

Questions answered by NCAT – February 2010

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Two Week Wait (2ww)

A trust has agreed with the PCT that patients to whom the 14-day standard applies and who are not available or declined to attend either of the two 14-day appointments offered, are given an urgent appointment for when they are available, but are downgraded off the 62 day pathway with agreement from the GP. Patient can then be upgraded to a 62 day pathway if cancer is subsequently suspected. Is this acceptable?

It is possible for a GP to downgrade a referral. However it is not within the spirit of the rules for a Trust to ask a GP to downgrade because the patient is unavailable. The downgrade should really be because the GP no longer thinks an urgent referral is necessary eg because a consultant has advised that cancer is highly unlikely.

A Trust has agreed with their PCT that for patients who are unavailable for the whole of the 2 week period the clock will start on the first day they are available. They are not re referred just held until that date – is that acceptable?

No - that is not acceptable. Once the trust has received the referral the clock has started and cannot be paused because the patient chooses not to be available. The operational standard has been revised to allow for this.

Do you have any plans to change the 2ww operational standard?

There are no plans to change the 2ww operational standard at the present time but DH does keep operational standards under review. I have agreed with DH that I will submit to them any evidence that I receive related to the impact of issues such as patient choice on cancer waits performance so that they can take this info into account during any review. I will therefore pass your enclosed information on to Tim Hancox at DH and ask for his comments.

Is there any news on the legal right to be seen within two weeks under the NHS Constitution?

There is a DH consultation document out at the moment about this and other proposed rights under the NHS constitution. You should be able to find it on the DH website:

http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_108012

[Post Q&A Note: the consultation is now complete]

Symptomatic breast 2ww

Most of our breast 2ww breaches are due to patient choice – do you have any comment on this?

The operational standard has been revised to allow for patient choice. If you believe that patient choice is a bigger issue than the operational standard allows for and you have taken all appropriate action (e.g. to ensure GPs give patients appropriate info etc) I would suggest that you collect evidence of this and submit it to DH (via timothy.hancox@dh.gsi.gov.uk) to take it into account if/when they review the operational standard.

Whilst downgrading is not in the spirit of the rules is it a complete no no for 2 week symptomatic breast referrals patients?

A 2ww referral can only be downgraded by the GP that made the referral.

How do we record symptomatic breast patients who are under 16 ie. do we record them as symptomatic breast patients and track them as such or as children's cancers? What happens to these patients once they are uploaded to Open Exeter?

There is no age specification for the symptomatic breast standard. For an under 16 with breast symptoms that were not suspicious of cancer you would use the 'TWO WEEK WAIT CANCER OR SYMPTOMATIC BREAST REFERRAL TYPE' of Code 16. Code 2 (suspected children's cancer) is only used for referrals with suspected cancer.

31d treatment (first or subsequent)

A patient is first seen at Trust A. Following a MDT meeting at Trust A attended by a surgeon from Trust B, it is agreed with the patient will be referred to Trust B for surgery. They are then referred to Trust B where the patient has an appointment with the surgeon at which a further assessment is made and the surgery discussed in detail with the patient. Which date should be considered the decision to treat date – is it at Trust A when the patient agrees to be referred to Trust B for consideration of surgery, or is it at Trust B when the exact detail of the surgery is confirmed with the patient?

The DTT is the first of the two dates if the patient has agreed to proceed with surgery then but the second of the two dates if they only agreed to be referred for discussion about whether surgery is the best option and the agreement was then at that second meeting.

A patient is seen by a chest physician on date A. The preferred MDT option for surgery is conveyed to the patient and a referral is made to the surgeon at another Trust. An outpatient appointment is made for the patient to see the surgeon on date B - at this OPA the risks, outcomes, arrangements etc related to surgery are discussed and the patient and the surgeon agreed to proceed with surgery. In this scenario, we would report that the DTT was Date B not Date A– would you agree?

If the patient agreed the surgical treatment plan (risks, outcomes etc have been discussed) with the physician and is added to a waiting list at Date A, then that should be recorded as the DTT date. If however, the physician discusses the MDT decision for surgery with the patient and the patient agrees to be referred onto the surgeon, subsequently meets with the surgeon at Date B, when risks, outcomes etc are discussed and the patient added to a waiting list, then Date B should be recorded as the DTT.

