Fiona
Subject: RE: Tracking Update W/C 25/09/2017

Wow – fantastic news.

Well done to everyone – just need to keep on top of this now.

Sharon

From: Graham, Vicki
Sent: 25 September 2017 15:38
To: Reddick, Fiona; Glenny, Sharon
Subject: Tracking Update W/C 25/09/2017
Importance: High

Hi,

Please see below tracking update for w/c 25.09.17.

Breast – Up to date
Skin & Brain – Up to date
Lung – Up to date
UGI& LGI – Up to date
H&N & Others – Up to date
Urology – Up to date
Gynae & Haematology – Gynae up to date – Haematology being looked as Wendy on leave.

Regards,

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)*

Graham, Vicki

From: Graham, Vicki <[redacted]>
Sent: 04 July 2019 11:51
To: Glenny, Sharon
Subject: RE: Tracking Update W/C 01.07.19

Importance: High

Hi Sharon

Please see below update in relation to tracking.

Gynae & UGI – Up to date
Head & Neck – Will be up to date by tomorrow (at present about 60% tracked) Current tracker on leave.
Urology – 80% Tracked – Tracker currently on 1 week's leave – Sarah has been looking at this in her absence. Was up to date last week.
Lower – Up to date
Breast – Up to date
Skin –Up to date
Brain – Up to date
Lung – 50% Tracked – this is due to tracker being off on leave. Tomorrow will be spent focusing on tracking.
Haematology – Being tracked at present and should be up to date by end of tomorrow.

The sites that were hugely behind (**Urology, UGI** & **LGI** – up to 4 weeks at times) due to increased referrals have improved significantly with the help of additional staff. Now if a site is behind, due to annual leave, it will not be a whole week behind as we have additional staff who are in a position to help out – on-going staff training is continuing as there is a lot to learn across all sites, but the benefit is being seen with the tracking being more or less up to date across the majority of sites.

Many thanks,

Vicki Graham
Cancer Services Co-ordinator
Trackers Office
Basement
Telephone: [redacted]

Graham, Vicki

From: Graham, Vicki <[redacted]>
Sent: 04 July 2019 11:51
To: Glenny, Sharon
Subject: RE: Tracking Update W/C 01.07.19

Importance: High

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Many thanks,

Vicki Graham
Cancer Services Co-ordinator
Trackers Office
Basement
Telephone: [redacted]

Graham, Vicki

From: Graham, Vicki <Personal Information redacted by the USI>
Sent: 28 January 2016 11:32
To: Clayton, Wendy; Muldrew, Angela
Subject: RE: UGI & LGI tracking

Wendy,

Griania is happy to do overtime and will let me know prior to doing this. Rachel is happy to come in on a Monday and Tuesday from 9-12 for the next while (This will be claimed as time). I will stay on some nights if required,

Regards,

Vicki

Cancer Services Co-Ordinator
Mandeville Unit
Telephone: Personal Information

From: Clayton, Wendy
Sent: 28 January 2016 11:01
To: Muldrew, Angela; Graham, Vicki
Subject: RE: UGI & LGI tracking

Thanks Angela

Vicki – can you see if any of the Trackers are available for overtime to do LGI/UGI tracking please?

Regards

Wendy Clayton
Operational Support Lead
Cancer & Clinical Services / ATICs
Southern Trust

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

From: Muldrew, Angela
Sent: 28 January 2016 10:47
To: Clayton, Wendy
Subject: UGI & LGI tracking

Wendy

Just to let you know it unlikely that I will be able to look at any LGI & UGI tracking over the next couple of weeks as I have retesting and processing mapping to complete for RISOH and then I am out of the office week commencing 8th Feb (annual leave 8th – 10 February then CaPPS meeting on 11th and possible RISOH on 12th)

Thanks

Angela Muldrew
RISOH Implementation Officer
Tel. No. Personal Information redacted by the USI

Graham, Vicki

From: Graham, Vicki <Personal Information redacted by the USI>
Sent: 01 February 2016 09:20
To: Muldrew, Angela
Cc: Clayton, Wendy
Subject: RE: Tracking Update

Yes not a problem, Rachel is working on the notifications now.

Regards,

Vicki

Cancer Services Co-Ordinator
Mandeville Unit
Telephone: Personal Information redacted by the USI

From: Muldrew, Angela
Sent: 01 February 2016 07:51
To: Graham, Vicki
Cc: Clayton, Wendy
Subject: RE: Tracking Update

Hi Vicki

Can you please ask Rachel to focus on UGI & LGI when she is in today and tomorrow.

Thanks

Angela Muldrew
RISOH Implementation Officer
Tel. No. Personal Information redacted by the USI

From: Graham, Vicki
Sent: 29 January 2016 15:23
To: Muldrew, Angela
Subject: Tracking Update
Importance: High

Hi Angela,

Please see below tracking update as of 29.01.16.

Tracking update

Ann	Lung - 70% Up to date
Vicki	Gynae - up to date
Vicki	Head & Neck - up to date
Vicki	Breast - Up to date
Rachel	Covering Breast – Skin to be tracked today (Was up to date as of last week)
Rachel	Others & Brain – Up to date
Griania	LGI & UGI – Has not got looking at much tracking

Regards,

Vicki

Cancer Services Co-Ordinator
Mandeville Unit
Telephone: Personal Information redacted by the UOI

Southern Health and Social Care Trust

Quality Care - for you, with you

DRAFT

ADMINISTRATIVE & CLERICAL Standard Operating Procedure No.

Title	Urology Multi-disciplinary Administrative Process	
S.O.P. Number		
Version Number	v1.0	**Supersedes:** v0.1
Author	Vicki Graham	
Page Count		
Date of Implementation		
Date of Review		**To be Reviewed by: OSL's**
Approved by		

Urology Multi-disciplinary Meeting (MDM) Administrative Process

The Breast MDM is held every Thursday at 2.15 pm in Tutorial Room 1, Medical Education Centre. The meeting membership consists of:

Consultant Urologist
Consultant Oncologists
Consultant Radiologists
Associate Specialists
Consultant Pathologist
Specialist Urology Nurse
GP with specialist interest
Palliative Care Nurse
MDT Co-Ordinator

It is the responsibility of the MDM Co-ordinator to undertake the following tasks to ensure the efficient and smooth running of the meeting:

Patients listed for MDM

There are 6 methods of patients being added to the Urology MDM:

1) Prostate Assessment Clinic: Kate O'Neill, Urology Nurse Specialist e-mails me through a list in advance of planned biopsies and details are added onto Capps if not a 62 day patient. I also receive a confirmation of biopsies performed on the day. Patients are then added to the correct MDM and pathology discussed.

2) Tracking: Whilst updating tracking if there are any patients who have had investigations performed and tracker is unsure of results, or if results are reported and are not normal name is added to MDT to clarify further management.

3) Haematuria clinic DHH: Clinic outcome from haematuria clinic are e-mailed through to tracker. This informs tracker if patient is being discharged or requires further investigations and if patient is needed to be discussed @ MDM.

4) Secretaries/ Audio typist: If typing up a clinic and Doctor has requested for case to be discussed @ MDM, the letter is either e-mailed or posted via internal mail to tracker. Information is then updated onto CaPPs so all relevant information is available for discussion.

5) Surgery lists: Paulette (Mr Young's Secretary) e-mails Tracker through a copy of the scheduled theatre list. This allows tracker to check and add any confirmed cases. Tracker is not included in any other Consultants Theatre list distribution list.
6) Consultants: To discuss change of management plans, results, radiology etc.

7) Mr O'Brien leaves down with Tracker all patient's with updated narrative on patients that he would like discussed. All information is to be copied onto Capps. (Narratives can be quite lengthy)

8) Radiology:-Tracker can be advised of radiology results and details are added so case can be discussed @ MDM as most of these tend to be incidental findings.

9) Cases that are deferred from the previous week's MDM.

Administrative process before MDM

1. Copy of the patient list emailed to Urology Distribution list on the Wednesday at 1.00pm. Cut off time for adding patients to MDM is Tuesday lunch time. Copy list of MDM patients is given to Band 2 to allow time for tracking and requesting charts.

2. List of patients who have to be discussed for radiology results is emailed to Radiologist including clinical background on the patient & why they need discussed. MDM Co-ordinator has a copy of Radiology rota & sends this email to whichever radiologist was on the Assessment clinic that week.

3. On Wednesday, the day before the MDM, Mr O'Brien has requested an MDM update report on every patient and pathology printed out and put into a folder to allow time for preparation prior to the meeting. Tracker prints off the individual MDM update.

4. 8 copies of the patient list are printed off prior to the MDM meeting. (Band 3 when available)

5. Band 2 pulls charts & tracks charts prior to MDM.

6. MDM Co-ordinator goes to Tutorial Room 1 MEC

Administrative process after MDM

1. Go through histopathology & radiological reports for each patient & type results into MDM outcome if these were not available prior to MDM.

2. Update MDM outcomes that has been dictated verbally and hand written down during MDM Copy all MDM discussions into diary.

3. Create Letters & MDM reports.

4. E-mail each Secretary each individual patient's MDM outcome if patient is to be reviewed, added to W/L etc. and advise them what is to be actioned following MDM.

   Mr Glackin: Liz Troughton EXT Personal Information redacted by
   Mr Young: Paulette Dignam EXT Personal Information redacted by
   Mr O'Brien: Monica McCorry EXT Personal Information redacted by

   E-Mail Leanne Hanvey, Urology Specialist Nurse Secretary any patient's names that require Day4 appointments. Leanne EXT Personal Information redacted by

   E-mail all DHH outcomes individually to Mr Brown's Secretary, Joanne Brown & advise of what is to be actioned post MDM.

   If there are any ward histologies to be cancelled / appointed I e-mail Sharon McDermott, Ward Clerk in 3ESU.

Any patients that will require BCG or MMC (Mitomycin C), bladder chemotherapy I e-mail Emma McCann who is a Nurse in 3ESU and advise that patient will be requiring treatment. Janis deals with all chemotherapies in 3ESU but she does not have an e-mail.

5. E- Mail MDM update to distribution list once all outcomes are updated.

6. Print off any histopathology reports for patients being referred to oncology.

7. Oncology referral being e-mailed directly to Dr Houghton @ Belfast Trust and her Secretary, Hazel Cantley and advise that paper copy will follow.

8. GP Letter and MDM reports printed for each patient that was discussed. (Band 3 when available)

9. Oncology referrals printed off and attached to histopathology report

10. GP Letters & oncology referrals taken to Mr O'Brien, Chair of Urology MDM to sign on Friday morning. (Band 2) Mr O'Brien usually has a clinic in Thorndale Unit.

11. When documents are signed GP letters are posted out to GP and oncology referrals are posted along with a copy of pathology report to the relevant oncologist.

12. GP letters are photocopied as are oncology referrals and are joined up with MDM outcome and are filed into chart. (Tracker)

13. Tracker goes through returned letters and checks that there have been no corrections, if corrections are required to be made, CaPPs is undated, letter's & MDM outcome is reprinted and returned for signing.

14. Tracker checks through MDM outcomes and splits into "CANCER" & "NON CANCER" to be filed into chart by Band 2.

15. MDM minutes are performed, including number on list, cases discussed etc.

16. MDM minutes are emailed to Urology team.

17. Once the MDM outcome have been filed into medical chart, the tracker goes through each individual chart and has to check, PAS & CaPPs to see if patient is to be re discussed . Each chart is then tracked out to previous location. Tracker re tracks charts back. Most weeks there are between 30-40 charts (This can take at least 1-2 hours.)

18. Tracker brings charts over to Medical Records and slots into appropriate place for return to location)

Graham, Vicki

From: Graham, Vicki <[redacted]>
Sent: 18 November 2016 16:09
To: Glenny, Sharon
Subject: Breast SOP 181116
Attachments: Breast SOP 181116.docx

Importance: High

Hi Sharon,

Please see attached Breast SOP. Could you please read over and if happy update coversheet that you have approved and when you would like this reviewed?

If you are happy with this format I will be applying to all tumour sites.

Regards,

Vicki

Southern Health and Social Care Trust

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ADMINISTRATIVE & CLERICAL Standard Operating Procedure No.

Title	Gynae Multi-disciplinary Administrative Process	
S.O.P. Number		
Version Number	v1.0	**Supersedes:** v0.1
Author	Wendy Kelly	
Page Count		
Date of Implementation	11th May 2015	
Date of Review		**To be Reviewed by:**
Approved by	Vicki Graham	

Gynae Multi-disciplinary Meeting (MDM) Administrative Process

The Gynae MDM is held every Tuesday at 1.00pm in Tutorial Room 1, MEC and video-conferences to the Gynaecology consultants in Daisy Hill Hospital. The meeting and membership consists of:

Consultant Gynaecologists
Consultant Pathologists
Consultant Radiologists
Palliative Consultant
Staff Grades
Clinical Nurse Specialist
Palliative Care Nurse Specialist
Ward Sister
MDT Co-Ordinator

- No charts required for Gynae MDM
- Gynae MDM list circulated to Gynae team by Monday lunchtime by tracker. There is a problem with the Gynae MDM list so select all (ctrl +a) and copy and paste into the email.

