NHS England

West Midlands Clinical Networks and Clinical Senate

West Midlands Inter Trust Breach Allocation policy

Coversheet for West Midlands Clinical Network Agreed Documentation

This sheet is to accompany all documentation agreed by the West Midlands Strategic Clinical Network Expert Advisory Groups. This will assist the Clinical Network to endorse the documentation and request implementation.

Document Title	West Midlands Inter Trust Breach Allocation Policy	
Published date	October 2016	
Document Purpose	A policy document providing clarification regarding the responsibilities of referring and treating providers in the West Midlands in relation to the national breach allocation guidance.	
Authors	West Midlands Cancer Clinical Network	
References	See Contents page	
Consultation Process	Breach Allocation policy circulated for comment to Stakeholders August 2016 Document discussed and approved at Cancer Trust Managers meeting on 3rd October 2016	
Review Date (must be within three years)	March 2017	
Approval Signatures:	**On behalf of the Trust Cancer Managers**  Jenny Donovan (Chair) Date: 20.10.16	**On behalf of the West Midlands Clinical Network**  Rob Gornall (Clinical Director) Date: 20.10.16

West Midlands Inter Trust Breach Allocation Policy

Version number: 10

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Contents

1 Introduction and purpose

National Breach Allocation Guidance (Appendix A) was published in April 2016, aiming to provide a fairer method of cancer breach allocation when treatment is delayed between referring and treating providers. It requires local policies to be in place by October 2016 that support the achievement of day 38 as a target handover date. This document was produced following a workshop on 21st June 2016 with representatives of providers and commissioners within the West Midlands Clinical Network, as well as representation from the NHS England (West Midlands) Director of Commissioning Operations (DCO) team. It outlines the process for inter-provider transfers within the West Midlands Clinical Network and the principles of breach allocation when transferring patients between Trusts, reflecting the national recommendation for collaborative relationships between referring and treating organisations.

An inter-provider transfer (IPT) involves transferring a patient's care from one provider to another for staging (according to clinical pathway), treatment and follow-up and this guidance applies to all cancer pathways and all sources of referral from 1st October 2016. The aim is that all patients on a cancer pathway are transferred between providers by day 38 or before in order to ensure timely treatment and achievement of the 62 day standard. This applies to both two-provider and multiple provider transfers. This guidance should support a smooth transition for patients into tertiary centres, as well as encouraging transparency and ownership of pathways that enable targeted improvement where a need is identified.

It is recognised that day 38 is easier to deliver for some pathways, for example Skin and Breast, but it is asserted nationally that it should be possible to ensure that the aggregate target is met so that 85% of all cancer patients are treated within this time. Local cancer networks in the West Midlands (for example commissioners, providers, SRGs, vanguard sites) will be required to work together collaboratively to review complex pathways and adopt good practice as outlined in the national guidance. Work will continue across the cancer pathways to improve earlier diagnosis and treatment with locally agreed tumour specific timed pathways to support the national strategic aim of ensuring all people with a suspected cancer are diagnosed within 28 days by 2020.

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

- Patients receive appropriate assessment, diagnosis and treatment within the specified target times
- The patient journey is appropriately monitored, with key events communicated between all providers involved in the patient pathway
- Problems are escalated appropriately and in a timely manner to the relevant staff so that remedial action can be taken
- Breaches are agreed and appropriately allocated between providers as defined in national guidance (April 2016)

This policy document and supporting documentation is available on the West Midlands Clinical Network and Clinical Senate website.

2 Inter Provider Transfers

An IPT occurs when a patient follows a pathway of care that involves a referral and transfer of care to another provider for staging (according to clinical pathway) treatment and follow-up and from all initial referral sources (e.g. GP/GDPs, cancer screening programmes, consultant upgrades onto the 62 day pathway, patients presenting with recurrences and/or metastases). The guidance applies to referrals to all tertiary providers in the West Midlands, including referrals for treatment from Trusts outside the Network.

Currently within the West Midlands there are four main tertiary providers:

- The Royal Wolverhampton NHS Trust
- University Hospitals Birmingham NHS Foundation Trust
- University Hospital of Coventry and Warwickshire NHS Trust
- University Hospitals of North Midlands NHS Trust

Transfers to these Trusts would be treated as a standard/ two-provider inter provider transfer (IPT).

Occasionally a tertiary provider may also then have to transfer a patient onto a specialist provider such as the Royal Orthopaedic Hospital. This is treated as a multi provider transfer.

2.1 Minimum information required for standard referrals

The tertiary alert system will continue and then the clock will start for an IPT once the receiving Trust has received the standard IPT referral form accompanied by:

- Clinical referral letter, including Performance status, BMI, Medical History and Medication, if applicable
- Histology slides and report
- Staging and Radiological Images and report
- Assurance that patient is aware of the referral to another Trust
- Specialist Multi-Disciplinary Team (SMDT) referral form (where appropriate)

It is the responsibility of the referring Trust to complete all relevant patient pathway tests, as outlined in the timed pathways, before transferring the patient. Discussion at MDT should not be delayed if the complete clinical dataset is unavailable, but any resulting transfer of the patient to the tertiary provider must be accompanied by the full set of information. Breaches attributed to failing to provide the complete clinical dataset by day 38 will be allocated to the referring Trust

It is the responsibility of the receiving Trusts to record date of receipt of the histology and other results from the referring Trust. The receiving Trust will confirm when all of the required information has arrived and notify the referring Trust of the clock start date. Contact details are available in Appendix D to facilitate communication regarding outstanding information.