In summary, as long as the patient and the chest physician do not agree that surgery is the care plan you can go with date B i.e. the patient needs to be told that surgery is probably the best option but they need to discuss this with the surgeon to confirm etc.

How should TACE (trans arterial chemo embolisation) be recorded - we are recording it as chemo but are having difficulty defining when these are subsequent treatments as patients may have TACE over a number of years or months?

I don't know anything about TACE but each COURSE of chemo is counted as a subsequent treatment. Where there are changes in drug type or combo we need to be pragmatic ie if it was decided to change the drug mix but the treatment carried on uninterrupted I wouldn't class that as a subsequent treatment. The GFOCW advisory board advised that the key would be whether a new consent form had been signed or not ie. if it has then it should be classed as a new treatment and therefore a new 31d period.

Does lymph node excision count at first treatment?

It depends. If lymph node excision is purely diagnostic/staging then it is not classed as treatment. However if it is to excise possible cancer then it could be a treatment.

A diagnostic procedure undertaken as therapeutic in intent (i.e. the intention is to remove the tumour) will count as FDT, irrespective of whether the margins were clear. A purely diagnostic procedure (including biopsy) does not count as a FDT unless the tumour is effectively removed by the procedure. If the intention was diagnostic but the excised tissue was found to be malignant the procedure could count as FDT if the tumour had effectively been removed by the excision.

If a patient has a PICC line inserted on Day 1, enabling chemo treatment to be delivered and they receive the chemo itself on Day 2, should Day 1 be the treatment start date? Is the modality surgery (as in the case of a palliative stent insertion) or chemo?

I would go for the date of the chemo delivery as the date the treatment started not the insertion of the picc line. That being the case we would code the drug treatment at the cancer treatment modality not the insertion of the picc line.

I have a patient who is being treated for an Ovarian Primary with Chemotherapy. Following her 3rd Cycle a breast lump was discovered on a scan which turned out to be a new Breast Primary. The problem is that they would have used the same chemo regimen to treat this so are not changing her treatment plan. How do we report this as there is no start date for the Breast Primary but the chemo is now being used to treat both cancers?

In this scenario the patient is incidentally diagnosed with a second primary cancer but the treatment they are already receiving for their initial primary cancer will also be the treatment for the new primary. The CWT-Db has not really been set up for this scenario so we need to take a pragmatic approach. I would therefore advise that you set up a new record for the new cancer (an incidental finding and hence a 31d period) and that you class the DTT date for this second cancer and the treatment start date for this second cancer as the same day.

If a decision is made to treat a patient with Hormone treatment, and the patient is asked to collect their prescription from the GP, who should be reporting this treatment?

When a drug treatment is prescribed, whichever organisation prescribed it records it. If the patient leaves the hospital with the prescription for the first batch of drugs and is to be supported for the remainder of course at the GP practice it is still the acute provider that should be reporting the treatment activity. If, however, the GP prescribes the treatment or the prescription is sent to the GP for action the PCT should be recording the activity.

Classic 62d (ie. from 2ww)

A patient was referred to the Lower GI team as a GP 2WW and following a flexi sig was diagnosed with rectal cancer. During the staging process the patient had an MRI which raised the suspicion of a bladder cancer (a second primary). The decision has been made to remove the suspected bladder tumour prior to having treatment for the rectal primary. If a new bladder primary is confirmed from the bladder surgery should we record the bladder surgery as FDT under the 2WW pathway or the treatment for the rectal cancer once given?

In this scenario, a 2ww referral has resulted in the identification of 2 primary cancers, a rectal cancer (which was suspected) and a bladder cancer (which was not). The decision was to treat the bladder cancer first. It would be acceptable for this to be classed as the FDT and end the 62d pathway as the bladder cancer was identified following the 2ww referral. The rectal cancer would then have a 31d period only but should have a separate PPI if possible.

A patient has been referred under 2 week rule to the lower GI team. The pt was seen within 14 days but was unable to undergo any investigations due to being morbidly obese. She has got lot of co- morbidities and the team cannot progress on the pathway. Can they close the 62 day pathway, or does she stay on?

