# Document Control

<table>
<thead>
<tr>
<th>Title</th>
<th>West Yorkshire, Harrogate and York Cancer Inter-Provider Transfers (IPT) Operating Framework</th>
</tr>
</thead>
</table>
| **Author(s)** | Lead Cancer Managers and MDT Cancer Leads from:  
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Leeds Teaching Hospitals NHS Trust  
Mid Yorkshire Hospitals NHS Trust  
York Teaching Hospital NHS Foundation Trust |
| **Owner** | West Yorkshire & Harrogate Cancer Alliance |

## Version Control

<table>
<thead>
<tr>
<th>Version/Draft</th>
<th>Date</th>
<th>Revision Summary</th>
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<tr>
<td>1.0</td>
<td>31/01/2019</td>
<td>Initial version</td>
</tr>
<tr>
<td>1.1</td>
<td>30/4/2019</td>
<td>Revised to include updates to the National Cancer Waiting Times Monitoring Dataset Guidance v10.0</td>
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## Contributors to current version

<table>
<thead>
<tr>
<th>Contributor</th>
<th>Author/Editor</th>
<th>Section/Contribution</th>
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# Information Reader Box

<table>
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<th><strong>Title</strong></th>
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Calderdale and Huddersfield NHS Foundation Trust  
Harrogate and District NHS Foundation Trust  
Leeds Teaching Hospitals NHS Trust  
Mid Yorkshire Hospitals NHS Trust  
York Teaching Hospital NHS Foundation Trust |
| **Sign off Requirements** | To be ratified by Trust Cancer Boards  
To be endorsed by the West Yorkshire and Harrogate Cancer Alliance Board |
| **Sign off Date** | January 2019 |
| **Published** | May 2019 |
| **Next Review Date** | January 2021 |
| **Proposed Target Audience for Consultation / Final Statement** | WY&H Cancer MDT Teams  
WY&H Lead Cancer Nurses  
WY&H Lead Cancer Managers  
WY&H Lead Cancer Commissioners |
| **Proposed Circulation List for Final Statement** | All WY&H Cancer Alliance guidelines will be made available electronically on the website. No hard copies will be supplied. |
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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 time 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 West Yorkshire & Harrogate Cancer Alliance.
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 v10:


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.

2.3 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.

2.4 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.

2.5 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.

2.6 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.

2.7 Visiting clinicians to local MDT

When a visiting clinician attends a local MDT meeting at a referring unit and 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.

2.8 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.

2.9 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.
2.10 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 West Yorkshire, Harrogate and York Providers. 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 CWT 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.

Referrals between organisations will make it clear whether the referral is for MDT advice/guidance/opinion or for MDT treatment. 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.

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:

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

   c) Summary of Specialist and Local MDT’s across West Yorkshire & Harrogate by Tumour Site

<table>
<thead>
<tr>
<th>SITE</th>
<th>LOCAL MDT</th>
<th>SPECIALIST MDT(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anal Cancer</td>
<td></td>
<td>Leeds</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s (PTC)</td>
<td></td>
<td>Leeds</td>
</tr>
<tr>
<td>Colorectal Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CUP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty</td>
<td>Location</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>---------------------------</td>
<td></td>
</tr>
<tr>
<td>Gynaecology</td>
<td>Leeds</td>
<td></td>
</tr>
<tr>
<td>Haematology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head and Neck</td>
<td>Bradford</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Leeds/ Mid Yorksople</td>
<td></td>
</tr>
<tr>
<td>Liver</td>
<td>Leeds</td>
<td></td>
</tr>
<tr>
<td>Lung</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Melanoma</td>
<td>Leeds</td>
<td></td>
</tr>
<tr>
<td>Brain and CNS</td>
<td>Leeds</td>
<td></td>
</tr>
<tr>
<td>Pancreatic</td>
<td>Leeds</td>
<td></td>
</tr>
<tr>
<td>Penile (Supra-Network)</td>
<td>Leeds</td>
<td></td>
</tr>
<tr>
<td>Pituitary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soft Tissue Sarcoma</td>
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<td></td>
</tr>
<tr>
<td>Skin</td>
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<td></td>
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<tr>
<td>Testicular (Supra-Network)</td>
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<tr>
<td>Thyroid</td>
<td>Leeds</td>
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<tr>
<td>TYA (PTC)</td>
<td>Leeds</td>
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<td>Upper GI</td>
<td>Bradford</td>
<td></td>
</tr>
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<td></td>
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<td>Bradford</td>
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</tr>
<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Mid Yorkshire</td>
<td></td>
</tr>
</tbody>
</table>
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 providers 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 CWT 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.
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 v10.0.

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.

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 in Table 1 below.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>62-day wait (overall pathway)</th>
<th>38-day wait (investigative phase)</th>
<th>24-day wait (treatment commencement phase)</th>
<th>62-day standard</th>
<th>38-day wait report</th>
<th>24-day wait report</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Investigating Provider (IP)</td>
<td>Treatment provider (TP)</td>
<td>Investigating</td>
<td>Treatment</td>
<td>Investigating</td>
<td>Treatment</td>
</tr>
<tr>
<td>1 IF: SUCCESS SUCCESS SUCCESS THEN: 0.5 0.5 0.5 0.5 0.5 1 1 1 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 IF: SUCCESS SUCCESS BREACH THEN: 0 0 0 1 1 0 0 0 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 IF: SUCCESS BREACH SUCCESS THEN: 0 0 0 1 1 0 0 0 1</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>4 IF: BREACH SUCCESS BREACH THEN: 0 0 0 1 1 0 0 0 1</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 IF: BREACH BREACH SUCCESS THEN: 0 1 1 0 0 0 1 1 1</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>6 IF: BREACH BREACH BREACH THEN: 0 0.5 0.5 0 0.5 0 1 0 1</td>
<td></td>
<td></td>
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</tbody>
</table>

Responsibility for the breach will be established in accordance to the guidance described in the National Cancer Waiting Times Monitoring Dataset Guidance v10.0 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.

A template will be completed for each case. A copy of the 38 Day IPT Discrepancy Form is attached in Appendix 2.
11 Governance Arrangements

The governance arrangements for this policy are as follows:

- Trust Executive Team (each provider) for agreement and implementation.
- WY&H Strategy and Operations Group (COOs)
- West Yorkshire and Harrogate Cancer Alliance
12  IPT Supporting Documentation

12.1  Interdependencies

1. Clear definitions of specialist versus local commissioning of diagnostic and therapy services is key to making sure that a ‘full house’ of appropriate workup is done pre-IPT.

2. Clear definition/expectation of the level of anticipatory work-up / anticipatory outcome planning to be undertaken by locality MDTs/MDTM to allow parallel pathways.

3. Rebuilding a ‘local cancer network’ to facilitate education, training and quality assurance and making optimal use of limited clinical manpower: MDT protocolisation and use of novel approaches.

4. Planning of adequate capacity for diagnostics across West Yorkshire & Harrogate.

5. Agreeing who takes an overall lead in this.

6. IT infrastructure across the region requires investment.

7. Clear Service Level Agreements (SLA) between organisations should be contracted.
### Specialist MDT Discussion Dates and Times for Cancer Centre Acceptance

