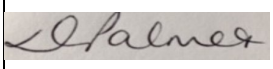
West Midlands Cancer Alliance Inter Provider Transfer of Care Allocation Policy

October 2025



Coversheet for West Midlands Cancer Alliance Agreed Documentation

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

Document Title	West Midlands Cancer Alliance Inter Provider Transfer of Care Allocation Policy (v12)	
Published Date	November 2025	
Document Purpose	A policy document providing clarification regarding the responsibilities of referring and treating providers in the West Midlands in relation to the National breach allocation guidance.	
Authors	John Elliott, WMCA Programme Manager	
References	See contents page.	
Consultation Process	The current West Midlands Cancer Alliance Inter Provider Transfer of Care Allocation Policy (v11) was reviewed, updated and agreed by Cancer Trust Managers and Lead Nurses on 20th March 2025.	
Review Date (must be within three years)	November 2028	
Approval Signatures	On behalf of Trust Cancer Managers	On behalf of West Midlands Cancer Alliance
	Debra Palmer, Chair of Cancer Trust Managers and Lead Nurses  Date: 14.11.2025	Lydia Fresco, Clinical Director  Date: 14.11.2025

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1. Introduction and Purpose

National Breach Allocation Guidance (NHS England, 2016) was first published in April 2016, aiming to provide a fairer method of cancer breach allocation when treatment is delayed between referring and treating providers. It required local policies to be in place by October 2016 that supported the achievement of day 38 as a target handover date.

The West Midlands Inter Trust Breach Allocation Policy (v10, 2016) first published in October 2016, has been reviewed and updated to align to **the National Cancer Waiting Times Monitoring Dataset Guidance (v12 2023)**, and is now named the West Midlands Cancer Alliance Inter Provider Transfer of Care Allocation Policy. The scope of this policy incorporates all cancer referrals between Providers; including adults and children of all ages as described in the national guidance.

In 2016 the original policy was developed with representatives from each of the West Midlands health systems and the published policy circulated to the then STP Chief Executive Officers, Trust Chief Operating Officers, Cancer Clinical Leads and Cancer Trust Managers, Cancer Commissioning Leads and Directors of Nursing, NHS England Locality Directors and Directors of Nursing for the North and West Midlands, NHS Improvement and the Cancer Alliance.

The policy has been updated in 2025 with the input of Cancer Trust Managers and Lead Nurses to reflect the changes to the national guidance. The policy is published on the West Midlands Cancer Alliance website and has been endorsed by the West Midlands Cancer Alliance Board.

The document outlines the process for inter-provider transfers (IPTs) within the West Midlands Cancer Alliance and sets out in detail the principles of breach allocation when transferring patients between Trusts and reflects the National recommendation for collaborative relationships between referring and treating organisations.

An IPT involves transferring a patient's care from one provider to another for staging (according to clinical pathway), treatment and follow-up and this guidance applies to all cancer pathways and all sources of referral from April 2019 onwards.

The aim is that all patients on a cancer pathway are transferred between providers by day 38 or before (as per the locally agreed West Midlands Cancer Alliance best practice timed pathways) in order to ensure timely treatment and achievement of the 62-day standard. Timed pathways can be found on the West Midlands Cancer Alliance website (Appendix 9.2).

This applies to both two-provider and multiple provider transfers. This guidance should support a smooth transition for patients into tertiary centres, and back to the referring centre (where appropriate), as well as encouraging transparency and ownership of pathways that enable targeted improvement where a need is identified.

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

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

This policy document and supporting documentation is available on the following link to the West Midlands Cancer Alliance website:-
http://wmcanceralliance.nhs.uk

2. Inter Provider Transfers (IPT)

This policy applies to IPTs where the patient's pathway transfers from one provider to another for any reason (i.e. cancer diagnostics, staging, treatment, and follow-up from all initial referral sources including GP/GDPs, cancer screening programmes, consultant upgrades onto the 62-day pathway, subsequent treatments and patients presenting with recurrences and/or metastases) and is based on the guidance contained within National Cancer Waiting times Monitoring Dataset Guidance (v12 2023).

The guidance applies to referrals to all tertiary providers in the West Midlands, including referrals for treatment from Trusts outside the Alliance.

Within the West Midlands there are four main tertiary providers:

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

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

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

2.1 Minimum Information Required for Standard Referrals

It is the responsibility of the referring Trust to ensure the correct process is followed for all IPT referrals. An inter-provider transfer may not be recognised as a referral without receipt of the minimum data set, which consists of two parts:

MDT referral proforma and minimum dataset:

- Clinical referral letter, including cancer waiting time and pathway information, medical history, BMI and medication, if applicable.
- Histology slides and report as specified on the MDT referral proforma.
- Staging and radiological images and report.
- Assurance that patient is aware of the referral to another Trust.
- Specialist Multi-Disciplinary Team (SMDT) referral form (where appropriate).

It is the responsibility of the referring Trust to complete all relevant patient pathway tests, as outlined in the timed pathways, before transferring the patient. Discussion at MDT maybe delayed until the minimum dataset is received. Breaches attributed to failing to provide the complete minimum dataset will be allocated to the referring Trust.