The 62d pathway would only end if the patient was told they did not have cancer. There remains diagnostic uncertainty in this case so the clock keeps ticking. Under the old rule a medical suspension would have been allowed, under the new rules the operational standard has been revised to take this into account.

If you are saying that the patient has decided not to have any further diagnostic tests because of her co-morbidities then a diagnosis will not be reached, no treatment record will be updated and hence no 62d pathway would be created - the cancer pathway would be assumed to have stopped at date first seen.

We have a 2ww/62 day lung patient whose ideal diagnostic pathway would have been to have a lung biopsy to confirm/rule out a cancer diagnosis. The patient declined a lung biopsy and the clinical decision was for the patient to have an interval CT to see if the lesion had progressed or resolved. We kept the patient on the 62 day pathway during this period. Unfortunately following the CT and other diagnostic tests cancer was confirmed and the patient was referred to a tertiary centre who are now querying whether the patient should have been removed from the 62 day classic pathway as refusing tests. My understanding is that the patient can only be removed from the pathway as refusing tests if they refuse ALL tests and also that the patient agrees to being removed from the pathway. As the patient had been offered an alternative test (albeit with an inherent wait due to clinical reasons) I believe that this patient cannot be removed and has to continue on the original pathway. Is this right?

I believe you are right ie the patient refused test A but you offered an alternative. It was the patient's choice to wait for this alternative approach and the revised operational standards take account of breaches due to patient choice.

Do the access 'rules' (eg. re DNAs) remain in place along the full 62 day pathway, particularly around the diagnostic testing period eg from day 14 - day 21?

Yes the rules in general apply eg you can refer back to a GP after multiple DNAs, you can refer back after multiple cancellations with pt agreement etc.

If a patient is told that they do not have a cancer diagnosis (based on a clinical opinion only) then they can come off 62d tracking. Our clinicians have nervousness about giving patients the all clear. Basically their patient's tests are all coming back clear but they want to follow the patients' up for monitoring purposes. The Trust would like to agree a set of words to say to patients that could enable them to be signed off the 62d pathway but does not give the patient 100% guarantee that they do not have cancer. They are proposing: 'At this current time, given the tests and investigations we have done, we do not feel you have cancer.' . Do you think that is sufficient to stop the 62d clock?

DH have advised that [this is not acceptable ie to say 'you feel a pt does not have cancer' in DH view leaves an element of doubt ie you are not giving them the all clear.](#)

62d upgrade

What is the operational standard for the consultant upgrade standard?

No operational standard has been set for the 62d consultant upgrade standard as yet as DH do not have sufficient data to calculate one.

62d Screening

Our colposcopy service has recently been through their colposcopy/lab QA re-accreditation process and the accreditation team have said that a biopsy is not good enough to 'disprove' a cancer and that the results of an excisional intervention are the only acceptable formal non-cancer diagnosis that should be used when deciding to stop tracking a suspected cancer patient. Surely if the results of an (incisional) biopsy are unequivocally saying "non malignant" that is sufficient and should warrant a formal non-cancer diagnosis?

I can only respond from a cancer waits point of view ie how patients from the cervical screening programme fit within cancer waits rules etc. If a patient is referred (PRIORITY TYPE 2) from the screening programme with moderate or worse cytology then they are on the 62d pathway until cancer is ruled out. If it is ruled out the patient is on the 18w pathway for any treatment they may need for the condition identified. For cancer waits we do not dictate what does or does not need to happen to form a diagnosis. For cancer waits, it depends on what the patient has been told ie if a clinician feels able to tell a patient that they do not have cancer on the basis of the info/test results they have that is sufficient to end the 62d pathway for cancer waits.

We have a patient who was seen by the Breast Screening Service and they found a change on Mammogram and recalled her for further tests, she then underwent biopsies but the screening service were unable to get a diagnosis so they referred the patient to us for further tests. The patient then underwent diagnostic excision and was found to have a cancer – for which she was treated with mastectomy. Her pathway took 149 days from the date that the screening department 'read' the mammo to the date of first treatment. Does the date of 'read' by the Screening service still count if the patient does not have a diagnosis? Or does it then become the same as if the patient had been referred from GP and the date the screening service referred to the tertiary centre become the referral date?

