Inter-Provider Transfer (IPT) Policy

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Document Control

Name of document owner:	Aaron Tucker, Head of Programmes, Northern Cancer Alliance
Purpose:	To define the NCA operating protocol regarding the transfer of cancer pathways across organisations for patients being diagnosed and treated in North East and North Cumbria. The document should be read in conjunction with the latest national Cancer Waiting Times (CWT) guidance. At the time of writing this is Version 12.1. July 2025 (NHS England » National cancer waiting times monitoring dataset guidance)
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1. Background & Context

Statutory organisations are responsible for delivery of the NHS constitution standards related to cancer. These standards outline what patients can expect, and their rights when they are referred on a cancer diagnosis and treatment pathway. Cancer Waiting Times (CWT) measure the NHS' performance against these national NHS Constitution Standards, as well as a number of other metrics. These measures are used by local and national organisations to monitor the timely delivery of services to patients.

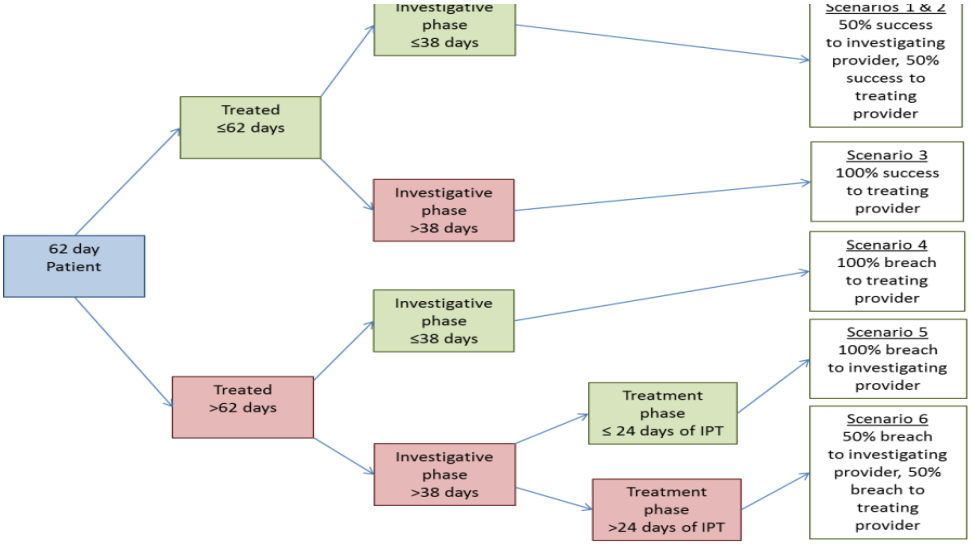
This policy defines the NCA operating protocol regarding the transfer of cancer pathways across organisations for patients being diagnosed and treated in North East and North Cumbria.

At the time of policy approval the current CWT guidance is Version 12.1. July 2025.

1.1 Pathway Allocation

The CWT standards outline that the allocation of performance compliance and breach is between a maximum of two organisations, regardless of how many providers have delivered the pathway. For patients whose care is delivered over two organisations (diagnostic and treatment phases) the following rules are in place:

	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



Where three or more Trusts are involved in the pathway the allocation is based on the following:

The pathway is split into two phases; investigating phase which is up to the final Inter-Provider Transfer and the 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 IPT
- 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 IPT
- 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.

1.2 Purpose of Inter-Provider Transfer Documentation

The diagnostic and treatment pathways for patients suspected of having cancer or those diagnosed with cancer often spread across multiple organisations. Communication between clinical teams and cancer pathway management teams is integral to safe, high quality and timely care, especially when patients are undergoing their care across multiple teams and organisations.

This document outlines the process for timely and effective communication between organisations, and where the responsibility for the patient sits in regard to attributable compliance / breach allocation aligned with the national Cancer Waiting Times standards.