DHH are in Committee Room 2. Both sides link into the virtual room - 7111035

MDM after work:

- ITD's for discussion at regional MDM and ITT's for treatment in BCH are sent to caroline.rainey Personal Information redacted by the USI
  And cc'd to: helen.smyth Personal Information redacted by the USI and 'tracy.waring Personal Information redacted by the USI
  (ITD's to be sent by 3pm latest on Tuesday)

- GOPD clinic appointments are emailed **by 3pm latest on Tuesday** to:
  pamela.wilson Personal Information redacted by the USI
  Edel.Canavan Personal Information redacted by the USI
  Annemarie.Kennedy Personal Information redacted by the USI
  June.McGaughey Personal Information redacted by the USI
  lesley-ann.brown Personal Information redacted by the USI
  Sarah.Jamieson Personal Information redacted by the USI
  Gladys.Allen Personal Information redacted by the USI
  Noeleen.Rose Personal Information redacted by the USI
  Margaret.Mullan Personal Information redacted by the USI
  Andrea.Cunningham Personal Information redacted by the USI
  Barry.Fletcher Personal Information redacted by the USI
  Sean.Lavery Personal Information redacted by the USI
  CiaranT.McCann Personal Information redacted by the USI
  Ann.Haugh Personal Information redacted by the USI
  LauraJ.Irwin Personal Information redacted by the USI
  Kate.Newell Personal Information redacted by the USI
  Julie.Toman Personal Information redacted by the USI
  Vicki.Graham Personal Information redacted by the USI
  Wendy.kelly Personal Information redacted by the USI

- Gynae MDM GP letters and MDM reports to be printed by Sarah McDonald, no longer print the Regional reports. Tracker to inform Sarah when they are ready for printing.
- Dr McCracken signs the GP letters, unless he is off & Dr Currie chairs the meeting.

GYNAE TRACKING/TARGETS:

Hysteroscopy & other diagnostics are to be performed by **day 20** from date of referral. Tracker to inform scheduler Lee Hamilton of target (ext: Personal Information redacted). Or for outpatient Hysteroscopy inform Anne-Marie Kennedy of target (ext: Personal Information redacted). If Hysteroscopy cannot be booked by day 20 - tracker to escalate.
MRI's are usually performed on Monday & will be discussed on Tuesday at MDM.
CAH surgery targets to be emailed to scheduler Lee Hamilton.

DHH target dates to be emailed to appropriate secretary:
Dr J Acheson, secretary: Dympna McIllroy
Mr D.Sim, secretaries: Lorraine McEneaney & Marie Jennings (job share)
Mr R.deCourcy-Wheeler, secretary: Angela Quinn
Dr K.McKinney, secretary: Carmel O'Hanlon
Dr K.Loane, secretary: Carmel O'Hanlon
Dr Kamath, secretary: Kathryn Hanna

GYNAE MDM ATTENDEES

DATE _____

PRESENT **APOLOGIES**

Please tick name if present

Dr G McCracken	_____
Dr A Currie	_____
Dr M Kamath	_____
Mr D Sim	_____
Dr C McGalie	_____
Dr R Shah	_____
Dr A Carson	_____
Dr L Johnston	_____
Dr B Adams	_____
Dr E Boggs	_____
Dr M Cosgrove	_____
Dr S Finnegan	_____
Dr T Hadjieva	_____
Dr NA Henderson	_____
Dr A Knox	_____
Dr T McCormick	_____
Dr G McKeown	_____
Dr R Sharma	_____
Dr H Sidhu	_____
Dr O Morris	_____
Dr T Anderson	_____
Jill Clarke	_____
Hazel McBurney	_____
Josephine O'Connor	_____
Sr Valerie Webb	_____
Sharon Quinn	_____
Stephanie Reid	_____
Wendy Kelly	_____
Cancer Tracker	_____
Band 3	_____

Gynae MDT

Tuesday 5th May 2015 @ 1.00pm

Tutorial Room 1 - MEC

PRESENT

Dr G McCracken (chair), Dr A Currie, Dr R Shah,
Dr M Kamath, Dr E Boggs, Dr A Carson, Dr L Johnston,
Valerie Webb, Sharon Quinn, Dr S Finnegan, Jill Clarke,
Dr N Kanwal, Dr A Knox, Marie Dabbous, Wendy Kelly (minutes)

MINUTES

1 APOLOGIES

N/A

2 MINUTES OF LAST MEETING

E-mailed to Gynae core members 29/04/15.

3 PATIENTS TO BE DISCUSSED

Patients were discussed as per patient list. There were 2 additional patients discussed:

- Personal Information redacted by the USI (Dr Loane) - Personal Information redacted by the USI Personal Information redacted by the USI lady was referred because of an incidental finding of dye uptake at PET for nodes in the lung. Her smears are up to date and normal. She had Menopause 25 years ago. She has no Gynae Complaints. She is otherwise fit and well. Endometrium was 11.55 mm. Hysteroscopy & biopsy 29/04/15. MDM ACTION: Pathology reports Grade I Endometrial carcinoma. Dr Loane to organise staging MRI scan.

- Personal Information redacted by the USI (Dr Currie) - Personal Information redacted by the USI with known VIN. Symptomatic. Vulval skin excision 21/04/15: VIN

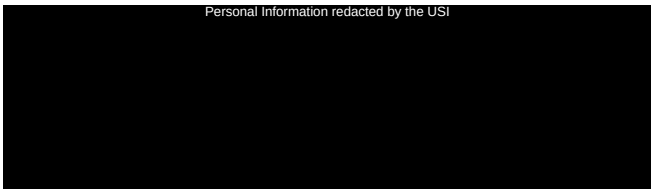
III, there is a tiny focus of well differentiated squamous cell carcinoma measuring 0.4 mm thick and 0.3 mm. Stage pT1a. MDM ACTION: To be discussed at Regional Gynae MDM.

4 NUMBER OF PATIENTS DISCUSSED:
13

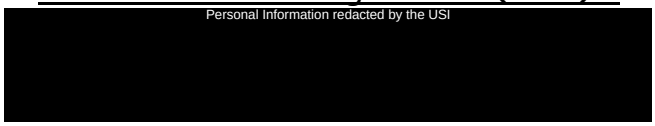
5 DATE OF TIME OF NEXT MEETING

Next Gynae MDM is **Tuesday 12/05/2015 @ 1.pm**, which will be held in Tutorial Room 1 MEC.

6 ANY OTHER BUSINESS
Audit of review appointments following MDM:
Dr McCracken's Clinic tomorrow:



Dr Currie & Dr Finnegan Clinic (Tues):



Southern Health and Social Care Trust

Quality Care - for you, with you

DRAFT

ADMINISTRATIVE & CLERICAL Standard Operating Procedure No.

Title	Urology Multi-disciplinary Administrative Process	
S.O.P. Number		
Version Number	v1.0	**Supersedes:** v0.1
Author	Pg 2-4 SOP Pg 5 Checklist Pg 6 Attendance Pg 7-8 Email List Pg 8 Minutes template	
Page Count		
Date of Implementation		
Date of Review		**To be Reviewed by: OSL's**
Approved by		

Urology Multi-disciplinary Meeting (MDM) Administrative Process

The Urology MDM is held every **Thursday** at **2.15 pm** in the Tutorial Room. MEC and video-conferences to the Consultant Oncologists in Belfast City Hospital.

The meeting membership consists of:
Consultant Urologist
Consultant Oncologists
Consultant Radiologists
Associate Specialists
Consultant Pathologist
Specialist Urology Nurse
GP with specialist interest
Palliative Care Nurse
MDT Co-Ordinator

All emails lists are attached see pages

1. Pre Meeting Work

Patient names will be emailed to the tracker from Prostate Assessment Clinic, Urology Nurse Specialist, Haematuria clinic DHH, Secretaries/ Audio typist, Surgery lists and Consultants to be added for discussion to the next appropriate Urology MDM.

The tracker will also schedule any patients who they feel are ready for discussion following results.

Summary contains: Summary from Consultant, any previous MDM information and outcomes, Radiology, Pathology (date & conclusion/Histology only), Prostate volume, eGFR.

Tuesday email preview list to pathology (see email list) asking will all pathology be ready in time for the MDM, move any that pathology say will not be ready to next week's meeting.

The day before the MDM, if Mr O'Brien is Chair, he has requested an MDM update report on every patient and pathology printed out and put into a folder to allow time for preparation prior to the meeting. Tracker prints off the individual MDM update.

Any patients listed for discussion of radiology that is not reported by Wednesday morning, move to next week's meeting.

Cut off time for adding patients to MDM is Tuesday lunch time.

Copy of the patient list emailed to **MDM Urology members** on the Wednesday at 1.00pm. Check if there is a Medical Rep(G:drive/Cancer Trackers/Urology) to attend meeting and advise of this in email.

After final checks on Thursday morning, advise Clerical officer MDM Preview List is ready to print.

Laptop only goes to the meeting.

2. Meeting Work

The Urology MDM is held in the Medical Education Centre (MEC), Tutorial Room 1 (First Floor). Set out Patient Preview List and attendance sheet (see attached).

Start up the laptop. Turn on desktop using generic login (Displayed on wall) and **Password:** Personal Information redacted by the USI . Turn on TV's using remote. Dial into virtual room – Personal Information redacted by the USI for DHH Consultant to be able to link in. Ensure presentation button has been pressed before meeting commences.

A few minutes before 3pm hang up on DHH and then dial into Personal Information redacted by the USI to link into Belfast.

Urology MDM outcomes are taken as notes during meeting (Chair to advise outcomes). Outcomes will be dictated by the Chair.

3. Post Meeting work

Update attendance.

Send individual email to each Urology Secretaries and cc Urology Nurses (see email list) listing any patients for review appointment – patient name and Hospital number.

Ensure all outcomes and pathology have been entered and MDM report and GP letter boxes have been ticked in the 'Referral and Further Details' section on Capps, and save.

MDM Update Report to be emailed out to all **MDM Urology members**.

Tracker to advise Clerical Officer GP letters & MDM reports are ready for printing.

Copy & paste final outcome Diary

Individually MDM reports are emailed to:

a) Daisy Hill Secretary (see list) with Daisy Hill patients.

Complete MDM minutes and email to all **MDM Urology members**.

Checklist

Urology Checklist	
Monday	
Tracking	
Add any patients required and update info	
Tuesday	
Send pathology preview list requesting notification of any that won't be ready	
Cut off for add on's is lunchtime	
Wednesday	
Update any final pathology & Radiology	
Remove any patients where pathology won't be ready	
Check if Medical Rep is providing lunch, inc in this in preview email	
Send out preview list	
After meeting	
Update any missing information, changes to reports & outcomes	
Email Secretaries all reviews	
Update attendance	
Send out updated MDM report & Minutes	
Advise Clerical officer Letters & Reports are ready to print	

Attendance list

Date:

Urology MDM Attendance	Please Tick √
Mr Glackin	
Mr Haynes	
Mr O'Brien	
Mr O'Donoghue	
Mr Brown	
Mr Young	
Dr Gareth McClean	
Dr Marc Williamson	
Kate O'Neill	
Stephanie Reid	
MDT Co-Ordinator	

Email list

Pathology:	Ann.Ward[redacted]
	Deborah.White[redacted]
	Gareth.McClean[redacted]
	Rajeev.Shah[redacted]
	Christina.Topping[redacted]
MDM Members:	Robin.Brown[redacted]
	Dolores.Campbell[redacted]
	CiaraA.Lyons[redacted]
	maureen.connolly[redacted]
	ursula.cummings[redacted]
	Paulette.Dignam[redacted]
	Noleen.Elliott[redacted]
	anthony.glackin[redacted]
	Vicki.Graham[redacted]
	Leanne.Hanvey[redacted]
	Mark.Haynes[redacted]
	janice.holloway[redacted]
	Jolyne.OHare[redacted]
	Bronagh.Larkin[redacted]
	teresa.loughran[redacted]
	Gareth.McClean[redacted]
	Mark.McClure[redacted]
	Richard.McConville[redacted]
	Kate.McCreesh[redacted]
	Jenny.McMahon[redacted]
	Shauna.McVeigh[redacted]
	aidan.o'brien[redacted]
	JohnP.ODonoghue[redacted]
	kate.oneill[redacted]
	Stephanie.Reid[redacted]
	NicolaJ.Robinson[redacted]
	Rajeev.Shah[redacted]
	patrick.sheridan[redacted]
	Christina.Topping[redacted]
	Elizabeth.Troughton[redacted]
	Matthew.Tyson[redacted]
	Ann.Ward[redacted]
	Deborah.White[redacted]

	Marc.Williams Personal Information redacted by the USI
	Michael.Young Personal Information redacted by the USI
	Cancer.tracker Personal Information redacted by the USI
Urology Nurses:	Dolores.Campbell Personal Information redacted by the USI
	kate.oneill Personal Information redacted by the USI
Clerical Officers:	Sarah.McDonald Personal Information redacted by the USI
	Ryan.Murphy Personal Information redacted by the USI
Radiologist:	Marc.Williams Personal Information redacted by the USI
DHH Consultant:	Robin.Brown Personal Information redacted by the USI
DHH Secretary:	joanne.obrien Personal Information redacted by the USI
Consultants Secretaries:	
Mr Glackin	Elizabeth.Troughton Personal Information redacted by the USI
Mr Young	Paulette.Dignam Personal Information redacted by the USI
Mr O'Brien	Noleen.Elliott Personal Information redacted by the USI
Mr O'Donoghue	NicolaJ.Robinson Personal Information redacted by the USI

MDT ******* CANCER MEETING
Day – DD/MM/YYYY

PRESENT
(Chair

MINUTES

1. APOLOGIES

2. MINUTES OF LAST MEETING

2. PRESENTATION OF CASES
Meeting start time and end time
?? cases were listed to be discussed.
Belfast City linked in.

4. **A.O.B**

5. DATE OF TIME OF NEXT MEETING

Any patients that will require BCG or MMC (Mitomycin C), bladder chemotherapy I e-mail Emma McCann who is a Nurse in 3ESU and advise that patient will be requiring treatment. Janis deals with all chemotherapies in 3ESU but she does not have an e-mail.

