NHS SCOTLAND

Framework for Effective Cancer Management

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Summary

Cancer has remained a priority during the COVID-19 pandemic, and will remain so as NHS Scotland continues to recover and remobilise. The development of clinical guidance, such as the Framework for the Recovery of Cancer Surgery has meant that the majority of cancer treatments have continued, with some patients travelling to other areas to receive treatment.

While the 31 day cancer waiting times standard (CWT) has been consistently met throughout the pandemic (from decision to treat to first treatment), the 62 day standard remains challenged (from urgent suspicion of cancer (USC) referral to first treatment).

The challenges facing the NHS in Scotland over the last year have been significant and the way in which care is delivered has changed. NHS Health Boards have been working tirelessly to see, assess and treat patients based on clinical urgency, with an increase in virtual consultations. Meanwhile, increased, appropriate health protection measures to keep patients and staff safe has reduced available capacity across most pathways, including cancer.

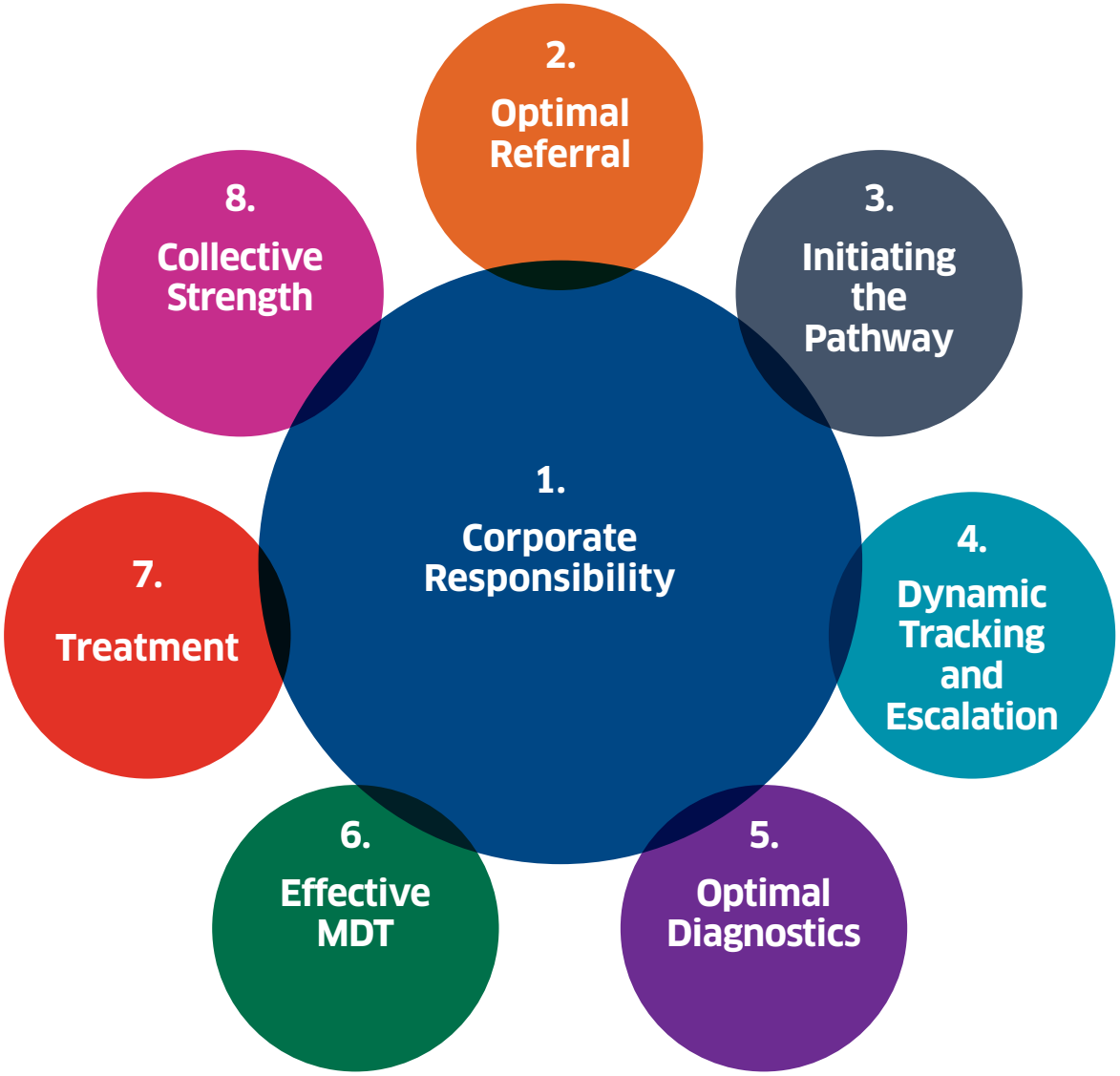
The £114.5 million National Cancer Plan, published December 2020, encompasses a wealth of work underway to redesign cancer services and increase services resilience.