Key Principles

This document will aim to address the following:

- Communication processes when patients undergo care in an organisation and the responsibility for the pathway remains with another provider
- Communication processes when a patient's care and the responsibility for the pathway transfers from one organisation to another
- The data items to be communicated and the expected practices (as stated below)

The document is designed to consider the patient first, system second and individual organisation third, with the IPT following the intended care plan as a principle.

2. When to record an Inter-Provider Transfer (IPT)

Inter-provider transfers (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.

Providers should review their pathways and agree when a patient transfers whether the responsibility of care remains with the referring provider or transfers to the receiving provider.

Where a request is made just for a **diagnostic or MDT discussion only and the responsibility for care is not formally transferred** this would **not be recorded as an IPT in the CWT system.**

Example scenarios where IPTs should be recorded are included below:

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
- IPT Date would from Trust B to Trust C (the transfer for treatment)

- Breach allocation would be between Trust A (First Seen Trust) and Trust C (Treating Trust)

Scenario 2

One IPT would be recorded

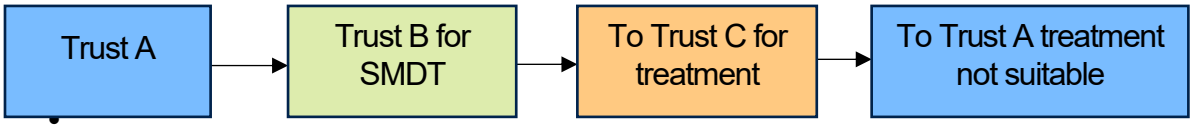
- One from Trust A to Trust C as patient has transferred to Trust C for treatment
- An IPT should not be recorded from Trust A to Trust B, as the patient just had a diagnostic at Trust B, and the patient was followed up with results at Trust A.

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.

Scenario 4



No IPT recorded

- **Transfer between Trust A and Trust B were for Specialist Multidisciplinary Team (SMDT) discussion**, the outcome of which was for treatment to commence at Trust C, so no IPT recorded as no transfer of patients care
- **Transfer** From Trust B to Trust C for Treatment,

- **Transfer** From Trust C back to Trust A if the planned treatment isn't suitable.

Treatment IPT

This documentation signifies that the patients care is being transferred from one organisation to another. This documentation should only be completed when no other care is planned on this active cancer pathway under the referring organisation, when you are referring for a first definitive treatment. This signifies the start of the treatment phase.

The treatment IPT should be accepted on the day it is received by an organisation providing the following criteria is met:

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 and management, 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 which includes the details of the pathway they are on (including if they already have a running 62-day pathway). All required diagnostics/imaging and associate results are available
- The patient has been discussed at an MDT and a treatment plan has been agreed
- (Where there is no local MDT and the referral (and onward care) is with the tertiary provider, the date of the IPT would be the date that the patient was suitable to be discussed at the specialist MDT.)
- All required information should be sent to receiving trust in a timely manner within agreed information sharing arrangements.

The receiving Trust should contact the referring organisation within 24 hours stating if the above criteria is not fulfilled. In this instance, the IPT date may be re-set to the date the missing information is provided. IPTs will not be re-set if the missing information is not highlighted within 24 hours or next working day. All IPT documentation should be sent to and from secure, generic email accounts.

IPTs should <u>not</u> be rejected back to referring organisations in the following circumstances:

- For the delivery of a diagnostic test or optimisation requested after the final treatment MDT - the receiving organisation may ask the referring organisation to perform the test if they have better waiting times, but the patient will remain the responsibility of the receiving organisation in terms of pathway and performance responsibility

- Any diagnostic test result that does not change the intended treatment type (i.e. reflex testing that does not change the plan for oncology, even if it might change the regimen etc). Providing this has been requested / initiated as per pathway protocol.
- Where a patient attends an appointment at the referring organisation as part of the Treatment pathway under the care of the receiving Trust (no matter who 'owns' the activity).