1. Oncology referral being e-mailed directly to Dr Houghton @ Belfast Trust and her Secretary, Hazel Cantley and advise that paper copy will follow.

2. Oncology referrals printed off and attached to histopathology report

3. Tracker goes through returned letters and checks that there have been no corrections, if corrections are required to be made, CaPPs is undated, letter's & MDM outcome is reprinted and returned for signing.

4. Tracker checks through MDM outcomes and splits into "CANCER" & "NON CANCER" to be filed into chart by Band 2.

Graham, Vicki

From: Graham, Vicki <[redacted]>
Sent: 22 September 2016 08:57
To: Glenny, Sharon
Subject: RE: 1-1

Yes not a problem as I also have a few meeting scheduled for this morning , catch up at some stage.

Regards,

Vicki

From: Glenny, Sharon
Sent: 21 September 2016 19:49
To: Graham, Vicki
Subject: RE: 1-1

Vicki

I have a few things in my diary at the one time tomorrow morning! Could we do a rain check and possibly later on tomorrow catch up?

Sharon

From: Graham, Vicki
Sent: 21 September 2016 16:57
To: Glenny, Sharon
Subject: 1-1

Hi Sharon,

Just checking if 1-1 is still on in the morning ?

Regards,

Vicki

Graham, Vicki

From: Muldrew, Angela [redacted]
Sent: 03 June 2016 11:37
To: Graham, Vicki
Subject: RE: Update from 1-1 yesterday

Come on down now

Angela Muldrew
RISOH Implementation Officer
Cancer Services
Tel. No. [redacted]

From: Graham, Vicki
Sent: 03 June 2016 11:37
To: Muldrew, Angela
Subject: RE: Update from 1-1 yesterday

Thanks Angela,

Yes I will call down surely and thanks for being so understanding I am just being honest, what time suits?

From: Muldrew, Angela
Sent: 03 June 2016 11:35
To: Graham, Vicki
Subject: RE: Update from 1-1 yesterday

Hi Vicki

[redacted]

Thanks

Angela Muldrew
RISOH Implementation Officer
Cancer Services
Tel. No. [redacted]

From: Graham, Vicki
Sent: 03 June 2016 10:40
To: Muldrew, Angela; Glenny, Sharon
Subject: Update from 1-1 yesterday
Importance: High

Hi Angela/Sharon

[redacted]

Personal Information redacted by the USI

[redacted]

Regards,

Vicki

Cancer Services Co-ordinator
Tracker Office
Ext Personal Information redacted by

Graham, Vicki

Subject: SOP'S
Location: Tracker office

Start: Wed 05/10/2016 15:00
End: Wed 05/10/2016 16:30
Show Time As: Tentative

Recurrence: (none)

Meeting Status: Not yet responded

Organizer: Graham, Vicki

Importance: High

Hi Sarah,

Could we please meet tomorrow (Anytime suits me tomorrow so you can change to a more convenient time that suits you depending on workload) to make a start on the Tumour Site SOP's.

Many thanks,

Vicki

Graham, Vicki

From: Graham, Vicki <[redacted]>
Sent: 18 January 2019 14:39
To: Babes, Leslie; Dabbous, Marie; Shannon, Hilda; Kelly, Wendy; McCartney, Rachel; McVeigh, Shauna; Moore, SarahM; Turkington, Ann E; White, Griania
Subject: Failsafe to ensure all patients are relisted for MDM discussion (Tracked & Not Tracked Patients)
Attachments: Failsafe to ensure all patients are relisted for MDM discussion (Tracked & Not Tracked Patients).docx

Importance: High

Hi,

Following on from our informal meeting please see attached SOP that has been drafted up by me and approved by Sharon today. This SOP came about as a recommendation following a Datix (IR1 Form) that was completed back in November. Could you please read over it and ensure that this is followed. This document is to protect all tracking team staff members, and so that you have the assurance that all patients who need listed for discussion are listed.

Regards

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

ADMINISTRATIVE & CLERICAL
Standard Operating Procedure
No.

Title	Failsafe to ensure all patients are relisted for MDM discussion. (Tracked & Not Tracked Patients)	
S.O.P. Number		
Version Number	v1.0	Supersedes: v0.1
Author	Vicki Graham	
Page Count	2	
Date of Implementation	November 2018	
Date of Review	November 2020	To be Reviewed by: Vicki Graham
Approved by	Sharon Glenny January 2019	

The purpose of this SOP is to ensure that all patients are relisted for MDM discussion, if indicated, following MDM Discussion.

- Patient Tracker/MDT Co-ordinator updates each individual MDM outcome for each patient.
- The outcome is added into the MDM Action Section (Which can be found at the bottom right hand side of Capp's MDM section)
- For each individual patient, once outcomes have been input please follow below steps.
- Tick on Referral and Further Details drop down box.
- Select MDM report
- Select GP Letter
- Select Draft option for GP Letter
- If a further discussion has been indicated you can enter this date in under the Next MDM Discussion section.
- Select the Grey button – Save + Generate Letters

The new Failsafe applies to all tumour sites and must be completed following each MDM by whoever covered the meeting.

- Once all MDM outcomes have been added in for each patient from the MDM Patient Preview List, with all the written outcomes, each patient is checked to ensure that all patients that are to be relisted for MDM Discussion have been added on again for discussion. Tick and initial to how that patient has been listed for re-discussion.
- Keep the MDM Patient Preview List for your own record for 2 years following MDM discussion for your own record.

Graham, Vicki

From: Graham, Vicki <[redacted]>
Sent: 23 January 2017 13:19
To: Corrigan, Martina
Subject: FW:Urology Escalation - [redacted] - Suspect.

Importance: High

Hi Martina,

Please see below patient who is at risk of breaching due to delay with 1st OPD - Day 32, and then subsequent delays with review following MDM, the flexible ureteroscopy being performed on Day 70, patient will be a definite breach if cancer is confirmed.

Regards,

Vicki

From: McVeigh, Shauna
Sent: 23 January 2017 11:29
To: Glenny, Sharon
Cc: Graham, Vicki
Subject: [redacted]

Hi,

Please see escalation of patient that Is currently on day 52 of his pathway, delay with 1st outpatient wasn't seen until day 32. Had CT performed prior to outpatient appointment – day 17. CT was suspicious for TCC, he was listed for MDM with report – day 34. Delay with review being booked post MDM had chased this up with Noleen, Mr Jacob secretary, review was booked (15 day wait post MDM). He was reviewed and has now been appointed for 10.02.17 for RF flexible ureteroscopy, this patient will be a definite breach if cancer is confirmed which is highly likely.

[redacted] [redacted] [redacted]

Day	Date	Event
17	19/12/2016	CT at (unknown)
32	03/01/2017	First Seen at Craigavon
33	04/01/2017	Patient requires MDM discussion - summary provided.
34	05/01/2017	MDM Action : Discussed at Urology MDM 05.01.17. For review with Mr Jacob to recommend RF flexible ureteroscopy.
40	11/01/2017	No review has been booked post MDM have chased this up with Noleen Mr Jacob secretary.
46	17/01/2017	Review has been for 20.01.17 (15 day wait post MDM) - will escalate this patient as he is at high risk of breaching. Secretary advised this was the earliest Mr Jacob had.
52	23/01/2017	Patient was reviewed on 20.01.17 and has been booked for flexible ureteroscopy for 10.02.17 - was advised this is next available - patient will be a definite breach if cancer is confirmed. Will escalate patient to OSL.
	10/02/2017	RF Flexible ureteroscopy to be performed.

Thanks

Shauna

Shauna Mcveigh
Cancer tracker / MDT Co-ordinator
Extension - Personal Information redacted

Graham, Vicki

From: Graham, Vicki [redacted] >
Sent: 24 December 2015 15:02
To: Davies, Caroline L
Cc: ri[redacted]; Corrigan, Martina
Subject: FW: UROLOGY ESCALATIONS

Importance: High

Follow Up Flag: Follow up
Flag Status: Flagged

Hi,

Please see below response from Martina regarding urology escalation – could patient please be contacted for Wednesday 30th as per below email?

Many thanks,

Vicki

From: Corrigan, Martina
Sent: 24 December 2015 15:01
To: Graham, Vicki
Cc: Clayton, Wendy; Glenny, Sharon; Young, Michael; ONeill, Kate; McMahon, Jenny
Subject: RE: UROLOGY ESCALATIONS

Thanks – Mr Young had said he could see some next Wednesday PM (30th).

Can you book into 2:00 and 2:30?? I have clinic set up on PAS.

Thanks again

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: [redacted]
Mobile: [redacted]
Email: [redacted]

From: Graham, Vicki
Sent: 24 December 2015 14:56
To: Corrigan, Martina
Cc: Clayton, Wendy; Glenny, Sharon
Subject: FW: UROLOGY ESCALATIONS
Importance: High

Martina,

Please see below escalations for your information.

Regards,

Vicki

From: rf Personal Information redacted by the USI
Sent: 24 December 2015 13:21
To: Graham, Vicki
Subject: UROLOGY ESCALATIONS

Hi Vicki the following patients are going to breach their first appointment deadline:

Personal Information redacted by USI DNA'd appointment on 14.12.15 booked to CDMHTDU 06.01.15 (HAEMATURIA) D23
Personal Information redacted by USI booked to CMDHTDU 06.01.15 D19

Regards Caroline

Red Flag Appointments.

Personal Information redacted by USI

Graham, Vicki

From: Glenny, Sharon [redacted]
Sent: 08 March 2018 09:00
To: ODonoghue, JohnP; Corrigan, Martina
Cc: McVeigh, Shauna; Graham, Vicki; Reddick, Fiona; Robinson, NicolaJ
Subject: RE: Urology escalation - [redacted]

That's no problem John, we are following normal escalation policy for cancer pathway but I am happy to copy you into any escalations specifically for your patients.

Kind regards

Sharon

From: ODonoghue, JohnP
Sent: 07 March 2018 17:30
To: Corrigan, Martina
Cc: McVeigh, Shauna; Graham, Vicki; Reddick, Fiona; Glenny, Sharon; Robinson, NicolaJ
Subject: RE: Urology escalation - [redacted]

Sharon,
This email is also intended for you, if I haven't replied promptly there is a very good reason.
In this case the email was opened and inadvertently not replied to. I generally reply very quickly!
Email me directly without having to go through this indirect route !
Regards,
John O'Donoghue

From: Corrigan, Martina
Sent: 07 March 2018 13:21
To: ODonoghue, JohnP
Cc: McVeigh, Shauna; Graham, Vicki; Reddick, Fiona; Glenny, Sharon; Robinson, NicolaJ
Subject: RE: Urology escalation - [redacted]

Hi John,

Can you advise please?

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

INTERNAL: EXT [redacted]
EXTERNAL : [redacted]
Mobile: [redacted]

From: Glenny, Sharon
Sent: 07 March 2018 12:27
To: Corrigan, Martina

Cc: McVeigh, Shauna; Graham, Vicki; Reddick, Fiona
Subject: FW: Urology escalation - [redacted]

Hi Martina

Please see urology escalation below – this patient is currently D45 and MRI is suspicious of tumour - we are awaiting response from Mr O'Donoghue regarding this patient proceeding to TRUSB. Any assistance you can offer would be greatly appreciated.

Regards

Sharon

From: McVeigh, Shauna
Sent: 07 March 2018 12:14
To: Glenny, Sharon
Cc: Graham, Vicki
Subject: FW: Urology escalation - [redacted]

Hi,

Please see update on this patient who is on day 48 of his pathway. He had his MRI performed and there was a delay in it being reported, it has now been reported and it is suspicious for tumour, had emailed the report to Mr O'Donoghue to ask is he to proceed to TRUSB, response awaited, no request for biopsy. He is at high risk of breaching if cancer is confirmed which is likely.

29 16/02/2018 MRI(Expected on 16/02/18) at Craigavon
34 21/02/2018 Await MRI to be reported Will email radiology to get MRI reported.
41 28/02/2018 MRI reported - The examination is degraded by patient movement and is of reduced diagnostic quality. Probable (PIRADS 5) tumour within the peripheral zone of the left gland apex. No gross evidence of extracapsular extension within the limitations of movement artefact. Nonspecific (PIRADS 3) signal change elsewhere within the peripheral zone. Dilatation of the left mid and distal ureter. Low T2 signal change in the posterior bladder is thought to be artifactual.
41 28/02/2018 Patient most likely requires a biopsy will email JOD to advise of report. Patient has been escalated to OSL.
45 04/03/2018 No response from JOD nothing booked on PAS and no biopsy request on system.