The plan commits to incorporate the new ways of managing cancer pathways and services across NHS Scotland that have emerged as a result of COVID-19, by undertaking a refresh of the Framework for Effective Cancer Management. The Framework, initially developed in 2018, provided every Health Board that delivers cancer care in Scotland with the tools to effectively manage cancer patients and recover waiting times by promoting best practice, alongside hands-on expert support.

The Framework has been refreshed for NHS Scotland's Cancer Management Teams and will be accompanied by in-depth advice and support to Boards from the National Performance Manager for Cancer, who will review local cancer pathway management processes, from beginning (referral) to end (treatment). In line with this Framework, detailed recommendations and action plans will be developed in partnership with every Health Board in Scotland, to ensure it is embedded and that USC patients move timeously through their pathway, with any backlogs that have emerged as a result of the pandemic cleared.

The recently published NHS Recovery Plan commits to achieving the 62 day cancer waiting times standard over the course of the parliamentary term – this Framework will be central to these efforts and will require collective collaboration between primary and secondary care teams, with the patient and their carers needs at the centre. Only when all eight key elements of the Framework are embedded, will effective cancer management begin to be fostered.

The Framework's Eight Key Elements



1. Corporate Responsibility

All NHS Health Boards have a duty and responsibility to ensure efficient and effective systems, structures and processes are in place to manage patients who are referred with an urgent suspicion of cancer (USC), or diagnosed through alternative routes, in a timely manner.

1.1 Board Chief Executives (BCE) and Executive Teams should be clear and consistent in the message to all staff that cancer is a priority.

1.2 Strong leadership from designated Cancer Manager and Clinical Lead for Cancer.

1.3 Agreed governance and management structure for cancer, including Cancer Management Group or equivalent, with a cross-section of Senior Managers from cancer pathways (i.e. Radiology, Pathology, Medical Director, Lead Cancer Clinicians, and Nurse Specialists). This clear structure should aid agreed timed patient pathways, data analysis, Standard Operating Procedures (SOP) and effective breach analysis.

1.4 NHS Board Lead Cancer GP must be a core member of the Cancer Management Group.

1.5 Comprehensive awareness and understanding of the 62 and 31 day cancer standards - for all staff involved in the pathway from cancer trackers and MDT Coordinators to Registrars and Consultants.

1.6 Agreed timeline to clear any backlog, and trajectory to meet cancer waiting times standards, in every NHS territorial Board for teams to collectively deliver a clear, shared goal.

1.7 Named Cancer Framework Champion in every NHS Board.

1.8 Ongoing engagement with Realistic Medicine Champions to ensure principles embedded across cancer pathways.

1.9 The patient should be at the heart of all care. Effective communication channels should be in place to ensure all relevant team members and the patient are aware of and central to processes, timelines and next steps.

2. Optimal Referral

Ensuring a patient is on the right pathway at the right time is essential to ensure those at higher risk of cancer are seen and treated as quickly as possible. This is also essential for those that do not have cancer so they and their families receive reassurance as soon as possible. Fitness for treatment should be considered at the earliest opportunity with prehabilitation and brief intervention principles applied as appropriate.

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2.1 Cancer pathways should be co-produced with Primary and Secondary Care Teams and signed off by the Clinical Lead for each tumour group.

2.2 Cancer pathways should be monitored closely by the tracking team and Cancer Manager to ensure patients are managed within agreed timescales from referral to treatment.

2.3 All tumour specific pathways must be reviewed, updated if required and signed-off by the tumour specific Clinical Lead annually (at a minimum), as new technologies, ways of working and treatments advance and evolve.

2.4 Boards must ensure the capacity to effectively manage the demand of urgent suspicion of cancer (USC) referrals is in place and provision can be flexed when required in times of referral variation (i.e. when breast screening mobile units are in the area or seasonal differences).

2.5 A process to release any ring-fenced USC slots must be in place to reduce the potential of lost capacity, should these urgent slots not be required.

