Cancer Waiting Times: Inter Provider Transfer Policy

Prepared by: SE Cancer Alliances

Document control

Version and date	Final v 1.0
Date issued	27.01.2026
Policy review date	27.01.2027
Target audience	SE system partners, acute trusts
This document replaces	N/A

Document sign off

Cancer Alliances	**Sign off date**
Kent and Medway Cancer Alliance	27.01.26
Surrey and Sussex Cancer Alliance	23.01.26
Thames Valley Cancer Alliance	21.01.26
Wessex Cancer Alliance	19.01.26

Contents

1 Glossary 5

2 Purpose of document 6

3 Background and aim 6

3.1 Background 6

3.2 Aim 6

4 Definition and principles 6

4.1 Definition 6

4.2 Principles 7

4.3 Completion of treatment 8

5 Minimum data set 8

5.1 Clinical data set 8

5.2 Cancer waiting times data set 9

6 Multi-disciplinary and Specialist Multi-Disciplinary team meetings. 9

7 Referrals for treatment not requiring SMDT discussion 10

8 In-reach / Out-reach clinicians 10

9 Data protection 10

10 Patient tracking 11

11 Escalation processes 11

11.1 Breach allocation reporting 12

11.2 Disagreements regarding IPT date 13

11.3 Agreement, escalation and arbitration steps 13

12 Governance 14

13 Disclaimer 15

Appendix 1 – Tumour site specific IPT clinical datasets 16

13.1 Breast 16

13.2 Colorectal 17

13.3 Gynaecology 17

13.4 Head and Neck 18

13.5 Brain 19
13.6 Lung 19
13.7 Upper Gastro-intestinal 20
13.8 Urology 20
13.9 Haematology 21
13.10 Skin 22
Appendix 2: Inter provider transfer and 62 day breach reallocation 23
Appendix 3: Details of provider breach reallocation 24
Appendix 4: Version control and changes 25

1 Glossary

CPET	Cardiopulmonary Exercise Testing
CT	Computerised tomography
CWT	Cancer Waiting Times
DRE	Digital rectal examination
EBUS	Endobronchial ultrasound
EUA	Examination under anaesthetic
EUS	Endoscopic ultrasound
FBC	Full blood count
FEV1	Forced expiratory volume
FNAC	Fine needle aspiration cytology
GP	General Practitioner
GDP	General Dental Practitioner
hCG	Human chorionic gonadotropin
IPT	Inter Provider Transfer
ICR	InfloFlex Cancer Registry
LDH	Lactate dehydrogenase
mpMRI	Multi-parametric Magnetic Resonance Imaging
MT	Medical thoracoscopy
OGD	Oesophago-gastro-duodenoscopy
PFTs	Pulmonary function tests
PET	Positron emission tomography
SCR	Somerset Cancer Registry
SMDT	Specialist Multi-Disciplinary Team
TLCO	Transfer Capacity of Lung for Carbon monoxide
VO2	Volume of oxygen

2 Purpose of document

This document provides guidance for cancer services, clinical and operational teams regarding the referral of patients between NHS Trusts for clinical management of cancers and suspected cancers where specialist services are not available locally. This policy should be used to ensure a smooth transition for patients between Trusts, aiding transparency and ownership of the pathway.

3 Background and aim

3.1 Background

This policy applies to all Inter Provider Transfers (IPTs) for cancer care between all Trusts within the South East Cancer Alliances' footprint. Where a receiving Trust does not sit within the same Alliance footprint as the referring Trust, the Alliance guidance that applies to the receiving Trust should be applied.

This guidance sets out the process required to ensure patients are referred in line with National Cancer Waiting Times Monitoring Dataset Guidance, v12.1 (2025)

3.2 Aim

The aim of this policy is to define and clarify the point that constitutes the IPT and the circumstances that mark a formal transfer of care and responsibility. The policy aims to ensure the timely transfer of clinical and administrative information between Trusts when an IPT occurs so that:

- Patients receive appropriate assessment, diagnosis and treatment within the national cancer waiting time standards.
- The patient journey is appropriately monitored with key events communicated between all Trusts involved in the patient pathway.
- Delays or issues are escalated appropriately and in a timely manner to the relevant staff so that remedial action can be taken, following this agreed escalation process / policy including timescales and nominated leads.
- There is consistent understanding regarding the assignment of 62 day performance across shared pathways, in relation to IPT reallocation (both breaches and compliant pathways) between Trusts.