Thanks

Shauna

From: McVeigh, Shauna
Sent: 14 February 2018 16:17
To: Glenny, Sharon
Cc: Graham, Vicki [redacted]
Subject: Urology escalation - [redacted]

Hi,

Please see escalation of patient that is a suspect cancer and is on day 27 of his pathway, 1st OP he was seen on day 12. An adjustment was added for waiting on repeat PSA, following this an MRI scan was requested and this has been appointed for day 29, (14 day wait). He may require a TRUS biopsy depending on MRI findings. He could be at risk of breaching if cancer is confirmed.

[redacted]

Day Date Event

12 22/01/2018 First Seen at Daisy Hill
13 23/01/2018 Suspension Start : Suspension - Medical Await PSA
13 24/01/2018 Clinic outcome 22.01.18 - I have rechecked his PSA today and if it is still elevated I will get an MRI of his prostate. I have also given him an information leaflet on prostate biopsies.
13 31/01/2018 Suspension End : Suspension - Medical Await PSA
14 01/02/2018 Patients PSA remains elevated - have advised JOD as clinic letter had advised an MRI would be requested.
15 02/02/2018 JOD advised that MRI has been requested - don't see the request on sectra as yet.
22 09/02/2018 MRI has been appointed for 16.02.18.
27 14/02/2018 MRI is to be performed on 16.02.18 (14 day wait for scan) will escalate this patient to OSL at risk of breaching if cancer is confirmed.
29 16/02/2018 MRI(Expected on 16/02/18) at Craigavon

Thanks

Shauna

Shauna Mcveigh
Cancer Tracker / MDT Co-ordinator
Ext Personal Information redacted by the

Graham, Vicki

From: Graham, Vicki [redacted]
Sent: 06 September 2019 09:58
To: Nelson, Amie
Subject: RE: Lower GI Escalations - A/W Investigations

Hey Amie

I know, you try and make improvements in one part of the pathway and it impacts on other areas ! Pressures at every step of the way ☹

Talk soon,

Vicki

From: Nelson, Amie
Sent: 06 September 2019 09:55
To: Graham, Vicki
Subject: RE: Lower GI Escalations - A/W Investigations

Thank you!!

Looks like our virtual clinic to reduce the first appt waiting time has scuppered us…solve one problem, create another.

Amie

From: Graham, Vicki
Sent: 06 September 2019 09:43
To: Nelson, Amie
Cc: Glenny, Sharon; Reddick, Fiona; Clayton, Wendy; Conway, Barry; Carroll, Ronan; Lee, Sinead
Subject: FW: Lower GI Escalations - A/W Investigations
Importance: High

Hi Amie,

Please see below patients who have been delayed in their pathway due to 1st OPD and the capacity issues with scopes. The below dates were the next available.

I will keep you updated if any of these patients continue on RF pathway following scopes.

Regards,

Vicki
Cancer Services Co-ordinator
Telephone: [redacted]

From: Lee, Sinead
Sent: 05 September 2019 18:36

To: Graham, Vicki
Subject: Lower GI Escalations - A/W Investigations

Vicki,

Please see below escalations for patients awaiting investigations:

Site : Lower GI
Name : Personal Information redacted by the USI
Casenote : Personal Information redacted by the USI
HCN Personal Information redacted by the USI
Trust First Seen : Southern
Trust First Treated : No Trust First Treated Recorded

Day	Date	Event
0	15/07/2019	Suspect Cancer 'Red Flag' referral from GP referred to South Tyrone
0	15/07/2019	AWAITING FIRST APPT.
7	22/07/2019	Awaiting first appointment to be booked.
25	09/08/2019	Awaiting first appointment to be booked.
39	23/08/2019	CAKNSUR APPT 050919 ESCALATED DAY 58
52	*05/09/2019*	*For RF OGD & Colon as per clinic. TCI - 05/10/19. Day 82. Escalated to CSC.*
52	**05/09/2019**	**First Seen** at South Tyrone

Site : Lower GI
Name : Personal Information redacted by the USI
Casenote : Personal Information redacted by the USI
HCN Personal Information redacted by the USI
Trust First Seen : Southern
Trust First Treated : No Trust First Treated Recorded

Day	Date	Event
0	15/07/2019	Suspect Cancer 'Red Flag' referral from GP referred to Craigavon
2	17/07/2019	AWAITING AN APPOINTMENT
4	19/07/2019	Awaiting appointment to be booked.
25	09/08/2019	Awaiting first appointment to be booked.
39	23/08/2019	CAKNSUR APPT 050919 ESCALATED DAY 58
52	*05/09/2019*	*For RF OGD and Colonoscopy as per clinic. TCI - 02/10/19. Day 79. Escalated to CSC.*
52	**05/09/2019**	**First Seen** at Craigavon

Site : Lower GI
Name : Personal Information redacted by the USI
Casenote : Personal Information redacted by the USI
HCN Personal Information redacted by the USI
Trust First Seen : Southern
Trust First Treated : No Trust First Treated Recorded

Day	Date	Event
0	22/07/2019	Consultant Upgrade to 'Red Flag' referred to Craigavon
8	30/07/2019	Other referred to Craigavon
39	30/08/2019	FOR VIRTUAL CLINIC WITH MR MCKAY 01.09.19
41	**01/09/2019**	**First Seen** at Craigavon
45	*05/09/2019*	*Virtual Clinic outcome - For RF Colonoscopy. TCI - 28.09.19 - Day 68. Escalated to CSC.*

Site : Lower GI
Name : Personal Information redacted by the USI
Casenote : Personal Information redacted by the USI

HCN [redacted]
Trust First Seen : Southern
Trust First Treated : No Trust First Treated Recorded

Day	Date	Event
0	22/07/2019	Consultant Upgrade to 'Red Flag' referred to Craigavon
39	30/08/2019	FOR VIRTUAL CLINIC WITH MR MCKAY 01.09.19
41	**01/09/2019**	**First Seen** at Craigavon
45	*05/09/2019*	*Virtual Clinic outcome - For RF Colonoscopy. TCI - 09.09.19 - Day 49. Escalated to CSC.*

Site : Lower GI
Name : [redacted]
Casenote : [redacted]
HCN [redacted]
Trust First Seen : Southern
Trust First Treated : No Trust First Treated Recorded

Day	Date	Event
0	22/07/2019	Suspect Cancer 'Red Flag' referral from GP referred to Daisy Hill
39	30/08/2019	FOR VIRTUAL CLINIC WITH MR MCKAY 01.09.19
41	**01/09/2019**	**First Seen** at Craigavon
45	*05/09/2019*	*Virtual Clinic outcome - For RF Colonoscopy. TCI - 24.09.19 - Day 64. Escalated to CSC.*

Site : Lower GI
Name : [redacted]
Casenote : [redacted]
HCN [redacted]
Trust First Seen : Southern
Trust First Treated : No Trust First Treated Recorded

Day	Date	Event
0	22/07/2019	Suspect Cancer 'Red Flag' referral from GP referred to Daisy Hill
39	30/08/2019	FOR VIRTUAL CLINIC WITH MR MCKAY 01.09.19
41	**01/09/2019**	**First Seen** at Craigavon
45	*05/09/2019*	*Virtual Clinic outcome - For RF Colonoscopy. TCI - 24.09.19 - Day 64. Escalated to CSC.*

Site : Lower GI
Name : [redacted]
Casenote : [redacted]
HCN [redacted]
Trust First Seen : Southern
Trust First Treated : No Trust First Treated Recorded

Day	Date	Event
0	22/07/2019	Suspect Cancer 'Red Flag' referral from GP referred to Daisy Hill
39	30/08/2019	FOR VIRTUAL CLINIC WITH MR MCKAY 01.09.19
41	**01/09/2019**	**First Seen** at Craigavon
45	*05/09/2019*	*Virtual Clinic outcome - For RF Colonoscopy. TCI - 24.09.19 - Day 64. Escalated to CSC.*

Site : Lower GI
Name : [redacted]
Casenote : [redacted]
HCN [redacted]
Trust First Seen : Southern
Trust First Treated : No Trust First Treated Recorded

Day	Date	Event
0	22/07/2019	Suspect Cancer 'Red Flag' referral from GP referred to Craigavon
3	25/07/2019	AWAITING APPOINTMENT
7	29/07/2019	Awaiting first appointment to be booked.
39	30/08/2019	FOR VIRTUAL CLINIC WITH MR MCKAY 01.09.19
41	**01/09/2019**	**First Seen** at Craigavon
45	*05/09/2019*	*Virtual Clinic outcome - For RF Colonoscopy. TCI - 30.09.19 - Day 70. Escalated to CSC.*

Site : Lower GI
Name : Personal Information redacted by the USI
Casenote : Personal Information redacted by the USI
HCN Personal Information redacted by the USI
Trust First Seen : Southern
Trust First Treated : No Trust First Treated Recorded

Day	Date	Event
0	22/07/2019	Consultant Upgrade to 'Red Flag' referred to Daisy Hill
39	30/08/2019	FOR VIRTUAL CLINIC WITH MR MCKAY 01.09.19
41	**01/09/2019**	**First Seen** at Craigavon
45	*05/09/2019*	*Virtual Clinic outcome - For RF OGD & Colonoscopy. TCI - 24.09.19 - Day 64. Escalated to CSC.*

Site : Lower GI
Name : Personal Information redacted by the USI
Casenote : Personal Information redacted by the USI
HCN Personal Information redacted by the USI
Trust First Seen : Southern
Trust First Treated : No Trust First Treated Recorded

Day	Date	Event
0	22/07/2019	Suspect Cancer 'Red Flag' referral from GP referred to Craigavon
3	25/07/2019	AWAITING APPOINTMENT
7	29/07/2019	Awaiting first appointment to be booked.
39	30/08/2019	FOR VIRTUAL CLINIC WITH MR MCKAY 01.09.19
41	**01/09/2019**	**First Seen** at Craigavon
45	*05/09/2019*	*Virtual Clinic outcome - For RF Flexi Sig. TCI - 16.09.19 - Day 56. Escalated to CSC.*

Site : Lower GI
Name : Personal Information redacted by the USI
Casenote : Personal Information redacted by the USI
HCN Personal Information redacted by the USI
Trust First Seen : Southern
Trust First Treated : No Trust First Treated Recorded

Day	Date	Event
0	22/07/2019	Suspect Cancer 'Red Flag' referral from GP referred to Craigavon
2	24/07/2019	AWAITING APPOINTMENT
7	29/07/2019	Awaiting first appointment to be booked.
39	30/08/2019	FOR VIRTUAL CLINIC WITH MR MCKAY 01.09.19
41	**01/09/2019**	**First Seen** at Craigavon
45	*05/09/2019*	*Virtual Clinic outcome - For RF Flexi Sig. TCI - 16.09.19 - Day 56. Escalated to CSC.*

Site : Lower GI
Name : Personal Information redacted by the USI
Casenote : Personal Information redacted by the USI
HCN Personal Information redacted by the USI

Trust First Seen : Southern
Trust First Treated : No Trust First Treated Recorded

Day	Date	Event
0	23/07/2019	Suspect Cancer 'Red Flag' referral from GP referred to Daisy Hill
38	30/08/2019	FOR VIRTUAL CLINIC WITH MR MCKAY 01.09.19
40	**01/09/2019**	**First Seen** at Craigavon
44	*05/09/2019*	*Virtual Clinic outcome - For RF Flexi Sig. TCI - 19.09.19 - Day 58. Escalated to CSC.*

Site : Lower GI
Name : Personal Information redacted by the USI
Casenote : Personal Information redacted by the USI
HCN Personal Information redacted by the USI
Trust First Seen : Southern
Trust First Treated : No Trust First Treated Recorded

Day	Date	Event
0	23/07/2019	Suspect Cancer 'Red Flag' referral from GP referred to Daisy Hill
38	30/08/2019	FOR VIRTUAL CLINIC WITH MR MCKAY 01.09.19
40	**01/09/2019**	**First Seen** at Craigavon
41	02/09/2019	Suspension Start : Suspension - Patient Reasons Cancelled due to social arrangements
41	*05/09/2019*	*Virtual Clinic outcome - For RF Colonoscopy. TCI - 04.10.19 - Day 66. Escalated to CSC.*
41	09/09/2019	Suspension End : Suspension - Patient Reasons Cancelled due to social arrangements

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Site : Lower GI
Name : Personal Information redacted by the USI
Casenote : Personal Information redacted by the USI
HCN Personal Information redacted by the USI
Trust First Seen : Southern
Trust First Treated : No Trust First Treated Recorded

Day	Date	Event
0	24/07/2019	Suspect Cancer 'Red Flag' referral from GP referred to Craigavon
2	26/07/2019	AWAITING APPOINTMENT
7	31/07/2019	Awaiting first appointment to be booked.
30	23/08/2019	Still awaiting date for first appointment.
37	30/08/2019	FOR VIRTUAL CLINIC WITH MR MCKAY 01.09.19
39	**01/09/2019**	**First Seen** at Craigavon
43	*05/09/2019*	*Virtual Clinic outcome - For RF OGD & Colonoscopy. TCI - 28.09.19 - Day 66. Escalated to CSC.*

Site : Lower GI
Name : Personal Information redacted by the USI
Casenote : Personal Information redacted by the USI
HCN Personal Information redacted by the USI
Trust First Seen : Southern
Trust First Treated : No Trust First Treated Recorded