2.6 Direct access for Primary Care to diagnostics with appropriate locally agreed referral processes must be in place.

2.7 Local arrangements should be in place for Advanced Nurse Practitioners (ANP) other nursing staff, pharmacists, dentists, optometrists, NHS24, paramedics and others to ensure their USC referrals can be made and accepted.

2.8 Secondary Care should consider all appropriate USC referrals that meet the Scottish Referral Guidelines for Suspected Cancer from the Primary Care Team.

2.9 Use of RefHelp or equivalent in Primary Care will help ensure the patient is being put on the right pathway at the point of referral.

2.10 An audit of Primary Care referrals should be undertaken in collaboration with General Practice clusters at least annually and discussed with local Cancer Management Groups to support compliance and any lessons shared.

2.11 Working with third sector groups such as Macmillan Cancer Support Scotland and Cancer Research UK to maximize the use of their well-established training packages.

2.12 Primary Care should consult with clinical guidance developed during Covid-19, to support the effective management of USC referrals, for example the USC lung guidance, published July 2020.

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3. Initiating the Pathway

It is good practice to ensure that all USC referrals are vetted promptly and appointed for a consultation (be that in person or virtually) and/or investigation to take place within two weeks of receipt of referral. This will ensure the patient is directed to the right pathway as soon as possible.

3.1 Adopt ACRT (Active Clinical Referral Triage), ensuring that all referrals to secondary care (including advice and patient initiated referrals) are triaged by a senior clinical decision-maker to evidence-based, locally agreed pathways after reviewing all the appropriate electronic patient records.

3.2 Agree vetting standards with agreed timescales e.g. within 48 hours of receipt of USC referral.

3.3 The primary care clinician who has made the USC referral must be informed promptly that it has been regraded and the reason for the regrading. Referrals should only be regraded if not consistent with the Scottish Referral Guidelines for Suspected Cancer. The referrer should be given the opportunity to provide further information to support the original priority of the referral. Ensuring the patient is informed of any change in urgency of referral is key and this should be done through a locally agreed process.

3.4 Clinical teams should work with service managers to ensure that there is appropriate clinic and diagnostic capacity to meet USC demand.

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4. Dynamic Tracking and Escalation

Dynamic tracking should be core business to actively monitor the patient as they move through their pathway, keeping within agreed milestones.

Any slowing of the pathway or challenges should be promptly acted upon by the skilled tracking staff, following the locally agreed Cancer Management Standard Operating Procedure (SOP).

All staff involved in the cancer pathway, from referral to treatment, should be thoroughly familiar with the escalation process, including when this should take place and to whom, to help avoid any delays.

4.1 The process of dynamic tracking and escalation should be agreed and detailed in the Cancer Management Standard Operating Procedure (SOP), which should be reviewed and updated annually.

4.2 The SOP should be disseminated widely to all those involved in the cancer pathway, to ensure everyone is clear on their role and associated timed milestones.

4.3 Tracking staff should be empowered by the Cancer Senior Management Team to make strong links with Service Managers & Diagnostic Teams to enable them to undertake effective escalation and ensure effective and efficient communication between all relevant parties.

4.4 Tracking staff must be knowledgeable in the latest version of the cancer waiting times (CWT) Data & Definitions Manual.

4.5 Tracking staff must be fully aware of the appropriate application of waiting times adjustments (WTA), sharing best practice across the cancer tracking network in NHS Scotland.

4.6 All staff involved in the cancer pathway should respond promptly to any Cancer Tracker's escalation.

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5. Optimal Diagnostics

Ensuring USC patients are effectively managed through the diagnostic element of the pathway is critical if the 62 day waiting times standard is to be met. Patients often require multiple, sometimes complex and invasive tests to determine whether they have cancer or not – this often requires input from Radiology, Endoscopy and Pathology Teams. There should be effective communication with the patient during the diagnostic phase of the pathway. Once fully implemented, Single Point of Contact (SPoC) will provide valuable support to patients and their families throughout the whole pathway.

5.1 Ensure all requests for diagnostic tests are made promptly to meet the Multidisciplinary Team (MDT) timetable. Any investigations that require a pre-Covid-19 test must be arranged timeously in line with the agreed local process.

5.2 All diagnostic requests must be appropriate and clearly marked as USC. This enables Diagnostic Teams to prioritise their workload and ensure reports are available for the weekly Multidisciplinary Team (MDT) meetings where patients' next steps are discussed and agreed by clinical experts.

5.3 The Cancer Management Team should actively monitor all diagnostic turnaround times, as agreed in the SOP.

5.4 The MDT Coordinator and/or Tracker must work closely with tumour specific Clinical Leads and Diagnostic Teams to ensure sufficient turnaround time for diagnostic reports, as required.