2.2 Referrals to a Specialist Multi-Disciplinary Team (SMDT) meeting

Referrals to a SMDT should include the histology slides and report, the staging and radiological images and report and IPT referral form, if appropriate.

2.3 Referrals for diagnostics and treatment without SMDT discussion

Where a SMDT discussion is not required for referrals for diagnostics and treatment, the clinical referral letter should be accompanied by the IPT referral form, including date of diagnosis and basis of diagnosis where a definitive diagnosis has been confirmed. Treating Trusts should support referring Trusts through agreed communication and collaboration to complete locally agreed diagnostics for site specific pathways as soon as possible. Where staging is not fully completed before referral due to complexity of the tumour pathway, referring Trusts should refer the patient as soon as possible to complete staging in tertiary Trust.

2.4 Referrals back to referring Trusts

Where the decision of the treating Trust is to refer the patient back to their original referrer, best practice would be to complete the referral at the earliest possible opportunity to allow first treatment within the 62 days. The Clinical Network will work with commissioners and providers to identify an agreed Network-wide referral date.

3 Timed Pathways

All cancer providers use day 38 as a maximum handover date to the treating Trust, allowing 24 days for the treating Trust to meet the 62 day target. However, some tumour pathways may require a shorter handover date than day 38 to ensure timely care.

Work has already taken place regionally through clinical workshops to review current pathways. Tumour specific timed pathways have been developed and agreed for Upper Gastroesphageal cancers (see Appendix C) with Head and Neck, Lung and Breast currently in development. It is anticipated that timed pathways will be developed for Urological, Colorectal and Gynaecological cancer in the next 12 months. **At present, these pathways are aspirational and should not be used to determine breach allocation currently.** Timed pathways will reflect the complexity of multi provider pathways for certain tumour groups such as partial staging due to tertiary providers providing complex diagnostics. A referring Trust should aim to transfer a patient with a complex pathway as soon as possible to the tertiary centre to enable them to complete staging and commence treatment within 24 days of receipt of patient.

4 Data protection

Referrals should be sent electronically where possible or faxed to a central point within the receiving Trust. Referrals should include the appropriate clinical information and the correct demographic information to allow the patient to registered at the receiving Trust. Demographic information can be provided by a CaRP form or an IPT form.

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

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

5 Patient tracking

It is the responsibility of all providers to ensure that systems are in place for the effective tracking and navigation of all cancer patients. The originating provider will continue to track the patient once the referral has been made to the tertiary provider.

The tertiary provider will start to track the patient as soon as the IPT form has been received. A patient cannot be listed for an SMDT meeting until the IPT form is received with the minimum agreed information.

The designated person for tracking patients at the originating provider is responsible for ensuring that the Lead Cancer Manager/designated person at the tertiary provider is informed of any key events or potential changes to the target transfer date for any patients that will be referred to that tertiary provider. If any problems arise they should escalate this to their Lead Cancer Manager.

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

the originating Trust has access to the tertiary Trusts' electronic recording system. This returned form is known as the IPT weekly report.

It is encouraged that the use of systems be reinforced by verbal updates between people who are responsible for tracking in provider Trusts.

All providers involved should agree a clear process to communicate essential patient information electronically, escalate any key issues which are likely to impact on patient care and maintain regular contact, preferably weekly, as a minimum requirement. An agreed action plan with timescales should be used to address issues.

6 IPT data capture

In addition to implementation of this local policy, providers are also required to collect IPT data from 1st October 2016. It has been acknowledged nationally that there will be no IT system that can capture complete IPT data until at least April 2017. In the interim, providers and commissioners have agreed a minimum data set to support compliance with local breach allocation policies.

6.1 Minimum dataset for interim IPT data capture

- NHS number
- Referring Trust
- Treating Trust(s)
- Tumour site
- Date of referral
- Date of transfer
- Date of treatment

The above minimum data set will be completed for each transfer by the referring Trust. It will be reported through normal provider Trust cancer registry systems to Trust performance teams and to the relevant Clinical Commissioning Groups.

Robust lines of communication, including verbal contact, should be established between all people who collect Cancer Waiting Times data. Queries and anomalies, especially potential breaches, should be highlighted and resolved as quickly as possible.

6.2 Escalation of issues relating to inter-provider transfers

It is recommended good practice for all providers to ensure that there is an agreed protocol in place for the appropriate escalation of suspected and confirmed cancer patients. An effective protocol would include:

- Clear procedures for action/ further escalation at all levels of the organisation with identified roles for each level of escalation through to an executive lead (or equivalent)
- Clear escalation timescales, e.g. how long the Cancer Service Manager has to resolve an issue before it is raised to the executive lead.
- Escalation trigger points linked to individual pathway timescales
- Escalation trigger points for any patient without a diagnosis by IPT agreed day
- Information about how the Priority Target Listing (PTL) will be monitored and used to proactively navigate patients through agreed timed pathways.

7 References

NHS England (2016) **National breach allocation guidance** Available from: https://www.england.nhs.uk/wp-content/uploads/2016/03/cancr-brch-allocatn-guid-2016.pdf

NHS England (2015) **Cancer Waiting Times: A Guide** (Version 9) Available from: http://systems.digital.nhs.uk/ssd/cancerwaiting/documentation

8 Appendices

8.1 National breach allocation guidance (April 2016)

National Cancer Breach Allocation Guidance

Produced by NHS England and NHS Improvement

April 2016

Contents

NHS England commitment to promoting equality and tackling health inequalities:

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regards to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it;
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities.