Standard IPT referral form

Inter-provider transfer form – mandatory fields completed as a minimum. This dataset includes the national cancer waiting times dataset plus the inter-provider referral date. This should be sent via SCR e-tertiary system if available. The tertiary alert system will continue and the clock will start for an IPT once the receiving Trust acknowledges receipt of the **standard IPT referral form** accompanied by the Alliance agreed **MDT referral proforma and minimum dataset**:

The IPT form should also be accompanied by:

- MDT referral form (to include performance status) clearly indicating the question required to be answered by the MDT
- The outcome from any local MDT on the SCR proforma
- Clarification of whether the IPT is for treatment, MDT discussion or diagnostics
- Staging and radiological images and report.
- Pathology reports – slides also to be sent allowing 48 hours for reporting upon receipt
- Clinical referral letter, cancer waiting time and pathway information, BMI, medical history and medication, if applicable.

It is the responsibility of the referring Trust to complete all relevant patient pathway tests, as outlined in the timed pathways, before transferring the patient. Discussion at MDT maybe

delayed until the minimum dataset is received.

Breaches attributed to failing to provide the complete minimum dataset will be allocated to the referring Trust.

It is the responsibility of the referring Trust to advise patients they have been referred on a cancer pathway and will be receiving an appointment which they should accept and not cancel or change.

It is the responsibility of the receiving Trust to acknowledge receipt of the referral and to confirm acceptance or rejection **within 24 hours** by the use of the following standard e-mails:-

Acceptance:

Dear Colleague

You have recently forwarded a cancer referral for patient XXXXXXXXXX.

We can confirm receipt of the MDT referral proforma and minimum data set required for referrals (as outlined in the West Midlands Cancer Alliance Inter Provider Transfer of Care Allocation Policy) as of XXXXXXX

Kind regards

Cancer Services Team
XXXX Hospital

Rejection:

SUBJECT: INCORRECT REFERRAL – URGENT ACTION NEEDED

Dear Colleague

You have recently forwarded a cancer referral for patient XXXXXXXXXX.

Unfortunately, the information that you have sent does not meet the minimum data set required, and as such the referral is incomplete.

With the aim of supporting the pathways of patients referred into the Cancer MDTs at XXXX Hospital and in line with the minimum information required for referrals (as outlined in the West Midlands Cancer Alliance Inter Provider Transfer of Care Allocation Policy), the following documents need to be sent to (add trusts own referral details e.g. generic .net email address) in order for any referral to be considered complete;

- Fully completed MDT referral proforma.
- Histology slides and report as specified on the MDT referral proforma.
- Images and imaging report attached to the referral email.
- Clinical letter.
- Assurance patient is aware.
- Tertiary alert

As soon as the minimum data set is received via the above email we will action the referral and forward you an acknowledgement of acceptance **within 24 hours**.

Kind regards

Cancer Services Team
XXXX Hospital

The receiving Trust will record the date of receipt of the histology and other results from the referring Trust and confirm to the referring Trust when all of the required information has arrived and the clock start date.

All tertiary referrals are to be sent electronically to a generic inbox and not to individually named members of the Team.

These generic inboxes must only be used for receiving tertiary referrals.

Contact details and generic email details are available in the West Midlands Cancer Alliance Directory for Cancer Tracking and Escalation document (available on request).

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

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

It is the responsibility of the referring Trust to complete the initial pre tertiary diagnostic tests, as outlined by the Best Practice timed pathways.

2.3 Referrals for Diagnostics and Treatment without SMDT Discussion

Where a SMDT discussion is not required for referrals for diagnostics and treatment, the clinical referral letter should be accompanied by the IPT referral form, including date of diagnosis and basis of diagnosis where a definitive diagnosis has been confirmed.

It is the responsibility of the treating Trust to support referring Trusts through agreed communication and collaboration to only complete diagnostics for site specific pathways.

Where staging is not fully completed before referral due to complexity of the tumour pathway, referring Trusts should refer the patient as soon as possible to complete staging in the tertiary Trust.

Where there are agreed standard operating procedures in place between referring and treating Trusts for specialised Consultants to work in the referring Trust, it remains the responsibility of the referring Trust to ensure patients are transferred using the standard IPT process.

2.4 Referrals Back to Referring Trusts

Where the decision of the treating Trust is to refer the patient back to their original referrer, best practice would be to complete the referral **within 24 hours** of this decision being made to allow first treatment within the 62 days.

Where patients have been discussed at MDT only, appropriately detailed MDT outcome notes will be sent as standard **within 24 hours.**

3. Timed Pathways

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

These locally agreed shorter handover dates will reflect the complexity of multi provider pathways for certain tumour groups such as partial staging due to tertiary providers providing complex diagnostics. A referring Trust should aim to transfer a patient with a complex pathway as soon as possible to the tertiary centre to enable them to complete staging and commence treatment within 24 days of receipt of patient.

