Humber and North Yorkshire
Cancer Alliance

HUMBER AND NORTH YORKSHIRE CANCER INTER PROVIDER TRANSFERS (IPT) OPERATING FRAMEWORK

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i Document Control

Title	Humber and North Yorkshire Cancer IPT Operating Framework
Author(s)	The Oversight and Assurance Group -Humber and North Yorkshire Cancer Alliance Members: Hull Teaching Hospitals NHS Trust Northern Lincolnshire and Goole Trust York and Scarborough Teaching Hospitals NHS Foundation Trust
Owner	The Oversight and Assurance Group – Humber and North Yorkshire Cancer Alliance

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Contributors to current version		
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ii Information Reader Box

Title	Humber and North Yorkshire Cancer IPT Operating Framework
Author(s)	The Oversight and Assurance Group -Humber and North Yorkshire Cancer Alliance Members: Hull Teaching Hospitals NHS Trust Northern Lincolnshire and Goole Trust York and Scarborough Teaching Hospitals NHS Foundation Trust
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1 Introduction

Many cancer pathways involve a transfer of care and responsibility between two or more acute providers. This Inter Provider Transfer (IPT) Operating Framework has been developed to ensure the timely transfer of clinical and administrative information between providers when an IPT occurs. This framework covers all cancers and organisations. There are three parts to the framework; i) the principles and definitions, ii) the operational and administrative procedure detail and iii) the cancer pathways and minimum data sets required.

The aim of the Operating Framework is to ensure:

- Patients receive appropriate assessment; diagnosis and treatment within the specified cancer waiting times standards
- 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
- Breach reasons are agreed and breaches appropriately allocated between providers in accordance with the National Cancer Breach Reallocation Guidance, NHS England 2016

It is recognised that many cancer pathways are more complex than others, but that the 85% threshold for 62 day pathways should be achievable. This can be complicated by patient choice factors, access to diagnostic tests and capacity, multi-disciplinary team (MDT) meeting timings and arrangements and referral processes. This may be adjusted as other areas influence and as other partnerships and the Cancer Alliance evolves. This Operating Framework is not intended to resolve the complexities that surround shared pathways; but to standardise the administrative processes for referring and receiving referrals across providers.

During the development of this framework, a number of interdependencies have been identified and these are described in in section 12.1 of this document. The implications arising from the adoption of this Framework will be taken forward through the Humber and North Yorkshire Cancer Alliance Oversight and Assurance Group.

2 Principles and Definitions

2.1 Inter-Provider Transfer (IPT)

The IPT is the 'definitive' transfer of the patient's care that results in the delivery of the initial treatment intervention at the treating organisation.

A pathway may contain several inter-organisation transfers, but not all are IPTs. For example, referring to another organisation for a test or specialist opinion does not in itself constitute an IPT.

An IPT can only occur when the treating and referring organisations differ. For example, a pathway that includes a transfer, but then returns back to the referring organisation for treatment (or best supportive care or watch-and-wait if to be carried out by that organisation) is not an IPT.

It follows that there can only be a maximum of one IPT per pathway*.

**NHS Digital is currently in the process of replacing the system for uploading Cancer Waiting Times and updating Guidance. The definitions in this document reflect the ones described in the National Cancer Waiting Times Monitoring Dataset Guidance v12.0 (August 2023):*
https://www.england.nhs.uk/wp-content/uploads/2023/08/PRN00654-national-cancer-waiting-times-monitoring-dataset-guidance-v12.pdf

The date for the IPT should be recorded as when the responsibility of care is transferred. This date should not change with the result of any diagnostics because the patient's care should always be the responsibility of one provider. If, for example, a patient is transferred for diagnostics and this is also a treatment, the IPT will stand.

This will be reviewed as and when all three Trusts implement the eTeriary module on Somerset Cancer Register (SCR) for all IPTs.

2.2 IPT Operational Procedure (OP)

This provides greater detail about what is required for IPT and should map onto the patient pathways. These will be comprehensive and cover all pathway permutations by Tumour Site Specific Groups (TSSG) and by referring and treating organisation.

Diagnostics work up

Pathways leading up to an IPT should be designed such that all locally deliverable processes are complete prior to IPT.

Deviation from this should be an exception and, when required, agreed by the receiving clinical team and carefully documented in the MDT minutes by both the receiving and referring teams.

If any of the agreed minimum dataset content is missing, the IPT date is deferred until the missing data is available. This can be driven by administrative staff. If IPT data quality is

incomplete, such that an element of the pathway needs to be repeated then the IPT date will be deferred until the new data is available.

Cancer pathways and minimum set of data for IPT

The minimum set of data from the referring organisation to support an IPT must be enough for the receiving organisation to proceed to treatment delivery as defined in the individual IPT documents.

The referring organisation is responsible for providing the minimum set of data for IPT and the receiving organisation is responsible for ensuring that this minimum set of data is complete prior to central MDT. This minimises delays for patients and ensures timely discussion at central MDT.

Pathways are designed to allow for further investigations by the referrer following an IPT. The OP and the agreed pathways will define the timescales by which these must be completed in order for the treating organisation to deliver treatment within the 62 day standard.

Testing before or after the IPT, wherever this is performed, will be 'owned' against the organisation 'holding' the case: pre-IPT it is the referrer, post-IPT it is the receiving organisation.

Pathways conditional upon specialist opinion

Referral to specialist MDT/treating organisation for an opinion does not constitute an IPT unless all of the requirements for IPT are met. Pathways should be designed with sufficient capacity and time for this.

Positioning of clinical review and proceed to treatment

The minimum dataset from the referring organisation must be available for a review to take place in the receiving organisation.

If the criteria for the IPT are met, the date of the IPT is the date of the referral for the review PROVIDED all of the minimum clinical dataset to deliver the opinion is physically available to the clinician at the location that the clinical review will take place and the patient is aware. If this information is not available, the IPT date is deferred until it is.

Visiting Clinicians

When a visiting clinician attends a local MDT meeting at a referring unit and the decision is made to transfer for treatment, provided the information to make the decision is available, this constitutes an IPT subject to the minimum data set requirements being met and the patient being made aware.

If a patient is seen locally by a visiting clinician and remains under the responsibility of the treating trust, the IPT date will stand to avoid patients being bounced backwards and forwards

Positioning of treatment options/choice

If all options are available for a patient to choose from, including a locally deliverable treatment that locally delivered treatment must be declined before the IPT can occur. That

does not mean that a referral cannot be made for non-locality review, but the IPT date will not occur until after the locally-based treatment is declined. A concurrent, rather than sequential, process into each option may be appropriate for timeliness.

Positioning of testing that enables treatment to go ahead

Patients need to be fit for the treatments proposed or may need supportive procedures. Any testing or procedure to support fitness to treat should be set out within the pathway and, if needed prior to IPT, clearly described within the IPT-OP.

These procedures should be complete before the proposed definitive treatment date: if they are not and the referring organisation has responsibility for delivering them as described within the pathway, then the IPT date moves to the date that the procedure is completed. Good communication between referring and treating organisations will ensure this works.

All of the above are presuming that the data set is complete and shadow tracking continues.

Pathways involving more than two organisations

IPTs only move 'one-way'. A transfer back to the referring organisation nullifies an IPT. That is, if a patient does not meet the minimum criteria or is being transferred back for local treatment, the IPT is nullified. This may result in a 2-way or even single organisation pathway if the patient is found unsuitable (or declines) the treatment for which they have been referred.

3 Inter Provider Transfers and Timed Pathways

IPTs from any initial referral source should be made in accordance with clinically agreed pathways and datasets agreed by the Humber and North Yorkshire acute Trusts. Any specialist diagnostics or treatment requiring completion by a particular day will be explicitly described in the clinical dataset requirements.

Timed clinical pathways, when available, will be updated regularly to ensure that key deadlines in the pathways remain relevant to the achievement of treatment within 62 days. Adherence to these timescales is mandatory to allow delivery of the full and completed pathway within national cancer waiting times (CWT). By exception, failure to adhere to specific pathway timescales should be escalated at the earliest opportunity allowing both the referring and receiving provider to formulate a remedial action plan. This escalation could be either operational or strategic, or both depending on the level of intervention that is required to resolve the escalated issue.

Due to the potential pathway timing of 'opinion only' referrals for discussion at a specialist multi-disciplinary team (SMDT) – the complete clinical dataset may not be fully available (as not yet completed). This should not delay discussion and is recognised by both referring and receiving Trusts. However, the full IPT elements are required once a decision has been made to ***transfer the responsibility of care*** to the tertiary or receiving provider. This must include both the clinical and CWT datasets.

Referral for diagnostics should follow the agreed timescales specified by site specific pathways and be accompanied by the Cancer Waiting Times dataset. An SMDT referral form will not be required in these circumstances unless the patient's case requires discussion at the SMDT meeting first.

4 Handover Date

In all cases, the referral for treatment (or specialist diagnostics) should be made no later than day 38.

The IPT date will be recorded as the day when all the elements of the clinical dataset and the CWT dataset are received by the treating trust.

5 Data Capture and Pathways and Minimum Dataset

IPT clinical minimum dataset are detailed below.