Day	Date	Event
0	24/07/2019	Suspect Cancer 'Red Flag' referral from GP referred to Craigavon
1	25/07/2019	AWAITING APPOINTMENT
5	29/07/2019	Awaiting first appointment to be booked.
30	23/08/2019	Still awaiting date for first appointment.
37	30/08/2019	FOR VIRTUAL CLINIC WITH MR MCKAY 01.09.19
39	**01/09/2019**	**First Seen** at Craigavon
43	*05/09/2019*	*Virtual Clinic outcome - For RF CT AP - 11.09.19.*

Site : Lower GI
Name : Personal Information redacted by the USI
Casenote : Personal Information redacted by the USI
HCN Personal Information redacted by the USI
Trust First Seen : Southern
Trust First Treated : No Trust First Treated Recorded

Day	Date	Event
0	23/07/2019	Suspect Cancer 'Red Flag' referral from GP referred to Craigavon
2	25/07/2019	AWAITING APPOINTMENT
6	29/07/2019	Awaiting first appointment to be booked.
38	30/08/2019	FOR VIRTUAL CLINIC WITH MR MCKAY 01.09.19
40	**01/09/2019**	**First Seen** at Craigavon
44	*05/09/2019*	*Virtual Clinic outcome - For RF OGD & Colonoscopy. TCI - 25.09.19 - Day 64. Escalated to CSC.*

Site : Lower GI
Name : Personal Information redacted by the USI
Casenote : Personal Information redacted by the USI
HCN Personal Information redacted by the USI
Trust First Seen : Southern
Trust First Treated : No Trust First Treated Recorded

Day	Date	Event
0	23/07/2019	Suspect Cancer 'Red Flag' referral from GP referred to Daisy Hill
38	30/08/2019	FOR VIRTUAL CLINIC WITH MR MCKAY 01.09.19
40	**01/09/2019**	**First Seen** at Craigavon
44	*05/09/2019*	*Virtual Clinic outcome - For RF Colonoscopy. TCI - 24.09.19 - Day 63. Escalated to CSC.*

Site : Lower GI
Name : Personal Information redacted by the USI
Casenote : Personal Information redacted by the USI
HCN Personal Information redacted by the USI
Trust First Seen : Southern
Trust First Treated : No Trust First Treated Recorded

Day	Date	Event
0	18/07/2019	Suspect Cancer 'Red Flag' referral from GP referred to Craigavon
6	24/07/2019	AWAITING APPOINTMENT
11	29/07/2019	Awaiting first appointment to be booked.
28	15/08/2019	Still awaiting date for first appointment.
43	30/08/2019	FOR VIRTUAL CLINIC WITH MR MCKAY 31.08.19
44	**31/08/2019**	**First Seen** at Craigavon
49	*05/09/2019*	*Virtual Clinic outcome - For RF OGD and biopsies and review at DMK clinic end of sept. TCI - 13.09.19 - Day 57. Escalated to CSC.*

Site : Lower GI
Name : Personal Information redacted by the USI
Casenote : Personal Information redacted by the USI
HCN Personal Information redacted by the USI
Trust First Seen : Southern
Trust First Treated : No Trust First Treated Recorded

Day	Date	Event
0	18/07/2019	Suspect Cancer 'Red Flag' referral from GP referred to Daisy Hill

27 14/08/2019 Awaiting first appointment to be booked.
43 30/08/2019 FOR VIRTUAL CLINIC WITH MR MCKAY 31.08.19
44 31/08/2019 First Seen at Daisy Hill
45 01/09/2019 Suspension Start : Patient Cancelled (CNA) Patient offered 03/09/19 but cancelled
45 03/09/2019 RF CTC has been requested at time of virtual clinic. CTC request outsourced to IS to be performed on 03.09.19.
45 05/09/2019 CTC - 16/09/19 - Day 46. Escalated to CSC.
45 15/09/2019 Suspension End : Patient Cancelled (CNA) Patient offered 03/09/19 but cancelled

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Site : Lower GI
Name : Personal Information redacted by the USI
Casenote : Personal Information redacted by the USI
HCN Personal Information redacted by the USI
Trust First Seen : Southern
Trust First Treated : No Trust First Treated Recorded

Day Date Event
0 18/07/2019 Suspect Cancer 'Red Flag' referral from GP referred to Craigavon
6 24/07/2019 AWAITING APPOINTMENT
11 29/07/2019 Awaiting first appointment to be booked.
28 15/08/2019 Still awaiting date for first appointment.
43 30/08/2019 FOR VIRTUAL WITH MR MCKAY 31.08.19
44 31/08/2019 First Seen at Craigavon
47 03/09/2019 RF CTC requested at time of virtual clinic on 31.08.19 - This has been outsourced to 352 on 03.09.19 to be performed. This is to be appointed.
49 05/09/2019 CTC - 26.09.19 - Day 70. Escalated to CSC

Site : Lower GI
Name : Personal Information redacted by the USI
Casenote : Personal Information redacted by the USI
HCN Personal Information redacted by the USI
Trust First Seen : Southern
Trust First Treated : No Trust First Treated Recorded

Day Date Event
0 19/07/2019 Suspect Cancer 'Red Flag' referral from GP referred to Banbridge
26 14/08/2019 Awaiting first appointment to be booked.
42 30/08/2019 FOR VIRTUAL CLINIC WITH MR MCKAY 31.08.19
43 31/08/2019 First Seen at Banbridge
48 05/09/2019 Virtual Clinic outcome - For RF Colonoscopy. TCI - 27.09.19 - Day 70. Escalated to CSC.

Site : Lower GI
Name : Personal Information redacted by the USI
Casenote : Personal Information redacted by the USI
HCN Personal Information redacted by the USI
Trust First Seen : Southern
Trust First Treated : No Trust First Treated Recorded

Day Date Event
0 19/07/2019 Suspect Cancer 'Red Flag' referral from GP referred to Craigavon
5 24/07/2019 AWAITING APPOINTMENT
10 29/07/2019 Awaiting first appointment to be booked.
28 16/08/2019 Still awaiting date for first appointment.
42 30/08/2019 FOR VIRTUAL CLINIC WITH MR MCKAY 31.08.19
43 31/08/2019 First Seen at Craigavon

46 03/09/2019 RF CTC requested at time of virtual clinic - CTC outsourced to IS on 03.09.19 - to be appointed.
48 05/09/2019 CTC - 13.09.19 - Day 56. Escalated to CSC.

Site : Lower GI
Name : Personal Information redacted by the USI
Casenote : Personal Information redacted by the USI
HCN Personal Information redacted by the USI
Trust First Seen : Southern
Trust First Treated : No Trust First Treated Recorded

Day	Date	Event
0	19/07/2019	Suspect Cancer 'Red Flag' referral from GP referred to Craigavon
5	24/07/2019	AWAITING APPOINTMENT
10	29/07/2019	Awaiting first appointment to be booked.
28	16/08/2019	Still awaiting date for first appointment.
42	30/08/2019	FOR VIRTUAL CLINIC WITH MR MCKAY 31.08.19
43	**31/08/2019**	**First Seen** at Craigavon
46	03/09/2019	RF CTC requested at time of virtual clinic - outsourced CTC on 03.09.19 to be performed - to be appointed.
48	*05/09/2019*	*CTC - 13.09.19 - Day 56. Escalated to CSC.*

Site : Lower GI
Name : Personal Information redacted by the USI
Casenote : Personal Information redacted by the USI
HCN Personal Information redacted by the USI
Trust First Seen : Southern
Trust First Treated : No Trust First Treated Recorded

Day	Date	Event
0	19/07/2019	Suspect Cancer 'Red Flag' referral from GP referred to Craigavon
5	24/07/2019	AWAITING APPOINTMENT
10	29/07/2019	Awaiting first appointment to be booked.
28	16/08/2019	Still awaiting date for first appointment.
42	30/08/2019	FOR VIRTUAL CLINIC WITH MR MCKAY 31.08.19
43	**31/08/2019**	**First Seen** at Craigavon
46	03/09/2019	RF CTC requested at time of virtual clinic - outsourced to 352 03.09.19 to be performed.
48	*05/09/2019*	*CTC - 12.09.19 - Day 55. Escalated to CSC.*

Sinéad Catherine Joanne Lee
Cancer Tracker/MDT Co-ordinator

✉ **Southern Health & Social Care Trust**
Cancer Trackers Office
Basement
Craigavon Area Hospital
Lurgan Road, Portadown

☎ **Ext.** Personal Information redacted by the USI
Personal Information redacted by the USI

Graham, Vicki

From: Reddick, Fiona <Personal Information redacted by the USI>
Sent: 09 February 2018 15:21
To: Graham, Vicki; Glenny, Sharon
Subject: meeting Monday

Hi Vicki/Sharon

Unfortunately I have ben sked to attend a meeting on Monday from 2-4pm and relay need to attend this. I am keen to meet on mondya as I am on leave fr a few days next week and want to talk through a few things prior to leave to include

- Stacy's post
- Personal Information maternity cover
- Escalation Policy
- Personal Information redacted by the USI patient – Datix
- Skin MDT proposal vc link to regional and then local
- Escalation policy
- Cancer Performance ahead of monthly meeting Thursday

Would you both be available at 12 midday to meet instead

Regards

Fiona

Fiona Reddick
Fiona Reddick
Head of Cancer Services
Southern Health and Social Care Trust
Macmillan Building
Personal Information redacted by the USI
Personal Information redacted by the USI

Graham, Vicki

From: Graham, Vicki <Personal Information redacted by the USI>
Sent: 23 May 2014 13:24
To: McCleery, Sharon
Subject: RE: Oncology referral - Personal Information redacted by the USI

You too !

Vicki

From: McCleery, Sharon [Personal Information redacted by the USI]
Sent: 23 May 2014 13:07
To: Graham, Vicki
Subject: RE: Oncology referral - Personal Information redacted by the USI

Great

Enjoy the long weekend J

From: Graham, Vicki [Personal Information redacted by the USI]
Sent: 23 May 2014 13:07
To: McCleery, Sharon
Subject: RE: Oncology referral - Personal Information redacted by the USI

Thanks Sharon,

No problem, I will leave this will Urology Nurse Specialist's as they will be present when patient is being reviewed on 02.06.14.

Thanks again,

Vicki

From: McCleery, Sharon [Personal Information redacted by the USI]
Sent: 23 May 2014 12:16
To: Graham, Vicki
Subject: RE: Oncology referral - Personal Information redacted by the USI
Importance: High

Hi Vicki

Looking a massive favour our doctors say this referral is urgent and want to see him asap after he is told his diagnosis ie 03rd June the day after. I have scanned our appointment letter to you and would it be possible for to you make sure this is given to him at his appointment with Mr Glackin as obviously we can't send it?

Thanks

Sharon

From: Graham, Vicki [Personal Information redacted by the USI]
Sent: 22 May 2014 17:18

To: McCleery, Sharon
Subject: Oncology referral - Personal Information redacted by the USI
Importance: High

Hi Sharon,

Please see Oncology referral following MDM today. Please note that patient will not be reviewed by Mr Glackin until 02.06.14 so patient will not be aware of diagnosis until then.

Many thanks,

Vicki

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Meeting with RF Appointment Staff Monday 27th April 2015 @ 11.15am

Seminar Room, Mandeville Unit

Present: Vicki Graham, Marie Dabbous, Caroline Davies, Carol Ritchie, Diane Davidson

Chair: Angela Muldrew

	Action
Angela welcomed everyone and advised that this was a brief meeting to discuss the changes that are due to happen over the next couple of weeks. Rota of detailed changes including new seating arrangement has been emailed out to all staff. Marie is to be released from adding patients on for discussion on a weekly basis, but will be there for support in times of leave/sick. Marie will then be able to concentrate on the booking of RF General Surgery & Gastro appointments. The main areas discussed were –	
Vicki to check with Kelly/Rachel regarding the putting on of Breast Clinic patients & when Marie can stop adding these on for discussion.	Vicki to update Marie on Kelly's training & when she is happy to add Breast packs on herself. It is anticipated that this will happen over the next week or so.
Training of new sites	
Diane is to sit with Aisling over the next week for training of Gynae & ENT sites.	
Marie to sit with Diane for up to date training on General Surgery & Gastro processes.	Caroline to hold x2 slots per session when releasing slots to RBC until further notice.
Aisling to complete SOP on 'others' tumour site.	
From week commencing 4th May that Carol's new hours (over Tuesday & Wednesday) are to commence. Patricia Watt is aware of these new hours and is in agreement. Caroline is to pick up on Carol's work over this time.	Vicki to check with Aisling is SOP is complete for ENT & Gynae sites.
CCG Printing & ORE'ing	
New seating plan was discussed and all were happy with new arrangements. Vicki had included Carol to ORE on a Monday PM, but on discussion this will be changed as Vicki mentioned that she would prefer book to remain in the General Office, to reduce the risk of referrals being lost/misplaced.	Vicki to revise ORE'ing rota and circulate to Band 3 Staff. Phone Rota is also to be included.

