

Gateway reference: 04237

Managing long waiting cancer patients – policy on “backstop” measures

Summary

This document explains the process for managing “long waiting” cancer patients on 62 day pathways and describes the ‘backstop’ waiting time beyond which patients should be specifically reviewed for potential harm. It advises that any cancer patients waiting 104 days or more from referral to the first definitive treatment should be reviewed in accordance with the process outlined below. The selection of 104 days is to align with the reporting capabilities of the Open Exeter data collection system.

This process should be viewed in conjunction with the *Eight Key Priorities* for improving cancer waiting times (recognising these are short term measures), the NHS Interim Management and Support publication, “*Delivering Cancer Waiting Times – A Good Practice Guide*” and the NHS England publication “*Building the NHS of the Five Year Forward View England - The NHS England Business Plan 2015-2016*”

Background

The NHS has set maximum waiting time standards for access to healthcare. In England, waiting time standards for cancer care come under two headings:

- The individual patient right (as per the NHS Constitution);
- The standards by which, individual providers and commissioners are held accountable by the Department of Health for delivering (as per the NHS Operating and NHS Performance Frameworks)

This policy refers specifically to the number of days between urgent GP referral and first definitive treatment for cancer patients.

The Going Further on Cancer Waiting Times operational standards have been designed to take in to account the practicalities of managing very complex diagnostic pathways, patients who are temporarily clinically unfit for cancer treatment, and those who choose to defer their diagnosis or treatment for personal reasons. For these reasons, some patients may have a recorded waiting time in excess of 62 days, which is both accurately reported and is clinically directed in the best interests of the patient concerned.

It is also recognised that a small proportion of patients will have a recorded waiting time of more than 104 days for this reason i.e. 6 weeks beyond a breach of the 62 day standard. The exact approaches to managing patients with a long waiting time, both proactively and retrospectively, require clarification so that avoidable non-clinical factors can be identified and separated from clinically appropriate management, and patient choice. Equally, providers should have effective processes in place to review such patient pathways and escalation approaches for delays which may have direct clinical significance and/or have resulted in a harm event for the delayed patient concerned.

Policy objectives

This 'backstop' policy aims to ensure that the cancer operational standards, performance management and reporting arrangements act as a tool to improving access times for all cancer patients. The paper aims to describe a process by which patient pathways with significantly long waiting times are reviewed on a patient-specific and thematic basis. There must be a direct link between such reviews and internal processes for effective clinical governance and risk management within provider organisations, and timely information sharing with clinical commissioning groups as appropriate.

Process for managing long waiting cancer patients

The process below explains how to manage cancer patients with long waiting times on 62 day cancer pathways.

What is a long waiting time?

- Generally, any waiting time of over 62 days from urgent referral to treatment is classified as a long wait.
- For the purposes of this document however, long waiting times means those in excess of 104 days (the backstop measure). Some patients will have a legitimate long waiting time for cancer diagnosis and treatment, for either choice or medical reasons. The operational standard for delivery of cancer care within 62 days of urgent referral was set at 85%, to take account of these cases.
- Patients classified as "long waiters" are expected to form a minority of cases breaching the operational standard.

How are patients with a long waiting time identified?

- In accordance with the *Eight Key Priorities*, all trusts should maintain a weekly patient tracking list (PTL) and hold a weekly PTL meeting, involving the departments directly supporting and overseeing the delivery of cancer waiting times. This would support the daily management and monitoring of cancer waits.
- The PTL meeting should be able to review a patient-specific list of those waiting on a cancer waiting times pathway, against any of the 31 and 62 day standards. Performance and capacity data for the 14 day wait to first seen standard should also be reviewed (as required). The patient-specific list may be split in different ways, depending on local practice, but should allow decisions to be taken at the meeting which can respond to individual patient delays, as required.

How are patients with a long waiting time tracked?

- All Trusts must have electronic records to track patient pathways and to provide evidence of action taken to expedite diagnosis and treatment within agreed timeframes where necessary. All actions taken to progress patient pathways should be notarised on this electronic record and reviewed regularly (at least weekly).

- It is essential that tracking of cancer patients continues after a breach has occurred by the provider responsible for the patient's care, and also following any patient transfer to another provider, for the purposes of either the delivery of treatment, or diagnostic tests and investigations.