Timed pathways can be found on the West Midlands Cancer Alliance website; http://wmcanceralliance.nhs.uk

4. Data Protection

Standard IPT referrals should be sent electronically to the agreed generic tertiary referral inbox within the receiving Trust or via SCR e-Tertiary if available. Referrals should be accompanied by: -

- MDT referral form (to include performance status) clearly indicating the question required to be answered by the MDT
- The outcome from any local MDT on the SCR proforma
- Clarification of whether the IPT is for treatment, MDT discussion or diagnostics
- Staging and radiological images and report.
- Pathology reports – slides also to be sent allowing 48 hours for reporting upon receipt
- Clinical referral letter, cancer waiting time and pathway information, BMI, medical history and medication, if applicable.
- Assurance that the patient is aware of the referral to another Trust.
- SMDT referral form (where appropriate).
- Referring Trusts root cause analysis for all breached referrals.

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

In exceptional cases, for example where electronic transfer is not possible due to technical failure, local business continuity arrangements should be followed.

All Organisations delivering health care should have existing business continuity arrangements in place to manage a situation where Information Technology (IT) systems are unavailable for a significant period of time. These arrangements should be developed locally, agreed and shared with all stakeholders, be user friendly and safe. They should be tested on a regular basis as part of disaster recovery planning.

This also applies to the rare occasions when the NHS e-Referral Service is not available.

5. Patient Tracking

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

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

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

The Lead Cancer Manager \ Designated Person at the tertiary provider is responsible for ensuring that the IPT form is updated to reflect treatment planning, key events and changes to target dates. They must ensure that this is electronically transferred to Lead Cancer Managers \ Designated Person at the referring provider on a weekly basis. This returned form is known as the IPT weekly report.

It is the responsibility of both the referring and treating Trust to validate all IPT referrals prior to upload. It is encouraged that the use of electronic systems be reinforced by verbal updates, preferably on a weekly basis, between people who are responsible for tracking. There should be a clear process to escalate any issues that are likely to impact on patient care with an agreed action plan with timescales used to address these.

6. Recording Inter-Provider Transfers (IPT)

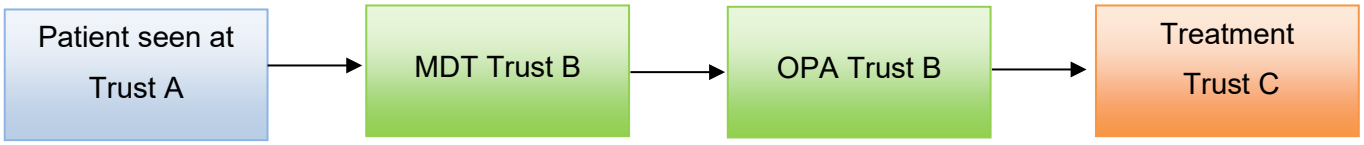
IPTs should be recorded when the responsibility for care is formally transferred.

The date that a referral request is received by the provider will mark the point at which the IPT is made.

Where a patient has only been referred for MDT discussion, diagnostic testing or second opinion and care has not been formally transferred, this would be a referral without a transfer of care and not be recorded as an IPT.

6.1 Example scenarios where IPTs should be recorded

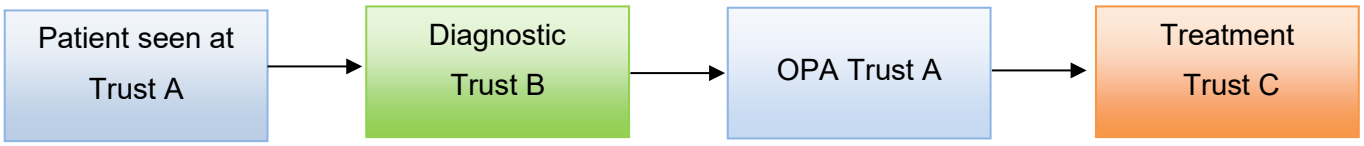
Scenario 1



Two IPTs would be recorded

- One from Trust A to Trust B as patient is discussed at MDT and followed up at Trust B (so transfer of care has taken place)
- One from Trust B to Trust C as patient has transferred to Trust C for treatment

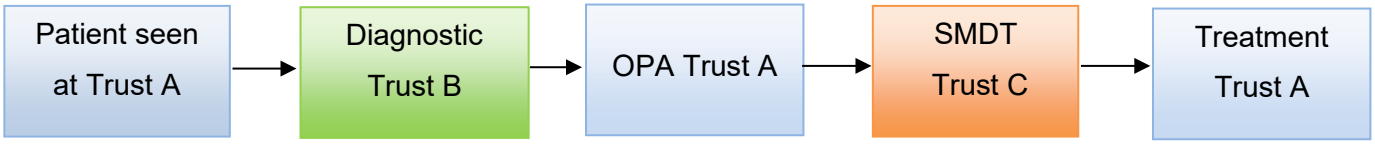
Scenario 2



One IPT would be recorded

- One from Trust A to Trust C as patient has transferred to Trust C for treatment
- An IPT should not be recorded from Trust A to Trust B, as the patient just had a diagnostics at Trust B, and the patient was followed up with results at Trust A.

Scenario 3



No IPT would be recorded

- Transfer between Trust A and Trust B were just for diagnostics for which follow-up was at Trust A, so no IPT recorded as no transfer of patients care.
- Transfer between Trust A and Trust C was just for a Specialist Multidisciplinary Team (SMDT) discussion, the outcome of which was for treatment to commence at Trust A, so no IPT recorded as no transfer of patients care.