The starting point for this standard is the receipt of the referral for further assessment after the screening mammogram ie when the reader(s) decide to recall the woman for further assessment (rather than return her to routine recall) and that referral is received. In your scenario the clock started when the referral was received for the further tests. The 62d screening clock continues to tick until either the patient is told that they do not have cancer or until cancer is confirmed and treated. In your case the patient had a longer pathway due to diagnostic uncertainty etc but the clock would continue to tick from the receipt of the referral above - the operational tolerance for the 62d screening standard has been set at 90% to allow for the fact that some patients will choose to wait longer, some will not be fit to be treated within the timescales, some will have diagnostic uncertainty etc.

A patient is recalled by screening, is assessed and is considered not to have a cancer but the screening centre decide they will see the patient again in 6 months in case of developments. A) Do we close off the 62 day screening pathway? and B) Should something be discovered 6 months down the line, do we log as an incidental finding?

If the patient is told they do not have cancer then the 62d pathway is closed. If cancer is found at a later point this is an incidental finding and the patient would be on the 31 day pathway.

Pauses

A Trust has agreed with their PCT that for patients who are unavailable for the whole of the 2 week period the clock will start on the first day they are available. They are not re-referred just held until that date – is that acceptable?

No - that is not acceptable. Once the trust has received the referral the clock has started and cannot be paused because the patient chooses not to be available. The operational standard has been revised to allow for this.

If a patient is referred to another hospital for a biopsy which leaves the patient in critical care, is that a treatment and whose treatment is it and what “treatment” is it or does the clock keep ticking until the patient is well enough to be treated?

The clock would keep ticking. This would previously have been a medical suspension.

If patient DNAs their first outpatient appointment then there is a patient clock stop. If a patient DNAs a second OP appointment, then a Trust can discharge back to GP (after agreement from GP and consultant). What happens if the Trust choose not to discharge after second DNA, but would like to pursue the patient appointment. Can the Trust stop the clock again, and so on until they choose to discharge? And would this apply for the symptomatic breast 2ww too?

If a Trust chooses not to discharge after second DNA, but would like to pursue the patient appointment they can re-set the clock after each DNA ie reset to when patient re-books. This would apply to the symptomatic breast 2ww standard too.

Breaches

How are breaches of a 62 day bowel screening period managed?

Any breach is shared between:

- The Trust COMMISSIONED to provide the appt classed as DATE FIRST SEEN. For bowel screening this is the appt with the SSP to discuss suitability for colonoscopy;
- The Trust COMMISSIONED to provide the first definitive treatment.

We have prescribed a pt with a chemo script as part of their combined treatment plan, and referred to X Trust for radiotherapy as we do not provide it. I understand that the chemo script is recorded as FDT as given before the radiotherapy but would X Trust share any breach?

If a patient is having chemorad and the chemo is first then the date of the chemo is the date the 31d/62d clocks stops. It is the provider commissioned to provide the chemo that is responsible for any breach of the 31d and would share a 62d breach with the trust commissioned to provide the DATE FIRST SEEN.

The trust providing the r/t would not share the breach in your scenario unless they were the trust commissioned to provider the DATE FIRST SEEN appt.

Can a PCT commissioned to provide a referral service and early diagnostics during the 62 day period share breaches?

A PCT (in its provider capacity) can share a breach.

Performance management

We are a tertiary centre for Radiotherapy. A near by hospital is referring patients to us for short course radiotherapy before the patient then receives surgery. The radiotherapy treatment and subsequent surgery must take place within 7-10 days of the radiotherapy delivery. The referring Trust, because of capacity issues is not able to match the surgery date with the radiotherapy and subsequently we are breaching both 31 and 62 day targets through no fault of our own. What would you advise?

Capacity is not a reason to allow any pause or adjustment. If you cannot carry out treatment on time due to capacity issues elsewhere then I strongly advise that you raise this with your commissioners and also your SHA GFOCW lead.