Reporting of cancer patients with a long waiting time

- The Trust Board should receive routine reports on cancer waiting times performance. These reports must show performance against each of the cancer operational standards and the actions being taken to improve and sustain cancer performance.
- These reports should be presented in a way which allows the Trust Board to see the number and proportion of patients with a long waiting time.
- Where required (see below), the Trust Board should see outcomes of the root cause analysis (RCA) in relation to the cancer pathway/s concerned, and may request further forms of exception reporting as required by local circumstances.
- Clinical Commissioning Groups (CCGs or equivalent) may request further exception reporting and ensure that themes identified within the RCAs are embedded in the Trust's Cancer Improvement Plan.

When is a root cause analysis required?

- RCA should always be carried out for each pathway not meeting current standards (i.e. failing the 85% standard), by reviewing the last ten patient breaches and near misses (defined as patients who came within 48 hours of breaching).
- Long waiting patients, as defined by this policy, should be the subject of individual RCA. These should be reviewed in the weekly PTL meetings.
- In addition for long wait patients (over 104 days) with a confirmed cancer diagnosis a clinical harm review should be undertaken (see below).
- In the case of shared pathways, all providers involved in the patients care should participate in the RCA. The providers must communicate with each other at an early stage to agree which trust will lead on the RCA. Normally, the treating Trust would lead the RCA, or, if the delay reason is very clear and attributable to the actions/inactions of a provider then they should lead the process.
- Trusts should avoid each commencing a separate RCA process and not identifying the delay reasons for stages of the pathway managed by the other provider/s and vice-versa. They should also consider the possibilities for early escalation to Trust Boards and Commissioning Clinical Leads, should a Serious Incident (SI) likely to have occurred (see sections below).
- Where any provider in shared pathways is concerned that a RCA should have been undertaken or potential harm event investigated in line with this guidance, then the Medical Director or Lead Cancer Clinician should contact their counterpart at the earliest opportunity.

How should a root cause analysis take place?

- A typical approach is to map each appointment, diagnostic test, investigation, MDT discussion or delay reason as a specific "step" and to analyse the pathway in terms of each step/delay as being either unavoidable or avoidable, using a Red, Amber, and Green (RAG) system. Other approaches are available and the scope of the RCA will depend on the circumstances of the case.
- The RCA should involve a senior oversight by either the Lead Cancer Clinician, or by another consultant within the multi-disciplinary team.

- The RCA process must be supported by the departments involved in the pathway (such as radiology and pathology, or the chemotherapy, surgical and radiotherapy service as appropriate). The Lead Cancer Manager and/or Lead Cancer Nurse would also be expected to be involved with the RCA process.
- For long waiting patients the RCA must be completed as soon as possible after the patient receives their cancer care. In many cases, it will be possible to commence the RCA process sooner, when the delays are initially identified, tracked, and where possible mitigated via the weekly PTL meeting. Where the RCA identifies a delay/s which caused the breach, then the breach should be reported on as “avoidable” and, where a thematic issue, be addressed via an Improvement Plan.

Process for potential clinical harm reviews

- Where an individual patient with a confirmed cancer diagnosis has waited over 104 days, there should be a clear, transparent process in place to identify if the extended delay has caused harm to the patient.
- Where there was a medical reason for the patient to wait for cancer treatment then there should be clear evidence that the patient pathway has been reviewed at regular intervals.
- If either a single delay or a sequence of delays can be shown to have resulted in a serious harm event for the patient concerned, or the available evidence suggests that this may have been the case, then the Trust/s where such delays occurred should follow their policy for investigating and reporting the case as a SI. It would be good practice to undertake SI-type reviews for cases of harm not considered to be ‘serious’ under SI definitions.
- A serious communication breakdown or administrative error in a patient pathway may also be considered as a SI. This would depend on the overall circumstances and the actual/potential consequences of the error/s concerned.
- The RCA will shape the terms of reference for the SI investigation process.
- Where a SI investigation commences the Trust must follow its escalation process through to the senior clinical lead at the relevant CCG (or other process as locally agreed).

Regional review

- In turn, the CCG Clinical Lead will bring details of such cases for discussion at the next Clinical Quality Reference Group (CQRG) meetings and may refer to either the senior leadership team within a Strategic Clinical Networks (SCNs), or other cancer focussed commissioning or provider collaborations as appropriate, to ensure specific knowledge-share.
- Additionally, CQRG’s will work with the Regional teams to ensure that themes are captured and support provided where serious concerns are highlighted in providing timely care to patients.
- The Commissioning Clinical Lead would be expected to confirm with the provider the actions taken as a result of the SI, as part of its overall existing process.