4 Definition and principles

4.1 Definition

The National Cancer Waiting Times (CWT) Monitoring Dataset Guidance indicates that Inter Provider Transfers (IPTs) should be recorded when the responsibility for care is formally transferred. This formal referral should be made from one provider to another where transfer of care of the patient is expected to be undertaken. The date that a referral request is received by the receiving Trust will mark the point at which the IPT is made (NHSE 2020).

A referral with a transfer of care occurs when:

- The patient has been informed they are being referred to another Trust, meaning the receiving Trust can act freely in arranging next steps of the pathway.
- The purpose of the referral is clear.
- The fully completed minimum clinical data set and minimum CWT data set are received by the receiving Trust. The details will vary by tumour type and are agreed in the locally determined appendices.
- A complete IPT form is included with the referral or provided separately.

It is highly recommended that a formal transfer occurs from the referring Trust key worker, usually a cancer clinical nurse specialist, to the receiving Trust key worker, again usually a cancer clinical nurse specialist. The patient must be informed that they are being transferred to another key worker.

4.2 Principles

This policy applies to IPTs where the patient's pathway, and the formal responsibility for care, transfers from one Trust to another for any reason i.e. cancer diagnostics, staging, treatment and follow-up from all initial referral sources, including General Practitioner (GP) / General Dental Practitioner (GDP), cancer screening programmes, consultant upgrades onto the 62 day pathway, subsequent treatments and patients presenting with recurrences and/or metastases and/or progressions.

This policy applies to referrals to all tertiary providers in the South East.

The referring Trust should notify the receiving Trust of any likely / impending referrals as soon as this is known. It is the responsibility of the referring Trust to put in place systems to ensure that all referrals are made within one working day of decision to refer the patient.

It is the responsibility of the referring Trust to make the patient aware of the referral and cancer diagnosis (if applicable) prior to the referral.

When completing the referral, the "Tertiary Referral Reason" dropdown box on relevant cancer tracking system e.g. Somerset / InfloFlex must be completed and the "Primary Treatment" option and the "Formal Transfer of Care" box must be ticked in all cases by the referring Trust Multi-Disciplinary Team (MDT) coordinator/ Patient Pathway Coordinator (PPC) or designated person.

Referrals should be sent to the cancer office team at the receiving Trust, to a specified generic email address with the relevant tumour site stated in the "subject" field. The email will only include details for a single patient; multiple patients' information should not be sent in the same email. Where systems are shared it should be agreed between Trusts what results are required to be manually sent with any IPT.

All IPTs should be made at the earliest opportunity. The underlying principle is that the receiving Trust would have all the information they need to progress the patient and should be “in control” of the patient’s pathway from the date they are considered to have received the referral.

All information must be sent to the correct contacts as specified in advance by the receiving Trust to be considered “received”. Where elements of the minimum data set are sent separately, it will be the date that the receiving Trust receives the last piece of information that will be recorded as the IPT received date.

It is the referring Trust’s responsibility to ensure that the IPT is complete, and all requirements of the minimum data set (MDS) are met.

If the receiving clinician confirms that they have enough information in order to progress the pathway without the full MDS, the IPT should be considered complete from the day the referral is received in the generic mailbox.

It is the responsibility of the receiving Trust to send a notification that the IPT referral is incomplete with an explanation, within three working days after receipt. This information must be sent to the correct contacts as specified in advance by the referring Trust. If the information is never received, the defined IPT date will default to the Decision to Treat date, as defined in National Cancer Waiting Times Monitoring Dataset Guidance, v12.1 (2025)

.

An IPT for transfer of care would not be recorded when a patient is only referred between Trusts for a diagnostic test or Specialist Multi-Disciplinary Team (SMDT) discussion, as the responsibility of care has not been formally transferred at this stage.

4.3 Completion of treatment

In a situation where a patient completes treatment at the receiving Trust and care is to be formally transferred back to the referring Trust, an IPT form must be sent. It is highly recommended that an end of treatment summary is also sent to the accepting clinical team.