We have recently received the following response from the CQC about their breach reallocation policy: *'Thank you for your enquiry regarding the 2009/10 cancer urgent referral to treatment performance indicator and breach reallocation policy. We are currently in consultation with the Department of Health to reach an agreement regarding our proposed review of the breach reallocation policy. Once an agreement has been reached, we will make the policy and associated form available to trusts on our website as part of the published indicator. In the meanwhile, trusts that wish to request the reallocation of breaches may continue to do so using the old form, available here: http://www.cqc.org.uk/db/documents/Reallocation_form_200904291418.doc Once the new policy has been agreed and published, trusts will be given the opportunity to submit requests for reallocation of breaches according to the new policy, providing that these reallocations have been agreed by all the trusts involved. We hope this resolves your enquiry, however if you require further assistance please do not hesitate to contact us'* Does NCAT have an update on this?

I have spoken to DH and I'm afraid that there is no additional information that I can share at the present time. The CQC have consulted DH about their proposed review of the reallocation policy and DH has responded but we now need to wait and see what CQC publish as a result. In the interim you just need to assume the policy will remain unchanged.

Do you know where we may be able to find national cancer waiting times data that is submitted for all Trusts in England broken down by cancer site – we are particularly keen to learn lessons from Trusts doing well on urology?

It is not possible for an individual Trust to see other Trust data at tumour level from the CWT-Db. You could speak to your cancer network who could access that data for all Trusts in your network. For information on Trusts outside of your network I would suggest that you email DH (cancer-waits@dh.gsi.gov.uk) and ask if they would be able to share with you the details of a sample of Trusts that appear from reported performance to be doing well for urology. I will also ask them if it is possible to provide this for all tumour areas as I would find it useful to approach Trusts that appear to be performing well to see what lessons I can learn and share more widely.

Dataset

Organisation Code (Patient Pathway Identifier Issuer)

Can you think of any reason why a Trust would be entering an Organisation Code (Patient Pathway Identifier Issuer) that is different to the Organisation Code (Provider First Seen)?

Yes. Patient Pathway Identifier is generated by a Trust receiving an initial referral on the pathway. This may not be the Trust where the patient is first seen e.g. if the initial referral was an error or the patient chooses to be seen elsewhere.)

Cancer Treatment Modality

How would we code electrochemotherapy?

I have not heard of 'electrochemotherapy' but from the description you forwarded I would class it as cancer treatment modality code 14 (anti-cancer drug regiment (other)).

How should Octreotide be recorded for GFOCW?

I understand that it is a hormone drug - if that is the case I would use CANCER TREATMENT MODALITY Code 03.

CWTDb

What is the process for getting a PCT set up on the CWT-Db as a 'provider organisation'?

To set a PCT up on the system you can either raise a log with the helpdesk or contact Tim Hancox direct (timothy.hancox@dh.gsi.gov.uk).

Tumour-specific

Breast

We have a patient who was diagnosed with Breast cancer and had surgery as FDT. Following this they were placed on hormones and we recorded this as subsequent treatment. Recently the patient has decided that she preferred the option of Oophrectomy so that she can discontinue lifelong hormones. Is the oophrectomy a subsequent treatment?

Oophrectomy would be a subsequent treatment in this scenario as it is replacing hormone treatment which was classed as a subsequent treatment.

Gynae

We have had some discussions about Borderline Ovarian Histology. I have always reported these on CWT could you confirm that this is the correct policy.

It depends if they have a C code or not. C codes are within the scope of cwt standards. D codes are not (except breast in situ).

Haematology

We have a haematology patient who had MDS which transformed into AML. The treatment was watch and wait. The AML has now transformed into CML – treatment plan is again to watch and wait. Should we report the CML as a new pathway or would it be a subsequent treatment on the existing pathway?

This would be a subsequent treatment as the cancer transformed.

A patient with a Haematological cancer was seen and consented to have steroids (Dexamethasone) for several months, after which they would likely commence on chemotherapy. The aim of the steroids was to actually shrink the tumour and it has done so in this case, so it has acted as an enabling treatment. Are we therefore able to class the steroids as the first treatment, and the chemo as a subsequent treatment?

I have discussed this query with a clinical advisor as I have not come across it before. They advised that this seemed a very long time to be giving steroids in order to shrink the tumour to enable chemo to start. They asked what protocol was being followed. Are you able to provide this additional information so that I can give you definitive advice please?