Angela advised that when you are down for ORE'ing that this is what you are solely to do. No phone calls are to be dealt with to minimise disruption/distraction so that full concentration is given at all times. While this new process will be time consuming Angela advised that this is what Ronan Carroll wants to be done for each and every RF referral. Angela also advised to remember with regards to printing of CCG referrals to make sure that is x number is printed that x number print out. ? Process in Daisy Hill Hospital with regards to spreadsheet. Skin referrals only require to be logged onto Telederm spreadsheet as long as referrals are logged in red book. All phone calls are to be dealt with by whoever is on rota for that time period, regardless of site. This will be good experience for all tumour sites. The process is to remain the same for Breast referrals – that these are brought straight round to RBC. Angela advised that is any referral is not back from triage on Day 4 that they are to be escalated.	If all referrals are ORE'd, spreadsheet is updated you are able to catch up on your own workload. Vicki to update red book with a column for being added to spreadsheet. Vicki to check with Wendy regarding process for Daisy Hill Hospital.
<u>RBC Cover</u> RBC cover is to begin each morning @ 09.00 for Caroline on a Wednesday, Carol on Thursday & Diane on a Friday. Angela asked at this point if everyone was happy with the changes. All staff agreed that they were. Angela advised that a file is to be used for RF appointments. This is to keep referrals separate i.e. triage, appointments to be booked, escalations etc. Vicki is to check at the end of the week if a file is being used by individual members of staff, and that this will be monitored to ensure standardised work.	Diane advised that she uses file & sleeves. Angela advised that these are to be no longer used as a way of keeping referrals. All referrals in sleeve are to be filed in file by the end of the week.

Caroline raised that due to limited space that the files are being kept in the trays for referrals. Caroline feels that these should be placed beside referrals tray. All files are to be clearly marked (Tumour Site) New process for Ophthalmology has been agreed by Wendy Clayton. This was emailed to Band 3's on Friday 24.04.15 **Teamwork** Angela discussed the merits of teamwork and that everyone has to comply and work along with each other, and that is times of annual leave/sick leave that this is when it needs to be applied, and that everyone has to help out and that the work does not fall on one person. Angela also reiterated that all leave is to be discussed as a team and is agreed before contacting Vicki with request. All leave has to be approved before anything can be booked. **AOB** Emails are to be read and actioned on a regular basis and cannot be left for long periods of time before responding. Vicki advised all staff to use calendar tool on Microsoft outlook to help prevent meetings/training being missed. Angela advised of a new training sheet to be completed for all staff. Vicki is currently working on this and will be completed by the end of the week. **New processes** Angela at the end of the meeting reiterated the new processes, and the reason that these have been implemented was due to a recent serious incident, and advised that if any member of staff is advised of anything like this i.e. from GP surgery /secretary that they are to inform Vicki/Angela immediately of what has happened so that they can investigate fully and make OSL & Head of Cancer Services aware that something might happen instead of once it has happened.	Files to be placed beside referral trays.

Clear Desk Policy Vicki has asked that a clear desk policy is adhered to among all staff to reduce the risk of referrals being lost. **PAS Awareness Session** Angela advised that the PAS Awareness Session which was scheduled for 01.05.15 has been cancelled and new date will be circulated.	

Tracker Meeting
Cancer & Clinical Services Division
23rd March 2016 @ 09.00am
Seminar Room, Mandeville Unit

Present

Vicki Graham (Minutes)	Wendy Kelly	Shauna McVeigh
Griania White	Kelly George	Rachel McCartney

Apologies

Ann Turkington

Minutes of Previous Minutes
Minutes of previous meeting were agreed.

Trust Excellence Award
Vicki advised that the Tracking Team has been nominated for the behind the scenes award. This is a great privilege to be nominated and that it reflects all the hard work and dedication that the trackers put into their work, which is greatly appreciated. Vicki thanked the trackers for all their hard work. Tracking Team are to be updated on nomination status once finalists have been decided.

Change of OSL
Vicki advised that Sharon Glenny will be taking over from Wendy Clayton from 01.04.16, along with Heather Troughton, who will be the new Assistant Director for Cancer & Clinical Services.

Tracking
Vicki advised the team to scan down all of the patients on the tracking list and looks out for the boxes that are empty and have no 1st OPD entered. While it is the appointment staff responsibility to appoint and escalate 1st OPD if this cannot be booked by Day 10-14, and while they try to update 1st OPD date in CaPP's [redacted] staff will be very short and could be down to 1WTE, and this duty may not be completed. Having the 1st OPD added is a great help to the tracker but it is the trackers responsibility for all patients on the tracking list and scanning down for empty boxes is a failsafe to ensure that no one has progressed along pathway without being tracked.

Personal Information redacted by the USI

CaPP's – If you see something has been downgraded on PAS or added to the waiting list this can be downgraded on Capps.

MDM Cover
Vicki circulated tracker MDM cover for the next few months, including the summer holidays, and has asked that trackers familiarise themselves with meetings and the processes before and after MDT that they are due to cover, or could be asked to cover in periods of annual leave and sickness.

Escalation Policy – Vicki circulated the escalation policy along with the agenda for this morning's meeting. This is to be referred to when tracking.

Kettle & Toaster – Angela had attended fire training and advised that these are to be kept in a kitchen setting only due to being a fire risk Fire safety offices will be carrying out on the spot checks.

Easter Leave – Was circulated to all trackers and all were happy with arranged cover and time off work.

Annual Leave

No annual leave requests

AOB

Kelly & Rachel advised that the Radiologists' were having difficulties in displaying the images on desktop from NIPACS. There has been a recent NIPACS update performed and perhaps the desktop is not compatible or needs to be updated to correct version. Vicki is to log with IT.

Update – Vicki has logged this with IT and will update.

Date of Next Meeting – Wednesday 20th April @ 09.00am – Seminar Room – Mandeville Unit

Tracker Meeting
Cancer & Clinical Services Division
Monday 2 April 2012 @ 1000h
Venue Tutorial Room 2, MEC

Present

Angela Montgomery (Chair)	Ann Turkington (notes)	Shauna McVeigh
Sharon Reid	Hilda Shannon	Vicki Graham
Wendy Kelly	Marie Dabbous	Sarah McDonald

1. Apologies

Alison Blakely
Lesley-Ann Brown
Alison Porter
Wendy Clayton

2. Minutes of Previous Minutes

Notes of last week's meeting not yet available.

3. ITT Patient discussions & Escalations

See attached.

4. Risk Areas:

As before.

Recent PET waiting times – around 2 weeks.

Faxing patient details is no longer allowed, as per new Trust policy. This will impact on sending PET requests as PET office will not accept emailed requests. Issue to be discussed at Lung MDM this week. There will be an impact also with respect to Oncology and forwarding referrals to STH (clinic prep and DSU) and DHH.

First appointments – ENT, Lung, General Surgery, Urology, Gynae

5. Breaches

March performance is currently standing at:

62-day	89.2%	31-day 97.1%	14-day breast 100%
Target	95%	98%	

All patients completing in March should be closed by end of day on Thursday. Breach reports to be prepared also by Thursday. Angela to circulate list of names of breaches.

6. Overtime and Tracking Update

Gynae and Haem up-to-date; Skin is behind
Upper and Lower up-to-date
Lung – around 95% tracked; Head & Neck – 62-days up-to-date, 31-days – mostly fine
Urology – up-to-date. Vicki to look at Day 4 times from Friday.
Breast and others up-to-date.

Angela to speak to Jane Scott re getting Breast letters typed at DHH.

Angela advised that suspect cancers with a benign pathology should be closed. If any doubt exists, tracker should speak to a clinician.

Shauna, Marie and Lesley-Ann are unlikely to be able to go to every MDM but they will attend when they are able to.

7. Annual Leave

Vicki off Wednesday, Thursday and Friday.
Sarah off on Thursday.
Shauna off from Tuesday to Friday.
Hilda off W/C 07.05.12.
Sharon off next week.

8. AOB

Skin MDM to start on 10.05.12 at the earliest.

Hilda offered to take on Gynae when Skin MDM starts. Angela will look at workloads.

Sarah and Alison are to divide their workload, with each taking responsibility for specific sites.

9. Date of Next Meeting

Next Trackers' meeting will take place on 16.04.12.

Graham, Vicki

From: McAlister, Linda < Personal Information redacted by the USI >
Sent: 27 April 2016 17:55
To: Glenny, Sharon; Clayton, Wendy; Meredith, Lorraine; Scott, Jane M; Barron, Caroline; Graham, Vicki; Meredith, Lorraine; Muldrew, Angela; Park, Denise; Reaney, Gillian
Subject: A&C mtg 29.4.16
Attachments: CCS ATICS Admin Staff meeting 190216.docx

Notes of previous meeting on 19th February as attached.

Regards.

Linda McAlister
Service Administrator
Pathology & Laboratory Service
Tel Personal Information redacted by the USI

From: Clayton, Wendy
Sent: 27 April 2016 10:27
To: Meredith, Lorraine; Scott, Jane M; Barron, Caroline; Graham, Vicki; McAlister, Linda; Meredith, Lorraine; Muldrew, Angela; Park, Denise; Reaney, Gillian
Cc: Glenny, Sharon
Subject: Agenda A&C mtg 29.4.16

Dear all

Please find attached agenda for Friday's Admin Managers meeting which is scheduled for:

Friday, 29th April 2016
11am
Meeting Room, Admin Floor, CAH

Kind regards

Wendy Clayton
Operational Support Lead
Southern Trust

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

CCS/ATICS Admin Staff Meeting

Notes of meeting held Friday 19th February 2016 at 11am
Meeting Room, Admin Floor, CAH (VC Available)

Present:
Wendy Clayton Angela Muldrew Vicki Graham
Lorraine Meredith Gillian Reaney Caroline Barron Linda McAlister

Agenda	Discussions	Action
Apologies	Denise Park	
Finance/Budgets	Wendy reviewed Financial Performance Report Month 09- December 2015 as previously circulated to administrators. Non recurring allocations referenced, not as much anticipated to be available in forthcoming year. Current agency staff contracts to be reviewed and retained where possible if vacancies exist.	**All**
Performance Access targets	**End of Financial Year 15/16** With Easter falling at end of March close down expected to be 24/25th March – all attendances and disposals to be complete in all areas. Breakdown of performance targets for each area discussed. Wendy requested if possible that all PTLs are booked by 25th March. • Gillian's IS PTLs to be reset – reasonable offers to be made by 18th March. • Ultra sound additional sessions being booked – review position on Friday.	
HR Issues	**DHH** 1 agency due to leave today 1 vacancy **ATICS** 4 agency 1 vacancy **Radiology** 2 agency If long term sick continues agency staff to be retained. **Labs** 3 vacancies 2 long term sick – OH referral advised **Cancer**: 2 agency 6 bank 1 vacancy to be filled next Tuesday	Gillian Linda

	1 long term sick **Breast Screening** 1 Bank Discussions followed re recruitment via EOI and possible retention of some staff recruited against winter pressures. Wendy to communicate further with Caroline and Mary on these matters. Flexibility of contracts to be checked for transfer of agency to bank.	 Wendy & Caroline All
Operational Issues	**Standard Operational Procedures:** SOPs to be reviewed and distributed to all staff including agency as required. **Complaints:** Training completed by Service Administrators. Wendy has supply of leaflets if required for cascade training. Gillian and Caroline to work on specific training suitable for radiology staff. Advice to be sought from Vivienne Kerr as necessary	 All All Gillian & Caroline
PAS Working Group	Data Quality Report has been run – no real change. Plan remains to move to Patient Centre. New starts are being trained on Patient Centre rather than PAS. Patient Centre training to be organised for Vicki and Caroline.	 Vicki & Caroline
LEAN	Further action postponed for 6 months.	
KSF	Ongoing within all areas.	All
AOB	• NIECR – Lorraine's requests via Infra Portal referred to Kate Cunningham; ongoing. Gillian stated that her request on behalf of reception staff was denied as available info was "too sensitive" for staffing group. Correspondence to be sent to Wendy for follow up.	 Gillian
Date of Next Meeting	Meeting scheduled for 22nd April postponed to Friday 29th April 2016 at 11am in Meeting Room.	

Graham, Vicki

From: Graham, Vicki <Personal Information redacted by the USI>
Sent: 28 January 2016 11:32
To: Clayton, Wendy; Muldrew, Angela
Subject: RE: UGI & LGI tracking

Wendy,

Griania is happy to do overtime and will let me know prior to doing this. Rachel is happy to come in on a Monday and Tuesday from 9-12 for the next while (This will be claimed as time). I will stay on some nights if required,

Regards,

Vicki

Cancer Services Co-Ordinator
Mandeville Unit
Telephone: Personal Information

From: Clayton, Wendy
Sent: 28 January 2016 11:01
To: Muldrew, Angela; Graham, Vicki
Subject: RE: UGI & LGI tracking

Thanks Angela

Vicki – can you see if any of the Trackers are available for overtime to do LGI/UGI tracking please?

Regards

Wendy Clayton
Operational Support Lead
Cancer & Clinical Services / ATICs
Southern Trust

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

From: Muldrew, Angela
Sent: 28 January 2016 10:47
To: Clayton, Wendy
Subject: UGI & LGI tracking

Wendy

Just to let you know it unlikely that I will be able to look at any LGI & UGI tracking over the next couple of weeks as I have retesting and processing mapping to complete for RISOH and then I am out of the office week commencing 8th Feb (annual leave 8th – 10 February then CaPPS meeting on 11th and possible RISOH on 12th)

Thanks

Angela Muldrew
RISOH Implementation Officer
Tel. No. Personal Information redacted by the USI

Red Flag Pathway

Previously requested information from Cancer Centre: -

Belfast agreed protocol for confirmed prostate cancer patient who are under surveillance is - 3 monthly PSA and DRE, with a repeat TRUS @ 2 years. This is based on the Royal Marsden protocol.