Introduction

This guidance has been produced to inform a more refined system of cancer breach allocation between referring and treating trusts across England, recommending collaborative relationships between referring and treating organisations and development of local breach allocation polices with support from local networks. To ensure timely transfer of care it is advised that local policies use day 38 as a clear, single target date by which handover from referring trusts to treating trusts should take place. It is expected that all cancer providers will develop and implement breach allocation policies and local data collection by 1 October 2016.

It is acknowledged that nationally there will be no IT system that can capture complete Inter Provider Transfer (IPT) data until at least April 2017. In the interim, trusts will need to create local systems to collect IPT data and support compliance with local breach allocation policies, building on any locally timed pathways that already exist and continue to be developed, enabling providers to deliver timely cancer care and support earlier diagnosis.

Background

A review of the current national allocation of breach policy, as set out in Cancer Waiting Times – A Guide (v 8.1)[1], was undertaken by the National Tripartite Cancer Waiting Times Taskforce in August 2015.

Accountability for patients that breach their cancer waiting times targets is currently shared automatically between the 'first seen' provider and the 'treating' provider irrespective of where the majority of delay to the patient's pathway occurs. This can have a significant impact on the reported performance of specialist centres. Around

15% of 62 day pathways are shared between providers, including patients who are referred back to their original trust. These patients typically take up to 50% longer to complete their pathway than patients treated in their presenting hospital and are therefore more at risk of breaching the standard. A third of all breaches of the 62 day standard are shared patients.

Additionally, there are many specialist tertiary centres where a significant number of patients are late referrals, sometimes already beyond day 62. Their work may be

timely, but the current system makes them share the accountability for breaches.

[1] *Cancer waiting times - a guide 2015*

Aims and objectives

This guidance aims to provide a fairer method of cancer breach allocation when treatment is delayed between referring and treating providers. We recommend collaborative relationships between referring and treating organisations involved in the cancer pathway to support the development of local breach allocation polices; to advise local networks (for example commissioners, providers, networks, system resilience groups (SRGs), vanguard sites) in agreeing the minimum data sets required to inform a single clear handover date for the transfer of patient care from referring organisations to treating organisations. The process should simplify complex pathways between multiple providers.

To ensure timely transfer of care it is advised that local policies agree day 38 as a clear, single target date by which handover from referring trusts to treating trusts takes place. By defining a clear breach allocation guideline it is hoped that all stakeholders involved in cancer pathways will be able to clearly identify where in the pathway focus is required to improve performance of the whole pathway. The overarching aim is to support joint working between providers and commissioners, thereby reducing variations in cancer pathways and seeking opportunities for early diagnosis. Local policies should be reviewed annually to ensure they are relevant and fit for purpose.

This guidance also supports the aims of "Achieving world-class cancer outcomes: a strategy for England 2015-2020"[2].

Limitation of current IPT data

At present it is not possible to capture IPT data nationally. The current cancer waiting times system is over 15 years old and, due to the age of the system, making changes to it is difficult and carries significant risk to the continued operation of the system. The system is in the process of being decommissioned.

Since 2014 NHS England and the Health and Social Care Information Centre (HSCIC) have been working to introduce a new data item within the cancer waiting times system on the "Referral Request Received Date (Inter Provider Transfer)" and,

[2] Cancer strategy for England 2015-2020

subject to satisfactory testing, data is expected to flow from April 2016. In theory, this new data item could be used to update all the reports in the cancer waiting times system from the current 50:50 split for breaches with a new breach allocation policy. However, this would be a sub-optimal solution for pathways with more than two providers.

Ad-hoc solutions based on the raw data downloads have been considered, however, these are not thought to be viable since they would be sub-optimal for multi provider pathways and inconsistent with all the existing pre-specified reports and aggregate.

The multi-provider pathway issue, which would require new data items to be developed, can realistically only be addressed through the commissioning of a replacement system, which it is intended will be in place by April 2017.

Interim IPT data capture

As an interim arrangement, until a permanent replacement for the cancer waiting times standards database is in place by April 2017, local providers are encouraged to develop their own systems to demonstrate how breach allocation information will be shared and taken into account for assessment purposes. The long term aim is to move to health economy wide reporting as soon as possible or as soon as cancer alliances are in place to foster continuing collaborative responsibility and accountability. Appendix 1 outlines suggestions as to how to capture local data.

Process for managing IPT

The following sections outline the rationale for a defined handover date and a process to manage IPT pathways between two providers and more than two providers.