6.1 Principles around recording of Inter-provider transfers

Requirements:

- Referral without a transfer of care
  - Where a patient has only been referred for an MDT discussion, diagnostic test or second opinion.
- Referral with a transfer of care
  - Patient has been informed they are being referred to another provider, meaning the receiving provider can act freely in arranging next steps of the pathway
  - The purpose of the referral is clear
  - All relevant clinical information is included. The details will vary by tumour type, and regionally and should be agreed locally.
  - A complete IPT form is included with the referral or provided separately

- All required diagnostics/imaging and associate results are available

6.2 Referral timelines

- The receipt of referral and IPT form should be recorded as the date of receipt of referral:- REFERRAL REQUEST RECEIVED DATE (INTER-PROVIDER TRANSFER)
- This includes when a referral is received on a non-working day and at any time of the day
- Where a completed referral information and/or IPT form is not received then the REFERRAL REQUEST RECEIVED DATE (INTER-PROVIDER TRANSFER) would be recorded as the date when the completed information is received
- Receiving providers should acknowledge receipt of the referral/IPT, or feedback if additional information is needed within one working day.

6.3 Information required by receiving providers

The CWT system requires submission of the REFERRAL REQUEST RECEIVED DATE (INTER-PROVIDER TRANSFER). This is the date when the receiving provider receives the referral request for the patient and the patient files/ records (minimum clinical data set) that will enable them to continue the patient's diagnostic investigation pathway or commence treatment.

The following data items are mandated by the CWT system for an Inter-Provider Transfer:

NHS NUMBER
NHS NUMBER STATUS INDICATOR
PATIENT PATHWAY IDENTIFIER*
CANCER REFERRAL TO TREATMENT PERIOD START DATE*

*only one of these fields is required to be accepted by the system but both are preferable. Where a patient is on the 62-day consultant upgrade standard the PATIENT PATHWAY IDENTIFIER is mandated

The following further data items should be included in an IPT

- Service requested date (inter-provider transfer)
- Referral request received date (inter-provider transfer)
- Organisation identifier (referring)
- Organisation identifier (receiving)
- Cancer transfer referring reason (inter-provider transfer)
- Cancer transfer receiving reason (inter-provider transfer)
- Tumour site
- Date of treatment

Appendix 9.3 shows a full table of data items definitions.

It will be reported through normal provider Trust cancer registry systems to Trust performance teams and to the relevant Integrated Care Boards.

Robust lines of communication, including verbal contact, should be established between all people who collect cancer waiting times data. Queries and anomalies, especially potential breaches, should be highlighted and resolved as quickly as possible as per the agreed process identified in section 5 of this document.

It is mandatory to record all IPT transfers on 62 day pathways and report a reason for delay when patients wait over 62 days to start their first definitive treatment. Appendix 9.4 provides additional guidance for specific codes, which gives further clarity on the use of delay reasons.

6.4 Calculating Performance

All providers involved in a patient's pathway should work together to address any delays, wherever they occur.

In the new approach the 62 day pathway is divided between the investigating and treating providers. Day 38 is the last day on which the final IPT should be made to the treating provider, except for those locally agreed tumour specific timed pathways and handover standards.

Where more than two providers are involved in a patient's care, patient activity is never split to less than 0.5 of a patient case and will only be allocated to one investigating and one treating provider. Performance in the investigation phase will be measured using the total cumulative days a provider spends with the patient.

Appendix 9.5 shows a full breakdown for how performance will be assessed.

Appendix 9.6 provides some additional example patient scenarios to show how 2 provider and multi-provider allocations will be assessed.

6.5 Escalation of Issues Relating to Inter Provider Transfer

It is recommended good practice for all providers to ensure that there is an agreed protocol in place for the appropriate escalation of suspected and confirmed cancer patients. This process should be included within a Trusts own internal access policy as standard.

An effective protocol would include:

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

6.6 Arbitration Process

Where Cancer Trust Managers are unable to agree a date of transfer, disputes should be escalated to the Senior Operations Manager responsible for Cancer within each Trust for resolution. Where clinical expertise is required the Trusts Clinical Cancer leads should also be included in those discussions.

Any disputes that remain unresolved between trusts should then be escalated to the relevant Integrated Care Boards (ICBs). It remains the responsibility of both the referring and receiving ICB to act as the ultimate arbitrators in breach resolution.

Any disputes should be resolved before the National Cancer Waiting Time submission deadline.

7. Inter Transfer Provider Breaches and Root Cause Analysis

ICBs will receive breach information monthly (submitted through formal contracting routes) from provider Trusts accompanied by root cause analysis (RCA) of any breaches.

To understand the cause of late referrals, it is the responsibility of the referring trust to complete RCA's for all IPT patients breaching day 38, 62 or 104 (or breaching other locally agreed tumour specific transfer days) regardless of whether the patient has commenced treatment. This learning should be shared within the appropriate teams.

The RCA should include a timeline of the patient pathway up to the date of referral. Each pathway step/delay should be analysed as being either unavoidable or avoidable using a Red, Amber and Green (RAG) system.