<table>
<thead>
<tr>
<th></th>
<th>MDT Cut-off Day (BRADFORD)</th>
<th>MDT Meeting Day (BRADFORD)</th>
<th>MDT Cut off day (LEEDS)</th>
<th>MDT Meeting day (LEEDS)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brain/CNS</strong></td>
<td>X</td>
<td>X</td>
<td>3.30 pm – Monday</td>
<td>9.30-11.00am Wednesday</td>
</tr>
<tr>
<td><strong>Rehab</strong></td>
<td></td>
<td></td>
<td>3.30 pm – Monday</td>
<td>11.15-12.00 – Wednesday</td>
</tr>
<tr>
<td><strong>Pituitary</strong></td>
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<td>3.30 pm – Monday</td>
<td>11.30-1.30pm Wednesday</td>
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<td><strong>Breast</strong></td>
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<td><strong>12.30-1.30 – Thursday</strong></td>
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<td><strong>Diagnostic</strong></td>
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<td>12.00 – Monday</td>
<td>9.00-10.30am Tuesday</td>
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<td>3.30 pm - Wednesday</td>
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<td><strong>CUP</strong></td>
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<td><strong>12.30-1.30 pm – Tuesday</strong></td>
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<tr>
<td><strong>Colorectal</strong></td>
<td>X</td>
<td>X</td>
<td>1.00 pm - Wednesday</td>
<td><strong>8.30-10.30 am – Monday</strong></td>
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<tr>
<td><strong>Anal</strong></td>
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<tr>
<td><strong>Hepatobiliary – Pancreas</strong></td>
<td>X</td>
<td>X</td>
<td>12.00 – Monday</td>
<td>8.00-12.00 – Thursday</td>
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<tr>
<td><strong>Hepatobiliary - Liver</strong></td>
<td></td>
<td></td>
<td>12.00 - Wednesday</td>
<td>8.00-12.00 – Friday</td>
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<tr>
<td><strong>Endocrine</strong></td>
<td></td>
<td></td>
<td>3.00 pm – Monday</td>
<td><strong>Fortnightly 5.00-7.00 – Wed</strong></td>
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<tr>
<td><strong>Gynaecology</strong></td>
<td>X</td>
<td>X</td>
<td>1.00 pm – Monday</td>
<td><strong>8.00-12.00 – Wednesday</strong></td>
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<tr>
<td><strong>Haematology</strong></td>
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* List of admin support details for Leeds MDTs in table below
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<th>Time</th>
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<td>Lymphoma/Myeloma/ LDP</td>
<td>12.30 – 10.30 pm</td>
<td>Thursday – Tuesday</td>
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<td>Myeloid leukaemia – acute/chronic</td>
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<td>1.00-2.00 – 1st Wed of month</td>
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<td><strong>Head and Neck</strong></td>
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<td>Monday – Wednesday</td>
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<td>Main 8-12 – Wednesday Mini (Diagnostic) – 12.30-2.30 - Thursday</td>
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<td><strong>Neuro-endocrine (NET)</strong></td>
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<td><strong>Specialist skin</strong></td>
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<td>following review by clinician</td>
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<td><strong>Skin – Melanoma</strong></td>
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<td><strong>Teenage/Young Adults (TYA)</strong></td>
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<td>2.45 - 3.30 - Thursday</td>
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<td>2.00 pm – 8.30 pm</td>
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<tr>
<td>HPB and Liver</td>
<td>X X 2.00 pm</td>
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<tr>
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<td>X X 2.00 pm</td>
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<td><strong>Urology</strong></td>
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<tr>
<td>Testicular</td>
<td>X X 5.00 pm</td>
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**Note:** Hours marked with an `X` indicate specific times that are reserved for particular consultations or reviews.
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<td>Penile</td>
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<td>8.00-8.30 –</td>
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<td></td>
<td>Thursday</td>
<td>Tuesday</td>
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<td>Germ Cell</td>
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<td>12.00 -</td>
<td>12.30-1.00 –</td>
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<td></td>
<td></td>
<td></td>
<td>Wednesday</td>
<td>Friday</td>
</tr>
<tr>
<td>Prostate/Bladder</td>
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<td>12.00 -</td>
<td>1.00-3.30 –</td>
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<td></td>
<td>Wednesday</td>
<td>Friday</td>
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<td>Kidney</td>
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<td>12.00</td>
<td>1.00-3.30 -</td>
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<tr>
<td>Soft tissue Sarcoma</td>
<td>X</td>
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<td>1.00 pm -</td>
<td>1.00-3.00 -</td>
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<tr>
<td></td>
<td></td>
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<td>Thursday</td>
<td>Monday</td>
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<td>Ext.</td>
<td>MDT Support</td>
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<tr>
<td><strong>Specialist MDT BRAIN &amp; CNS</strong></td>
<td>Katrina Evans</td>
<td>28461</td>
<td>Rose Lloyd</td>
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<tr>
<td></td>
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<td>Lesley Stevens</td>
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<tr>
<td><strong>Specialist MDT BRAIN/CNS - REHAB</strong></td>
<td>Katrina Evans</td>
<td>28461</td>
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<td>Lesley Stevens</td>
<td></td>
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<tr>
<td><strong>Specialist MDT BRAIN/CNS - PITUITARY</strong></td>
<td>Katrina Evans</td>
<td>28461</td>
<td>Rose Lloyd</td>
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<td>Lesley Stevens</td>
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<tr>
<td>BREAST</td>
<td>Caroline Stott</td>
<td>68546</td>
<td>Rachel Hargrave Anne-Marie Smith</td>
<td>68562</td>
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<tr>
<td>CANCER OF UNKNOWN PRIMARY (CUP)</td>
<td>Charlotte Lapping</td>
<td>67726</td>
<td>Marie Roberts Neil Wright</td>
<td>64906</td>
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<tr>
<td>COLORECTAL</td>
<td>Simone Lewis</td>
<td>65680</td>
<td>Marie Roberts Neil Wright</td>
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<tr>
<td>Specialist MDT ENDOCRINE</td>
<td>Charlotte Lapping</td>
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<td>Gaynor Jones Lisa McArdle</td>
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<tr>
<td>Specialist MDT GYNAECOLOGY</td>
<td>Sarah Waller</td>
<td>68759</td>
<td>Annabelle Townsend</td>
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<tr>
<td>HAEMATOLOGY - LYMPHOMA / MYELOMA/ LDP</td>
<td>Heather Hall</td>
<td>67860</td>
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# MDT Meeting Schedule and Admin Contact Details