Handover date

Analysis by the Department of Health Cancer Policy Team in 2011[3] indicated that an IPT date of around day 38 on the patient pathway would be an appropriate point of

[3] Review of Cancer Waiting Times Standards - 2011

transfer, which would encourage secondary and tertiary providers to examine and seek to streamline the respective parts of their care pathway.
It is recognised that all tumour site-specific pathways differ in their delivery. Although one size does not fit all, it is generally easier to measure the scale of breaches if the formula for doing so is simple. It is advised that all cancer providers use day 38 as a maximum handover date to the treating trust when developing local breach allocation policies; allowing 24 days for the treating trust to meet the 62 day target; although it is acknowledged that some tumour pathways may require a shorter handover date to ensure timely care. Setting day 38 as the single maximum transfer day for receipt of the clinically agreed minimum data set by the treating trust, means that for breach reallocation purposes treating trusts would have 24 days to meet the 62 day target. This would be simpler to manage and monitor and would also:

- enable benchmarking per tumour site
- allow comparison of performance across sectors
- enable comparison of providers and regions
- provide a target for timely access to diagnostic

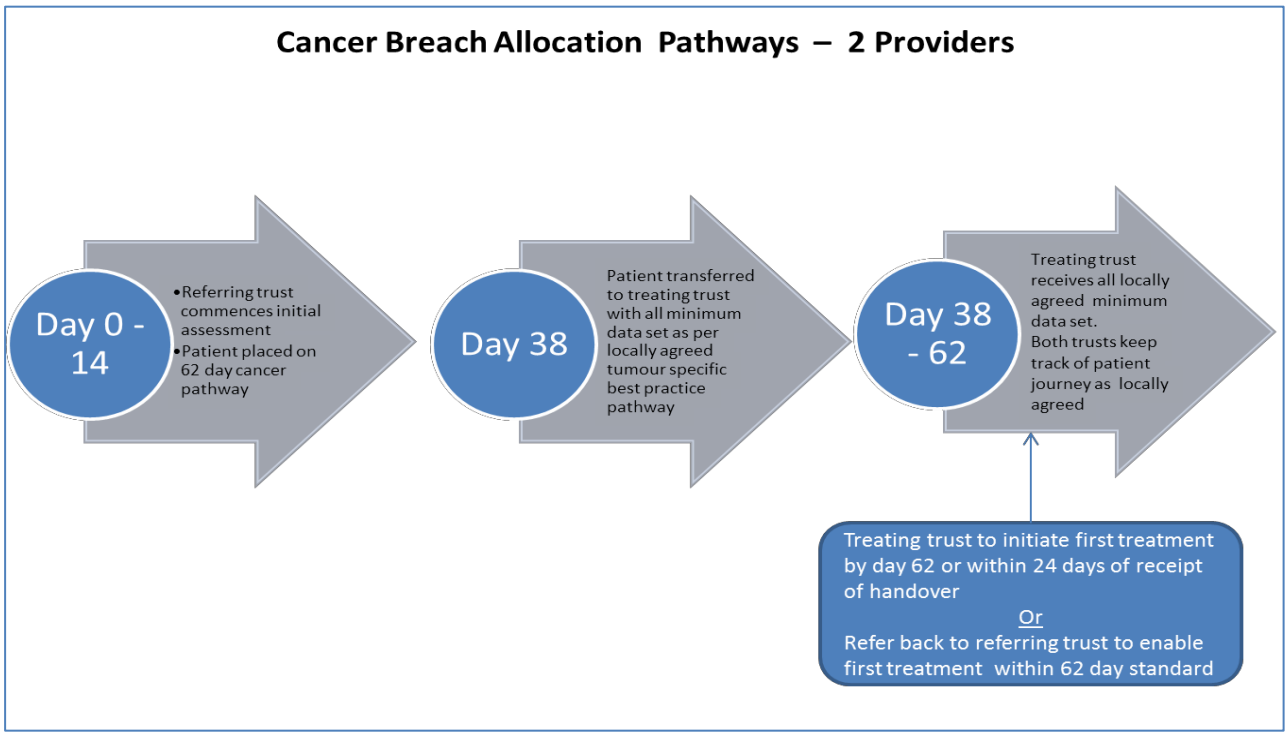
Two provider pathways

There are pockets of good practice across the country where organisations are trialing varying resolutions for breach reallocation with the aim of delivering a more equitable system with incentives for better pathway management. Examples of local practice are referenced in appendix 2.

It is advised that local policies use day 38 as a handover date for the agreed minimum data set where care is shared between two providers. Treating trusts should support referring trusts to complete locally agreed diagnostics for site specific pathways by this date or sooner.