RCA's need only be shared with the treating trust if requested as part of a harm review process and should then be shared within 24 hours of request.

Once the patient has commenced treatment, if a 104 day breach has occurred the treating Trust will lead the harm review process within a timely manner. All organisations involved in the care and service delivery of a patient in which a serious incident has occurred will work together to undertake one single investigation wherever possible and appropriate, utilising the RASCI framework model to support this process.

Where there is a delay in treating trusts receiving requested RCA's, the Chief Operating Officer and ICB (Director of Nursing/Quality Lead) for the referring trust will be notified of these delays by the designated person leading the investigation.

8. References

NHS England National Cancer Waiting Times Monitoring Dataset Guidance (2023)

Available from:

National Cancer Waiting Times Monitoring Dataset Guidance V12.0 (england.nhs.uk)

Cancer waiting times user guide

Available from:

Cancer waiting times user guide - NHS England Digital

IPT 6 Guidance (2021)

Available from:

CWT+-+IPT6+Guidance.pdf

NHS Digital NHS e-Referral Service: Business Continuity Guidance

Available from:
Business continuity guidance - NHS e-Referral Service - NHS England Digital

9. Appendices

9.1 West Midlands Cancer Alliance Website Link

http://wmcanceralliance.nhs.uk

9.2 IPT Minimum Data Set Checklist

This document draws on examples from a number of NHS providers as to what clinical information should accompany a referral in instances where patients care is transferred between providers in either the investigative or treatment phase of the cancer pathway. This checklist has been approved by the West Midlands Cancer Alliance and by the representatives who undertook the review of the West Midlands Inter Trust Breach Allocation policy.

The checklist below is the minimum data that the referring provider should complete at the inter-provider transfer point, so that only the relevant cancer waiting time information and relevant diagnostic information is shared.

Data name	Specific fields
Patient details	Patient name
	Patient contact no.
	NHS Number and Pathway ID
	Patient Address
	GP details
	Date of birth
	Patient informed of diagnosis (if applicable), reason for referral, and patient consented
Cancer Waiting Time and pathway information	Initial referral source (e.g. GP referral, A&E)
	Referring provider
	Referring clinician
	Referrer email
	Referrer contact no.
	Cancer Waiting Time (where applicable): ☐ Date of decision to refer ☐ Cancer referral period clock start date ☐ Cancer waiting time standard as applicable: □ 62 day (urgent GP) □ 62 day (screening) □ 62 day (upgrade) ☐ Date of upgrade (if applicable) ☐ Date patient informed of diagnosis (28 day clock stop) ☐ 28 day target date ☐ 62 day target date ☐ Adjustments to pathway (e.g. patient DNAs)
Clinical details: cancer site	Overview of clinical details: diagnosis and staging
	Comorbidities / relevant patient health information / past medical history / BMI / Medication / performance status
	MDT Details – dates, details of discussion, referral reason
Clinical details: Pathology, imaging and other relevant test results should be in agreement with the local hospitals and pathway specific	Histology
	Imaging

9.3 Delay Reasons

National Code	Description
01	**Clinic cancellation** *When any care provider initiated a cancelled outpatient clinic along any part of the pathway.*
02	**Out-patient capacity inadequate (i.e. no cancelled clinic, but not enough slots for this PATIENT)**
03	**Administrative delay** *Reasons can include but are not limited to: delay in letters, incorrect referral, inaccurate or insufficient data to proceed* *Includes administrative delays internal and external to the care provider.*
04	**Elective cancellation (for non-medical reason) for treatment in an admitted care setting** *When the cancellation has been initiated by the health care provider.* *Reasons can include but are not limited to: capacity or workforce issues, inaccurate or insufficient information to proceed with treatment.*
05	**Elective capacity inadequate (PATIENT unable to be scheduled for treatment within standard time) for treatment in an admitted care setting**
07	**Complex diagnostic pathway (many, or complex, diagnostic tests required)**
10	**Treatment delayed for medical reasons (PATIENT unfit for treatment episode, excluding planned recovery period following diagnostic test) in an admitted care setting** *Includes any clinical contra-indication to commencing treatment.* *Includes delay for investigations to determine if fit-to –proceed e.g. angiography*
11	**Diagnosis delayed for medical reasons (PATIENT unfit for diagnostic episode, excluding planned recovery period following diagnostic test)**
13	**Delay due to recovery after an invasive test (PATIENT DIAGNOSIS or treatment delayed due to planned recovery period following an invasive diagnostic test)**
14	**PATIENT Did Not Attend treatment APPOINTMENT** *Applicable to non-admitted only* *Excludes treatment planning (code 20).* *Excludes when patient fails to present for treatment in an admitted care setting (code 21).*
16	**PATIENT Choice (PATIENT declined or cancelled an offered Appointment Date for treatment)** *Includes admitted and non-admitted care.* *Excludes diagnostic tests (code 19).*
17	**PATIENT choice delay relating to first Out-Patient Appointment** *Includes appointments as part of new care models such as straight-to-test appointments and telephone consultation.*
18	**Health Care Provider initiated delay to diagnostic test or treatment planning** *HCP in this setting would be any organisation with appropriately trained staff to provide a treatment or diagnostic service.* *Excludes delay due to patient being medically unfit.*
19	**PATIENT initiated (choice) delay to diagnostic test or treatment planning, advance notice given**
20	**PATIENT Did Not Attend an APPOINTMENT for a diagnostic test or treatment planning event (no advance notice)**
21	**PATIENT failed to present for elective treatment (choice) in an admitted care setting**
22	**PATIENT care not commissioned by the NHS in England (waiting time standard does not apply) for treatment in an admitted care setting**
23	**Equipment breakdown** *Includes diagnostic and therapeutic equipment breakdown.*
24	**Inconclusive diagnostic result**
25	**Health Care Provider unable to make contact with PATIENT by telephone** *Form of contact not limited to telephone only*
26	**PATIENT choice (PATIENT declined or cancelled an offered Appointment Date for follow up APPOINTMENT)** *Not limited to face-to- face follow-up appointments*
97	**Other reason (not listed)**