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<tr>
<th>MDT Meeting</th>
<th>MDT Coordinator</th>
<th>Ext.</th>
<th>MDT Support</th>
<th>Ext.</th>
<th>Fax</th>
<th>Meeting Day/Time/Location</th>
<th>MDT Cut Off</th>
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<tbody>
<tr>
<td>HAEMATOLOGY</td>
<td>Heather Hall</td>
<td>67860</td>
<td>Annabelle Townend</td>
<td>67844</td>
<td>67876</td>
<td>Wednesday 12:30-2:00 MDT2, Level 7 Bexley Wing</td>
<td>Mon 12.00</td>
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<tr>
<td>MYELOID LEUKAEMIA - ACUTE/ CHRONIC</td>
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<tr>
<td>Supra-Network SMDT HAEMATOLOGY</td>
<td>Heather Hall</td>
<td>67860</td>
<td>Annabelle Townend</td>
<td>67844</td>
<td>67876</td>
<td>FIRST WEDNESDAY OF MONTH 1:00-2:00 HMDS, Level 3, Bexley Wing</td>
<td>Mon 12.00</td>
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<tr>
<td>- SKIN LYMPHOMA</td>
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<td>Specialist MDT HEAD &amp; NECK</td>
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<td>64024</td>
<td>Monday 8:00-10:00 MDT2, Level 7 Bexley Wing</td>
<td>Thurs 13.00</td>
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<tr>
<td>Specialist MDT HEPATOBILIARY (HpB) - PANCREAS</td>
<td>Amber Wilson</td>
<td>68569</td>
<td>Liam Herridge Holly Killip-Ross</td>
<td>68095</td>
<td>68617</td>
<td>Thursday 8:00-12:00 MDT2 Level 7 Bexley Wing</td>
<td>Mon 12.00</td>
</tr>
<tr>
<td>- LIVER</td>
<td>Amber Wilson</td>
<td>68569</td>
<td>Liam Herridge Holly Killip-Ross</td>
<td>68095</td>
<td>68617</td>
<td>Friday 8:00-12:00 MDT2, Level 7 Bexley Wing</td>
<td>Wed 12.00</td>
</tr>
<tr>
<td>LUNG</td>
<td>Cassy Billington</td>
<td>64685</td>
<td>Chloe Robson Tracey Stoker</td>
<td>64746</td>
<td>66150</td>
<td>MAIN MDT: Wednesday 8:00-12:00 MDT2 MINI (Diagnostic) MDT: Thursday 12:30-2:30 MDT2</td>
<td>Mon 12.00</td>
</tr>
<tr>
<td>Specialist MDT NEURO-ENDOCRINE (NET)</td>
<td>Charlotte Lapping</td>
<td>67726</td>
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<td>FORTNIGHTLY: Monday 11:00-12:00pm MDT2 Level 7, Bexley Wing</td>
<td>Thur 12.00</td>
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<tr>
<td>Specialist MDT PAEDIATRIC ONCOLOGY</td>
<td>Jill Doherty</td>
<td>22327</td>
<td>Barbara Pymer</td>
<td>22314</td>
<td>26375</td>
<td>Thursday 2:00-2:45 Paediatric Radiology Room, X-Ray Dept, B Floor, Clarendon Wing (with video link to MDT1, Bexley)</td>
<td>Tues 12.00</td>
</tr>
<tr>
<td>Specialist MDT PAEDIATRIC &amp; TYA HAEMATOLOGY</td>
<td>Jill Doherty</td>
<td>22327</td>
<td>Barbara Pymer</td>
<td>22314</td>
<td>26375</td>
<td>Monday 9:30-10:30 Paediatric Meeting Room, D Floor, Martin Wing, LGI (VC to HMDS, SJUH)</td>
<td>Thurs 12.00</td>
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<tr>
<td>MDT Meeting</td>
<td>MDT Coordinator</td>
<td>Ext.</td>
<td>MDT Support</td>
<td>Ext.</td>
<td>Fax</td>
<td>Meeting Day/Time/Location</td>
<td>MDT Cut Off</td>
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<tr>
<td>Specialist MDT SARCOMA</td>
<td>Sairah Begum</td>
<td>68994</td>
<td>Thomas Hughes</td>
<td>68090</td>
<td>68858</td>
<td>Monday 1:00-3:00 MDT2, Level 7 Bexley Wing</td>
<td>Thurs 13.00</td>
</tr>
<tr>
<td>Specialist MDT SKIN - MELANOMA</td>
<td>Lisa Varley (Ruth Johnson)</td>
<td>67742</td>
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<td>67758</td>
<td>Thursday 8:30-12:00 MDT2, Level 7 Bexley Wing</td>
<td>Tues 12.00</td>
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<tr>
<td>Specialist MDT SPECIALIST SKIN</td>
<td>Ruth Johnson (Lisa Varley)</td>
<td>24377   /</td>
<td>68096</td>
<td></td>
<td>24821</td>
<td>Wednesday 1:00-2:00 Seminar Room, Clinical Genetics, Level 3, Chapel Allerton Hospital</td>
<td>Fri 12.00 Following review by clinician</td>
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<tr>
<td>Specialist MDT TEENAGE/YOUNG ADULTS (TYA)</td>
<td>Jill Doherty</td>
<td>22327</td>
<td>Barbara Pymer</td>
<td>22314</td>
<td>26375</td>
<td>Thursday 2:45-3:30 MDT1, Level 7 Bexley Wing</td>
<td>Tues 12.00</td>
</tr>
<tr>
<td>Specialist MDT UPPER GI</td>
<td>Amber Wilson</td>
<td>68569</td>
<td>Liam Herridge Holly Killip-Ross</td>
<td>68095</td>
<td>68750</td>
<td>68617</td>
<td>Tuesday 8:30-11:00 MDT1, Level 7 Bexley Wing</td>
</tr>
<tr>
<td>Supra Network SMRT UROLOGY - PENILE</td>
<td>David Hammond</td>
<td>67098</td>
<td>Sophia Hussain Craig Nelson</td>
<td>68087</td>
<td>66909</td>
<td>64024</td>
<td>Tuesday 8:00-8:30 MDT2, Level 7 Bexley Wing</td>
</tr>
<tr>
<td>Supra Network SMRT UROLOGY - GERM CELL</td>
<td>David Hammond</td>
<td>67098</td>
<td>Sophia Hussain Craig Nelson</td>
<td>68087</td>
<td>66909</td>
<td>64024</td>
<td>Friday 12:30-1:00 MDT2, Level 7 Bexley Wing</td>
</tr>
<tr>
<td>Specialist MDT UROLOGY - PROSTATE/BLADDER</td>
<td>David Hammond</td>
<td>67098</td>
<td>Sophia Hussain Craig Nelson</td>
<td>68087</td>
<td>66909</td>
<td>64024</td>
<td>Friday 1:00-3:30 MDT2, Level 7 Bexley Wing</td>
</tr>
<tr>
<td>Specialist MDT UROLOGY - KIDNEY</td>
<td>David Hammond</td>
<td>67098</td>
<td>Sophia Hussain Craig Nelson</td>
<td>68087</td>
<td>66909</td>
<td>64024</td>
<td>Friday 1:00-3:30 MDT1, Level 7 Bexley Wing</td>
</tr>
<tr>
<td>CROSS-COVER</td>
<td>Nadia Khan</td>
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<td>Vacancy Patrick Carley</td>
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## 13 Appendix 1 Inter-Provider Transfer Pathways

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<tr>
<th>Title</th>
<th>West Yorkshire, Harrogate and York Cancer Inter-provider Transfer (IPT) Pathways</th>
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<tbody>
<tr>
<td>Summary</td>
<td>The 20 IPT Pathways are shown in alphabetical order by cancer site</td>
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</table>
| Author(s) | Lead Cancer Managers and site specific Cancer MDT Leads from:  
Airedale NHS Foundation Trust  
Bradford Teaching Hospitals NHS Foundation Trust  
Calderdale and Huddersfield NHS Foundation Trust  
Harrogate and District NHS Foundation Trust  
Leeds Teaching Hospitals NHS Trust  
Mid Yorkshire Hospitals NHS Trust  
York Teaching Hospital NHS Foundation Trust |
| Owner | West Yorkshire & Harrogate Cancer Alliance |
| Sign Off Procedure | All pathways have been signed off by the Site Specific Cancer MDT Leads. |
| Sign Off Date | January 2019 |
| Review Date | January 2021 |

**Version Control**

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<td>January 2019</td>
<td>Initial version</td>
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IPT Pathway for Specialist Colorectal Cancers – Anal (Airedale, Bradford, Calderdale, Harrogate, Mid Yorkshire and York Local MDT’s): January 2019

- **By Day 28**
  - Communication to patient on outcome (cancer confirmed or all-clear provided)

- **By Day 38**
  - IPT Referral from locality to Leeds Colorectal Specialist MDT for discussion and treatment plan
    - **IPT accepted if minimum diagnostic work-up and patient data complete**
      - Tracking handed over to Leeds (via MDT Co-ordinators)
      - Specialist Colorectal MDT (Leeds). Reviews investigations completed and decides treatment plan
      - Possible Post MDT Investigations:
        - Trans-rectal ultrasound, abdominal and thoracic CT, pelvic MRI (These may be done closer to the patient’s home and will not constitute a revised IPT)
      - Specialist Colorectal MDT (Leeds) to communicate MDT outcome (planning decision and place of treatment)
      - Decision to treat
        - Patient seen by treating consultant and consents to treatment (Consultant surgeon or Consultant Oncologist)

- **By Day 62**
  - First Definitive Treatment
    - Surgery, Chemotherapy, Radiotherapy or Best Supportive Care

**Minimum Pre-IPT Investigations required:**
- Patient aware of diagnosis and reasons for referral to another Trust
- Colonoscopy/Flexi. Sigmoidoscopy/CT/CT – as clinically indicated
- OPA Biopsy +/- EUA for Anal only

**Minimum Patient Data Required:**
- Demographics
- CWT minimum dataset
- Suspected cancer site
- Responsible Consultant
- Working diagnosis stage
- Relevant pathology & imaging scans and reports

By Day 28
Communication to patient on outcome (cancer confirmed or all-clear provided)

By Day 38
IPT Referral from locality to Leeds Colorectal Specialist MDT for discussion and treatment plan

IPT accepted if minimum diagnostic work-up and patient data complete.