Patients can be transferred between organisations for advice and guidance or diagnostic tests. However an IPT only occurs when the transfer is for treatment. An IPT for treatment must contain the core information as defined by the minimum data set for each pathway. Without this the IPT cannot be accepted.

To be effective, an IPT message must contain core information. An inter provider transfer will not be recognised without receipt of the minimum data set.

After an IPT is created, tracking may transfer back to the local trust, for example, a patient is having local diagnostics, but the IPT will stand.

a) Clinical Dataset

i. Bespoke (By MDT/Tumour site) IPT Referral Forms
Imaging and Pathology (with accompanying reports) or any pre-referral tests outlined within the pathways documentation. These should be supplied by the referring organisation as specified through the PACS IEP link (Radiology) or through OpenNet (Pathology). Transferring of Pathology and imaging across organisations requires a standardised process and checks and balances in place in order to meet the MDT cut-off times shown below.

ii. Local MDT outcome and whether SMDT clinician present.

iii. Parallel treatment planning is to be encouraged to facilitate pathway success. This could mean decisions at local MDT regarding treatment are made ahead of specialist MDT discussion.

b) Cancer Waiting Times Minimum Dataset
The following items are the minimum administrative data items required:

Name
Address
NHS No.
Date of birth
Contact details
Registered GP
Diagnosis Date
Referral details (e.g., 2-week wait, upgrade, etc.)
PPI No.
Originating unit
Date first seen
Site first seen
Diagnosis (*this may be a provisional diagnosis at the time of IPT)*

c) Summary of Specialist and Local MDTs across Humber and North Yorkshire by Tumour Site

	LOCAL MDTs					
SITE	**HUTH**	**NLAG**	**Y&S**	**SPECIALIST MDT (s)**		
Anal Cancer			✓	Hull	Leeds	
Bone Sarcomas					Birmingham	
Breast Cancer	✓	✓	✓			
Children's (PTC)					Leeds	
Colorectal Cancer	✓	✓	✓			
CUP	✓		✓	Hull		
Gynaecology	✓	✓	York	Hull		
Haematology	✓		✓	Hull		
Head and Neck	✓	✓	✓	Hull		
Liver					Leeds	
Lung	✓	✓	✓			
Melanoma				Hull	Leeds	
Brain and CNS				Hull		
Pancreatic				Hull	Sheffield	Shared Care
Penile (Supra-Network)					Leeds	
Pituitary				Hull		
Soft Tissue Sarcoma					Leeds	
Skin	✓		✓	Hull		
T-Cell Lymphoma (Supra-Network)				Hull		
Testicular (Supra-Network)				Hull	Leeds	Shared Care
Thyroid			✓	Hull	Leeds	
TYA (PTC)				Hull	Leeds	Shared care- Leeds Primary Treatment Centre- Hull provide local treatment where possible
Upper GI	✓	✓	York	Hull		
Urology	✓	✓	✓	Hull		

6 Data Protection

Each of the participating organisations should have a fully licensed and secure system allowing safe transfer of encrypted information. This should have Secure Socket Layer (SSL) certificates on every messaging server and messages should be sent across N3 if appropriate.

When necessary, additional information may be transferred between providers via email. This will only be accessible to the relevant and appropriate personnel within each provider organisation. Patient identifiable data will only be sent via secure, encrypted email accounts, which must be an nhs.net address.

In exceptional circumstances, when electronic system failure dictates – paper information should be scanned and e-mailed via nhs.net. The sending of paper information through the post is discouraged due to governance and pathway delay reasons; but if absolutely essential should be clearly marked “Private and Confidential - to be opened by the addressee only”. Paper information should not be sent through the post to a specific Clinician but to the relevant pathway co-ordinator.

7 Patient Tracking

It is the responsibility of all provider Trusts to ensure that systems are in place for the effective tracking and navigation of all cancer patients.

It is recommended that the referring organisation will continue to track the patient after the IPT (full minimum dataset) has been accepted by the receiving organisation. This is considered good practice as it allows monitoring that the patient's treatment is within cancer waiting time standards; enables escalation if appropriate (although actual responsibility for this lies with the receiving organisation at this stage); and allows the referring organisation to have a sense of expected shared breaches in advance of formal notification. Where a single cancer information system is used, dual tracking will not be required, and tracking will be continued by the receiving organisation. It is at the discretion of the referring organisation; some organisations will wish to continue with dual tracking.

The receiving organisation will start to track the patient as soon as the IPT has been received and accepted.

Pathway co-ordinators at the referring organisation are responsible for ensuring any key changes, events or adjustments which impact a patient's pathway target date are conveyed to the receiving organisation at the earliest opportunity.

Pathway co-ordinators at the receiving organisation are responsible for ensuring key changes, events or adjustments and treatment dates are conveyed to the referring organisation at the earliest opportunity to minimise unnecessary tracking and allow timely completion of cases. The future implementation of full inter-Trust messaging may provide an electronic solution to this requirement.

All Trusts using Somerset Cancer Register (SCR) intend to implement the electronic IPT process.

8 Escalation

Robust lines of communication, including verbal contact, should be established between all people who collect Cancer Waiting Times data, especially for inter-provider referrals that are a regular part of a patient pathway. Queries and anomalies, in particular potential breaches, should be highlighted and resolved as quickly as possible. Weekly conference calls between organisations should be in place to discuss patients on shared pathways and to agree transfer dates and breach allocation at the end of each month.

All providers will ensure that they have an agreed protocol in place for the appropriate escalation of suspected and confirmed cancer patients that supports the effective delivery of shared pathways.

9 Inter Provider Breach Allocation

All breaches which relate to a shared pathway where an IPT has taken place should be reviewed and breach reasons agreed by both the referring and the receiving organisation no later than five working days prior to upload. This should be in accordance with delay reasons described in the National Cancer Waiting Times Monitoring Dataset Guidance v12.0.

The weekly conference calls between organisations will provide the process for reviewing breach reports and reasons. The outcome of these discussions will be documented on the Cancer Information Systems of each organisation. Even though the IPT date may be agreed at the weekly teleconference meeting, something can be overlooked and primary treatment may change. These cases should be re-discussed at the teleconference for agreement (see flow chart in appendix 2).

Details of provider breach reallocation

The rules which assign 62 day performance where at least one transfer of care has occurred prior to first treatment are set out below in Table 1.

	Scenario					62 day standard						38 day wait report		24 day wait report	
						Investigating Provider (IP)			Treating provider (TP)			Investigating		Treating	
Scenario		62-day wait (overall pathway)	38-day wait (investigative phase)	24-day wait (treatment commencement phase)		Contribution to Numerator	Contribution to Denominator	**Patient allocation**	Contribution to Numerator	Contribution to Denominator	**Patient allocation**	Contribution to Numerator	Contribution to Denominator	Contribution to Numerator	Contribution to Denominator
1	IF:	SUCCESS	SUCCESS	SUCCESS	THEN:	0.5	0.5	**0.5**	0.5	0.5	**0.5**	1	1	1	1
2	IF:	SUCCESS	SUCCESS	BREACH	THEN:	0.5	0.5	**0.5**	0.5	0.5	**0.5**	1	1	0	1
3	IF:	SUCCESS	BREACH	SUCCESS	THEN:	0	0	**0**	1	1	**1**	0	1	1	1
4	IF:	BREACH	SUCCESS	BREACH	THEN:	0	0	**0**	0	1	**1**	1	1	0	1
5	IF:	BREACH	BREACH	SUCCESS	THEN:	0	1	**1**	0	0	**0**	0	1	1	1
6	IF:	BREACH	BREACH	BREACH	THEN:	0	0.5	**0.5**	0	0.5	**0.5**	0	1	0	1

Responsibility for the breach will be established in accordance to the guidance described in the National Cancer Waiting Times Monitoring Dataset Guidance v12.0 which defines the scenarios where there are pathways with multiple Inter Provider Transfers:

1. The first step to identify a single investigating provider to be ‘accountable’ for the investigation phase:

    - If the period from referral received to last transfer to treatment is 38 days or less (the ’38 day’ investigative phase):
        - The provider who has cumulatively spent the shortest amount of time with the patient is identified as the ‘accountable’ investigating provider.
        - If two or more providers saw the patient for the same amount of time, of those providers the one who saw the patient first is identified as the ‘accountable’ investigating provider.
    - If the period from referral received to the last transfer to treatment is over 38 days (the ’38 day’ investigative phase):
        - The provider who has cumulatively spent the longest amount of time with the patient is identified as the ‘accountable’ investigating provider.
        - If two or more providers saw the patient the same amount of time, of those providers the one who saw the patient last is identified as the ‘accountable’ investigating provider.

- The allocation is then applied, attributing the patient cases as described in Table 1 for the scenarios 1 to 6.

2. If a provider is involved in the investigative stage, and is also the treating provider (with another provider involved in between) the provider is considered separately in the calculations for responsibility for investigation and for treatment.

Providers will ensure performance accurately reflects their position following breach allocation and that this is conveyed through local governance and national reporting channels.

It is the responsibility of both referring and receiving providers to complete their relevant sections of the individual breach analysis. It is this full breach analysis which should be reviewed by both providers when deciding breach reasons.

Whenever possible, all breach reasons will be agreed between the referring secondary provider and the receiving provider no later than five working days prior to the National Data Centre upload deadline.