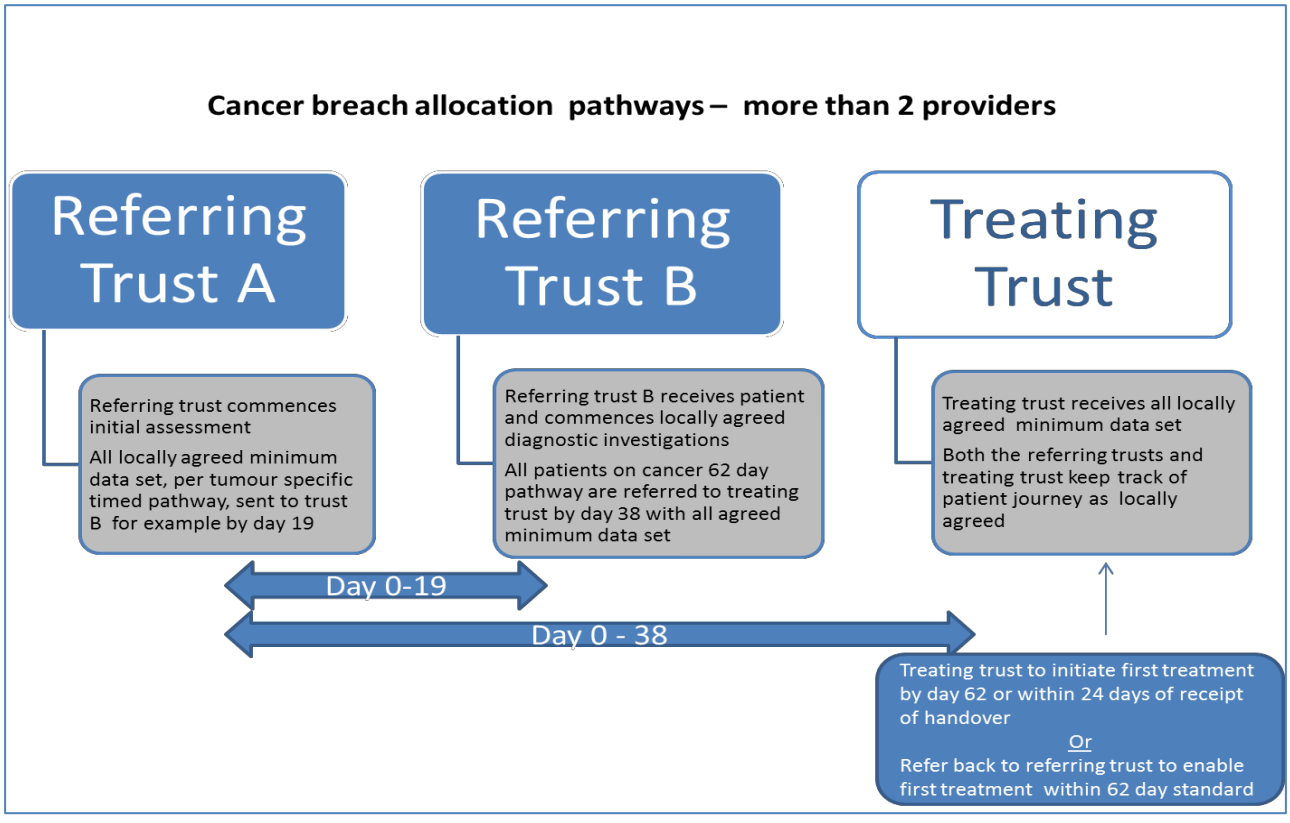
Where the decision of the treating trust is to refer the patient back to their original referrer best practice would be to complete the referral within the 24 day treatment window to allow first treatment within the 62 days.

This guidance recommends the following process:



Multi provider pathways

Managing a cancer pathway between multiple providers is more complex. Nationally there are examples of local practice where patient cancer pathways are effectively managed between multiple providers through collaborative working, as outlined in appendix 2. This guidance recommends the following process:



Where there are more trusts involved in the pathway the breach will be allocated to the trust that has taken the greatest time proportionally to refer on the patient.

Guiding principles to support local IPT breach allocation policies

From a patient perspective, timeliness of investigation and treatment should be a seamless process regardless of where they are along the pathway. This can be achieved through the following principles and guidance in appendix 3:

- All providers and commissioners to work collaboratively to ensure pathways are interlinked
- All providers to have locally agreed timed pathways per tumour group
- Treating trusts to ensure referring trusts are supported to deliver on agreed pathways
- There should be agreed, clinically led processes to analyse and resolve regular underperformance where either treating trust or referring trust(s) are unable to meet the agreed handover date or waiting time target on a regular basis
- Local networks (for example commissioners, providers, networks, system resilience groups (SRGs), vanguard sites) and providers need to agree how the minimum data set for stratified handover dates for each tumour pathway is evidenced
- Incentives to meet handover dates need to be agreed between commissioners and providers. As an example please see table 1 below and appendix 3
- Senior sign off processes need to be in place to ensure agreement of final breach allocation
- There should be a review process of breach allocations in place which links into service improvement for patient pathways
- Shared breach handover and success / failure should be reported at the provider board level. The medical director responsible at an executive level should ensure collaborative dialogue and action plans between referring and receiving organisations are implemented.

Scenario	Referral timeframe	Total timeframe	Allocation
1	> 38 days	≤ 62 days	100% of success allocated to the treating provider
2	≤ 38 days	≤ 62 days	50% of success allocated to the referring provider and 50% allocated to the treating provider
3	≤ 38 days	>62 days	100% of breach allocated to the treating provider
4	> 38 days	> 62 days, but treating trust treats within 24 days	100% of breach allocated to the referring provider
5	> 38 days	> 62 days and treating trust treats in >24 days	50% of breach allocated to the referring provider and 50% allocated to the treating provider

(> = more than, < = less than, ≤ = is less than or equal to)

Summary advice

- This guidance is effective from 1 April 2016.
- In the interests of national consistency, local breach allocation policies based on a 38 day handover standard and local data capture should be in place from 1 October 2016 across all cancer providers.
- National reporting of IPT data is expected to be in place by 1 April 2017, which will be possible once the revised national cancer waiting data system has been implemented.
- Local providers agree the use of day 38 as a handover date to the treating trust in local IPT policies for both two provider and more than two provider pathways.
- Where pathways involve more than two providers further inter-provider target transfer dates (for example day 19) before the 38 day handover to the treating provider need to be agreed locally.
- Treating trusts are encouraged to treat the patient within the 24 day window where referring trusts refer patients beyond day 38 to avoid breach allocation. Partners across providers work and review together.