Tracking handed over to Leeds (via MDT Co-ordinators)

Specialist Colorectal MDT (Leeds). Reviews investigations completed and decides treatment plan

Possible Post MDT Investigations:
Trans-rectal ultrasound, abdominal and thoracic CT, pelvic MRI (These may be done closer to the patient’s home and will not constitute a revised IPT)

Specialist Colorectal MDT (Leeds) to communicate MDT outcome (planning decision and place of treatment)

Decision to treat
Patient seen by treating consultant and consents to treatment (Consultant surgeon or Consultant Oncologist)

DTT Radiotherapy Leeds
DTT Surgery
DTT Chemotherapy
DTT Active Monitoring
DTT Palliative Care (BSC)

Leeds to refer back to local Provider for local treatment if appropriate and agreed

First Definitive Treatment
Surgery, Chemotherapy, Radiotherapy or Best Supportive Care

Next pathway review January 2021
IPT Pathway for Muscle Invasive/ High Risk Non-Muscle Invasive Bladder Cancer
(Leeds, Bradford and Mid Yorkshire SMDT’s)
Applicable for first definitive treatment only: January 2019

By Day 28
Communication to patient on outcome (cancer confirmed or all-clear provided)

IPT Referral from locality to Urology SMDT for patients with muscle invasive bladder cancer discussion and treatment plan

Proceed if minimum diagnostic work-up and patient data complete.

Tracking handed over to SMDT (via MDT Co-ordinators)

Specialist Urology MDT

SMDT communicate MDT outcome (planning decision and place of treatment)

Decision to treat
Patient seen by Consultant Urologist/Oncologist and decision to treat made

IPT Referral to Leeds for Radiotherapy (from Bradford/Mid Yorkshire)

By Day 38

Minimum Pre-IPT Investigations required:
- Patient aware of diagnosis and reasons for referral to another Trust
- Performance Status
- Histology from TURBT
- Staging CT of the abdomen, pelvis and chest

Core Minimum Patient Data Required:
- Patient demographics
- CWT Information
- Suspected Cancer
- Consultant in charge
- Working Diagnosis
- Stage
- Relevant pathology & scans/reports
- Clinical history and examination
- Histology report and operation findings
- Staging CT or MRI Scan
- SJOG RT booking document
- Height and weight
- FBC, UEs and LFTs

DDT Neo-adjuvant Therapy (local?)
DDT Surgery - Cystectomy (all SMDT’s)
DDT Radiotherapy (Leeds SMDT)
Best Supportive Care (delivered locally)

Intravesical BCG therapy

First Definitive Treatment
Surgery, Radiotherapy, Neo-Adjuvant Therapy

By Day 62

Next pathway review January 2021
IPT Pathway for Brain/CNS Tumour: January 2019

IPT Referral form to Brain/CNS SMDT for discussion and treatment plan/transfer of care

- Proceed if minimum diagnostic work-up and patient data complete.
- Tracking handed over to SMDT (via MDT Co-ordinators)

Specialist MDT

Possible Post MDT Investigations: i.e. MRI

SMDT communicate outcome

Decision to treat
- Patient seen by Consultant of relevant specialty

- DTT Surgery
- DTT Gamma Knife
- DTT Radiotherapy
- DTT chemotherapy
- DTT Palliative / Supportive Care

First Definitive Treatment
- Surgery, Gamma Knife, Radiotherapy, Chemotherapy or Palliative Care

Communication to patient on outcome (cancer confirmed or all-clear provided)

Minimum Pre-IPT Investigations required:
- Patient aware of diagnosis and reasons for referral
- CT or MRI
- Performance status
- Co-morbidities

Core Minimum Patient Data Required:
- Patient demographics
- CWT Information
- Completed LTHT CNS MDT Referral form
- Referring GP
- Relevant scans and reports

By Day 28

By Day 62

Next pathway review January 2021
13.4 Breast Cancer IPT Pathway

IPT Pathway for Breast Cancer: January 2019

Most breast patients will receive first treatment with the local provider however there will be a small percentage of patients who may need referral to other SMDT.

By Day 28

Local investigations completed
IPT Referral by day 28 if possible

Day 38 remains as the IPT standard. However teams should aspire to achieve day 28 if possible

Tracking handed over to SMDT (via MDT Co-ordinators)

Breast MDT Leeds
(likely treatment modalities agreed and possible surgery dates planned)

Possible Post MDT Investigations
2 attempts at biopsy, mammogram, ultrasound/ultrasound biopsy

SMDT communicate MDT outcome
(planning decision and place of treatment)

Decision to treat
Patient seen by Consultant Surgeon/Oncologist and decision to treat made

Minimum Pre-IPT Investigations required:
- Patient aware of diagnosis and reasons for referral to another Trust
- Mammogram
- Ultrasound
- MRI breast
- Second look ultrasound

Core Minimum Patient Data Required:
- Patient demographics
- CWT Information
- Suspected Cancer
- Consultant in charge
- Working Diagnosis
- Staging Information
- Relevant pathology/scans & reports

Communication to patient on outcome (cancer confirmed or all-clear provided)

First Definitive Treatment
Surgery, Chemotherapy or Palliative Care

By Day 62

Next pathway review January 2021

First Definitive Treatment
Surgery, Chemotherapy or Palliative Care

DTT Surgery +/- reconstruction
(tertiary/locally)

DTT Chemotherapy
(locally)

DTT Palliative Care
(locally)
IPT Pathway for Cervical Cancer: January 2019

By Day 38

IPT Referral from locality to Gynaecology SMDT for discussion and treatment plan

Proceed if minimum diagnostic work-up and patient data complete.

Tracking handed over to SMDT (via MDT Co-ordinators)

Specialist Gynaecology MDT

Possible Post MDT Investigations:
PET Scan

SMDT communicate MDT outcome (planning decision and place of treatment)

Decision to treat
Patient seen by Consultant Gynaecologist/Oncologist and decision to treat made

DTT Surgery local or Leeds
DTT Radiotherapy/Brachytherapy/
DTT Chemotherapy

First Definitive Treatment
Surgery, Chemotherapy, Radiotherapy

Next pathway review January 2021

Communication to patient on outcome (cancer confirmed or all-clear provided)

Minimum Pre-IPT Investigations required:
- Patient aware of diagnosis and reasons for referral to another Trust
- Clinical appointment/examination
- Smear test
- Biopsy - Punch Lletz

Core Minimum Patient Data Required:
- Patient demographics
- CWT Information
- Suspected Cancer
- Consultant in charge
- Working Diagnosis
- Staging Information
- Relevant pathology/scans and reports
13.6 Colon Cancer IPT Pathway

IPT Pathway for Specialist Colorectal Cancers: Colon
(Airedale, Bradford, Calderdale, Harrogate, Mid Yorkshire and York Local MDT’s): January 2019

By Day 28

Communication to patient on outcome (cancer confirmed or all-clear provided)

IPT Referral from locality to Colorectal Specialist MDT for discussion and treatment plan

IPT accepted if minimum diagnostic work-up and patient data complete.

Tracking handed over to Leeds (via MDT Co-ordinators)

Specialist Colorectal MDT (Leeds). Reviews investigations completed and decides treatment plan

Possible Post MDT Investigations:
PET CT, MRI liver

Specialist Colorectal MDT (Leeds) to communicate MDT outcome (planning decision and place of treatment)

Decision to treat
Patient seen by treating consultant and consents to treatment (Consultant surgeon or Consultant Oncologist)

DTT Surgery
DTT Chemotherapy
DTT Active Monitoring
DTT Palliative Care (BSC)

Leeds to refer back to local Provider for local treatment if appropriate and agreed

First Definitive Treatment
Surgery, Chemotherapy or Best Supportive Care

By Day 62

Minimum Pre-IPT Investigations required:
- Patient aware of diagnosis and reasons for referral to another Trust
- Colonoscopy/ Flexi.Sigmoidoscopy/CTC – as clinically indicated
- CT TAP or CT Chest if already has CT colonography CEA, OPA Biopsy

Minimum Patient Data Required:
- Demographics
- CWT minimum dataset
- Suspected cancer site
- Responsible Consultant
- Working diagnosis stage
- Relevant pathology & imaging scans and reports

Next pathway review January 2021
13.7 Early Rectal Cancer IPT Pathway

**IPT Pathway for Specialist Colorectal Cancers – Early Rectal**
(Airedale, Bradford, Calderdale, Harrogate, Mid Yorkshire and York Local MDT’s): January 2019

**IPT Referral from locality to Bradford Colorectal Specialist MDT via JMR or MAS for discussion and treatment plan**

- **Minimum Pre-IPT investigations for Early Rectal cancer identified (up to 3cm & 15cm for anal verge):**
  - Patient aware of diagnosis and reasons for referral to another Trust
  - Colonoscopy/CTC – as clinically indicated
  - CT TAP or CT chest if already has CT colonography
  - MRI pelvis
  - CEA