5 Minimum data set

The IPT will not be recognised as a referral without receipt of the minimum data set which consists of two parts:

5.1 Clinical data set

- Minimum data set for agreed pathways (see Appendix 1).
- Imaging and Pathology (if applicable and whichever applies) with accompanying reports (see Appendix 1).
- Completed SMDT referral proforma including patient history, performance status and co-morbidities.

- Confirmation that the patient has been made aware of the IPT and (if applicable) cancer diagnosis.

5.2 Cancer waiting times data set

- Inter Provider Transfer Form with mandatory fields completed (available from relevant cancer tracking system e.g. Somerset / InfloFlex). The data set includes the National Cancer Waiting Times Data Set plus the IPT referral date.

6 Multi-disciplinary and Specialist Multi-Disciplinary team meetings.

Patients can be referred to the Specialist MDT for diagnostics, opinion, treatment discussions and an IPT form must be sent to request the discussion with reason specified for discussion. IPTs for discussion does not constitute a formal transfer of care. **The IPT date for formal transfer of care is recorded as the date the clinical data set and CWT data set are received by the receiving trust. The IPT formal transfer of care should only be sent after the plan and the transfer of care has been communicated with the patient in line with the MDS where no further involvement is required by the referring Trust.** Referrals to a specialist MDT should be completed in accordance with the guidelines for governance and communication between local and specialist multi-disciplinary teams.

In the best interests of the patient, discussion at SMDT should not be delayed if the minimum clinical dataset is unavailable, unless the clinical information is required in order that the SMDT can have a full discussion of the case.

In cases where the required clinical information cannot be sent, the referring Consultant must discuss the case with the SMDT lead at the receiving Trust prior to MDT discussion.

If a Trust refers a patient to the receiving trust for an SMDT discussion as opinion only or for a diagnostic test only, and the subsequent outcome is for additional tests (beyond those in Appendix 1) or treatment to be undertaken locally at the referring Trust (based on the best interests of the patient) then:

- The receiving (tertiary) Trust will be responsible to ensure the outcome of the SMDT discussion is made clear to the referring Trust, providing a clear instruction of what further local tests or treatment are required.
- The referring Trust will treat all requests for further diagnostics as urgent and arrange further diagnostics as soon as possible, informing the receiving (tertiary) Trust of the diagnostic scheduled dates. Where the tertiary centre can progress the procedures or investigations in a more timely manner, they will enable this.
- Once the agreed additional tests have been completed at the referring Trust, if further discussion is required this should follow the process defined as above.

If the patient, after discussion of all treatment options with the relevant clinical teams, is either unsuitable or unwilling to proceed then the tertiary centre will formally refer the patient back to the original Trust by a formal IPT.

7 Referrals for treatment not requiring SMDT discussion

For those patients where the decision to refer for treatment to the receiving Trust has been made at a local MDT, the CWT data set and clinical data set (including confirmation that the patient is aware of the transfer of care) will be sent directly to the receiving trust. **The IPT date is recorded as the date the clinical data set and CWT data set are received at the receiving trust.**

8 In-reach / Out-reach clinicians

In-reach clinician referral occurs when:

- A clinician from the treating (receiving) Trust undertakes clinics at the referring (investigative) Trust, and/ or
- A clinician from the treating (receiving) Trust attends the local MDT meeting at the referring (investigative) Trust
- Activity and process of appointments is owned by the treating Trust but is delivered at the referring Trust location

Out-reach clinician referral occurs when:

- The activity and process of appointments is owned by the referring Trust at the referring Trust, by a clinician funded to go to that location by the referring trust.

The responsibility for the activity sits with the provider who is paid for the activity.

It is the responsibility of the referring Trust to ensure there are systems in place to send the IPT minimum data sets to the treating (receiving) Trust promptly so the IPT date can be formally recorded.

It is the responsibility of the treating (receiving) Trust to ensure the referring Trust is notified promptly of clinic outcomes where the in-reach clinician assumes care of the patient.

It is the responsibility of the treating (receiving) Trust to have systems in place to receive and track the patient. It is also the responsibility of the treating (receiving) Trust to ensure that processes are in place for local booking or admission forms to be processed in a timely manner for visiting clinicians. Local booking forms do not form part of the IPT minimum dataset and the IPT date should not be affected if there is a delay in the issuing or receiving of forms.