It is the responsibility of the Cancer Management Team of both the referring secondary provider and the receiving provider to ensure conformity to this process. Where no agreement can be achieved between two organisations, the breach information will be sent to another impartial organisation for another anonymised review by the cancer manager and the lead clinician to arbitrate and make a decision on the breach allocation.

10 Reconciliation

It is the responsibility of the treating provider (normally the tertiary centre) to upload final agreed breach reasons to National Data Centre for shared pathways. This will include those breach comments where agreement cannot be reached and for which both providers' reasons are recorded. It will also record when a referrer has not provided a breach reason.

Reconciliation should be sought between the two organisations initially. Where agreement is not reached the matter should be raised to the Lead Cancer managers for resolution. If agreement can still not be reached the matter will be taken to the Humber and North Yorkshire Cancer Alliance for a final decision.

See Appendix 2 – IPT Reconciliation Process Flow Chart

11 Governance Arrangements

The governance arrangements for this policy are as follows:

- Trust Executive Team (each provider) for agreement and implementation.
- Collaborative of Acute Providers
- Humber and North Yorkshire Cancer Alliance

12 Appendix 1 – Inter Provider Transfer Pathways

Title	Humber and North Yorkshire Cancer IPT Operating Framework
Summary	The 21 IPT Pathways are shown in alphabetical order by cancer site
Author (s)	The Oversight and Assurance Group -Humber and North Yorkshire Cancer Alliance Members: Hull Teaching Hospitals NHS Trust Northern Lincolnshire and Goole Trust York and Scarborough Teaching Hospitals NHS Foundation Trust
Owner	Humber and North Yorkshire Cancer Alliance
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12.1 Anal Cancer IPT Pathway

Core diagnostic investigations required Pre-IPT:

Pt aware of diagnosis and reasons for referral to another Trust

Colonoscopy/Flex Sigmoidoscopy/ CTC/CT – as clinically indicated

OPA biopsy +/- EUA

PET-CT reported

Core MDS required for IPT:

Patient demographics

Performance status (if available)

Co-morbidities (if available)

CWT information

Suspected cancer type

Consultant in charge

Working diagnosis

Staging information

Relevant pathology & imaging scans and reports

Following the first IPT, if the center clinician decides that further diagnostics are required, regardless of location under the accepting consultant, no further IPTs are required.

D0-14
After 2ww referral, core investigations and first clinical assessment to be completed, including mini-MDT (where available) to guide diagnostics.

D21-28
Diagnostics completed, clinical assessment and discussion of suspected diagnosis, information to patient and proposed plan (including WHO performance status and fitness assessment) recorded. Communication of diagnosis or all clear to patient, either face to face or by letter.

D21-28
Full MDT discussion where decision for cancer centre opinion/treatment is proposed. Diagnostic results should be available to inform definitive treatment decision. Results to be communicated to GP.

D28-31
Patient informed of MDT decision. Staging tests and results discussed. MDT plan dicussed and agreed with patient (surgery / SACT / Rtx / active monitoring / best supportive care / specialist palliative care)

D31-38
IPT patient for treatment. Dual tracking must be maintained by referring Trust and treating Trust.

D38-45
Post SMDT investigations to be completed (these may be done closer to the patients' home but do not consitute a revised IPT). SMDT outcome to be discussed and agreed with the patient. Outpatient appointment with surgeon and / or Oncologist. Treatment plan discussed and agreed with the patient. Patient to be referred back to local provider is local treatment available and agreed.

D45-57
Admission for surgical staging and / or definitive treatment (surgery / SACT / RTx TCI.

D57-62
Review pathological staging at MDT and consider surveillance or referral for adjuvant treatment. Onward referral made as appropriate. Results to GP and referring unit.

Post D62
Follow up agreed with the patient.

12.2 Bladder Cancer IPT Pathway

Core diagnostic investigations required Pre-IPT:

Pt aware of diagnosis and reasons for referral to another Trust

Histology from TURBT

Staging CT of abdo, pelvis & chest

Core MDS required for IPT:

Pt demographics

Performance status (if available)

Co-morbidities (if available)

CWT information

Suspected cancer type

Consultant in charge

Clinical history and examination - FBC, UEs & LFTs

Working diagnosis

Histology reports and operation findings

Staging CT or MRI

Relevant pathology & imaging scans and reports

Following the first IPT, if the center clinician decides that further diagnostics are required, regardless of location under the accepting consultant, no further IPTs are required.

D0-14
After 2ww referral, core investigations and first clinical assessment to be completed, including mini-MDT (where available) to guide diagnostics.

D21-28
Diagnostics completed, clinical assessment and discussion of suspected diagnosis, information to patient and proposed plan (including WHO performance status and fitness assessment) recorded. Communication of diagnosis or all clear to patient, either face to face or by letter.

D21-28
Full MDT discussion where decision for cancer centre opinion/treatment is proposed. Diagnostic results should be available to inform definitive treatment decision. Results to be communicated to GP.

D28-31
Patient informed of MDT decision. Staging tests and results discussed. MDT plan dicussed and agreed with patient (surgery / SACT / Rtx / active monitoring / best supportive care / specialist palliative care)

D31-38
IPT patient for treatment. Dual tracking must be maintained by referring Trust and treating Trust.

D38-45
Post SMDT investigations to be completed (these may be done closer to the patients' home but do not consitute a revised IPT). SMDT outcome to be discussed and agreed with the patient.

D45-57
Outpatient appointment with Urologist and / or Oncologist.
Treatment plan discussed and agreed with the patient.
Patient to be referred back to local provider if local treatment available and agreed.

D57-62
Admission for definitive treatment BCG/ SACT / RTx / BSC.

Post D62
Follow up agreed with the patient.

12.3 Brain / CNS Cancer IPT Pathway

Core diagnostic investigations required Pre-IPT:

Pt aware of diagnosis and reasons for referral to another Trust

CT or MRI

D0-14

After 2ww referral, core investigations and first clinical assessment to be completed, including mini-MDT (where available) to guide diagnostics.

D21-28

Diagnostics completed, clinical assessment and discussion of suspected diagnosis, information to patient and proposed plan (including WHO performance status and fitness assessment) recorded. Communication of diagnosis or all clear to patient, either face to face or by letter.

D21-28

Full MDT discussion where decision for cancer centre opinion/treatment is proposed. Diagnostic results should be available to inform definitive treatment decision. Results to be communicated to GP.

Core MDS required for IPT:

Pt demographics

Performance status (if available)

Co-morbidities (if available)

CWT information

Suspected cancer type

Consultant in charge

Clinical history and examination – FBC, UEs & LFTs

Working diagnosis

CT or MRI scans and reports

D28-31

Patient informed of MDT decision. Staging tests and results discussed. MDT plan dicussed and agreed with patient (surgery / SACT / Rtx / active monitoring / best supportive care / specialist palliative care)

D31-38

IPT patient for treatment. Dual tracking must be maintained by referring Trust and treating Trust.

D38-45

Post SMDT investigations to be completed (these may be done closer to the patients' home but do not consitute a revised IPT). SMDT outcome to be discussed and agreed with the patient.

Following the first IPT, if the center clinician decides that further diagnostics are required, regardless of location under the accepting consultant, no further IPTs are required.

D45-57

Outpatient appointment with surgeon and / or Oncologist.
Treatment plan discussed and agreed with the patient.
Patient to be referred back to local provider if local treatment available and agreed.

D57-62

Admission for definitive treatment surgery/ gamma knife/ SACT / RTx / BSC.

Post D62

Follow up agreed with the patient.

12.4 Breast Cancer IPT Pathway

Core diagnostic investigations required Pre-IPT:

Pt aware of diagnosis and reasons for referral to another Trust

Mammogram

Core Biopsy

HER2 (if clinically required)

SNB (if clinically required)

Ultrasound

MRI breast

Second look ultrasound / VAB

Core MDS required for IPT:

Pt demographics

Performance status (if available)

Co-morbidities (if available)

CWT information

Suspected cancer type

Consultant in charge

Clinical history and examination

Working diagnosis

U/S & MRI scans and reports

Following the first IPT, if the center clinician decides that further diagnostics are required, regardless of location under the accepting consultant, no further IPTs are required.

D0-14
After 2ww referral, core investigations and first clinical assessment to be completed, including mini-MDT (where available) to guide diagnostics.

D21-28
Diagnostics completed, clinical assessment and discussion of suspected diagnosis, information to patient and proposed plan (including WHO performance status and fitness assessment) recorded. Communication of diagnosis or all clear to patient, either face to face or by letter.

D21-28
Full MDT discussion where decision for cancer centre opinion/treatment is proposed. Diagnostic results should be available to inform definitive treatment decision. Results to be communicated to GP.

D28-31
Patient informed of MDT decision. Staging tests and results discussed. MDT plan dicussed and agreed with patient (surgery / SACT / Rtx / active monitoring / best supportive care / specialist palliative care)

D31-38
IPT patient for treatment. Dual tracking must be maintained by referring Trust and treating Trust.

D38-45
Post SMDT investigations to be completed (these may be done closer to the patients' home but do not consitute a revised IPT). SMDT outcome to be discussed and agreed with the patient.