- Local networks (for example commissioners, providers, networks, SRGs, vanguard sites) should work collaboratively to review complex IPT pathways and adopt good practice as outlined in the relevant national clinical guidance.
- Local systems should continue to work towards earlier diagnosis across all cancer pathways.
- Local health systems may choose to agree more challenging and tumour specific handover standards to support the national strategic priority on earlier diagnosis.
- The long term aim is to move to health economy wide reporting as soon as possible.

Appendix 1: Capturing local data

Clinically agreed national tumour specific pathway referral guides[4], which outline what level of information constitutes a referral along the pathway, should be adopted locally.

Agreed, timed, tumour specific pathways would be complex to manage without the availability of a sophisticated data collection system, both in terms of performance management and tracking of patients along the pathway. Practical agreement of the most appropriate handover date for each of the different tumour sites is paramount. The treating trust should record the day on which the patient enters their pathway; the agreed minimum data set is received with the necessary clinical information to treat the patient and this should be agreed with the referring trust prior to submission of the monthly data.

The development of a single IT solution is to be prioritised, which will enable easy data extraction for monitoring purposes, remove conflicting allocation structures for foundation and NHS trusts, enable sharing of capacity hotspots, and share design principles and best practice. Linking data collection systems, for example to Infoflex or Somerset, would contribute to reducing the number of requests for information both internally and externally.

[4] *NICE - Suspected cancer recognition and referral overview*

Appendix 2: Examples of local practice to manage IPT

Examples	Reference documents
Manchester and the London Cancer Alliance, are trialing breach reallocation involving two trusts whereby if a patient is referred on to a treating trust after day 42 of the pathway, the full breach reallocation will be assigned to the first / referring trust. If the referral is made before day 42, the full breach will be allocated to the treating trust.	
Guys and St Thomas' NHS Foundation Trust utilise timed, clinical pathways detailing the minimum data sets required at each transfer.	H&N Timed Pathway - Oct 2015 Inter trust referral for radical lung treatment Lung 62 day pathway - LCA feedback
The Clatterbridge Cancer Centre NHS Foundation Trust records receipt of transfer data locally and utilises senior sign off processes for agreement of reallocation of breaches.	JP Blank reallocation JP Summary JP CARP form

Examples	Reference documents
A cancer network has developed a locally agreed minimum threshold for transfer dates from secondary to tertiary centre. The network monitors compliance and produces a monthly network wide report. This report captures all the referral from various trusts to the tertiary centres within the network and reports at a board level for performance management. The easy to use attached spreadsheet has been anonymised and could be useful for the local networks.	Tertiary Trust IPT performance template

Appendix 3: Some guiding principles to support local policies

Where care of the patient is shared between two providers, if the referring trust transfers the care of the patient with all the relevant agreed minimum data set by day
38 then the treating trust, if it fails to meet the 62 day target, will take the full breach.

Where more than two trusts are involved in the diagnostic pathway, if a 38 day handover has been agreed to enable the treating trust to reach the 62 day threshold then any referral received beyond day 19, for example, would be attributable to the first referring trust and beyond 38 days to the second referring trust.

If the transfer of care is after day 38 treating trusts will not be allocated any breach but will endeavour to treat all patients within the 62 day pathway target.

In some cases transfer of care to the treating organisation may not possible by this date. However, the treating trust should still aim to start first treatment within 24 days (difference between 38 days and 62 days) of receipt of agreed minimum data set to avoid breach allocation. This should only affect a small number of patients and all providers need to agree a process to avoid unnecessary delays in these circumstances.

In terms of equitable incentives, where a patient does not breach the 62 day standard both the referring trust and the treating trust will receive 0.5 of a successful treatment, assuming the referring trust(s) met the agreed handover date(s).

Equally if a patient is referred after day 38, but the treating trust is able to treat in target, the treating trust will receive the benefit of successful treatment for a full patient.