Treatment IPTs from Screening Hubs

In line with the design of the national screening programmes, provider hubs are in place to provide initial diagnostics and then allowing choice for where patients prefer to undergo staging diagnostics and treatment (i.e. at their local hospital, rather than a screening centre).
The referral will be initiated after the tests have been carried out at the screening centre and the screening centre will complete a clinical referral form.

The provider hosting the screening centre will also complete the standardised daily inter-provider notification of transfer form, with all the relevant information for the 62 day pathway.
Treatment IPTs for these patients should completed in the same way as all other Treatment IPTs.

3. Pathway Management Communication

Each organisation should have an identified single point of contact email for the safe receipt of data to support IPT.

If personal email addresses are used for ad hoc communication outside the formal IPT, organisations should ensure robust mechanisms are in place to ensure communication is not prohibited or delayed as a result (such as copying in generic mailboxes).

3.1 Breach avoidance

Cancer managers should work collaboratively to robustly manage 62-day pathways and reduce the volume of system breaches.
This should include as a minimum:

- Early discussion regarding higher than normal positive cancers recorded at MDTs
- Early discussion regarding individual patients in advance of IPT in order to pre-plan pathways and avoid breaches
- Dialogue post IPT to manage and avoid breaches

- All receiving Trusts must work to the 62-day breach date as the primary target; not the 24 day treatment timeframe in the IPT allocation. This is in order to prevent breaches across the NENC system outside their own organisations
- Referring Trusts should aim to reduce their time to IPT to avoid system breaches; specifically where complex treatment is taking place. i.e. Head and Neck radiotherapy where the patient may need to attend a number of planning scans and mask fittings in advance

4. Pathway re-design and reducing IPTs

Reducing the number of IPT transfer points not only reduces the associated administrative burden but improves consistency within pathways.

To reduce variation in waiting times and deliver equitable pathway performance as a result of IPT, Trusts should ensure that where they deliver outreach clinics, the activity, the management of the appointment scheduling and the management of capacity is retained within their organisation.

5. Implementation

Organisations should immediately adopt this policy. Any non-compliance to items in section 1-3 should be addressed with immediate effect.

6. Appendix A Minimum dataset

The transferring provider must send a minimum dataset including:

- Referral details (date, source, tumour site)
- Diagnostic information (imaging, pathology)
- MDT outcomes (if available)
- Blood results
- Histopathology sample results
- Physiological tests
- Consultant referral letter including current medication
- Patient demographics and NHS number
- This ensures the receiving provider can continue tracking without delay.
- Patient demographic information
- Reflex testing results / list of tests requested with results outstanding and the organisations delivering these tests.

7. Appendix B Pathway Examples

7.1 Upper GI – OG

Example 1

Patient 1 is initially assessed at Trust A, where they undergo endoscopy and receive a confirmed diagnosis of oesophago-gastric (OG) cancer. The staging CT scan is completed at Trust A and the PET-CT requested by Trust A.

The patient is subsequently referred to the multidisciplinary team (MDT) at Trust B with the stated intention that definitive treatment will be delivered by Trust B. The date the referral is received at Trust B constitutes the Inter-Provider Transfer (IPT) date and responsibility for the patient's care formally transfers to Trust B from this date. If all diagnostic test results — excluding PET-CT and reflex testing for Oncology — are reported after the MDT date, this later date will be recorded as the Inter-Provider Transfer (IPT) date. Responsibility for the patient's care formally transfers to Trust B from this point.

Example 2

Patient 1 is initially assessed at Trust A, where they undergo endoscopy and receive a confirmed diagnosis of oesophago-gastric (OG) cancer. The staging CT scan is completed at Trust A and the PET-CT requested by Trust A.

The patient is subsequently referred to the multidisciplinary team (MDT) at Trust B with the stated intention that definitive treatment will be delivered by Trust A. No IPT date is recorded and there is no transfer of care. If the outcome is that patient will be treated at Trust B, the transfer of care would be the date of the MDT. If at any point the patient transfers to a service for a decision to treat, e.g., Oncology, where that activity belongs to Trust B (or another trust), a transfer of care should be recorded and IPT back to the treating trust would be when patient is referred for treatment.