9 Data protection

Email accounts, used for information transfer, should only be accessible to relevant and appropriate personnel within each individual provider organisation. The email

address must be a generic email address to allow secure transfer of encrypted information, both for sending and receiving information. The IPT is to be sent via e-tertiary referral through the cancer tracking system where possible.

10 Patient tracking

It is the responsibility of all providers to ensure systems are in place for the effective tracking and navigation of all cancer patients. Responsibility for tracking patients is with the receiving Trust once transfer of care is accepted.

It is recommended that generic email addresses are used, for notifications of impending IPT, updates and SMDT opinion only forms.

It is recommended that a dedicated email inbox is established and used when all the IPT documents are available, with a schedule for monitoring.

The receiving Trust will start to track the patient as soon as the inter-provider notification of transfer of care has been received, or the patient is listed for an SMDT meeting, whichever is sooner.

The MDT coordinator/ designated person at the referring Trust is responsible for ensuring that the MDT coordinator/ designated person at the receiving Trust is informed of any key events or changes to the target date for referred patients, up to the point of first treatment in order to ensure that data submitted for the purpose of cancer waiting time measures are aligned.

It is the responsibility of the receiving Trust to provide regular updates (at least weekly) to the referring Trust regarding pathway and tracking updates for IPT patients. The receiving Trust must ensure this is electronically transferred to the MDT coordinator/ designated person at the referring Trust.

Once the patient has commenced first definitive treatment, this should (where feasible) be communicated to the referring provider within a maximum of 7 days.

The MDT coordinator/ designated person at the receiving Trust is responsible for ensuring that the inter-provider transfer form is updated to reflect treatment planning, key events and changes to target dates, including if the pathway clock is stopped for any reason.

It is encouraged that the use of electronic systems be reinforced by verbal updates between MDT coordinators.

The tracking responsibility for the patient’s pathway lies with the Trust that is managing the next step in the pathway.

11 Escalation processes

Robust lines of communication, including verbal contact, should be established between all people who collect CWT data, especially for inter-provider referrals that are a regular part of a patient pathway.

In line with the Cancer waiting times guidance, IPT transfer by day 38 (referring provider) and 24 day decision to treat to treatment (receiving provider) influences the allocation of 62 day shared pathways ,both those that breach and those that are completed within target.

It is recommended good practice for all Trusts to follow their internal escalation policy. Prior to escalation, an initial investigation should be undertaken to determine whether or not there are any legitimate waiting time adjustments to be made and to verify that the decision to treat date is correct.

An effective escalation protocol might include:

- Clear procedures for action/ further escalation at all levels of the organisation with identified roles for each level of escalation through to executive lead (or equivalent)
- Clear escalation timescales e.g. how long the PPC/ MDT coordinator has to resolve an issue before it is raised to the next level, through to executive lead (or equivalent)
- Escalation trigger points linked to individual pathway timescales
- Escalation trigger points for any patient without a diagnosis by day 31 and without a decision to treat date by day 38
- Information about how the priority target listing (PTL) will be monitored and used proactively to navigate patients through agreed timed pathways.

11.1 Breach allocation reporting

Breach allocation reporting relies on date of receipt of the Inter Trust Referral. This constitutes the referral time frame with the following scenarios applied and will define the allocation of the breach or compliance against national targets.

Scenario	Referral timeframe	Total timeframe	Allocation
1	> 38 days	≤ 62 days	100% of success allocated to the treating provider
2	≤ 38 days	≤ 62 days	50% of success allocated to the referring provider and 50% allocated to the treating provider
3	≤ 38 days	>62 days	100% of breach allocated to the treating provider
4	> 38 days	> 62 days, but treating Trust treats within 24 days	100% of breach allocated to the referring provider

5	> 38 days	> 62 days and treating Trust treats in > 24 days	50% of breach allocated to the referring provider and 50% allocated to the treating provider.

(> = more than; < = less than; ≤ = is less than or equal to)

11.2 Disagreements regarding IPT date

Breaches: Discussions related to breached pathways and the agreement of breach reasons and IPT dates, is a well-established process between providers. This involves both completion of a standardised breach report by both providers; review of that breach report; and a discussion between teams in each responsible Trust, to determine agreement before the national submission deadline of that reporting period.