9.4 Allocation of Responsibility in 62 Day Pathways

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

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

Pathways with multiple Inter-Provider Transfers

The pathway is split into two phases

- Investigating phase which is up to the final Inter-Provider Transfer
- Treating phase which is after the final Inter-Provider Transfer

Allocation of the investigating provider is made on the following basis

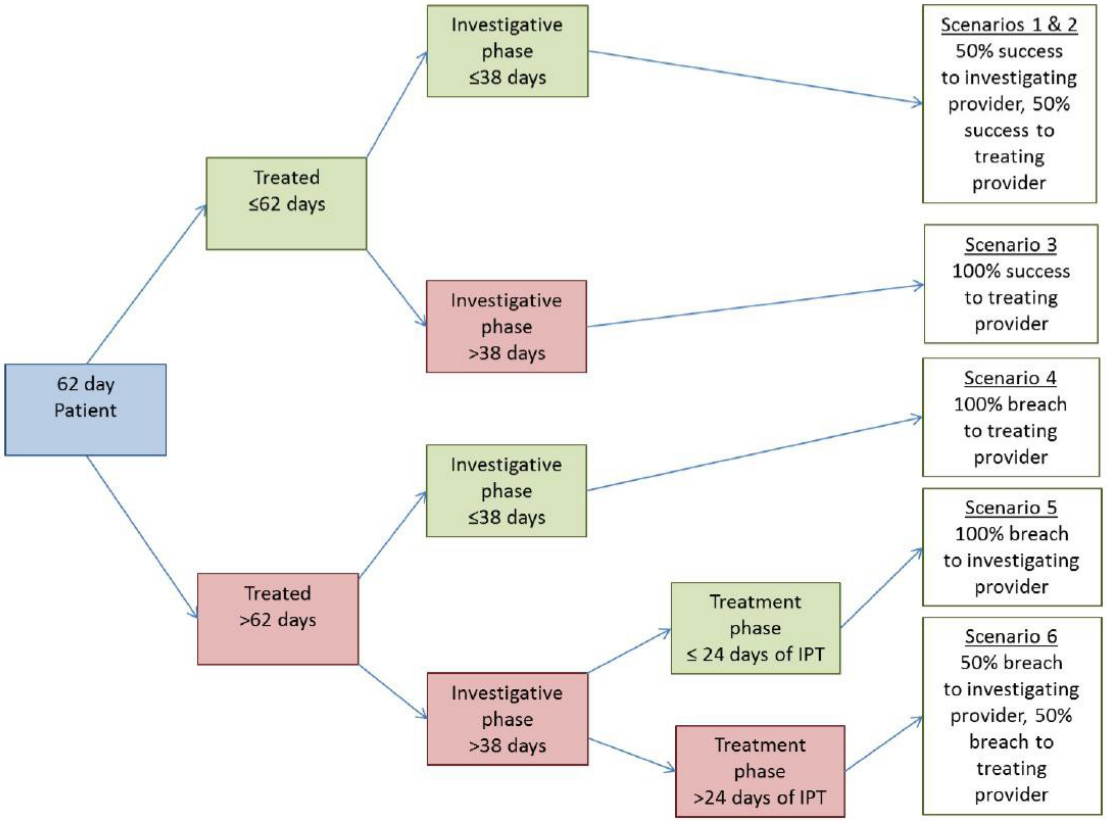
- If referral received to last IPT ≤38 days
    - Allocation to provider with shortest pathway up to last ITT
    - If one or more trusts have same length of pathway, pathway allocated to 1st provider on pathways

- If referral received to last IPT > 38 days
    - Allocated to provider with longest pathway up to last ITT
    - If one or more trusts have same length of pathway, pathway allocated to last trust on pathway

Once the allocation of investigation has been completed, then the rules to allocate cases and breaches apply in the same way as if there was only a single IPT in the pathway.