D45-57
Outpatient appointment with surgeon and / or Oncologist.
Treatment plan discussed and agreed with the patient.
Patient to be referred back to local provider if local treatment available and agreed.

D57-62
Admission for definitive treatment surgery/ SACT / RTx / Palliative/BSC.

Post D62
Follow up agreed with the patient.

12.5 Cervical Cancer IPT Pathway

Core diagnostic investigations required Pre-IPT:

Pt aware of diagnosis and reasons for referral to another Trust

Clinical appointment/examination

Smear test (if appropriate)

Biopsy / Lletz

Core MDS required for IPT:

Pt demographics

Performance status (if available)

Co-morbidities (if available)

CWT information

Suspected cancer type

Consultant in charge

Clinical history and examination - FBC, UEs & LFTs

Working diagnosis

Staging information

Relevant pathology/ scans/ reports

Following the first IPT, if the center clinician decides that further diagnostics are required, regardless of location under the accepting consultant, no further IPTs are required.

D0-14
After 2ww referral, core investigations and first clinical assessment to be completed, including mini-MDT (where available) to guide diagnostics.

D21-28
Diagnostics completed, clinical assessment and discussion of suspected diagnosis, information to patient and proposed plan (including WHO performance status and fitness assessment) recorded. Communication of diagnosis or all clear to patient, either face to face or by letter.

D21-28
Full MDT discussion where decision for cancer centre opinion/treatment is proposed. Diagnostic results should be available to inform definitive treatment decision. Results to be communicated to GP.

D28-31
Patient informed of MDT decision. Staging tests and results discussed. MDT plan dicussed and agreed with patient (surgery / SACT / Rbx / active monitoring / best supportive care / specialist palliative care)

D31-38
IPT patient for treatment. Dual tracking must be maintained by referring Trust and treating Trust.

D38-45
Post SMDT investigations to be completed (these may be done closer to the patients' home but do not consitute a revised IPT). SMDT outcome to be discussed and agreed with the patient.

D45-57
Outpatient appointment with surgeon and / or Oncologist.
Treatment plan discussed and agreed with the patient.
Patient to be referred back to local provider if local treatment available and agreed.

D57-62
Admission for definitive treatment surgery/ SACT / RTx / Palliative/BSC.

Post D62
Follow up agreed with the patient.

12.6 Colon Cancer IPT Pathway

Core diagnostic investigations required Pre-IPT:

Pt aware of diagnosis and reasons for referral to another Trust

Clinical appointment/examination

Colonoscopy/Flexi Sigmoidoscopy/CTC

CT TAP or CT chest if already has CTC/ CEA /Biopsy

MRI liver or PET-CT (reported) (Where clinically appropriate)

Core MDS required for IPT:

Pt demographics

Performance status (if available)

Co-morbidities (if available)

CWT information

Suspected cancer type

Consultant in charge

Clinical history and examination

Working diagnosis

Staging information

Relevant pathology/ scans/ reports

Following the first IPT, if the center clinician decides that further diagnostics are required, regardless of location under the accepting consultant, no further IPTs are required.

D0-14
After 2ww referral, core investigations and first clinical assessment to be completed, including mini-MDT (where available) to guide diagnostics.

D21-28
Diagnostics completed, clinical assessment and discussion of suspected diagnosis, information to patient and proposed plan (including WHO performance status and fitness assessment) recorded. Communication of diagnosis or all clear to patient, either face to face or by letter.

D21-28
Full MDT discussion where decision for cancer centre opinion/treatment is proposed. Diagnostic results should be available to inform definitive treatment decision. Results to be communicated to GP.

D28-31
Patient informed of MDT decision. Staging tests and results discussed. MDT plan dicussed and agreed with patient (surgery / SACT / Rtx / active monitoring / best supportive care / specialist palliative care)

D31-38
IPT patient for treatment. Dual tracking must be maintained by referring Trust and treating Trust.

D38-45
Post SMDT investigations to be completed (these may be done closer to the patients' home but do not consitute a revised IPT). SMDT outcome to be discussed and agreed with the patient.

D45-57
Outpatient appointment with surgeon and / or Oncologist.
Treatment plan discussed and agreed with the patient.
Patient to be referred back to local provider if local treatment available and agreed.

D57-62
Admission for definitive treatment surgery/ SACT / RTx /Active monitoring/ Palliative/BSC.

Post D62
Follow up agreed with the patient.

12.7 Early Rectal Cancer IPT Framework (Between 3cm & 15cm from anal verge)

Core diagnostic investigations required Pre-IPT:

Pt aware of diagnosis and reasons for referral to another Trust

Clinical appointment/examination

Colonoscopy/CTC as clinically indicated

CT TAP or CT chest if already has CTC

MRI pelvis

CEA

PET-CT (reported) if required

NB: Significant benign polyp not suitable for EMR-needs full colonic imaging only

Core MDS required for IPT:

Patient demographics

Performance status (if available)

Co-morbidities (if available)

CWT information

Suspected cancer type

Consultant in charge

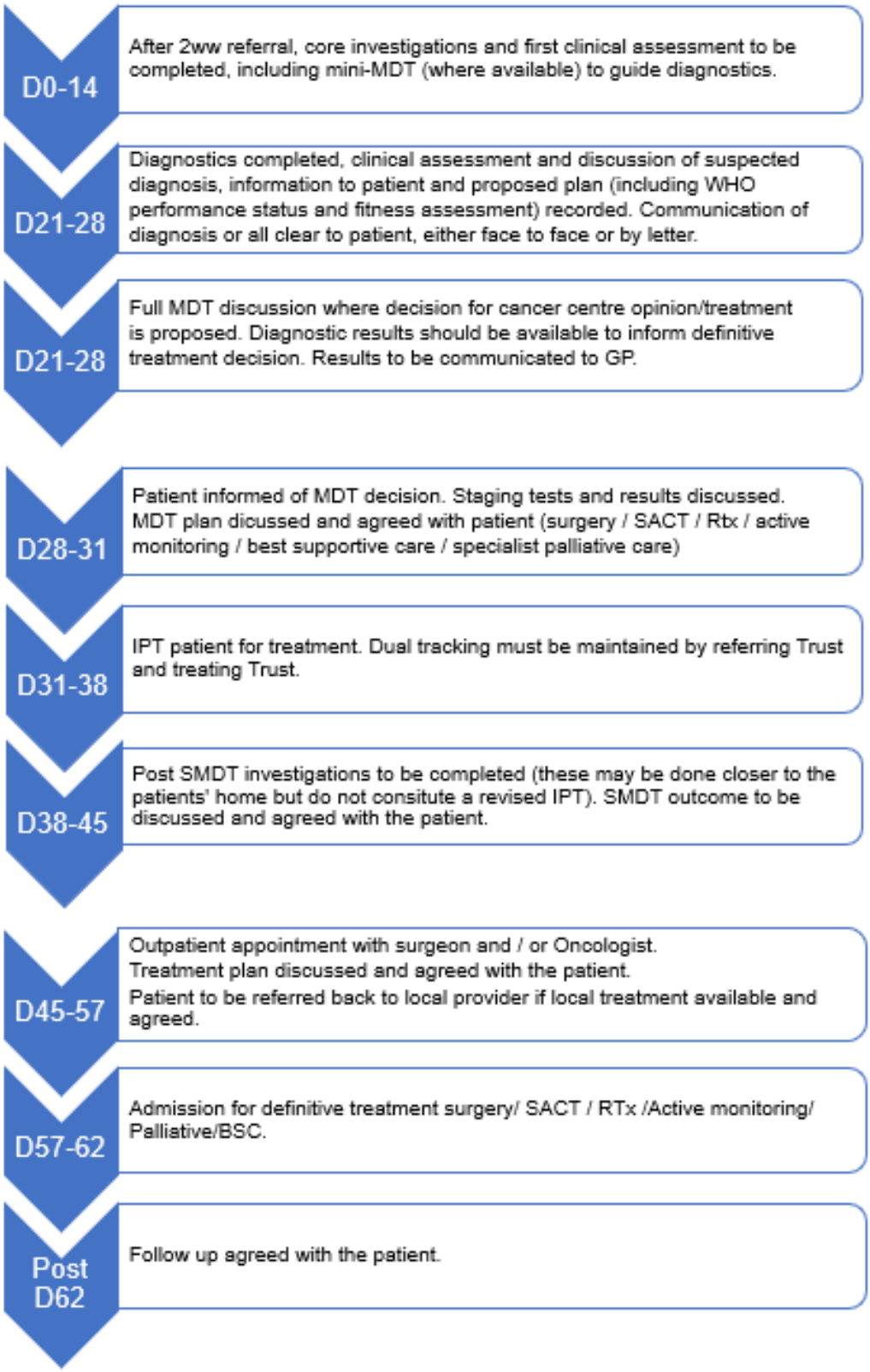
Clinical history and examination

Working diagnosis

Staging information

Relevant pathology/ scans/ reports

Following the first IPT, if the center clinician decides that further diagnostics are required, regardless of location under the accepting consultant, no further IPTs are required.