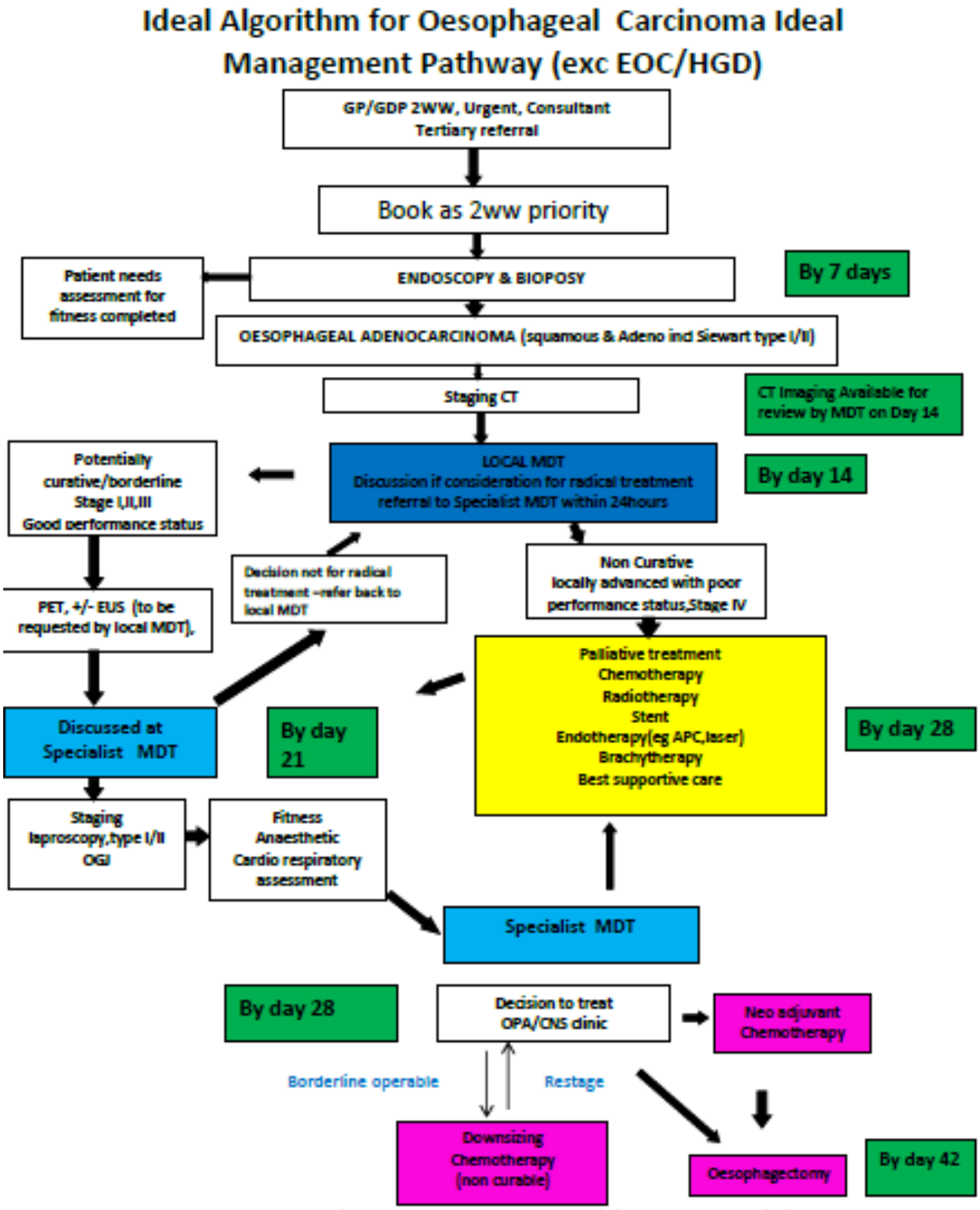
All providers involved should agree a clear process to communicate essential patient information electronically, escalate any key issues which are likely to impact on patient care and maintain regular contact, preferably weekly, as a minimum requirement.

Where possible, trust IT systems should be interlinked to enable timely access to essential data and diagnostic test results.

8.2 Appendix B: Examples of local scenarios

	Scenario	Referral time frame	Total timeframe	Breach Allocation
1	Patient A is referred from Walsall Healthcare Trust to University Hospital Birmingham (UHB)	After 38 days	First treatment at UHB by 62 days	100 % of success allocated to UHB
2	Patient B is transferred from South Warwickshire NHS FT (SWFT) to University Hospital Coventry & Warwickshire NHS Trust (UHCW)	Before or by day 38	First treatment at UHCW before or by 62 days	50% of success allocated to SWFT; 50% allocated to UCHW
3	Patient C is transferred from Shrewsbury & Telford Hospitals NHS Trust (SaTH) to University Hospital of the North Midlands (UHNM)	Before or by day 38	First treatment at UHNM received after day 62.	100% of breach allocated to UHNM
4	Patient D is transferred from Dudley Group Hospitals NHS Trust (DGH) to Royal Wolverhampton Hospitals NHS Trust (RWH)	After 38 days	First treatment at RWH after 62 days but patient treated within 24 days of patient being received	100% of breach allocated to DGH
5	Patient E is transferred from Wye Valley NHS Trust (WVH)to Worcester Acute Hospitals NHS Trust (WAH)	After 38 days	First treatment received at WAH after 62 days and after 24 days of patient being received	50% of breach allocated to WVH and 50% allocated to WAH