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

**Minimum Patient Data Required:**
- Demographics
- CWT minimum dataset
- Suspected cancer site
- Responsible Consultant
- Working diagnosis stage
- Relevant pathology & imaging scans and reports

**IPT accepted if minimum diagnostic work-up and patient data complete.**

Tracking handed over to Bradford (via MDT Co-ordinators)

**Specialist ERC MDT (Bradford). Reviews investigations completed and decides treatment plan**

Possible Post MDT Investigations:
- Flexible sigmoidoscopy and trans-rectal ultrasound

Specialist Colorectal MDT (Bradford) to communicate MDT outcome (planning decision and place of treatment)

**Decision to treat**
Patient seen by treating consultant and consents to treatment (Consultant surgeon or Consultant Oncologist)

- **DTT Radiotherapy** (Leeds) for consideration of neo-adjuvant radiotherapy followed by TEMS surgery in Bradford

- **DTT Surgery** (TEMS at Bradford)

If not suitable for local resection (TEMS) returned to referring hospital for resectional surgery
(T-stage >3, lymph node involvement, ERC > 3cm, beyond 15cm from anal verge)

First Definitive Treatment
Surgery or Radiotherapy

**Communication to patient on outcome** (cancer confirmed or all-clear provided)

Next pathway review
January 2021

York Local MDT’s (excerpt taken from the North East Yorkshire Humber Clinical Alliance (Cancer): Guidelines for the Management of Adult Patients with Colorectal Cancer 2012) currently refer pts for rectal endosonography to the Hull Rectal Endosonography service based at Castle Hill Hospital (using the U/S request Form) or to or to Ms Gita Kaur at Scunthorpe General Hospital. York Teaching Hospitals NHS Trust have historically referred this group of patients directly to Mr Andy Hunter based at Castle Hill Hospital
IPT Pathway for Endometrium/Womb Cancer: January 2019

Communication to patient on outcome (cancer confirmed or all-clear provided)

IPT Referral from locality to Gynaecology SMDT for discussion and treatment plan

- Proceed if minimum diagnostic work-up and patient data complete.

Tracking handed over to SMDT (via MDT Co-ordinators)

Specialist Gynaecology MDT

Possible Post MDT Investigations:
- Chest x-ray

SMDT communicate MDT outcome (planning decision and place of treatment)

Decision to treat
- Patient seen by Consultant Gynaecologist/Oncologist and decision to treat made

DDT Surgery local or Leeds
DDT Radiotherapy Leeds
DDT Chemotherapy

First Definitive Treatment
- Surgery, Radiotherapy, Chemotherapy

Next pathway review January 2021

Minimum Pre-IPT Investigations required:
- Patient aware of diagnosis and reasons for referral to another Trust
- Clinical appointment/examination with ultrasound scan report (test done prior to referral by GP)
- Direct to Hysteroscopy clinic +/- Endometrial biopsy (outpatient) – (7 days for pathology report)
- Ultrasound scan (14 days to test)
- GA Hysteroscopy +/- endometrial biopsy (7 days for pathology report)
- MRI pelvis (14 days to test)

Core Minimum Patient Data Required:
- Patient demographics
- CWT Information
- Suspected Cancer
- Consultant in charge
- Working Diagnosis
- Stage
- Relevant pathology/scans and reports
Head & Neck Cancer IPT Pathway

IPT Pathway for Head & Neck Cancer : January 2019

By Day 28

1. First seen <14 days
2. Investigations planned and biopsy if possible in clinic

Communication to patient on outcome (cancer confirmed or all-clear provided)

By Day 31

Local investigations completed
Referral for clinical opinion by day 31

Proceed if minimum diagnostic work-up and patient data complete.

Joint SMDT Leeds
(likely treatment modalities discussed and possible definitive treatment dates planned)

Post-MDT Investigations (not obligatory):
- PET/CT
- US +/- FNA
- Repeat EUA/Biopsy

SMDT communicate MDT outcome
(planning decision and place of treatment)

Decision to Treat
Patient seen by Consultant Surgeon/Oncologist and decision to treat made

By Day 38

Definitive surgery +/- reconstruction where applicable

DTT Primary Non-surgical (e.g. Chemoradiotherapy)

DTT Palliative Surgery or Radiotherapy or Chemotherapy

DTT Palliative Care (locally)

First Definitive Treatment Surgery, Non-surgical Treatment or Palliative Care

By Day 62

Core Minimum Patient Data Required:
- Patient demographics
- CWT Information
- Suspected Cancer
- Consultant in charge
- Working Diagnosis
- Staging Information
- Relevant pathology/scans & reports

Minimum Pre-IPT Investigations required:
- Patient aware of diagnosis and reasons for referral to another Trust
- Imaging - staging MRI/CT and OPT +/- PET CT*
- Diagnostic biopsy (see text regarding p16 and EBV status for HNUP)
- Performance status
- Co-morbidities
- Smoking and alcohol status

By Day 28

Next pathway review January 2021

1. First seen <14 days
2. Investigations planned and biopsy if possible in clinic

Communication to patient on outcome (cancer confirmed or all-clear provided)

By Day 31

Local investigations completed
Referral for clinical opinion by day 31

Proceed if minimum diagnostic work-up and patient data complete.

Joint SMDT Leeds
(likely treatment modalities discussed and possible definitive treatment dates planned)

Post-MDT Investigations (not obligatory):
- PET/CT
- US +/- FNA
- Repeat EUA/Biopsy

SMDT communicate MDT outcome
(planning decision and place of treatment)

Decision to Treat
Patient seen by Consultant Surgeon/Oncologist and decision to treat made

By Day 38

Definitive surgery +/- reconstruction where applicable

DTT Primary Non-surgical (e.g. Chemoradiotherapy)

DTT Palliative Surgery or Radiotherapy or Chemotherapy

DTT Palliative Care (locally)

First Definitive Treatment Surgery, Non-surgical Treatment or Palliative Care

By Day 62

Core Minimum Patient Data Required:
- Patient demographics
- CWT Information
- Suspected Cancer
- Consultant in charge
- Working Diagnosis
- Staging Information
- Relevant pathology/scans & reports

Minimum Pre-IPT Investigations required:
- Patient aware of diagnosis and reasons for referral to another Trust
- Imaging - staging MRI/CT and OPT +/- PET CT*
- Diagnostic biopsy (see text regarding p16 and EBV status for HNUP)
- Performance status
- Co-morbidities
- Smoking and alcohol status

By Day 28

Next pathway review January 2021
Local investigations completed. Referral for clinical opinion by day 31

There are occasions when some imaging and associated reports are completed in the days immediately prior to MDTM. The radiologists who are core Leeds/MYH H&N MDT members always take and present the cases, so there is no relevance to having reports in Leeds 3 days prior to the MDTM.

Joint SMDT Leeds

This is complex, and involves all member organisations from early in pathway

- Local biopsy (with central histopathology review of all cases - send blocks with slides at same time for p16 testing if oropharyngeal cancer (OPSCC) or p16 and EBV testing for head and neck cancer unknown primary (HNCUP))
- MRI/CT – staging scans,
- OPT radiograph and organise dental assessment OPA, where clinically indicated, in oral cavity, oropharyngeal, nasopharyngeal, HNCUP and salivary gland malignancies

Consider PET-CT if clinical assessment & MRI/CT suggest HNCUP with diagnostic USS + FNA/core biopsy

- Performance status, smoking and alcohol history
- Clinical contact, breaking bad news & patient awareness of diagnosis

* this is due to the recent change in staging to TNM 8th edition mandating p16 status in clinical staging of OPSCC and p16 + EBV status in clinical staging of HNCUP. Collaboration between local and central histopathology to QA p16/EBV immunostaining locally can be explored where feasible to streamline this aspect of the pathway

** in MDTs where there is local access to the Restorative Dentistry team this should be organised locally in order to avoid delay in patient pathway progress. In a set-up, such as the LTHT/MYH MDT, Restorative Dentistry is based centrally in Leeds, therefore an OPT radiograph is required but dental assessment OPA will be arranged in the MDT meeting/clinic (thus not required for IPT)

*** only for HNCUP: in the absence of an identifiable Head and Neck UADT primary site on cross sectional anatomical imaging (MRI/CT), a PET-CT scan should be arranged in order to aid location of the primary site and, guide examination under anaesthesia and targeted biopsies
Liver Cancer IPT Pathway

IPT Referral from locality to Liver SMDT for discussion and treatment plan

Proceed if minimum diagnostic work-up and patient data complete.