5.5 Diagnostic Teams should work in tandem with Cancer Management to explore where diagnostic tests can be coordinated, as opposed to being sequential. This can reduce the number of steps in a pathway and avoid patients having to travel to multiple appointments.

5.6 Ensure any national Covid-19 related guidance associated with diagnostic investigations are disseminated to relevant Clinical Teams and considered collectively alongside Cancer Management i.e. guidance for the use of qFIT in the prioritisation of patients with colorectal cancer.

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6. Effective Multidisciplinary Team (MDT) Meetings

The MDT is the culmination of patient examinations/consultations and diagnostic investigations. Most MDT meetings take place on a weekly basis, usually on the same day each week and can be local (discussing patients from within one NHS Board), or regional (discussing patients from more than one Board within a region). The MDT provides a professional forum to discuss patients' results and explore and agree the most effective treatment options available. It is crucial that all MDTs are coordinated and managed effectively to ensure there's clinical agreement on the next step of the patient's pathway and a decision to treat is not delayed.

6.1 Each MDT should be well organised with a robust terms of reference (ToR).

6.2 The current day which the patient is on in their pathway should be available and clearly communicated in the MDT meeting so every effort is made to treat the patient within the 62 or 31 day standard.

6.3 The MDT coordinator and/or tracker should be well prepared, ensuring all diagnostic reports are available on time for the MDT discussion.

6.4 The MDT outcome should be clearly recorded and filed (i.e. on clinical portal).

6.5 Any actions from the MDT should be taken forward in a timeous manner by the responsible owner.

6.6 Outcome of MDT should be shared with the patient, and their GP practice, as soon as possible following the meeting.

7. Treatment

A discussion will take place following the MDT between the patient and their clinical team to explore the most effective treatment options available and agree a treatment plan. This could involve surgery, radiotherapy, chemotherapy, immunotherapy, palliative care or a combination of options. The benefit and need for prehabilitation/rehabilitation should also be considered at this time.

During the pandemic, patients have been treated based on clinical risk and available clinical evidence and guidance such as the Framework for the Recovery of Cancer Surgery. Any changes to treatment plans that have occurred during this time should be agreed collectively between the patient and clinical team and recorded appropriately.

7.1 National clinical prioritisation guidance should be embedded to ensure local, regional and national resources are managed appropriately for cancer treatments.

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7.2 There should be an agreed process for pre-treatment isolation and COVID-19 testing to minimise any Covid-19 related risks that may delay treatment commencing.

7.3 Any WTA in the pathway should be applied appropriately and documented.

7.4 Patients should be informed at the point of decision-making of the expected timescales to wait for treatment.

8. Collective Strength

Cancer Management Teams across Scotland must foster effective working relationships across a variety of clinical disciplines that cancer pathways cut across. This will ensure the efficacy of timed pathways to improve and sustain cancer waiting times performance as well as patient experience & outcomes.

8.1 Attendance/representation from each NHS Board at the National Cancer Managers Forum (CMF) is expected to share good practice, especially those emerging during the pandemic i.e. Community Phlebotomy.

8.2 Attendance/representation from each NHS Board at the national CWT Data and Definitions Group is expected.

8.3 Weekly data submission and reporting for the weekly call with Scottish Government officials (monthly for Island Boards) should be part of core business for Cancer Management.

8.4 In the event that a patient breaches a cancer waiting times standard, effective Breach Analysis reports must be carried out and discussed with tumour specific Clinical Lead to avoid future similar breaches.

8.5 Cancer Management Teams should engage locally, regionally and nationally in regards to Clinical Prioritisation to help identify variance in access to care.

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Glossary of Terms

AHPs	**Allied Health Professions** A diverse group of clinicians who deliver high-quality care to patients across a wide range of care pathways and in a variety of different settings. They play an important role in the cancer pathways and modern health and social care services. *AHPs include dietitians, physiotherapists, diagnostic radiographers, therapeutic radiographers, speech and language therapists.
ANP	**Advance Nurse Practitioner (ANP)** A highly skilled nurse who can be placed within primary care to clinically assess and make decisions on referral to secondary care, where there is a suspicion of cancer. ANPs can also be found within secondary care, often playing a core role in cancer pathways be that running clinics or performing diagnostic tests for example.
ACRT	**Active Clinical Referral Triage (ACRT)** Ensuring that all referrals to secondary care (including advice and patient-led referrals) are triaged by a senior clinical decision maker to evidence-based, locally agreed pathways after reviewing all the appropriate electronic patient records.
CMF	**Cancer Manager Forum (CMF)** Network of Cancer Managers, and others who participate in managing cancer patients, across NHS Scotland. The peer-to-peer forum, that meet quarterly, enables the group to seek support and build successes from shared experiences.
GP	**General Practitioner (GP)** GPs are largely found in Primary Care and are often the source of referral for patients to secondary care where there is a suspicion of cancer.