Reasons for changing to active treatment are PSA doubling time < 3 years, upgrade or significant increase in tumour volume on repeat TRUS.

RED FLAG PATIENTS-

Red flag patients - 62 day patients (Yellow paper)

Cancer Tracker is only aware of patients who have been referred in by GP via Red Flag fax machine- These are called 62 day patients and are downloaded onto Capp's system automatically via PAS. Please see breakdown of pathway.

Date of 1st OPD - Day 10 - 14

Diagnostics - Day 20 - Diagnostics are to be performed & patient to be discussed @ MDM with findings so that if a patient s care is to be transferred that this is to be done by Day 28. (Prostate patients are medically suspended from date of biopsy for 6 weeks to allow time to healing (clock restarts after this period)

Date of decision to treat - Ideally this is to be made by day 28 from date of referral. This is when a patient is informed of management plan. All tests have been carried out prior to this consultation. There are 31 days from the date decision to treat until the target date for 1st definitive treatment. The date decision to treat can occur at any stage through pathway (31 day target within a 62 day pathway)

1st Definitive treatment - To be performed before or on target date any later and this is a breach.

31 Day patients - Clock does not start until cancer is confirmed.

A 31 day patient is someone who is referred from Consultant to Consultant or via A&E.

If a patient is in theatre and findings are suspicious – contact tracker as it is most likely that she will not be aware of patient if it is an incidental finding.

If you see a patient at clinic and patient's status is upgraded to RF please notify tracker of patient's details so information can be added to Capps and patient can then be tracked, otherwise tracker will not be aware of patient and will not be tracked.

All confirmed cancers are only tacked until patient has had their first definitive treatment-

Bladder Tumours - Surgery

Renal cell carcinoma – Surgery/ Active Monitoring

Testicular - Surgery

Prostate - Treatment options can be hormones, radiotherapy, brachytherapy, surgery. Once a patient has had any of these this is deemed first definitive treatment and patient will be closed on the Capps system as pathway complete.

If patient has had 1st definitive treatment, please notify me if you would like any patient discussed.

My contact details are-

Vicki Graham- Personal Information redacted by the USI

Direct line Personal informatio

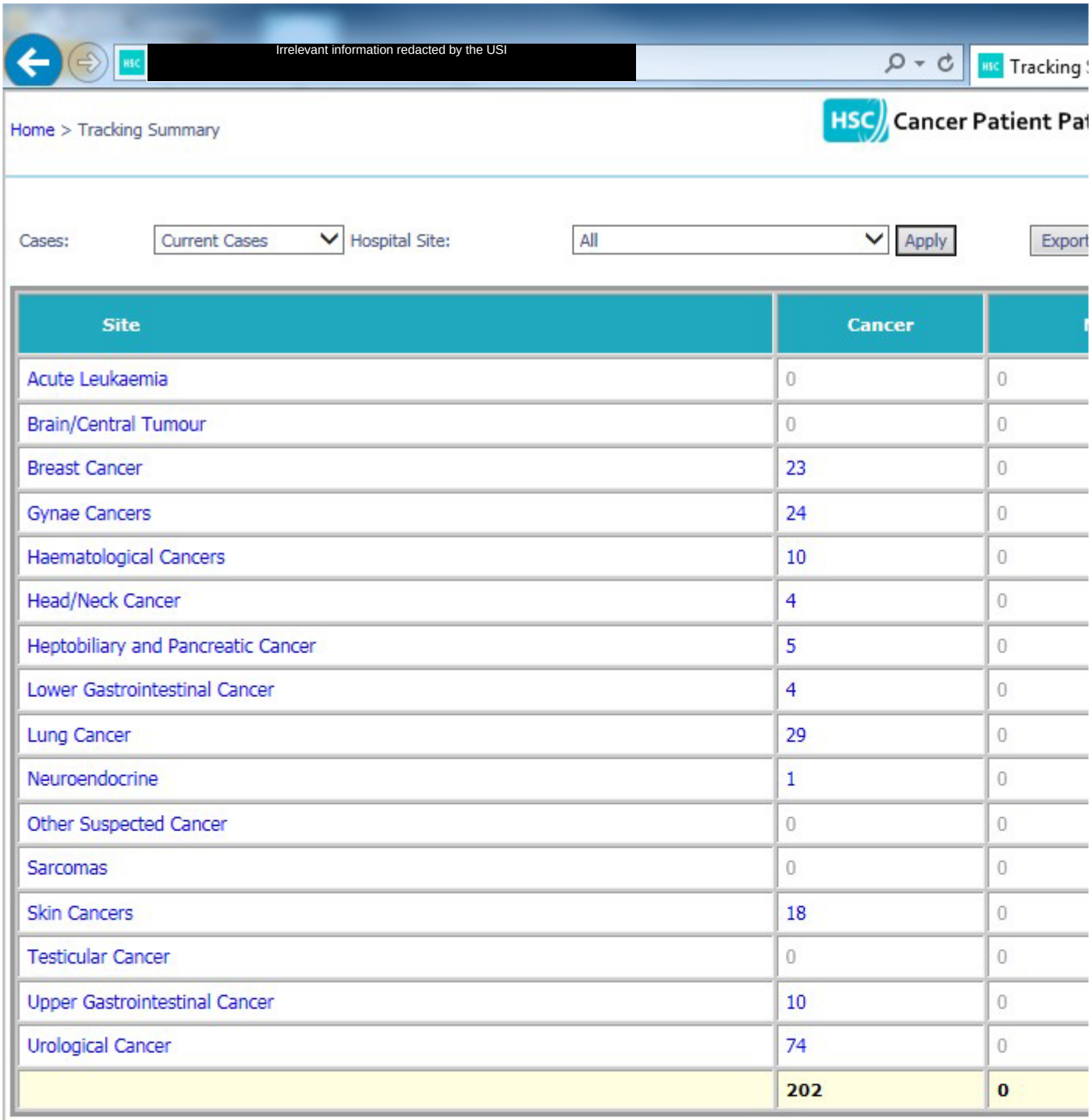
Graham, Vicki

From: Graham, Vicki [redacted]
Sent: 03 September 2019 14:43
To: Glenny, Sharon
Subject: RE: Tracking Update W/E 30.08.19

Importance: High

Hi Sharon

Just wondering if an email has been sent out to the HoS's and AD's advising of current situation with tracking. I am just very worried about some sites, especially LGI as it has not hit over 1000+ patients – I never remember it as big as this, and skin is now up at 443, with Urology and UGI also in the 400's - these numbers are huge.



Site	Cancer	
Acute Leukaemia	0	0
Brain/Central Tumour	0	0
Breast Cancer	23	0
Gynae Cancers	24	0
Haematological Cancers	10	0
Head/Neck Cancer	4	0
Heptobiliary and Pancreatic Cancer	5	0
Lower Gastrointestinal Cancer	4	0
Lung Cancer	29	0
Neuroendocrine	1	0
Other Suspected Cancer	0	0
Sarcomas	0	0
Skin Cancers	18	0
Testicular Cancer	0	0
Upper Gastrointestinal Cancer	10	0
Urological Cancer	74	0
	202	**0**

Many thanks,
Vicki

From: Graham, Vicki
Sent: 02 September 2019 16:29
To: Glenny, Sharon; Reddick, Fiona
Subject: RE: Tracking Update W/E 30.08.19
Importance: High

Afternoon,

Please see below tracking update as of Friday 30.08.19. The tracking team remain under a lot of pressure due to on-going sick and annual leave in the team. This has resulted in a lot of cross cover, with the focus solely being on MDM prep and then attending the MDM's and the MDM outcomes. Below is a rough guide as to where we are at now. No site at present is really fully up to date. Unfortunately I have no other staff members from any areas that could help out due to not being trained in this area. The tracker team as a whole is a risk area. This could impact on performance further as tracking will not be up to date.

[redacted]

Tracker MDT cover for over the next few weeks.

Day		Meeting to be covered	Cover	Comment
Monday	02/09/2019	[redacted]		Ann, Hilda & Sarah A/L [redacted]
Tuesday	03/09/2019			Ann & Hilda A/L - [redacted]
Wednesday	04/09/2019			Hilda A/L - [redacted]
Thursday	05/09/2019	UGI & LGI	Wendy	Hilda & Shauna A/L - [redacted]
Thursday	05/09/2019	Skin	Sarah	Hilda & Shauna A/L - [redacted]
Thursday	05/09/2019	Urology	Sinead	Hilda & Shauna A/L - [redacted]
Friday	06/09/2019			Hilda & Shauna A/L - [redacted]
Monday	09/09/2019	[redacted]		[redacted]
Tuesday	10/09/2019			
Wednesday	11/09/2019			
Thursday	12/09/2019	Skin	Sarah	
Friday	13/09/2019			
Monday	16/09/2019	[redacted]		[redacted] &Wendy A/L
Tuesday	17/09/2019	Gynae		Wendy A/L
Wednesday	18/09/2019			Wendy A/L
Thursday	19/09/2019			Wendy A/L
Friday	20/09/2019			Wendy A/L

Tracking Update as of 02.09.19 as per tracking team.

Marie – Head & Neck – ENT - Tracking - About 60% up to date. Notifications – 5.5 pages to do.

Others – Tracking – About 80% up to date. Notifications – 1.5 pages to do
Brain – Full track – Up to date.
Marie helped put on patient's summary for skin MDM and covered the Urology MDM, put on the outcomes, did the review emails, after-work

Wendy – Gynae & UGI **– 14 ½ pages of notifications on UGI still to do, working through them today & Wednesday. Gynae was up to date on Friday 30.08.19 – 1.5 pages of notifications today.**

Shauna – Urology – **About 1 week behind now due to being on a week's leave. Shauna is on leave Thursday & Friday this week.**

Sinead – **Haematology & LGI - Had no time for tracking this week, though I did look through Upper, Lower and Haem tracking for OC and old referrals to make sure none is missed.**
Sinead helped out/covered the below areas-- Lung MDM 28.09.19 – Completed
Skin MDM 29.08.19 – Completed
Regional Skin MDM 05.09.19 – I have added on patients and requested their charts.
Lung MDM 04.09.19 - I am just awaiting on scans and pathology's and its ready for Ann coming back next week. I have sent out the list for charts.
Urology MDM 05.09.19 – I will start working on this on Monday.

Hilda – LGI – **At least 1.5 week's behind due to annual leave**

Griania – Skin – **At least 2 week's behind** Personal Information redacted by the USI **& tracker who has been assigned to help cover site is on leave. Due back tomorrow.**

Catherine – Breast –**1 week behind** Personal Information redacted by the USI

Ann – Lung – **1 week behind due to annual leave.**

Regards,

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

From: Graham, Vicki
Sent: 27 August 2019 12:31
To: Glenny, Sharon; Reddick, Fiona
Subject: Tracking Update W/E 23.08.19 & update on Tracking team
Importance: High

Afternoon,

Please see below tracking update as of Friday 23.08.19. Prior to me going on leave at the start of August we were in a good strong place with regards to tracking but unfortunately due to annual leave and sick leave the team have been left quite short and I have advised them that the priority is the MDM's, which has impacted in the tracking. Annual leave and sick leave continues to be on-going in the team so tracking is unlikely to improve for the next couple of weeks unfortunately. I will keep you updated as to how things are progressing, but just to make you aware that things will not be up to date. Would you like me to forward out to the teams or would that be best to come from one of your email?

Sick leave: [redacted] to cover this site I have made a few changes to ensure that her site has been covered in relation to the MDM and possibly tracking (This is a new site for Sarah but she has covered the MDM many times but tracking will be new and have made arrangements to go over this with her as and when required). [redacted] has kindly agreed to increase her hours to 30 per week upon her return to free up Sinead, as she was helping add on patients for MDM and prep the MDM by sending lists to pathology and radiology on these days, so that Sinead can concentrate on the other MDM's that need covered, and if possible carry out some tracking.

I have included the below schedule for trackers, and the cover required to MDM'S for the next couple of weeks.

Day		Meeting to be covered	Cover	
Monday	19/08/2019	[redacted]		Hilda A/L & [redacted]
Tuesday	20/08/2019			Hilda A/L & [redacted]
Wednesday	21/08/2019	Breast	Sinead	Hilda A/L & [redacted]
Thursday	22/08/2019	Skin	Sarah	Hilda A/L & [redacted]
Thursday	22/08/2019	UGI & LGI	Sinead	Hilda A/L & [redacted]
Friday	23/08/2019			Hilda A/L & [redacted]
Monday	26/08/2019	[redacted]		
Tuesday	27/08/2019			Shauna & Sarah A/L & [redacted]
Wednesday	28/08/2019	Lung	Sinead	Shauna & Ann A/L & - [redacted]
Wednesday	28/08/2019	Breast		Shauna & Ann A/L & - [redacted]
Thursday	29/08/2019	Skin	Sinead	Shauna, Ann & Sarah A/
Thursday	29/08/2019	Urology	Marie	Shauna, Ann & Sarah A/
Friday	30/08/2019			Shauna & Ann A/L - [redacted]

Day		Meeting to be covered	Cover	Comment
Monday	02/09/2019	[redacted]		Ann, Hilda & Sarah A/L - [redacted]
Tuesday	03/09/2019			Ann & Hilda A/L - [redacted]
Wednesday	04/09/2019			Hilda A/L - [redacted]
Thursday	05/09/2019	UGI & LGI	Sarah	Hilda & Shauna A/L - [redacted]
Thursday	05/09/2019	Skin	Sarah	
Thursday	05/09/2019	Urology	Sinead	Hilda & Shauna A/L - [redacted]
Friday	06/09/2019			Hilda & Shauna A/L - [redacted]

Tracking Update as of 23.08.19 as per tracking team.