On liaising with the clinical team, the patient above was given steroids due to chest symptoms and the mass on his chin. One of the AVBD protocol drugs- Bleomycin-is highly toxic on the lungs so it wasn't appropriate to start the patient straight on the Chemo without first a period of Dexamethasone. The clinical team feel this should be regarded as an enabling treatment, as per the GFWCW guidance.

This sounds like it would have been a medical suspension under the old rules and, as such has been taken into account in the revised operational tolerances ie. NOT an enabling treatment that can be classed as FDT. Colleagues at DH have agreed.

Head & Neck

In the HILO trial, a patient may receive radioactive iodine (admitted treatment) or may have a combination treatment receiving Thyrogen (non admitted treatment) for two consecutive days prior to the radioactive iodine. If a patient declined to start treatment until after xmas a pause would have been possible if they were on the radioactive iodine arm but not if they were on the thyrogen arm – is that correct? Also the 31 day standard is live for chemotherapy but not for 'other' treatments – how is this managed for these treatment options?

If this is a national trial (in NCRN portfolio) then the trial protocol dictates what is the FDT.

The fact that radioactive iodine on its own is classed as 'other' treatment and the patient on a trial would have something classed as 'drug' treatment first which is a live standard should not really be the consideration. The aim should be to deliver both of these treatments within 31d it is just that the one classed as 'other treatments' is not being performance managed centrally. If the patient was on a 62d pathway it would not matter that the patient was having radioiodine treatment the 62d standard would still apply so you would still need to deliver the treatment in a reasonable time.

The relevant pauses apply for the treatment the patient is having irrespective of whether the treatment is part of a trial ie if an admitted treatment is needed a pause can occur and if a non-admitted treatment is needed then it cannot.

In summary, you have to go along with the trial protocol in terms of what is an FDT and what treatments are applicable for pauses (admitted). The primary concern should be what is best for the patient (eg taking part in this trial) and not if it makes it harder to meet standards.

If you think that participation in a particular trial has a detrimental impact on performance (eg. due to high patient numbers taking part etc) then you can submit an extenuating circumstances claim to the CQC.

Lower GI

Many LGI patients are on a 6 monthly, 12 monthly or 5 year recall to check that they are still clear of cancer, or the cancer remains under control with their current treatment. The recall includes CT and/or endoscopy. These tests are booked well in advance to ensure the date offered to the patient matches the recall check programme dates. What would be the DTT?

If cancer was found at a recall appointment and treated at the same time I would class the DTT and the treatment date as the date of the recall procedure.

Skin

Patient referred by 2WW by GP to Dermatology, seen by consultant and has said 'BCC' and wants to see patient in 12 weeks for excision as he wants it to grow. We have asked consultant and he expects it to be BCC or less. Do we keep on cancer wait time and continue monitoring or do we cancel off record, and then after excision in 12 weeks if a cancer is found open up as incidental find?

You only take a patient off 62 day monitoring if they have been told that they do not have cancer. In the case of suspected skin cancer referrals, as BCCs are not counted on 62d pathway, the patient could come off the 62d pathway if they have been told that they do not have cancer or they have been told that they have a BCC ie. if the consultant is willing to make a clinical diagnosis without pathology and tell the patient that clinical diagnosis then they can come off monitoring. If not, ie the consultant says, I'm pretty sure it is not cancer but will do some further tests in 12 weeks etc then they remain on monitoring.

Upper GI

Should we be recording Intramucosal Carcinomas for Upper G.I.?

It depends how they are coded. If they have an ICD-10 C code then yes. If not then no.

Urology

Induction course of intravesical immunotherapy can be followed by maintenance intravesical programme. Would this be another subsequent treatment or classed as the same treatment package?

I would advise that you look at whether or not the patient signed a new consent form for the maintenance intravesical programme. If so then I would class it as a subsequent treatment. If not, then I would class the induction and maintenance therapy as one treatment.

We have pts that have undergone radical radiotherapy as a first treatment for bladder cancer who are then transferred back to the originating trust. The patient is seen in the originating trust's outpatient department clinic and a cystoscopy is agreed for a follow up assessment of their bladder now that radiotherapy has been completed. The patient is usually consented at this outpatient clinic appointment. The consenting discussions will include – if anything sinister found, it will be treated if it is at all possible whilst doing the cystoscopy. As we hope this cystoscopy is a new baseline for their bladder status to assess the impact of radiotherapy, if any cancer was found when would the DTT date be?