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GDP	**General Dental Practitioner (GDP)** Dentists can also refer patients urgently where there is a suspicion of cancer of the mouth/neck.
MDT	**Multi-Disciplinary Team Meeting (MDT)** The MDT is a diverse group of clinical professionals (medical, nursing, allied health professionals (AHPs), radiological, pathological, oncological etc.) working together to reach and grade a cancer diagnosis. The MDT will discuss a range of clinical investigative results to agree treatment options for patients diagnosed with cancer. An MDT will usually meet on a weekly basis to ensure cancer treatments and holistic needs can be agreed and delivered in a timeously manner. The MDT attendance, discussion and decisions must be recorded, filed and shared appropriately e.g. clinical portal and sent to the GP.
PREHABILITATION	**PREHABILITATION** Prehabilitation helps a patient prepare as best they can for treatment. A 'universal' prehabilitation focuses on physical activity, psychological support, nutritional care, smoking cessation and alcohol reduction to prepare people for their cancer treatment

RefHelp	**RefHelp** RefHelp is a local referral management website providing accurate, up-to-date guidance to support NHS Lothian referrers with their referrals to secondary care services. It reflects a consensus between local clinicians at the interface and seeks to build relationships and understanding across primary and secondary care. The guidance provided is designed to be readily accessible and to help referrers – GPs, secondary care clinicians, dentists, optometrists, practice nurses, third sector, etc. – make the best possible referrals(including USOC referrals) in Lothian. As a trusted source of evidence-based referral information, RefHelp is constantly evolving to ensure the content reflects the latest referral advice and guidance. As such, clinical specialties are asked to review their content every two years. The team consists of Primary Care Referrals Advisors and Outpatient Redesign project staff who work with clinical specialties to develop and review their patient pathways and referral guidelines.
SOP	**Standing Operating Procedure (SOP)** A set of step-by-step agreed instructions manual compiled by the NHS Cancer Management Team to help staff carry out the routine operating procedures in a consistent manner. The SOP will achieve efficiency, quality input and uniformity while reducing error and misinformation. The Cancer SOP should be clear in dynamic tracking and escalation to ensure pathways are managed effectively. The SOP supports and empowers the staff to perform their job function consistently and appropriately.
ToR	**Terms of Reference (ToR)** ToR's are a set of collective priorities for delivery of a task in an efficient manner with descriptions on the roles and responsibilities of the function and for staff members in certain designated positions e.g. Chairmanship, agenda, meeting schedule etc. A Cancer MDT ToR (for example) will explain the process of the clinical discussions and outcomes. The tumour specific ToR will support the professional discussion in a managed environment to ensure consistency and efficiency with followed actions.

USC	**Urgent Suspicion of Cancer (USC)** When there is a referral to secondary care where the patient has signs and symptoms that that are suspicious and may lead to a cancer diagnosis. The referral will be promptly managed in secondary care to ensure the appropriate pathway and tracking commences as soon as possible.
WTA	**Waiting Times Adjustments (WTA)** Within a cancer pathway there may be some areas of delay. These pathway delays can be adjusted to discount periods of patient unavailability, patient induced delays and medical suspensions. Patients may choose time to consider their options or in some instances the patient has other medical conditions that need to be considered before any treatment plans or investigations can take place.
62 DAY CANCER WAITING TIMES STANDARD	Measures the time from the **date of receipt of initial urgent suspicion of cancer (USC) referral into secondary care** until the date of first treatment. There is a 95% compliance for this standard. This includes • Patients urgently referred **with a suspicion of cancer** by a primary care clinician (ANP, GP or GDP); • Patients who attend A&E/direct referrals to hospital where the signs and symptoms are consistent with the cancer diagnosed as per the Scottish Referral Guidelines; • Patients referred through a National Cancer Screening Programme.
31 DAY CANCER WAITING TIMES STANDARD	The Board of first treatment is responsible for meeting 95% compliance with the 31-day standard, measuring the time from the **date of decision to treat** until the date of first treatment. This includes all patients diagnosed with cancer, regardless of the route of referral.

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Edinburgh
EH1 3DG

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