12.8 Endometrial / Womb Cancer IPT Pathway

Core diagnostic investigations required Pre-IPT:

Patient aware of diagnosis and reasons for referral to another Trust

MRI pelvis

Clinical appointment/examination

U/S images and report

Hysteroscopy +/- endometrial biopsy results

Tumour markers-CA125, CA199 and CEA

Core MDS required for IPT:

Patient demographics

Performance status (if available)

Co-morbidities (if available)

CWT information

Suspected cancer type

MDT outcome (if local MDT in place)

Consultant in charge

Clinical history and examination - FBC, UEs & LFTs

Working diagnosis

Staging information

Relevant pathology/ scans/ reports

Following the first IPT, if the center clinician decides that further diagnostics are required, regardless of location under the accepting consultant, no further IPTs are required.

D0-14
After 2ww referral, or abnormal imaging, core investigations and first clinical assessment to be completed to guide diagnostics.

D21-28
All diagnostics, clinical assessment and discussion of suspected diagnosis completed, information to patient and proposed plan (including WHO performance status and fitness assessment) recorded. Communication of diagnosis or all clear to patient, either face to face or by letter.

D21-28
Full local MDT discussion where local and cancer centre opinion/treatment is discussed. Diagnostic results should be available to inform definitive treatment decision.

D28-31
Local MDT outcome to be discussed and plan agreed with the patient and the outcome to be communicated to the GP. IPT for diagnostic intervention, SMDT or definitive treatment (if possible at this point).

D31-38
Staging tests completed (locally where possible). IPT patient if care not already transferred. Dual tracking must be maintained by referring Trust and treating Trust.

D38-45
Post SMDT investigations to be completed (locally where possible, this does not consitute a revised IPT). SMDT outcome to be discussed and agreed with the patient.

D45-57
Outpatient appointment with surgeon and / or Oncologist.
Treatment plan discussed and agreed with the patient.
Patient to be referred back to local provider if local treatment available and agreed.

D57-62
Admission for definitive treatment surgery/SACT /RTx /Active monitoring/ Palliative/BSC.

Post D62
Follow up agreed with the patient.

12.9 Gynaecology Cancer IPT Pathway

Core diagnostic investigations required Pre-IPT:

GP assessment, ultrasound scan, CA125- imaging scans and reports

CT/MRI (14 days since test) imaging scans and reports

Ultrasound scan (14 days since test) imaging scans and reports

Tumour markers, CA125, CA199, CEA (48 hours since test)- reports

Core MDS required for IPT:

Pt demographics

Performance status (if available)

Co-morbidities (if available)

CWT information

Suspected cancer type

Consultant in charge

Working diagnosis

Staging information

Following the first IPT, if the center clinician decides that further diagnostics are required, regardless of location under the accepting consultant, no further IPTs are required.

D0-14

After 2ww referral, or abnormal imaging raising suspicion for ovarian cancer, core investigations, first clinical assessment to be completed, including mini-MDT (where available) to guide diagnostics.

D21-28

Diagnostics completed, clinical assessment and discussion of suspected diagnosis, information to patient and proposed plan (including WHO performance status and fitness assessment) recorded. Communication of diagnosis or all clear to patient, either face to face or by letter.

D21-28

Full MDT discussion where decision for cancer centre opinion/treatment is proposed. Diagnostic results should be available to inform definitive treatment decision. Results to be communicated to GP. IPT for diagnostic intervention. SMDT or definitive treatment (if possible at this point).

D28-31

Patient informed of MDT decision. Staging tests and results discussed. MDT plan dicussed and agreed with patient (surgery / SACT / Rtx / active monitoring / best supportive care / specialist palliative care)

D31-38

IPT patient for treatment where required. Dual tracking must be maintained by referring Trust and treating Trust.

D38-45

Post SMDT investigations to be completed. SMDT outcome to be discussed and agreed with the patient. Outpatient appointment with surgeon and / or Oncologist. Treatment plan discussed and agreed with the patient. TCI date for definitive surgery / SACT / RTx given to the patient.

D45-57

Admission for surgical staging and / or definitive treatment (surgery / SACT / RTx.

D57-62

Review pathological staging at MDT and consider surveillance or referral for adjuvant treatment. Onward referral made as appropriate. Results to GP and referring unit.

Post D62

Follow up agreed with the patient.

12.10 Head and Neck Cancer IPT Pathway

Core diagnostic investigations required Pre-IPT:

Patient aware of diagnosis and reasons for referral to another Trust

Staging MRI/CT and OPG/Transnasal Endoscopy (TNE) /FNA/ PET CT/Pharyngoscopy where clinically appropriate

Diagnostic biopsy

Core MDS required for IPT:

Patient demographics

Performance status (if available)

Co-morbidities (if available)

Smoking & alcohol status (if available)

CWT information

Suspected cancer type

Consultant in charge

Clinical history and examination

Working diagnosis

Staging information

Relevant pathology/ scans/ reports

Following the first IPT, if the center clinician decides that further diagnostics are required, regardless of location under the accepting consultant, no further IPTs are required.

D0-14
After 2ww referral, core investigations and first clinical assessment to be completed, including mini-MDT (where available) to guide diagnostics.

D21-28
Diagnostics completed, clinical assessment and discussion of suspected diagnosis, information to patient and proposed plan (including WHO performance status and fitness assessment) recorded. Communication of diagnosis or all clear to patient, either face to face or by letter.

D21-28
Full MDT discussion where decision for cancer centre opinion/treatment is proposed. Diagnostic results should be available to inform definitive treatment decision. Results to be communicated to GP.

D28-31
Patient informed of MDT decision. Staging tests and results discussed. MDT plan dicussed and agreed with patient (surgery / SACT / Rtx / active monitoring / best supportive care / specialist palliative care)

D31-38
IPT patient for treatment. Dual tracking must be maintained by referring Trust and treating Trust.

D38-45
Post SMDT investigations to be completed (these may be done closer to the patients' home but do not consitute a revised IPT). SMDT outcome to be discussed and agreed with the patient.

D45-57
Outpatient appointment with surgeon and / or Oncologist.
Treatment plan discussed and agreed with the patient.
Patient to be referred back to local provider if local treatment available and agreed.

D57-62
Admission for definitive treatment surgery/ SACT / RTx /Active monitoring/ Palliative/BSC.

Post D62
Follow up agreed with the patient.

12.11 Liver Cancer IPT Framework – Pathway to Leeds

Core diagnostic investigations required Pre-IPT:

Pt aware of diagnosis and reasons for referral to another Trust

U/S, CT Liver, tumour markers (ca19-9, alpha feta protein) Child-Pugh/MELD status (coag, LFTs)

Core MDS required for IPT:

Patient demographics

Performance status (if available)

Co-morbidities (if available)

CWT information

Suspected cancer type

Consultant in charge

Clinical history and examination

Working diagnosis

Staging information

Relevant pathology/ scans/ reports

Following the first IPT, if the center clinician decides that further diagnostics are required, regardless of location under the accepting consultant, no further IPTs are required.

D0-14
After 2ww referral, core investigations and first clinical assessment to be completed, including mini-MDT (where available) to guide diagnostics.

D21-28
Diagnostics completed, clinical assessment and discussion of suspected diagnosis, information to patient and proposed plan (including WHO performance status and fitness assessment) recorded. Communication of diagnosis or all clear to patient, either face to face or by letter.

D21-28
Full MDT discussion where decision for cancer centre opinion/treatment is proposed. Diagnostic results should be available to inform definitive treatment decision. Results to be communicated to GP.

D28-31
Patient informed of MDT decision. Staging tests and results discussed. MDT plan dicussed and agreed with patient (surgery / SACT / Rtx / active monitoring / best supportive care / specialist palliative care)

D31-38
IPT patient for treatment. Dual tracking must be maintained by referring Trust and treating Trust.

D38-45
Post SMDT investigations to be completed (these may be done closer to the patients' home but do not consitute a revised IPT). SMDT outcome to be discussed and agreed with the patient.

D45-57
Outpatient appointment with surgeon and / or Oncologist.
Treatment plan discussed and agreed with the patient.
Patient to be referred back to local provider if local treatment available and agreed.

D57-62
Admission for definitive treatment surgery/ablation/SACT /Active monitoring/ Palliative/BSC.

Post D62
Follow up agreed with the patient.

12.12 Lung Cancer IPT Pathway

Core diagnostic investigations required pre-IPT:

Staging CT thorax and upper abdomen (adrenals/liver) +/- supraclavicular fossa

Radical treatment:

PET-CT

Brain imaging (CT/MRI) if N ≥2 or T ≥3 disease

Staging EBUS if any enlarged of FDG avid hilar/mediastinal lymph nodes

Pathological confirmation of lung cancer where amenable/appropriate

Full lung function for spirometry and diffusion capacity

Functional assessment, e.g., shuttle walk, CPET, CPEX, 6 minute walk or stair assessment*

Echocardiogram if IHD, murmur, abnormal ECG or suspected pneumonectomy

CPEX if ppo-FEV1 or ppo-DLCO ≥40%

Non-radical treatment:

Staging CT thorax and upper abdomen (adrenals/liver) =/- supraclavicular fossa

Histology

Full lung function

*N.B. patients with PS 0 and normal lung function may not require formal testing of their exercise tolerance and this should be decided and documented at MDT prior to referral

Core MDS required for IPT:

Pt demographics

Performance status (if available)

Co-morbidities (If available)

CWT information

Suspected cancer type

Consultant in charge

Working diagnosis

Staging information

Following the first IPT, if the center clinician decides that further diagnostics are required, regardless of location under the accepting consultant, no further IPTs are required.