Tracking handed over to SMDT (via MDT Co-ordinators)

Specialist Liver MDT

Possible Post MDT Investigations: Biopsy, MRI, PETCT

By Day 38

Specialist Liver MDT

Communicate outcome (planning decision and place of treatment)

Decision to treat

Patient seen by Consultant Surgeon/ Oncologist/Gastroenterologist/Hepatologist/ Radiologist and decision to treat made

By Day 62

DDT Surgery (resection/assess for transplant) (LHTH)

DDT ablation (RFA, microwave, PEA) (LHTH)

DDT Palliative Care (locally)

DDT TACE, chemotherapy

First Definitive Treatment: Surgery, Chemotherapy, Ablation, TACE or Palliative Care

By Day 19

IPT Referral from locality to Liver SMDT for discussion and treatment plan

Minimum Pre-IPT Investigations required:
- Patient aware of diagnosis and reasons for referral to another Trust
- US, CT Liver, tumour markers (ca19-9, alpha feta protein) Child- Pugh/MELD status (coag, LFTs)
- Performance status
- Co-morbidities

Core Minimum Patient Data Required:
- Patient demographics
- CWT Information
- Suspected Cancer
- Consultant in charge
- Working Diagnosis
- Staging Information
- Relevant pathology/scans and reports

By Day 28

Communication to patient on outcome (cancer confirmed or all-clear provided)

By Day 28

Communicate outcome (planning decision and place of treatment)

Next pathway review January 2021
IPT Pathway for Lung Cancer – (reflecting the newly agreed surgical workup): January 2019

**Core diagnostic investigations:**
- Patient aware of suspected/confirmed diagnosis and reasons for referral to another Trust
- Staging CT thorax and upper abdomen (adrenals/liver) +/- supravacuicular fossa

**Radical treatment**
- PET-CT
- Brain imaging (CT/MRI) if N ≥2 or T ≥3 disease (agreed minimum requirement)
- Staging EBUS if any enlarged or 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) +/- supravacuicular fossa
- Histology recommended
- 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 discussions prior to referral

**Core Minimum Patient Data Required:**
- Patient demographics
- Performance status
- Co-morbidities
- CWT Information
- Suspected cancer
- Consultant in charge
- Working diagnosis
- Staging Information

**IPT by day 38**
- Outpatient appointment with surgeon (DTT)
- Surgical pre-admission. May require dual referral with clinical oncology

**By Day 45**
- Admission for surgical staging (TCI for definitive surgery given to patient)
- Admission for definitive surgery
- Review pathological staging at MDT and consider surveillance or referral for adjuvant treatment

**By Day 57**
- If not suitable for definitive surgery after staging refer to clinical or medical oncologist
- Results to GP and referring unit
- Follow-up to be agreed

**Results to GP**
- Full MDT discussion where decision for cancer centre opinion/treatment is proposed. PET results should be available to inform definitive treatment decision. Biopsy results may be pending or result already available.
- Patient informed of MDT decision
- Staging tests and results discussed
- MDT plan discussed and agreed with patient

**Communication to patient on outcome**
(cancer confirmed or all-clear provided)

**CT guided biopsy requested or results already available**

**Core Minimum Patient Data Required:**
- Patient demographics
- Performance status
- Co-morbidities
- CWT Information
- Suspected cancer
- Consultant in charge
- Working diagnosis
- Staging Information

**Oncology (Radiotherapy/Chemotherapy)**

**By Day 14**
- Outpatient appointment with surgeon (DTT)
- Surgical pre-admission. May require dual referral with clinical oncology

**By Day 26**
- Clinical assessment and discussion of suspected diagnosis, information to patient and proposed plan (including WHO performance status and fitness assessment) recorded

**By Day 28**
- Full MDT discussion where decision for cancer centre opinion/treatment is proposed. PET results should be available to inform definitive treatment decision. Biopsy results may be pending or result already available.
- Patient informed of MDT decision
- Staging tests and results discussed
- MDT plan discussed and agreed with patient

**Dual tracking is maintained by referring Trust and treating Trust (following consultation with patient to agree MDT decision)**

**Possible MDT Investigations after MDT but ideally to be undertaken prior to day 38**
(e.g. MRI, CPEX, CT guided biopsy)

**By Day 45**
- Outpatient appointment with surgeon (DTT)
- Surgical pre-admission. May require dual referral with clinical oncology

**By Day 57**
- If not suitable for definitive surgery after staging refer to clinical or medical oncologist
- Results to GP and referring unit
- Follow-up to be agreed

**Results to GP**
- Full MDT discussion where decision for cancer centre opinion/treatment is proposed. PET results should be available to inform definitive treatment decision. Biopsy results may be pending or result already available.
- Patient informed of MDT decision
- Staging tests and results discussed
- MDT plan discussed and agreed with patient

**Communication to patient on outcome**
(cancer confirmed or all-clear provided)

**Fully MDT by day 21-28**
- Clinical assessment and discussion of suspected diagnosis, information to patient and proposed plan (including WHO performance status and fitness assessment) recorded

**Results to GP**
- Full MDT discussion where decision for cancer centre opinion/treatment is proposed. PET results should be available to inform definitive treatment decision. Biopsy results may be pending or result already available.
- Patient informed of MDT decision
- Staging tests and results discussed
- MDT plan discussed and agreed with patient

**By Day 28**
- Admission for surgical staging (TCI for definitive surgery given to patient)
- Admission for definitive surgery
- Review pathological staging at MDT and consider surveillance or referral for adjuvant treatment

**Follow-up to be agreed**
- Results to GP and referring unit
- Oncology (Radiotherapy/Chemotherapy)

**Next pathway review January 2021**
Oesophageal, Oesophago Gastric Cancer IPT Pathway

IPT Pathway for Oesophageal, Oesophago-Gastric Cancer: January 2019

Communication to patient on outcome (cancer confirmed or all-clear provided)

By Day 28

Referral from locality to Upper GI SMDT for discussion and a clinical opinion

By Day 19 /38

Tracking handed over to SMDT (via MDT Co-ordinators)

Day 38 remains as the IPT standard. However teams should aspire to complete within 19 if it is a 3 way pathway

Day 38

Specialist Upper GI MDT

Possible Post MDT Investigations: Laparoscopy and Endoscopy, PET, EUS and/or MRI

Specialist Upper GI MDT

Communicate outcome (planning decision and place of treatment)

Decision to treat

Patient seen by Consultant Surgeon/Oncologist/Gastroenterologist and decision to treat made

DDT Surgery (Bradford/Leeds)

DDT Neoadjuvant chemotherapy (locally)

DDT Radiotherapy (Leeds)

DDT Palliative Care (locally)

DDT Palliative Chemotherapy (locally)

First Definitive Treatment Surgery, Radiotherapy, Chemotherapy or Palliative Care

By Day 62

Next pathway review January 2021

Minimum Pre-IPT Investigations required:
- Patient aware of diagnosis and reasons for referral to another Trust
- CT and histology from OGD
- Performance status
- Co-morbidities

Core Minimum Patient Data Required:
- Patient demographics
- CWT Information
- Suspected Cancer
- Consultant in charge
- Working Diagnosis
- Staging Information
- Relevant pathology/scans and reports

Any investigations post MDT to be done within 10 days
IPT Pathway for Ovarian Cancer
(Leeds, Bradford, Mid Yorkshire and Calderdale & Huddersfield SMDT’s): January 2019

**By Day 38**
IPT Referral from locality to Gynaecology SMDT for discussion and treatment plan

Proceed if minimum diagnostic work-up and patient data complete.