Compliant: In accordance with CWT Guidance Version 12.1 (2025) the allocation of compliant shared pathways is dependent on the investigative provider meeting the IPT Day 38 standard (national performance reporting – this does not reflect national or regionally agreed timed pathway milestones which may differ from day 38 in terms of the ideal transfer deadline).

There are 3 scenarios related to compliant pathways identified in the reallocation table (CWT Vers.12.1, 4.6.5).

Of these, scenarios 1 and 2 result in no change to the even allocation of a shared compliant pathway between the two providers (each allocated 0.5 of the pathway success).

However, in scenario 3 – when the investigative provider has failed to transfer the patient by Day 38 – the treating provider is allocated the full pathway (reflecting as ‘1’ in both the denominator and numerator). The investigative provider ‘loses’ this pathway completely from their reporting activity.

Therefore, in the promotion of clear, visible and validated CWT reporting, it is essential that a process of agreement between providers is followed when the allocation of a compliant pathway will negatively impact the investigative provider. Whilst this situation does not require the production of a ‘breach type’ report – confirmation of the IPT date must reflect the same agreement, escalation and arbitration process as for breaches.

11.3 Agreement, escalation and arbitration steps

Investigative Provider and Treating Provider Agreement: Usual process is followed in the review and discussion of breached pathways. This will include completion of a single breach report populated by both providers, discussion between the respective cancer management teams and recording of the agreed breach reason, breach code and IPT date. It is the responsibility of those respective teams to update their local

reporting systems accordingly, with agreed details. Discussion of 'Scenario 3' compliant pathways should ideally be incorporated into this process (apart from the report element) to allow the investigative provider to review the pathway, provide challenge where necessary; and accurately adjust local predicted performance and expectations.

Investigative Provider and Treating Provider: There is failure to agree the IPT date between providers, BUT **this will result in no change to the allocation of the pathway**. In this case – the treating provider uploads the record as per their definition but records 'IPT Date not agreed' within the uploaded breach comment.

Investigative Provider and Treating Provider Escalation: There is failure to agree the IPT date between providers, which **results in a change to the allocation of the pathway**. In this case – each provider cancer management team will escalate internally to their Executive Leads for Cancer to gain opinion and feedback. Responses will then be reviewed in a further discussion between the respective provider's cancer managers. If agreement is reached at this stage – all agreed data items are completed and the record uploaded to the national system.

Failure to reach agreement at this stage should trigger direct discussion between the respective organisations agreed point of escalation (at equivalent level of seniority in both Trusts) in order to find resolution.

Should this step fail to achieve agreement the following arbitration process should be triggered:

Investigative Provider and Treating Provider Arbitration: The arbitration process should be followed when internal provider review and inter-provider discussion has failed to agree an IPT date; and which the IPT date defined by the treating (and reporting) provider will negatively impact performance (breach or compliant).

In this situation, the advice of the ICS or respective Cancer Alliance should be sought. The ICS/respective Cancer Alliance can review all facts related to the pathway including reference to the IPT Policy and minimum datasets (both administrative and clinical) and provide commentary to the providers within 3 working days of pathway escalation; and this will be taken as the deciding opinion.

Onward review of this process will be undertaken through the respective Cancer Alliance Cancer Manager's Working Group to ensure parity of process.

12 Governance

The governance arrangements for this policy are as follows:

- Kent and Medway Cancer Alliance for agreement and sign off
- Surrey and Sussex Cancer Alliance for agreement and sign off
- Thames Valley Cancer Alliance for agreement and sign off
- Wessex Cancer Alliance for agreement and sign off

13 Disclaimer

It is each provider’s responsibility to check that they are working in accordance with the latest version of this policy and that this has been shared within their own organisation.

Appendix 1 – Tumour site specific IPT clinical datasets

The following essential elements apply to ALL clinical datasets (unless otherwise specified):

Past medical history including Allergy, social history, height and weight

Bloods including FBC, U&Es, creatinine, eGFR, CRP, clotting factors (within last 3 months)

Biopsy - Histology blocks, slides and report must be available (report must contain minimum of cancer type and grade)

Appropriate imaging within a clinically appropriate timeframe (see tumour site specific lists)

Documented Performance Status (ECOG / WHO) and co-morbidities

Documented frailty score

Documented BMI

Confirmation that the patient is aware of the transfer of care (in order that the treating provider can progress the pathway promptly)

For all providers using shared Network imaging systems, the IEP transfer of radiology images and reports may be required for MDT discussion and transfer of care. A full and comprehensive list of relevant scans must be provided to the treating provider for confirmation that they have access and can be reviewed. Transfer of care will be accepted once any relevant scans have been reported.