D0-14 — After 2ww referral, or abnormal imaging raising suspicion for lung cancer, core investigations, first clinical assessment to be completed, including mini-MDT (where available) to guide diagnostics.

D21-28 — Diagnostics completed, clinical assessment and discussion of suspected diagnosis, information to patient and proposed plan (including WHO performance status and fitness assessment) recorded. Communication of diagnosis or all clear to patient, either face to face or by letter.

D21-28 — Full MDT discussion where decision for cancer centre opinion/treatment is proposed. Diagnostic results should be available to inform definitive treatment decision. Results to be communicated to GP. IPT for diagnostic intervention. SMDT or definitive treatment (if possible at this point).

D28-31 — Patient informed of MDT decision. Staging tests and results discussed. MDT plan dicussed and agreed with patient (surgery / SACT / Rtx / active monitoring / best supportive care / specialist palliative care)

D31-38 — IPT patient for treatment where required. Dual tracking must be maintained by referring Trust and treating Trust.

D38-45 — Post SMDT investigations to be completed. SMDT outcome to be discussed and agreed with the patient. Outpatient appointment with surgeon and / or Oncologist. Treatment plan discussed and agreed with the patient. TCI date for definitive surgery / SACT / RTx given to the patient.

D45-57 — Admission for surgical staging and / or definitive treatment (surgery / SACT / RTx.

D57-62 — Review pathological staging at MDT and consider surveillance or referral for adjuvant treatment. Onward referral made as appropriate. Results to GP and referring unit.

Post D62 — Follow up agreed with the patient.

12.13 Oesophageal Cancer IPT Pathway

Core diagnostic investigations required Pre-IPT:

Pt aware of diagnosis and reasons for referral to another Trust

CT

Histology from OGD

Core MDS required for IPT:

Pt demographics

Performance status (if available)

Co-morbidities (if available)

CWT information

Suspected cancer type

Consultant in charge

Clinical history and examination - FBC, UEs & LFTs

Working diagnosis

Staging information

Relevant pathology/ scans/ reports

Following the first IPT, if the center clinician decides that further diagnostics are required, regardless of location under the accepting consultant, no further IPTs are required.

D0-14

After 2ww referral, core investigations and first clinical assessment to be completed, including mini-MDT (where available) to guide diagnostics.

D21-28

Diagnostics completed, clinical assessment and discussion of suspected diagnosis, information to patient and proposed plan (including WHO performance status and fitness assessment) recorded. Communication of diagnosis or all clear to patient, either face to face or by letter.

D21-28

Full MDT discussion where decision for cancer centre opinion/treatment is proposed. Diagnostic results should be available to inform definitive treatment decision. Results to be communicated to GP.

D28-31

Patient informed of MDT decision. Staging tests and results discussed. MDT plan dicussed and agreed with patient (surgery / SACT / Rtx / active monitoring / best supportive care / specialist palliative care)

D31-38

IPT patient for treatment. Dual tracking must be maintained by referring Trust and treating Trust.

D38-45

Post SMDT investigations to be completed (these may be done closer to the patients' home but do not consitute a revised IPT). SMDT outcome to be discussed and agreed with the patient.

D45-57

Outpatient appointment with surgeon/gastroenterologist and / or Oncologist. Treatment plan discussed and agreed with the patient.
Patient to be referred back to local provider if local treatment available and agreed.

D57-62

Admission for definitive treatment surgery/SACT /RTx /Active monitoring/ Palliative/BSC.

Post D62

Follow up agreed with the patient.

12.14 Ovarian Canver IPT Pathway

Core diagnostic investigations required Pre-IPT:

Pt aware of diagnosis and reasons for referral to another Trust

CT/MRI

Clinical appointment/examination

U/S scan report and CA125 done by GP prior to referral

U/S images and report

Tumour markers-CA125, CA199 and CEA

Core MDS required for IPT:

Pt demographics

Performance status (if available)

Co-morbidities (if available)

CWT information

Suspected cancer type

Consultant in charge

Clinical history and examination - FBC, UEs & LFTs

Working diagnosis

Staging information

Relevant pathology/ scans/ reports

Following the first IPT, if the center clinician decides that further diagnostics are required, regardless of location under the accepting consultant, no further IPTs are required.

D0-14

After 2ww referral, core investigations and first clinical assessment to be completed, including mini-MDT (where available) to guide diagnostics.

D21-28

Diagnostics completed, clinical assessment and discussion of suspected diagnosis, information to patient and proposed plan (including WHO performance status and fitness assessment) recorded. Communication of diagnosis or all clear to patient, either face to face or by letter.

D21-28

Full MDT discussion where decision for cancer centre opinion/treatment is proposed. Diagnostic results should be available to inform definitive treatment decision. Results to be communicated to GP.

D28-31

Patient informed of MDT decision. Staging tests and results discussed. MDT plan dicussed and agreed with patient (surgery / SACT / Rtx / active monitoring / best supportive care / specialist palliative care)

D31-38

IPT patient for treatment. Dual tracking must be maintained by referring Trust and treating Trust.

D38-45

Post SMDT investigations to be completed (these may be done closer to the patients' home but do not consitute a revised IPT). SMDT outcome to be discussed and agreed with the patient.

D45-57

Outpatient appointment with surgeon and / or Oncologist.
Treatment plan discussed and agreed with the patient.
Patient to be referred back to local provider if local treatment available and agreed.

D57-62

Admission for definitive treatment surgery/SACT /RTx /Active monitoring/ Palliative/BSC.

Post D62

Follow up agreed with the patient.

12.15 Pancreatic Cancer IPT Pathway

York > Pathway to Leeds

Scarborough and NLAG > Pathway to HUTH

HUTH Core diagnostic investigations required Pre-IPT:

OGD

Pt aware of diagnosis and reasons for referral to another Trust

U/S and CT

LFTs, EUS / PET-CT

Tumour markers - CA19-9

Leeds Core diagnostic investigations required Pre-IPT:

Pt aware of diagnosis and reasons for referral to another Trust

U/S and CT

LFTs

Tumour markers - CA19-9

Core MDS required for IPT:

Pt demographics

Performance status (if available)

Co-morbidities (if available)

CWT information

Suspected cancer type

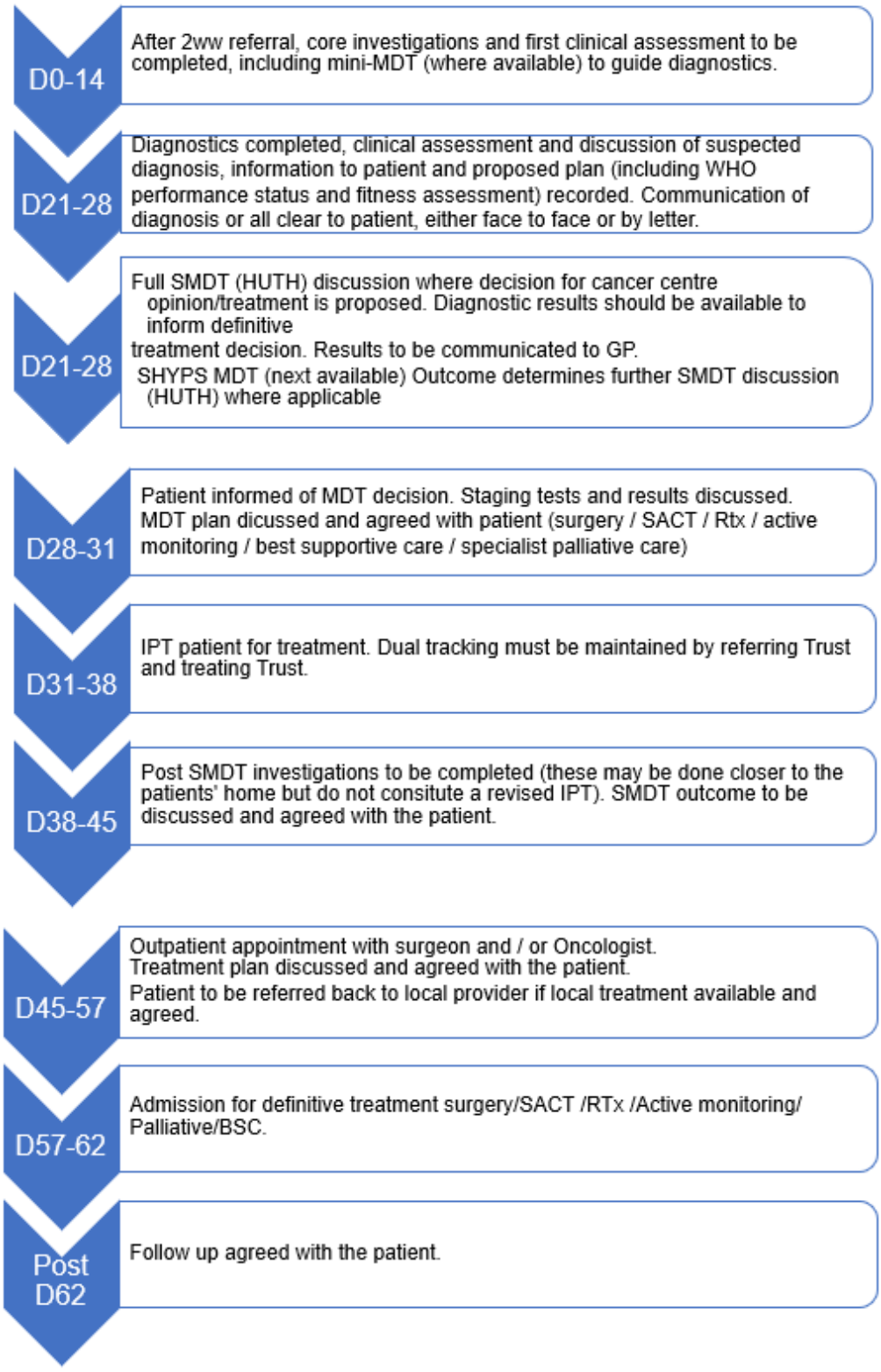
Consultant in charge

Working diagnosis

Staging information

Relevant pathology/ scans/ reports

Following the first IPT, if the center clinician decides that further diagnostics are required, regardless of location under the accepting consultant, no further IPTs are required.