Tracking handed over to SMDT (via MDT Co-ordinators)

**Specialist Gynaecology MDT**

Possible Post MDT Investigations:
- Upper and lower endoscopy

**SMDT communicate MDT outcome**
(Planning decision and place of treatment)

**Decision to treat**
Patient seen by Consultant Gynaecologist/Oncologist and decision to treat made

**By Day 62**

- **DTT Surgery local or Leeds**
- **DTT Chemotherapy Leeds**

**First Definitive Treatment**
Surgery, Radiotherapy, Chemotherapy

**Minimum Pre-IPT Investigations required:**
- Patient aware of diagnosis and reasons for referral to another Trust
- CT/MRI – (14 days to test)
- Clinical appointment/examination with ultrasound scan report and CA125 (tests done prior to referral by GP)
- Ultrasound scan (14 days to test)
- Tumour markers: CA125, CA199, CEA (48 hours)

**Core Minimum Patient Data Required:**
- Patient demographics
- CWT Information
- Suspected Cancer
- Consultant in charge
- Working Diagnosis
- Stage
- Relevant pathology & Imaging scans/reports

**Communication to patient on outcome** (cancer confirmed or all-clear provided)

Next pathway review January 2021
**IPT Pathway for Pancreatic Cancer: January 2019**

**Communication to patient on outcome** (cancer confirmed or all-clear provided)

**IPT Referral from locality to Pancreatic SMDT for discussion and treatment plan**

Proceed if minimum diagnostic work-up and patient data complete.

Tracking handed over to SMDT (via MDT Co-ordinators)

**Specialist Pancreatic MDT**

Possible Post MDT Investigations:
- EUS, MRI, ERCP +/- stent

Specialist Pancreatic MDT

Communicate outcome (planning decision and place of treatment)

**Decision to treat**

Patient seen by Consultant Surgeon/Oncologist/Gastroenterologist and decision to treat made

- **DTT Surgery (Leeds)**
- **DTT Radiotherapy (Leeds)**
- **DTT Palliative Care (locally)**
- **DTT Chemotherapy (Leeds)**

**First Definitive Treatment**
- Surgery, Radiotherapy, Chemotherapy or Palliative Care

**By Day 28**

- Next pathway review January 2021

**By Day 38**

**Core Minimum Patient Data Required:**
- Patient demographics
- CWT Information
- Suspected Cancer
- Consultant in charge
- Working Diagnosis
- Staging Information
- Relevant pathology/scans and reports

**Minimum Pre-IPT Investigations required:**
- Patient aware of diagnosis and reasons for referral to another Trust
- US and CT scan
- Performance status
- Co-morbidities
- LFT’s
- Ca19.9 tumour marker

Any investigations post MDT to be done within 10 days
**IPT Pathway for Penile Cancer SMDT at Leeds**

**Applicable for first definitive treatment only: January 2019**

By Day 38

- **IPT Referral from locality to Penile SMDT for discussion and treatment plan**
- Proceed if minimum diagnostic work-up and patient data complete.

- Tracking handed over to SMDT (via MDT Co-ordinators)

- Decision made regarding sequence of MDT, OPA and Imaging
  - Imaging OPA
  - Specialist imaging arranged as appropriate

- Specialist MDT

- SMDT communicate MDT outcome (planning decision and place of treatment)

- Decision to treat
- Patient seen by at Leeds and decision to treat made

By Day 62

- **First definitive treatment**
  - Surgery, Chemotherapy, Palliative Care

- Minimum Pre-IPT Investigations required:
  - Patient aware of diagnosis and reason(s) for referral to Leeds
  - Performance Status
  - Biopsy (Refer obvious cancer to Leeds or biopsy first if diagnosis is not clear)

- Core Minimum Patient Data Required:
  - Patient demographics
  - CWT Information
  - Suspected Cancer
  - Consultant in charge
  - Working Diagnosis
  - Stage
  - Relevant pathology/& imaging scans/reports

Next pathway review January 2021
Prostate Cancer IPT Pathway

IPT Pathway for Prostate Cancer (Leeds, Bradford and Mid Yorkshire SMDT's)
Applicable for first definitive treatment only: January 2019

By Day 38
IPT Referral from locality to Urology SMDT for discussion and treatment plan

Proceed if minimum diagnostic work-up and patient data complete.

Tracking handed over to SMDT (via MDT Co-ordinators)

Specialist Urology MDT

Possible Post MDT Investigations
Further scans (may include pelvic MRI, bone scan, CT and/or PET CT)

SMDT communicate MDT outcome (planning decision and place of treatment)

Decision to treat
Patient seen by Consultant Urologist/Oncologist to discuss choice of treatment and decision to treat made

IPT Referral to Leeds for Radiotherapy (from Bradford/Mid Yorkshire)

Hormones (delivered locally)
Best Supportive Care (delivered locally)
DTT Surgery (all SMDT's) IPT SMDT
DTT Radiotherapy/Brachytherapy (Leeds)
DTT Radiotherapy/Brachytherapy (Bradford Mid Yorks) IPT SMDT

First Definitive Treatment Surgery, Brachytherapy, Radiotherapy

Communication to patient on outcome (cancer confirmed or all-clear provided)

Minimum Pre-IPT Investigations required:
- Patient aware of diagnosis and reasons for referral to another Trust
- Performance Status
- Prostate biopsy
- Staging Scan(s) on basis of disease stratification (may include pelvic MRI, bone scan and/or CT)

Core Minimum Patient Data Required:
- Patient demographics
- CWT Information
- Suspected Cancer
- Consultant in charge
- Working Diagnosis
- Staging Information
- Relevant pathology & imaging scans/reports
- Clinical history and examination
- Histology report and operation findings
- Staging CT or MRI Scan/bone scan (not required for low risk patients)
- SJIO RT booking document
- Height and weight
- FBC, UEs and LFTs

By Day 28
Minimum Pre-IPT Investigations required:
- Patient aware of diagnosis and reasons for referral to another Trust
- Performance Status
- Prostate biopsy
- Staging Scan(s) on basis of disease stratification (may include pelvic MRI, bone scan and/or CT)

Core Minimum Patient Data Required:
- Patient demographics
- CWT Information
- Suspected Cancer
- Consultant in charge
- Working Diagnosis
- Staging Information
- Relevant pathology & imaging scans/reports
- Clinical history and examination
- Histology report and operation findings
- Staging CT or MRI Scan/bone scan (not required for low risk patients)
- SJIO RT booking document
- Height and weight
- FBC, UEs and LFTs

By Day 62
First Definitive Treatment Surgery, Brachytherapy, Radiotherapy

Next pathway review January 2021

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IPT Pathway for Renal Cancer (Leeds, Bradford and Mid Yorkshire SMDT’s) 
Applicable for first definitive treatment only: January 2019

- By Day 28
  - Communication to patient on outcome (cancer confirmed or all-clear provided)

- By Day 38
  - IPT Referral from locality to Urology SMDT for discussion and treatment plan
    - Proceed if minimum diagnostic work-up and patient data complete.
    - Tracking handed over to SMDT (via MDT Co-ordinators)

  - Specialist Urology MDT

  - Possible Post MDT Investigations:
    - MRI, Renal Biopsy, Contrast Enhanced US

  - SMDT communicate MDT outcome (planning decision and place of treatment)

- Decision to treat (DTT)
  - Patient seen by Consultant Urologist/Oncologist and decision to treat made

  - DTT Best Supportive Care (delivered locally)
  - DTT Surgery (all SMDT’s) IPT SMDT
  - DTT Image Guided Ablation (Leeds)
  - DTT Image Guided Ablation (Bradford/ Mid Yorks) IPT SMDT

- By Day 62
  - First Definitive Treatment 
    - Surgery, Image Guided Ablation

- Core Minimum Patient Data 
  - Required:
    - Patient demographics
    - CWT Information
    - Suspected Cancer
    - Consultant in charge
    - Working Diagnosis
    - Staging Information
    - Relevant pathology/scans and reports

- Minimum Pre-IPT Investigations required:
  - Patient aware of diagnosis and reasons for referral to another Trust 
  - Performance Status
  - Medical History
  - CT – Renal & Thorax
  - eGFR
  - FBC, LFT, Calcium

Next pathway review January 2021
IPT Pathway for Soft Tissue Sarcoma
(Airedale, Bradford, Calderdale, Harrogate, Mid Yorkshire and York Local MDT’s): January 2019