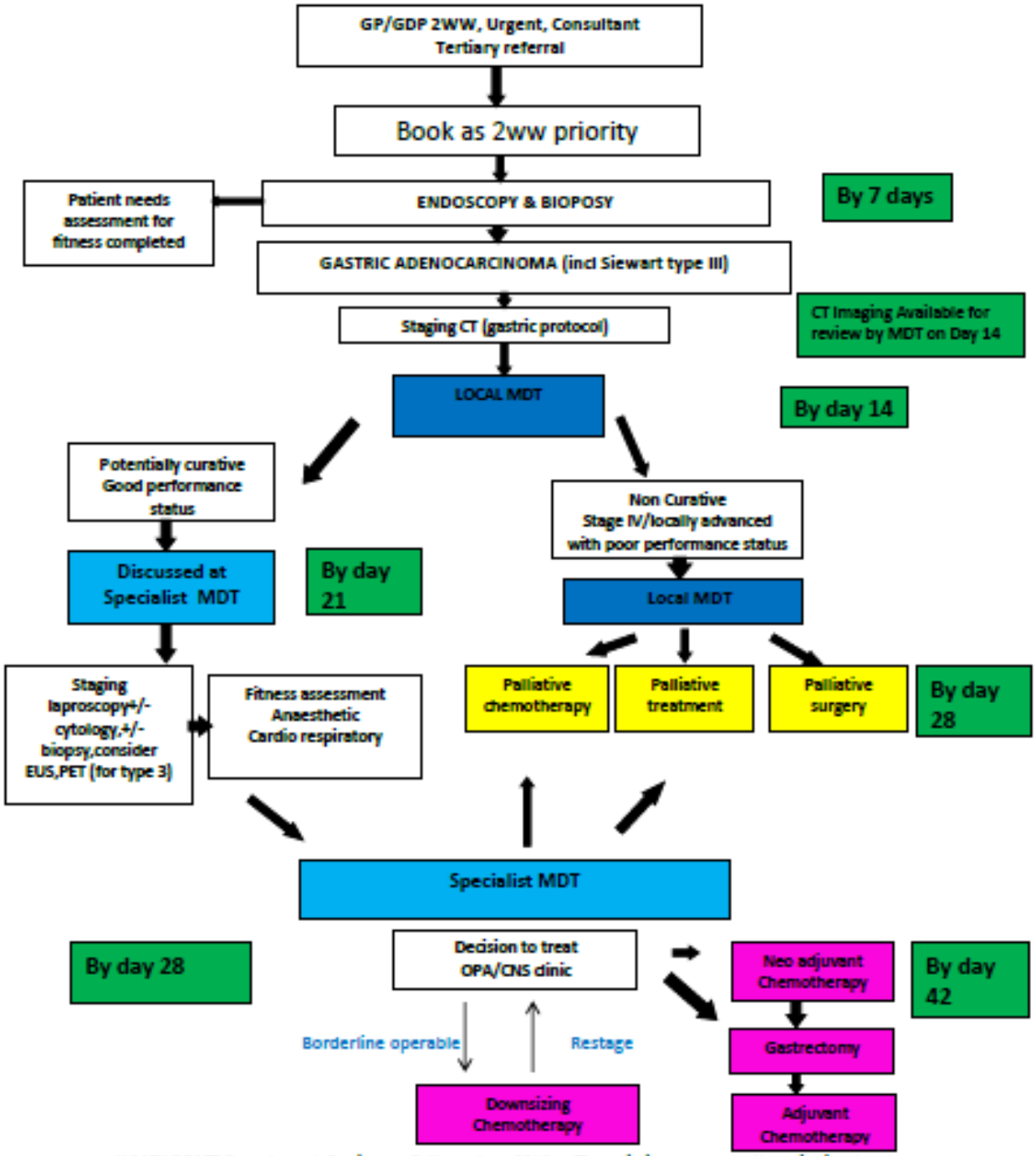
8.3 Appendix C: Timed pathways



WMCN DRAFT Oesophageal Carcinoma Pathway June 2016. These timings are currently aspirational and are an attempt to see what resource are required to comply with the new 2020 NHS cancer targets

WEST MIDLANDS CLINICAL NETWORK AND SENATE NHS

Ideal Algorithm for Gastic Carcinoma Ideal Management Pathway (exc EGC/HGD)



WMCN DRAFT Oesophageal Carcinoma Pathway June 2016. These timings are currently aspirational and are an attempt to see what resource are required to comply with the new 2020 NHS cancer targets

8.4 Appendix D: Key contacts for escalating issues

Trust	Name	Role	Email	Telephone
Birmingham Children's Hospital NHS Foundation Trust	Elaine Carrolan (first request for information)	Quality, Accreditation and Data Manager	elaine.carrolan@bch.nhs.uk	0121 333 9868
	Deta Almond (escalation of non-compliance)	Service Manager for Blood, Stem Cell and Cancer	deta.almond@bch.nhs.uk	0121 333 9999 x6786 07500 073852
Birmingham Women's NHS Foundation Trust	Lisa Parton	Macmillan Gynaecology/ Oncology CNS	lisa.parton@bwnft.nhs.uk	0121 626 4724
	Salmah Mahmood	Associate Chief Operating Officer/ General Manager, Gynaecology	salmah.mahmood@bwnft.nhs.uk	0121 626 4569
	Carole Nutting	Patient Access Manager	carole.nutting@bwnft.nhs.uk	0121 626 4565
Burton Hospitals NHS Foundation Trust	*Kerry Pape*	*Lead Nurse, Manager Cancer Services*	*kerry.pape@burtonft.nhs.uk*	

George Eliot Hospital NHS Trust	Fungisai Motsi	Macmillan Lead Cancer Nurse	fungisai.motsi@geh.nhs.uk	02476 155023
	Laura Gibson	Head of Performance and Transformation	laura.gibson@geh.nhs.uk	02476 155716
	Tina Robinson	Deputy Director of Operations	tina.robinson@geh.nhs.uk	01276 865080
Heart of England NHS Foundation Trust	Ben Parfitt	Head of Cancer Services	ben.parfitt@heartofengland.nhs.uk	0121 424 1164 07917 046147
	Tina Foulsham	Cancer Services Support Manager	tina.foulsham@heartofengland.nhs.uk	0121 424 2846
Mid Cheshire Hospitals NHS Foundation Trust (Leighton)	Delyth Owen	Lead Nurse/ Cancer Manager	delyth.owen@nhs.net	01270 612389
	Annette Lewis	Cancer Data Performance Manager	annette.lewis2@nhs.net	01270 273609
Sandwell and West Birmingham Hospitals NHS Trust	Ian Charles	Cancer Waiting Times Manager	ian.charles@nhs.net	0121 507 2618
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