12.16 Penile Cancer IPT Pathway

Core diagnostic investigations required Pre-IPT:

Pt aware of diagnosis and reasons for referral to another Trust

Biopsy

Core MDS required for IPT:

Pt demographics

Performance status (if available)

Co-morbidities (if available)

CWT information

Suspected cancer type

Consultant in charge

Working diagnosis

Staging information

Relevant pathology/ scans/ reports

Following the first IPT, if the center clinician decides that further diagnostics are required, regardless of location under the accepting consultant, no further IPTs are required.

D0-14
After 2ww referral, core investigations and first clinical assessment to be completed, including mini-MDT (where available) to guide diagnostics.

D21-28
Diagnostics completed, clinical assessment and discussion of suspected diagnosis, information to patient and proposed plan (including WHO performance status and fitness assessment) recorded. Communication of diagnosis or all clear to patient, either face to face or by letter.

D21-28
Full MDT discussion where decision for cancer centre opinion/treatment is proposed. Diagnostic results should be available to inform definitive treatment decision. Results to be communicated to GP.

D28-31
Patient informed of MDT decision. Staging tests and results discussed. MDT plan dicussed and agreed with patient (surgery / SACT / Rtx / active monitoring / best supportive care / specialist palliative care)

D31-38
IPT patient for treatment. Dual tracking must be maintained by referring Trust and treating Trust.

D38-45
Post SMDT investigations to be completed (these may be done closer to the patients' home but do not consitute a revised IPT). SMDT outcome to be discussed and agreed with the patient.

D45-57
Outpatient appointment with surgeon and / or Oncologist.
Treatment plan discussed and agreed with the patient.
Patient to be referred back to local provider if local treatment available and agreed.

D57-62
Admission for definitive treatment surgery/SACT /RTx /Active monitoring/ Palliative/BSC.

Post D62
Follow up agreed with the patient.

12.17 Prostate Cancer IPT Pathway – Pathway to Leeds

Core diagnostic investigations required pre-IPT:

Prostate biopsy results

Diagnostic imaging and staging imaging (MRI / bone scan and/or CT)- imaging scans and reports

Pathology /Histology/ operation notes and reports

FBC, U&Es and LFTs results

Core MDS required for IPT:

Pt demographics

Performance status (if available)

Co-morbidities (if available)

CWT information

Suspected cancer type

Consultant in charge

Working diagnosis

Staging information

Following the first IPT, if the center clinician decides that further diagnostics are required, regardless of location under the accepting consultant, no further IPTs are required.

D0-14 – After 2ww referral, or abnormal imaging raising suspicion for prostate cancer, core investigations, first clinical assessment to be completed, including mini-MDT (where available) to guide diagnostics.

D21-28 – Diagnostics completed, clinical assessment and discussion of suspected diagnosis, information to patient and proposed plan (including WHO performance status and fitness assessment) recorded. Communication of diagnosis or all clear to patient, either face to face or by letter.

D21-28 – Full MDT discussion where decision for cancer centre opinion/treatment is proposed. Diagnostic results should be available to inform definitive treatment decision. Results to be communicated to GP. IPT for diagnostic intervention. SMDT or definitive treatment (if possible at this point).

D28-31 – Patient informed of MDT decision. Staging tests and results discussed. MDT plan dicussed and agreed with patient (surgery / SACT / Rtx / active monitoring / best supportive care / specialist palliative care)

D31-38 – IPT patient for treatment where required. Dual tracking must be maintained by referring Trust and treating Trust.

D38-45 – Post SMDT investigations to be completed. SMDT outcome to be discussed and agreed with the patient. Outpatient appointment with surgeon and / or Oncologist. Treatment plan discussed and agreed with the patient. TCI date for definitive surgery / SACT / RTx given to the patient.

D45-57 – Admission for surgical staging and / or definitive treatment (surgery / SACT / RTx.

D57-62 – Review pathological staging at MDT and consider surveillance or referral for adjuvant treatment. Onward referral made as appropriate. Results to GP and referring unit.

Post D62 – Follow up agreed with the patient.

12.18 Renal Cancer IPT Pathway

Core diagnostic investigations required Pre-IPT:

Pt aware of diagnosis and reasons for referral to another Trust

Medical history

CT- Renal & Thorax

eGFR

Blood tests- FBC, LFT, Calcium

Core MDS required for IPT:

Pt demographics

Performance status (if available)

Co-morbidities (if available)

CWT information

Suspected cancer type

Consultant in charge

Working diagnosis

Staging information

Relevant pathology/ scans/ reports

Following the first IPT, if the center clinician decides that further diagnostics are required, regardless of location under the accepting consultant, no further IPTs are required.

D0-14
After 2ww referral, core investigations and first clinical assessment to be completed, including mini-MDT (where available) to guide diagnostics.

D21-28
Diagnostics completed, clinical assessment and discussion of suspected diagnosis, information to patient and proposed plan (including WHO performance status and fitness assessment) recorded. Communication of diagnosis or all clear to patient, either face to face or by letter.

D21-28
Full MDT discussion where decision for cancer centre opinion/treatment is proposed. Diagnostic results should be available to inform definitive treatment decision. Results to be communicated to GP.

D28-31
Patient informed of MDT decision. Staging tests and results discussed. MDT plan dicussed and agreed with patient (surgery /Image Guided Ablation/SACT / Rtx / active monitoring / best supportive care / specialist palliative care)

D31-38
IPT patient for treatment. Dual tracking must be maintained by referring Trust and treating Trust.

D38-45
Post SMDT investigations to be completed (these may be done closer to the patients' home but do not consitute a revised IPT). SMDT outcome to be discussed and agreed with the patient.

D45-57
Outpatient appointment with surgeon and / or Oncologist.
Treatment plan discussed and agreed with the patient.
Patient to be referred back to local provider if local treatment available and agreed.

D57-62
Admission for definitive treatment surgery/Image Guided Ablation/SACT /RTx /Active monitoring/ Palliative/BSC.

Post D62
Follow up agreed with the patient.

12.19 Soft Tissue Sarcoma IPT Pathway

York, Scarborough and HUTH > Pathway to Leeds

NLAG > Pathway to Sheffield

Core diagnostic investigations required Pre-IPT:

Pt aware of diagnosis and reasons for referral to another Trust

U/S

MRI per guideline

Thoracic CT requested prior to IPT

Core MDS required for IPT:

Pt demographics

Performance status (if available)

Co-morbidities (if available)

CWT information

Suspected cancer type

Consultant in charge

Working diagnosis

Staging information

Relevant pathology/ scans/ reports

Following the first IPT, if the center clinician decides that further diagnostics are required, regardless of location under the accepting consultant, no further IPTs are required.

D0-14

After 2ww referral, core investigations and first clinical assessment to be completed, including mini-MDT (where available) to guide diagnostics.

D21-28

Diagnostics completed, clinical assessment and discussion of suspected diagnosis, information to patient and proposed plan (including WHO performance status and fitness assessment) recorded. Communication of diagnosis or all clear to patient, either face to face or by letter.

D21-28

Full MDT discussion where decision for cancer centre opinion/treatment is proposed. Diagnostic results should be available to inform definitive treatment decision. Results to be communicated to GP.

D28-31

Patient informed of MDT decision. Staging tests and results discussed. MDT plan dicussed and agreed with patient (surgery /SACT / Rtx / active monitoring / best supportive care / specialist palliative care)

D31-38

IPT patient for treatment. Dual tracking must be maintained by referring Trust and treating Trust.

D38-45

Post SMDT investigations to be completed (these may be done closer to the patients' home but do not consitute a revised IPT). SMDT outcome to be discussed and agreed with the patient.

D45-57

Outpatient appointment with surgeon and / or Oncologist.
Treatment plan discussed and agreed with the patient.
Patient to be referred back to local provider if local treatment available and agreed.

D57-62

Admission for definitive treatment surgery/SACT /RTx /Active monitoring/ Palliative/BSC.