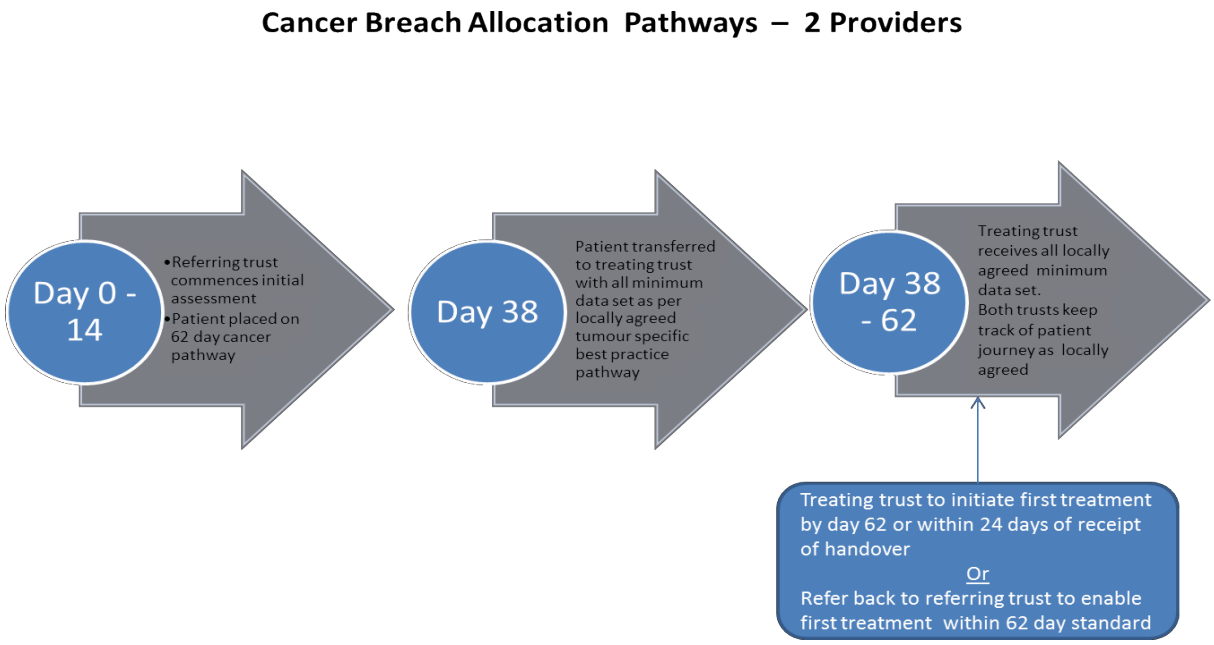
Pathways where treating provider is also involved in the investigative stage of the pathway

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.

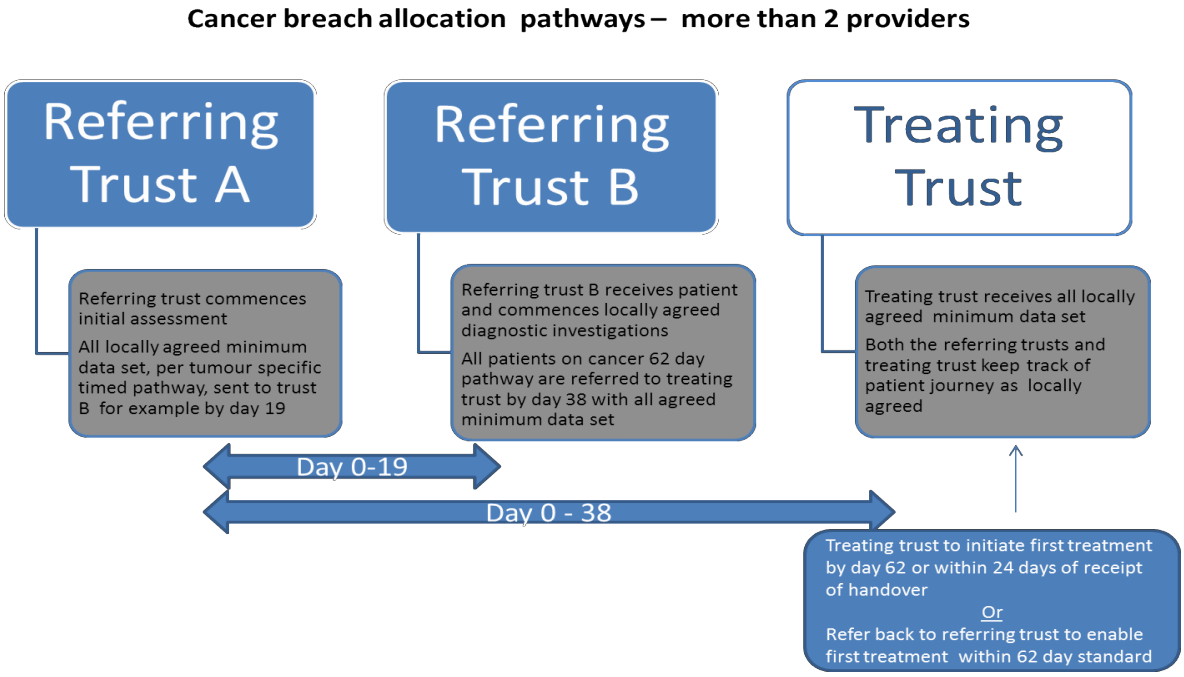

62 day Patient
Treated ≤62 days
Treated >62 days
Investigative phase ≤38 days
Investigative phase >38 days
Investigative phase ≤38 days
Investigative phase >38 days
Treatment phase ≤ 24 days of IPT
Treatment phase >24 days of IPT
Scenarios 1 & 2 50% success to investigating provider, 50% success to treating provider
Scenario 3 100% success to treating provider
Scenario 4 100% breach to treating provider
Scenario 5 100% breach to investigating provider
Scenario 6 50% breach to investigating provider, 50% breach to treating provider