**IPT Referral from locality Radiology team to Soft Tissue Sarcoma SMDT**

- IPT accepted if minimum diagnostic work-up and patient data complete.
- Tracking handed over to SMDT (via MDT Co-ordinators)

**Soft Tissue Sarcoma MDT**

- Possible Post MDT Investigations:
  - Image-guided biopsy
  - Staging CT
  - Diagnostic excision biopsy

**Specialist Sarcoma MDT**

- Communicate outcome (planning decision and place of treatment)

**Decision to treat**

- Patient seen by Consultant Surgeon/Oncologist and decision to treat made

**First Definitive Treatment**

- Surgery, Chemotherapy, Radiotherapy or Best Supportive Care

**Communication to patient on outcome**

By Day 28

Day 38 remains as the IPT standard however teams should aspire to day 21/28 if possible

**Minimum Pre-IPT Investigations required:**
- Patient aware of diagnosis or concerning imaging features and reason for referral to another Trust
- Performance status
- US
- MRI per guideline
- If sarcoma strongly suspected, thoracic CT should be requested prior to IPT

**Core Minimum Patient Data Required:**
- Patient demographics
- CWT Information
- Suspected Cancer
- Referring Consultant
- Working Diagnosis
- Relevant scans and reports

*IPT referral by 21 days if US alone and 28 days with MRI, using the referral for US date as the start point.

*Referring organisations are also required under the IOG to request an opinion of the SMDT for large or deep lipomas. This runs alongside the IPT process, and requires prompt turnaround back to the referring organisations who will usually continue to manage the patient, after receipt of advice from the SMDT. However, if the SMDT is concerned and takes over patient care, an IPT must be transacted. Therefore SMDT opinion must be provided before day 38, hence, referral for opinion must be made by day 28.

By Day 62

**DTT Surgical excision Leeds**

**DTT Radiotherapy Leeds**

**DTT Chemotherapy Leeds**

**By Day 45**

Next pathway review January 2021
IPT Pathway for Testicular Cancer at Leeds
Applicable for first definitive treatment only: January 2019

By day 28 of 2ww referral

Communication to patient on outcome (cancer confirmed or all-clear provided)

Within 48 hours of diagnosis

IPT Referral from locality to Testicular SMDT for first definitive treatment for patients with advanced disease only (*see criteria). Proceed if minimum diagnostic work-up and patient data complete.

Tracking handed over to SMDT (via MDT Co-ordinators)

Testicular SMDT

SMDT communicate MDT outcome (planning decision and place of treatment)

Decision to treat

Patient seen by Consultant Oncologist and decision to treat made

By Day 5

First Definitive Treatment

Chemotherapy prior to surgery at a later date (usually Leeds also)

Minimum Pre-IPT Investigations required:
- Patient aware of diagnosis and reasons for referral to another Trust
- Performance Status
- Full blood count
- U&E
- LFT, bone, Alpha fetoprotein, beta Hcg, LDH
- CXR
- Testis ultrasound

Core Minimum Patient Data Required:
- Patient demographics
- CWT Information
- Suspected Cancer
- Consultant in charge
- Working Diagnosis
- Staging Information
- Relevant pathology/imaging scans/reports

*Criteria for referral to centre prior to surgery:
The indication for discussing this between the managing Urologist and Dr Dan Stark (or deputy) in Leeds should be:
- Metastatic disease visible on chest X-ray
- Abdominal mass clinically evaluable or palpable
- Clinically significant cervical or axillary lymphadenopathy
- Weight loss >10% in the presence of a clinical testicular mass.

A consideration in these patients may well be performing ultrasound abdomen as well as ultrasound testis in the local hospital prior to telephone discussion with Leeds Medical Oncology with the result. Then planning for surgery, chemotherapy and definitive staging can take place simultaneously in Leeds.

Communication to patient on outcome (cancer confirmed or all-clear provided)

Next pathway review January 2021
IPT Referral from locality to Gynaecology SMDT for discussion and treatment plan

Proceed if minimum diagnostic work-up and patient data complete.

Tracking handed over to SMDT (via MDT Co-ordinators)

Specialist Gynaecology MDT

Possible Post MDT Investigations: Chest x-ray, repeat biopsy

SMDT communicate MDT outcome (planning decision and place of treatment)

Decision to treat
Patient seen by Consultant Gynaecologist/Oncologist and decision to treat made

DTT Surgery local or Leeds

DTT Radiotherapy Leeds

DTT Chemotherapy Leeds

First Definitive Treatment Surgery, Radiotherapy, Chemotherapy

Communication to patient on outcome (cancer confirmed or all-clear provided)

Minimum Pre-IPT Investigations required:
- Patient aware of diagnosis and reasons for referral to another Trust
- Clinical appointment/examination
- Biopsy (7 days for pathology report to MDT)

Core Minimum Patient Data Required:
- Patient demographics
- CWT Information
- Suspected Cancer
- Consultant in charge
- Working Diagnosis
- Stage
- Relevant pathology & Imaging scans/reports

Next pathway review January 2021
## Appendix 2 – 38-Day IPT Discrepancy Form

<table>
<thead>
<tr>
<th>Specialty/ Service</th>
<th>Trust A</th>
<th>Trust B</th>
<th>Trust C (3-way pathway)</th>
<th>Completed By:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Dataset Supplied (Y/N)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### 62-Day Target Date

<table>
<thead>
<tr>
<th>Activity/ Event</th>
<th>Date</th>
<th>Days between events</th>
<th>Day on Pathway</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral (start of pathway)</td>
<td></td>
<td>0</td>
<td>0</td>
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</tbody>
</table>

### Summary of Cause of Discrepancy

### Additional Relevant Information

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Version number: 1.1
<table>
<thead>
<tr>
<th>Code</th>
<th>Breach reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Clinic cancellation</td>
</tr>
<tr>
<td>2</td>
<td>Out-patient capacity inadequate (i.e. no cancelled clinic, but not enough slots for this</td>
</tr>
<tr>
<td>3</td>
<td>Administrative delay (e.g. failed to be rebooked after Did Not Attend, lost referral)</td>
</tr>
<tr>
<td>4</td>
<td>Elective cancellation (for non-medical reason)</td>
</tr>
<tr>
<td>5</td>
<td>Elective capacity inadequate (patient unable to be scheduled for treatment within</td>
</tr>
<tr>
<td>7</td>
<td>Complex diagnostic pathway (many, or complex, diagnostic tests required)</td>
</tr>
<tr>
<td>10</td>
<td>Treatment delayed due to co-morbidity (patient unfit for treatment episode, excluding</td>
</tr>
<tr>
<td>11</td>
<td>Diagnosis delayed due for medical reasons (patient unfit for diagnostic episode,</td>
</tr>
<tr>
<td>13</td>
<td>Delay due to recovery after an invasive test (patient diagnosis or treatment delayed</td>
</tr>
<tr>
<td>14</td>
<td>Patient Did Not Attend treatment appointment.</td>
</tr>
<tr>
<td>16</td>
<td>Patient Choice (patient declined or cancelled an offered appointment date for</td>
</tr>
<tr>
<td>17</td>
<td>Patient choice delay relating to first outpatient appointment</td>
</tr>
<tr>
<td>18</td>
<td>Health Care Provider initiated delay to diagnostic test or treatment planning</td>
</tr>
<tr>
<td>19</td>
<td>Patient initiated (choice) delay to diagnostic test or treatment planning, advance</td>
</tr>
<tr>
<td>20</td>
<td>Patient Did Not Attend an appointment for a diagnostic test or treatment planning</td>
</tr>
<tr>
<td>21</td>
<td>Patient failed to present for elective treatment (choice)</td>
</tr>
<tr>
<td>22</td>
<td>Patient care not commissioned by the English NHS (waiting time standard does not</td>
</tr>
<tr>
<td>98</td>
<td>Other reason</td>
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**MYHT codes:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>98a</td>
<td>Patient requests time to consider treatment options</td>
</tr>
<tr>
<td>98b</td>
<td>Diagnostic investigations capacity</td>
</tr>
<tr>
<td>98c</td>
<td>Inter-provider transfer capacity</td>
</tr>
<tr>
<td>98d</td>
<td>Tertiary provider delay</td>
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