Post D62

Follow up agreed with the patient.

12.20 Testicular Cancer IPT Pathway

York and Scarborough > Pathway to Leeds

HUTH and NLAG > Local MDT and Treatment

Core diagnostic investigations required Pre-IPT:

Pt aware of diagnosis and reasons for referral to another Trust

Visible metastatic disease on CXR

Abdo/Testis U/S

Blood tests -FBC, UEs, LFTs, bone, Alpha fetoprotein, beta Hcg, LDH

Core MDS required for IPT:

Patient demographics

Performance status (if available)

Co-morbidities (if available)

CWT information

Suspected cancer type

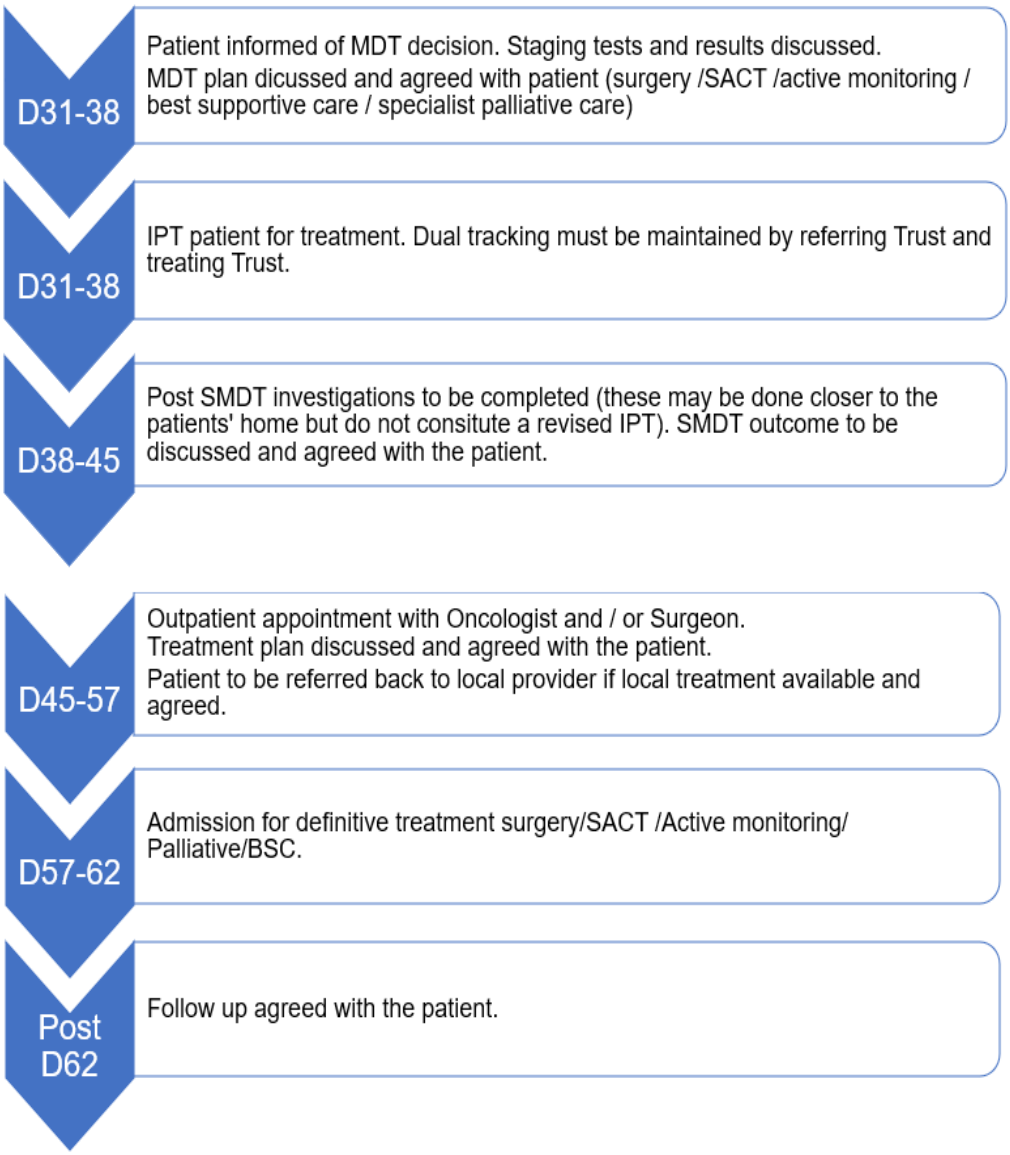
Consultant in charge

Working diagnosis

Staging information

Relevant pathology/ scans/ reports

Following the first IPT, if the center clinician decides that further diagnostics are required, regardless of location under the accepting consultant, no further IPTs are required.



12.21 Vulva Cancer IPT Pathway

Core diagnostic investigations required Pre-IPT:

Patient aware of diagnosis and reasons for referral to another Trust

Clinical appointment/examination

Biopsy

Core MDS required for IPT:

Patient demographics

Performance status (if available)

Co-morbidities (if available)

CWT information

Suspected cancer type

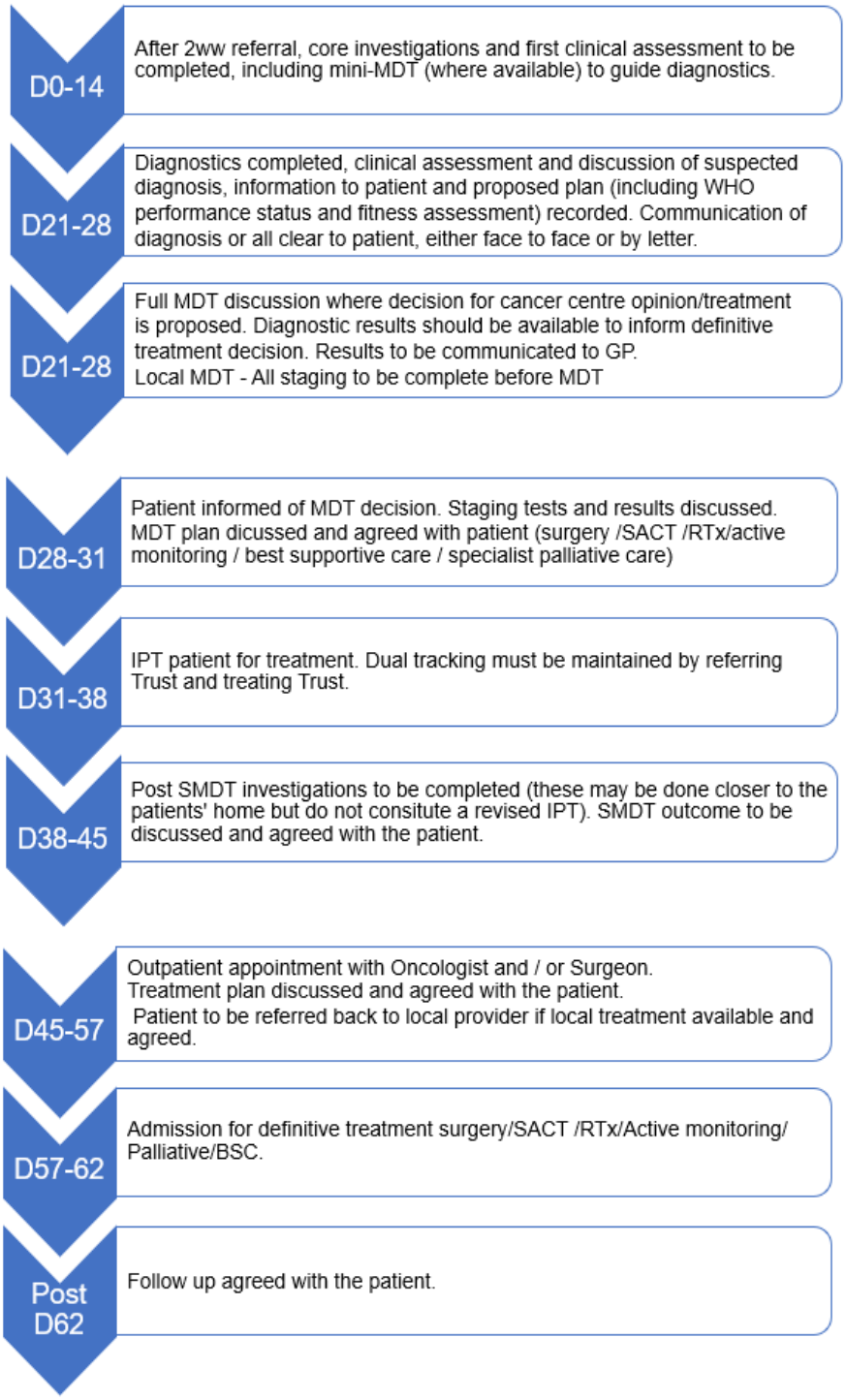
Consultant in charge

Working diagnosis

Staging information

Relevant pathology/ scans/ reports

Following the first IPT, if the center clinician decides that further diagnostics are required, regardless of location under the accepting consultant, no further IPTs are required.



13 Appendix 2 – IPT Reconciliation Process Flow Chart

Inter-Provider Transfer Resolution Process