Marie – Head & Neck –Fully up to date – Others, Neuroendocrine = 97% up to date.
Wendy – Gynae & UGI **– Gynae notifications up to date**. **UGI – 5 pages of notifications left – So would not be fully up to date.**
Shauna – Urology – **About 75% up to date (Due to planned leave this week is working on MDM prep for 29.08.19)**
Sinead – **Haematology & LGI – At least 1 week behind due to helping cover other MDM's during periods of annual & sick leave**
Hilda – LGI – **At least 1 week behind due to annual leave**
Griania – Skin – **At least 1 week behind** Personal Information redacted by the USI
Catherine – Breast – **At least 1 week behind** Personal Information redacted by the USI
Ann – Lung – **About 70% up to date (Working on Lung MDM for this week 28.08.19 due to planned leave)**

Please see below Tracking Team and the sites that they are currently covering.

Tracking Sites

Please see below changes for tracking. This is with immediate effect. (Email sent to the team as of last week when made aware of long term sick leave for Personal Information redacted by the)

Marie – Head & Neck (This includes all meetings linked with Head & Neck Site), Others, Sarcoma & Neuroendocrine tracking.
Wendy – Gynae (Tracking & Meeting) & Upper GI Tracking
Shauna – Urology (Tracking & Meeting)
Sinead – Haematology (Tracking & meeting prep) & LGI tracking. Leukaemia (Tracking & meeting)
Hilda – Lower (Tracking & UPGI & LGI meetings)
Personal Information redacted by the USI
Catherine – Breast (Tracking & meeting)
Ann – Lung (Tracking & meeting)
Sarah – Skin (Tracking & MDM Prep) & Urology & Brain tracking.

Regards,

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: 18 May 2015 10:50
To: Muldrew, Angela; Graham, Vicki
Subject: FW: Cancer SOP's
Attachments: Cancer Services SOP List.xlsx

This is great Angela. Once they are all drafted we can sit down and group them into their areas and talk through systematically. Put a date in my diary when you are both ready.

Thanks for all your help.

Regards

Wendy Clayton
Operational Support Lead
Cancer & Clinical Services / ATICs
Southern Trust

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

From: Muldrew, Angela
Sent: 18 May 2015 10:42
To: Clayton, Wendy; Graham, Vicki
Subject: Cancer SOP's

Hi

Find attached a list of SOP's that I think are needed for Cancer Services Admin. Could you review the list and see if there any others that you think we need?

Colour code:
-white - have been reviewed or have been written recently -red – I have emailed Alwyn to update -blue - I will update or write
-pink – Vicki would you be able to look at these?

Regards

Angela Muldrew
RISOH Implementation Officer
Tel. No. Personal Information redacted by the USI

Cancer Services SOP List

Title Of SOP	ApplicableTeam
Admin process for Bowel Cancer Screening	Bowel Screening
Breast Prosthesis Process	Breast Care
Breast Care Nurse SDA Admin Process	Breast Care
Recording patients on PAS who are assigned to the breast self- directed aftercare (SDA) pathway	Breast Care
Rapid Access PAS process for Breast Self- Directed Pathway (SDA) patients	Breast Care
Arranging Review Appointments Post MDM	Cancer Tracker
Communication Process Post MDM	Cancer Tracker
Gynae Multi-disciplinary Administrative Process	Cancer Tracker
Breast Multi-disciplinary Administrative Process	Cancer Tracker
Haematology Multi-disciplinary Administrative Process	Cancer Tracker
Leukaemia MDM	Cancer Tracker
Role of Tracker in Red Flag Radiology notifications	Cancer Tracker
Setting up access to Cancer Tracker Email Account	Cancer Tracker
Lung Multi-disciplinary Administrative Process	Cancer Tracker
Head & Neck Multi-disciplinary Administrative Process	Cancer Tracker
Lower GI (Colorectal) Multi-disciplinary Administrative Process	Cancer Tracker
Upper GI Multi-disciplinary Administrative Process	Cancer Tracker
Urology Multi-disciplinary Administrative Process	Cancer Tracker
Skin Multi-disciplinary Administrative Process	Cancer Tracker
Other Suspect Cancer Multi-disciplinary Administrative Process	Cancer Tracker
Brain Multi-disciplinary Administrative Process	Cancer Tracker
Printing & Filing Documents related to Cancer Multi-disciplinary Meetings (MDM's)	Cancer Tracking Clerical Officer
Mandeville Reception & Back Office Duties	Mandeville Admin
Booking Oncology Clinics held in Mandeville Unit	Mandeville Admin
Haematology & Oncology Clinic Preparation Process	Mandeville Admin
Mandeville Unit Preadmissions (Daycases and Chemo)	Mandeville Admin
Recording Mandeville Unit Ward Attenders	Mandeville Admin
Printing clinic lists from PAS	Mandeville Admin
Printing Labels from PAS	Mandeville Admin
Printing clinic lists using Order comms/Patient Centre	Mandeville Admin
Checking patients in at Mandeville Reception	
Haematology Appointments Booking Process	Mandeville Admin
Orthoptics Administrative & Clerical Duties	Orthoptics
Palliative Medicine Admin Duties	Palliative
Management of Red Flag Outpatient Appointments	RF Appointment
PAS process for booking Red Flag Oral Surgery Outpatient Appointments	RF Appointment
Releasing unused Red Flag slots on outpatient clinics	RF Appointment
Printing of RF CCG Referrals	RF Appointment
RF GP Fax Referrals	RF Appointment
Gynae RF Appointment process	RF Appointment
Urology RF Appointment process	RF Appointment

Gastro/Upper GI RF Appointment process	RF Appointment
General Surgery/Lower GI RF Appointment process	RF Appointment
Lung RF Appointment process	RF Appointment
ENT RF Appointment process	RF Appointment
Brain RF Appointment process	RF Appointment
Haematology RF Appointment process	RF Appointment
Other Suspect Cancer RF Appointment process	RF Appointment
Administrative Assistant duties for Stoma/Coloproctology Nursing Office	Stoma Care

Date of Implementation	Date of Review
May-15	
May-15	
Jan-15	Needs updated - Angela to do
Jun-14	Needs updated - Angela to do
Jun-14	Needs updated - Angela to do
Apr-15	
Apr-15	
May-15	
May-15	
May-15	
May-15	
Nov-14	
May-15	
Oct-14	
May-15	
May-15	
May-15	
May-15	
May-15	
May-15	
Jul-14	May-15
Aug-14	May-15
Needs written- Angela to do	
Needs written- Angela to do	
Dec-14	Needs updated - Angela to do
Jul-13	Emailed to Alwyn to review and update
Mar-14	
Apr-14	May-15
May-15	
Apr-15	
Apr-15	

May-15	

Southern Health and Social Care Trust

Quality Care - for you, with you

DRAFT

ADMINISTRATIVE & CLERICAL Standard Operating Procedure No.

Title	Urology Multi-disciplinary Administrative Process	
S.O.P. Number		
Version Number	v1.0	**Supersedes:** v0.1
Author	Vicki Graham	
Page Count		
Date of Implementation		
Date of Review		**To be Reviewed by: OSL's**
Approved by		

Urology Multi-disciplinary Meeting (MDM) Administrative Process

The Breast MDM is held every Thursday at 2.15 pm in Tutorial Room 1, Medical Education Centre. The meeting membership consists of:

Consultant Urologist
Consultant Oncologists
Consultant Radiologists
Associate Specialists
Consultant Pathologist
Specialist Urology Nurse
GP with specialist interest
Palliative Care Nurse
MDT Co-Ordinator

It is the responsibility of the MDM Co-ordinator to undertake the following tasks to ensure the efficient and smooth running of the meeting:

Patients listed for MDM

There are 6 methods of patients being added to the Urology MDM:

1) Prostate Assessment Clinic: Kate O'Neill, Urology Nurse Specialist e-mails me through a list in advance of planned biopsies and details are added onto Capps if not a 62 day patient. I also receive a confirmation of biopsies performed on the day. Patients are then added to the correct MDM and pathology discussed.

2) Tracking: Whilst updating tracking if there are any patients who have had investigations performed and tracker is unsure of results, or if results are reported and are not normal name is added to MDT to clarify further management.

3) Haematuria clinic DHH: Clinic outcome from haematuria clinic are e-mailed through to tracker. This informs tracker if patient is being discharged or requires further investigations and if patient is needed to be discussed @ MDM.

4) Secretaries/ Audio typist: If typing up a clinic and Doctor has requested for case to be discussed @ MDM, the letter is either e-mailed or posted via internal mail to tracker. Information is then updated onto CaPPs so all relevant information is available for discussion.

5) Surgery lists: Paulette (Mr Young's Secretary) e-mails Tracker through a copy of the scheduled theatre list. This allows tracker to check and add any confirmed cases. Tracker is not included in any other Consultants Theatre list distribution list.
6) Consultants: To discuss change of management plans, results, radiology etc.

7) Mr O'Brien leaves down with Tracker all patient's with updated narrative on patients that he would like discussed. All information is to be copied onto Capps. (Narratives can be quite lengthy)

8) Radiology:-Tracker can be advised of radiology results and details are added so case can be discussed @ MDM as most of these tend to be incidental findings.

9) Cases that are deferred from the previous week's MDM.

Administrative process before MDM

1. Copy of the patient list emailed to Urology Distribution list on the Wednesday at 1.00pm. Cut off time for adding patients to MDM is Tuesday lunch time. Copy list of MDM patients is given to Band 2 to allow time for tracking and requesting charts.

2. List of patients who have to be discussed for radiology results is emailed to Radiologist including clinical background on the patient & why they need discussed. MDM Co-ordinator has a copy of Radiology rota & sends this email to whichever radiologist was on the Assessment clinic that week.

3. On Wednesday, the day before the MDM, Mr O'Brien has requested an MDM update report on every patient and pathology printed out and put into a folder to allow time for preparation prior to the meeting. Tracker prints off the individual MDM update.

4. 8 copies of the patient list are printed off prior to the MDM meeting. (Band 3 when available)

5. Band 2 pulls charts & tracks charts prior to MDM.

6. MDM Co-ordinator goes to Tutorial Room 1 MEC

Administrative process after MDM

1. Go through histopathology & radiological reports for each patient & type results into MDM outcome if these were not available prior to MDM.

2. Update MDM outcomes that has been dictated verbally and hand written down during MDM Copy all MDM discussions into diary.

3. Create Letters & MDM reports.

4. E-mail each Secretary each individual patient's MDM outcome if patient is to be reviewed, added to W/L etc. and advise them what is to be actioned following MDM.

   Mr Glackin: Liz Troughton EXT Personal Information redacted by USI
   Mr Young: Paulette Dignam EXT Personal Information redacted by USI
   Mr O'Brien: Monica McCorry EXT Personal Information redacted by USI

   E-Mail Leanne Hanvey, Urology Specialist Nurse Secretary any patient's names that require Day4 appointments. Leanne EXT Personal Information redacted by USI

   E-mail all DHH outcomes individually to Mr Brown's Secretary, Joanne Brown & advise of what is to be actioned post MDM.

   If there are any ward histologies to be cancelled / appointed I e-mail Sharon McDermott, Ward Clerk in 3ESU.

Any patients that will require BCG or MMC (Mitomycin C), bladder chemotherapy I e-mail Emma McCann who is a Nurse in 3ESU and advise that patient will be requiring treatment. Janis deals with all chemotherapies in 3ESU but she does not have an e-mail.

5. E- Mail MDM update to distribution list once all outcomes are updated.

6. Print off any histopathology reports for patients being referred to oncology.

7. Oncology referral being e-mailed directly to Dr Houghton @ Belfast Trust and her Secretary, Hazel Cantley and advise that paper copy will follow.

8. GP Letter and MDM reports printed for each patient that was discussed. (Band 3 when available)

9. Oncology referrals printed off and attached to histopathology report

10. GP Letters & oncology referrals taken to Mr O'Brien, Chair of Urology MDM to sign on Friday morning. (Band 2) Mr O'Brien usually has a clinic in Thorndale Unit.

11. When documents are signed GP letters are posted out to GP and oncology referrals are posted along with a copy of pathology report to the relevant oncologist.

12. GP letters are photocopied as are oncology referrals and are joined up with MDM outcome and are filed into chart. (Tracker)

13. Tracker goes through returned letters and checks that there have been no corrections, if corrections are required to be made, CaPPs is undated, letter's & MDM outcome is reprinted and returned for signing.

14. Tracker checks through MDM outcomes and splits into "CANCER" & "NON CANCER" to be filed into chart by Band 2.

15. MDM minutes are performed, including number on list, cases discussed etc.

16. MDM minutes are emailed to Urology team.

17. Once the MDM outcome have been filed into medical chart, the tracker goes through each individual chart and has to check, PAS & CaPPs to see if patient is to be re discussed . Each chart is then tracked out to previous location. Tracker re tracks charts back. Most weeks there are between 30-40 charts (This can take at least 1-2 hours.)

18. Tracker brings charts over to Medical Records and slots into appropriate place for return to location)