If cancer was found at the cystoscopy and treated at the same time I would class the DTT and the treatment date as the date the cystoscopy took place.

Miscellaneous

Are you aware of any protocols for the management of private patients on cancer pathways?

This is being left for local determination and I have not seen any local policies - it is something that I could raise with the informatics forum at NDP if you want ie. to see if anyone has a protocols they would be willing to share.

When will v 6.6 of the GFOCW guidance be published?

We are aiming to have this published by April 2010.

Is there any site specific guidance available?

The site specific guidance is not yet out - it should be available in the summer. The GFOCW rules apply to all tumour types. NCAT produces monthly q and a which includes a section on any site specific queries received that month.

Hospital X is in the process of installing a new database facility for Cancer Audit and MDT. A question was raised by the breast team as to whether it was mandatory to collect co-morbidities and if so is this a local or national rule. I have looked at the NCDS which indicates that this data item is still under discussion. They also asked whether this data item had to be collected at MDT.

This question would best be answered by my colleague at the National Cancer Intelligence Network as it goes beyond cancer waits.

NCIN advise: The issue relating to co-morbidity continues to be explored further. Currently there is no mandated requirement to capture co-morbidity but it is being actively addressed through NCIN. We held a workshop last October and I attach a copy of the summary report. In this you will see that we have recommended further evaluation of the ACE27 co-morbidity scoring system. Within the next few weeks NCIN will be making a call for bids from networks, trusts, MDTs, etc to undertake some of this testing for us. If you are attending NDP then you will hear much more about this issue and the wider national cancer dataset initiatives and the impact this will have on local systems, etc.

Useful Links:

CWT Stats:

http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationsStatistics/DH_099885

CQC Indicators Constructions:

<http://www.healthcarecommission.org.uk/guidanceforhealthcarestaff/nhsstaff/annualhealthcheck/annualhealthcheck2008/09/qualityofs/nationalprioritiesacuteandspecialisttrusts.cfm>

GFOCW guidance:

<http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation#guidance>

Abbreviations/Acronyms

18w	18 week standard
2ww	Two week wait standard
31d	31 day standard
62d	62 day standard
AML	Acute Myeloid Leukaemia
Appt	Appointment
BCC	Basal Cell Carcinoma
CaB	Choose and Book
CA125	Cancer antigen 125 (a blood test)
CfH	Connecting for Health
CDS	Commissioning Dataset
CML	Chronic Myeloid Leukaemia
CNS	Clinical Nurse Specialist
CWT	Cancer Waiting Times
CWTDb	Cancer Waiting Times Database
DH	Department of Health
DNA	Did Not Attend
DSCN	DataSet Change Notice
DTT	Decision to Treat
ECAD	Earliest Clinically Appropriate Date
FDT	First Definitive Treatment
GFOCW	Going Further on Cancer Waits
GP	General Practitioner
HCP	Health Care Provider
ISB	Information Standards Board
LGI	Lower Gastro Intestinal
MDS	Myelodysplastic Syndromes
METS	Metastatic Disease
MHRA	Medicines & Healthcare Products Regulatory Agency
MRI	Magnetic Resonance Imaging
ODS	Organisation Data Service
OE	Open Exeter (ie where the CWTDDB is located)
OPA	Outpatient Appointment
PCT	Primary Care Trust
PET	Positron Emission Tomography
PPI	Patient Pathway Identifier
pTa	a low grade bladder tumour
Pt	Patient
PTL	Priority Target List
r/t	Radiotherapy
RTT	Referral to Treatment Time
SCC	Squamous Cell Carcinoma
SCR	Somerset Cancer Registry
SPC	Specialist Palliative Care
SSP	Specialist Screening Practitioner
TCI	To Come In Date
TCC	Transitional Cell Carcinoma
TURBT	Transurethral Resection of Bladder Tumour
TURP	Transurethral Resection of the Prostate
TWR	Two Week Wait
Tx	Treatment
UBRN	Unique Booking Reference Number