For all providers using a shared Pathology system, the reports of any relevant investigations will not need to be sent. A full and comprehensive list of those relevant investigations must be provided to the treating provider for confirmation that the reports can be reviewed.

Referral letters

Moleculars for oncology e.g. DPD

13.1 Breast

Bloods including eGFR

Mammogram, ultrasound, +/- MRI

Axilla imaging

CT chest abdomen pelvis (if node positive)

Biopsy - Histology blocks, slides and report (including LVI, ER and HER2 status)

Genetic testing results (where appropriate)

Sentinel lymph node biopsy (where appropriate)

13.2 Colorectal

Anal

Results from EUA

MRI pelvis/ rectum

Biopsy - Histology blocks, slides and report

Colon and early rectal

Ferritin

FIT test result

Colonoscopy report/ CTC report

CEA

CT chest abdomen pelvis

MRI pelvis

Biopsy - Histology blocks, slides and report

Consider: PET CT

13.3 Gynaecology

Cervix

Colposcopy findings

CT chest abdomen

MRI pelvis

Biopsy - Histology blocks, slides and report

PET (if required)

Endometrial

CA 125

Transvaginal Ultrasound (TV US)

Hysteroscopy findings (if performed)

CT chest abdomen pelvis (type 2 i.e. serous papillary, clear cell and MMMT)

MRI pelvis (type 1)

Biopsy - Histology blocks, slides and report

PET (if required)

Ovarian

CA 125

TVUS, or abdominal USS permitted where large (>10cm) abdomino-pelvic mass is present

CT chest abdomen pelvis

Ascites/ pleural effusion tap cytology

Biopsy - Histology blocks, slides and report

PET (if required)

Vaginal

CT chest abdo

MRI pelvis (and groins if lower 1/3)

Biopsy - Histology blocks, slides and report

PET (if required)

Vulval

CT chest abdomen

MRI pelvis and groins

Biopsy - Histology blocks, slides and report

13.4 Head and Neck

Oral cavity

MRI neck

CT neck and chest

Biopsy - Histology blocks, slides and report

Oro-pharynx

MRI neck

PET CT

Biopsy - Histology blocks, slides and report

Hypo-pharynx

MRI neck

CT neck and chest

PET in T4+/-N3

Biopsy - Histology blocks, slides and report

Naso-pharynx

MRI neck

CT skull base/ neck and chest

Biopsy - Histology blocks, slides and report

Larynx

MRI neck (in advanced tumours)

CT neck and chest

Sino nasal

MRI head and neck

CT neck and chest

Salivary gland

MRI neck

CT chest

Biopsy - Histology blocks, slides and report

Thyroid

USS neck

FNA report

If further biopsy - Histology blocks, slides and report

13.5 Brain

CT
MRI brain with contrast
Completed MDT referral proforma including patient history, performance status, prognosis (if primary malignancy) and co-morbidities.
Confirmation that the patient has been made aware of the IPT and (if applicable) cancer diagnosis.

Where appropriate:
CT CAP

Biopsy and report

13.6 Lung

CT chest abdomen

PET

Biopsy - percutaneous/ bronchoscopic/ US guided nodal

PFTs

FEV1 absolute value and % predicted

Anticoagulation therapy

Smoking status

Biopsy - Histology blocks, slides and report

Consider: EBUS +/- EUS (local nodes but no metastases or contiguous/ conglomerate invasive nodes but no metastases)

Consider for metastatic disease:

Contrast enhanced CT head (stage II) or MRI head (stage III)

Diagnostic bronchoscopy or EBUS if relevant

Pleural aspiration or MT if relevant

Consider for patients with borderline fitness/ existing respiratory disease:

TLCO

(CPET) (VO2 max result) and echocardiogram (ECHO)

13.7 Upper Gastro-intestinal

US/ CT chest abdomen pelvis

OGD

EUS (where available)

Biopsy report and slides

PET CT

Staging lap (if required)