9.5 Breach Allocation Scenarios

Breach Allocation for the 2 – provider pathway



Breach Allocation for the Multi Provider Pathways



Breach Allocation Examples

	Scenario	Referral Time Frame		Total Time Frame	Breach Allocation as per Guidance (pg. 33)
1	Patient A is referred from Walsall Healthcare Trust to University Hospital Birmingham (UHB)	After 38 days		First treatment at UHB by 62 days	Scenario 3 – 100% success to treating provider i.e. UHB
2	Patient B is transferred from South Warwickshire Foundation Trust (SWFT) to University Hospital Coventry & Warwickshire NHS Trust (UHCW)	Before or by day 38		First treatment at UHCW before or by 62 days	Scenarios 1 and 2 –success split: 50% of success allocated to SWFT; 50% allocated to UCHW
3	Patient C is transferred from Shrewsbury & Telford Hospitals NHS Trust (SaTH) to University Hospital of the North Midlands (UHNM)	Before or by day 38		First treatment at UHNM received after day 62.	Scenario 4 – 100% breach to treating provider i.e. UHNM
4	Patient D is transferred from Dudley Group Hospitals NHS Trust (DGoH) to Royal Wolverhampton Trust (RWT)	After 38 days		First treatment at RWT after 62 days but patient treated within 24 days of patient being received	Scenario 5 – 100% breach to investigating provider i.e. DGoH
5	Patient E is transferred from Wye Valley Trust (W VT) to Worcester Acute Hospitals NHS Trust (WAHT)	After 38 days		First treatment received at WAHT after 62 days and after 24 days of patient being received	Scenario 6 – breach split: 50% of breach allocated to WVT and 50% allocated to WAHT
6	Patient F is referred from South Warwickshire Foundation Trust (SWFT) to the Royal Orthopaedic Hospital (ROH) and then to University Hospital Birmingham (UHB)	After 38 days e.g. day 80	Patient spends 24 days receiving investigations at ROH and is then referred to University Hospital Birmingham (UHB) for Radiotherapy	First treatment received at UHB within 24 days of patient being received	Scenario 5 – 100% breach to investigating provider (that took the longest out of the two) i.e. SWFT becomes investigating provider so 100% of breach allocated to SWFT

7	Patient G is referred from Birmingham Women's Hospital (BWH) to Sandwell and West Birmingham (SWBH) and then to University Hospital Birmingham (UHB)	Before day 38 e.g. day 15	Patient spends 28 days at SWBH and is then referred to UHB for treatment	First treatment received after 62 days and after 24 days of patient being received	Scenario 4 – 100% of breach to treating provider i.e. UHB (the treatment phase is the final transfer from SWBH to UHB, and investigating providers avoid breach as they investigated within 38 days)
8	Patient H is referred from Wye Valley Trust (WVT) to University Hospital Birmingham (UHB) for diagnostic testing e.g. EUS first and then back to UHB for treatment in tertiary centre	IPT to be completed for treatment referral	If the period from referral received to last transfer to treatment is: -less than 38 days, the provider where the patient has spent the shortest time becomes the investigating provider (Allocation A) - greater than 38 days, the provider where the patient has cumulatively spent the longest time becomes the investigating provider (Allocation B)	See Appendix 9.6 for allocation for first treatment received after 62 days within/without 24 day treatment commencement phase	IPT will only be completed if responsibility of care is also transferred (i.e. diagnostic referral may not be an IPT if responsibility remains with WVT). If first treatment is after 62 days= scenario 4 to 6 (i.e. a breach). Then if referral received to last transfer is less than 38 days, 100% of breach will go to treating provider i.e. UHB. If referral received to last transfer is greater than 38 days, then breach will be scenario 5 or 6:- if treatment at UHB was within 24 days then it is scenario 5 i.e. 100% of breach assigned to the

					longest investigating provider (UHB), but if treatment at UHB was more than 24 days, then it is scenario 6 i.e. 50% of breach assigned to UHB as longest investigative provider, and 50% of breach assigned to UHB as treating provider (in total 100% of breach assigned to UHB)
9	Patient I is referred from Walsall Healthcare Trust to Royal Wolverhampton Trust (RWT)	Before or by day 38 with complete MDS. RWT have accepted patient	Prior to commencement of treatment treating trust/clinician requests further tests which are done at Walsall as closer for the patient		Not enough information to allocate. Depends on a) treated within 62 days or not, and then apply next stage b) investigative phase was before 38 days. If point a) is greater than 62 days, Walsall will avoid a breach (100% of breach to RWT). If point a) is less than 62 days, Walsall and RWT will share success.