7.2 Upper GI – HPB

Example 1

Patient 1 is initially assessed at Trust A, where they receive a confirmed diagnosis of HPB cancer. The staging CT scan is completed at Trust A.

The patient is subsequently referred to the multidisciplinary team (MDT) at Trust B with the stated intention that definitive treatment will be delivered by Trust B. The date the referral is received at Trust B constitutes the Inter-Provider Transfer (IPT) date and responsibility for the patient's care formally transfers to Trust B from this date.

Example 2

Patient 1 is initially assessed at Trust A, where they receive a confirmed diagnosis of HPB cancer. The staging CT scan is completed at Trust A.

The patient is subsequently referred to the multidisciplinary team (MDT) at Trust B with the stated intention that definitive treatment will be delivered by Trust A. No IPT date is recorded and there is no transfer of care.

Example 3

Patient 1 is initially assessed at Trust A, where they receive a confirmed diagnosis of HPB cancer. The staging CT scan is completed at Trust A.

The patient is subsequently referred to the multidisciplinary team (MDT) at Trust B for MDT discussion only, no IPT date is recorded and there is no transfer of care.

The patient is then transferred to Trust C for treatment. The date the referral is received is the IPT date and responsibility for the patient's care formally transfers to Trust C from this date.

7.3 Lung

Example 1

Patient 1 is initially assessed at Trust A, where they receive a confirmed diagnosis of Lung cancer. They are discussed at the MDT at Trust A.

A referral is made to Cardiothoracic at Trust B with the stated intention that definitive treatment will be delivered by Trust B. The date the referral is received is the IPT date and responsibility for the patient's care formally transfers to Trust B from this date.

Example 2

Patient 1 is initially assessed at Trust A, where they receive a confirmed diagnosis of Lung cancer. They are discussed at the MDT at Trust A.

A referral is made to Cardiothoracic at Trust B with the stated intention that definitive treatment will be delivered by Trust B. The date the referral is received is the IPT date and responsibility for the patient's care formally transfers to Trust B from this date.

The patient is not suitable for surgery so is transferred to Trust C for Oncology with the stated intention that definitive treatment will be delivered by Trust C. The date the referral is received is the IPT date and responsibility for the patient's care formally transfers to Trust C from this date.

7.4 Gynae

Example 1

Patient 1 is initially assessed at Trust A, and decision to refer to MDT for a treatment plan at Trust B and to be seen in clinic at Trust B, the date the referral is received is the IPT date and responsibility for the patient's care formally transfers to Trust B from this date. Patient receives treatment at Trust B.

Example 2

Patient 1 is initially assessed at Trust A, and decision to refer to MDT for a treatment plan at Trust B and to be seen in clinic at Trust B, the date the referral is received is the IPT date and responsibility for the patient's care formally transfers to Trust B from this date. Patient is seen at Trust B and a decision made to be treated locally at Trust A, the date the referral is received is the IPT date and responsibility for the patient's care formally transfers to Trust A from this date.

Example 3

Patient 1 is initially assessed at Trust A, and decision to refer to MDT for a plan at Trust B and to be seen in clinic at Trust B, the date the referral is received is the IPT date and responsibility for the patient's care formally transfers to Trust B from this date. Patient is referred to Trust C for treatment, the date the referral is received is the IPT date and responsibility for the patient's care formally transfers to Trust C from this date.

Example 4

Patient 1 is initially assessed at Trust A, and decision to refer to MDT for discussion only at Trust B. No IPT date is recorded and there is no transfer of care. Patient receives treatment at Trust A.

Example 5

Patient 1 is initially assessed at Trust A, and decision to refer to MDT only at Trust B. No IPT date is recorded and there is no transfer of care. Provider B transfers the patient on to provider C for treatment, the date the referral is received is the IPT date and responsibility for the patient's care formally transfers to Trust C from this date. The IPT is recorded from provider A to provider C.