HPB

US
CT chest abdomen pelvis
OGD
Biopsy report and slides
Liver function test with date of test included
MRI
Pathology (if available)
PET CT
If appropriate
Staging lap

EUS

13.8 Urology

Bladder

CT chest abdomen pelvis

Cystoscopy/ Transurethral resection of bladder tumour (TURBT)

Bladder Map (volume and position of tumour)

Histology biopsy blocks, slides and report

Consider:

CT urogram

MRI

Penile

CT chest abdomen pelvis

Histology biopsy blocks, slides and report

Prostate

DRE findings

Prostate specific androgen (PSA) at time of diagnosis (and PSA trend if available)

Gleason score

mpMRI and report including prostate volume and presence of prostate cancer highlighted (dated within 3 months of IPT)

PSMA PET scan for T3a/GS 4+4/PSA>20

Bone scan (where applicable)

Histology biopsy blocks, slides and report

Renal

Bloods including eGFR

CT chest

CT triple phase renal

Histology biopsy blocks, slides and report

Testicular

Tumour markers - alpha fetoprotein, beta HCG, LDH

CT chest abdomen pelvis

Histology biopsy blocks, slides and report

13.9 Haematology

FBC
U&E

LFT
LDH
CT NCAP or PET CT and histology (or immunophenotype if leukaemia) confirming haematological malignancy

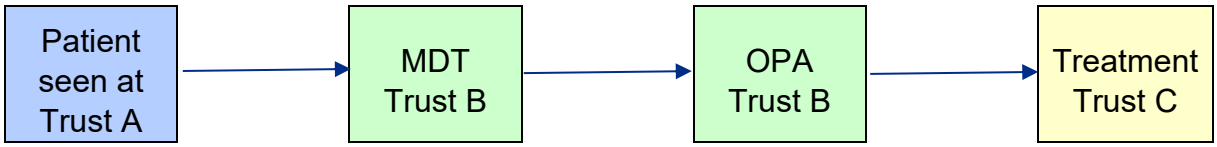
13.10 Skin

Melanoma:
Path
BRAF
CT CAP
PET

SCC
Path and CT

Appendix 2: Inter provider transfer and 62 day breach reallocation

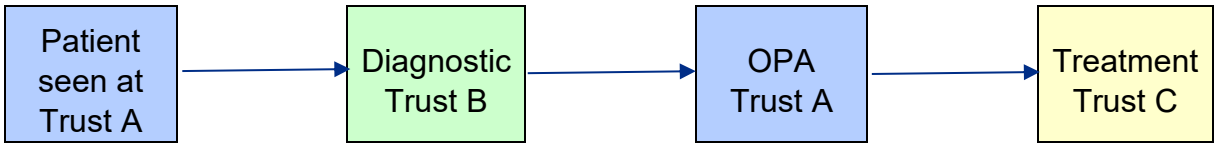
Scenario 1:



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

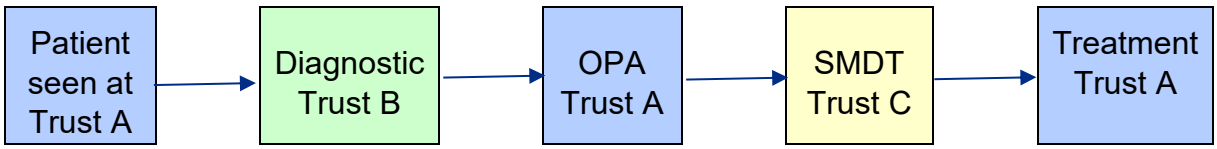
Scenario 2:



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.

Appendix 3: Details of provider breach reallocation

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

Appendix 4: Version control and changes

Date	Version	Comments
7.11.2025	0.1	Draft document
10.11.2025	0.1	Circulate draft document to acute trust's COO and Cancer Alliances for final comments
24.11.25	0.2	Discussion with Cancer Alliance leads on comments / feedback made by the trusts
26.11.25	0.2	Further discussion with Cancer Alliance leads on comments / feedback made by the trusts
10.12.25	0.3	Discussion with Cancer Alliance leads on comments / feedback made by the trusts
31.12.25	0.4	Discussion with Cancer Alliance leads on comments / feedback made by the trusts
16.1.26	0.5	Discussion with Cancer Alliance leads on comments / feedback made by the trusts
27.1.26	1.0	Final version published