

GFOCW: Questions answered by NCAT – August 2009

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Two Week Wait (2ww)

We have GP TWW referrals for gynaecology that either have 1st appointment at outpatient clinic, an ultrasound scan or they come to the colposcopy unit to have a CA125 only. Is a blood test such as CA125 allowed as 1st appointment for a GP TWW referral patient?

Comprehensive central guidance on what does and does not constitute a diagnostic clinic which could end the 2ww clock is not planned. In general terms we would assume it to be a clinic where tests will be carried out as part of a clinical pathway that seeks to rule a suspected cancer diagnosis in or out prior to an appointment with the consultant eg. straight to test for colonoscopy following 2ww referral for bowel symptoms. Cancer Waits Targets guidance version 5 (ie, the last version of guidance to support the original cancer waits standards) stated that CA125 was considered a first major diagnostic test for suspected ovarian cancer. I will however seek definitive clinical advice about the use of blood tests to stop the 2ww clock. In the interim you will need to make a local decision and I will get back to you when I have a definitive answer.

If a patient is an emergency admission for another condition prior to their first seen appointment against the 2ww referral and whilst an inpatient is seen by the team relevant to the 2ww referral as well and investigations confirm a benign diagnosis would the admission date be equivalent to DATE FIRST SEEN and the patient no longer tracked against the 62 day pathway as will have a benign diagnosis and Cancer Status of 03 – no new cancer found.

If a patient is admitted as an emergency admission prior to being seen for a two week wait appointment, and they are assessed as would have happened in the clinic they were waiting for and a benign diagnosis is given, then the date of the admission would be the clock stop for the two week wait. Subsequently the patient would (because of the benign diagnosis) be outside the scope of the 62-day standard, but the 18-week standard will still apply if they are not discharged.

If a patient is an emergency admission for another condition prior to their first seen appointment against the 2ww referral and there are no investigations by the relevant 2ww team: would the patient still be on the 2ww pathway and need to be given an appointment once they have recovered from their hospital admittance OR could the patient be discharged back to the GP for re-referral once they have recovered from their emergency admission for another condition?

If no investigation that could detect a cancer is carried out this admission is not equivalent to DATE FIRST SEEN and the patient will stay on the waiting list for the diagnostic clinic/OPA. However if it is inappropriate for them to remain on that list for some reason the clinician in secondary care should contact the GP to discuss withdrawing the referral so that the patient can be managed appropriately in primary care.

We are trying to sort out the access policy for our trust and we are trying to find out if the same rules apply to referrals for suspected cancer as to all other referrals.

The rules for cancer 2ww differ slightly ie. a person cannot be referred back to their GP after a single DNA of their first appointment whereas for 18w they can - see GFCOW guide v6.5 section on 2ww.

Are we required to offer the patient a choice of two appointments within the 14 day target?

No. For cancer it is a reasonable offer which is classed as ANY appointment within that 14 day period.

An imaging dept in our trust has indicated that they do not consider that an appt for barium enema and CT constitutes a 'first appt' ie when the clock stops for TWR pts. They are quoting the CWT Guidance v6.5 which states at A3.2 that '*DATE FIRST SEEN is when a patient is seen for the first time by a consultant or in a diagnostic clinic following the referral receipt*'. They believe that this appt is neither a clinic nor a consultant appt and so does not meet the above criteria. Please can you comment.

If the barium enema was part of the pathway (and clinically appropriate) to rule in or out cancer then I would have thought it could be date first seen but I will check with DH.

DH advice: if it is a consultant led service then it can stop the clock. If it is not a consultant-led service it would only stop the clock if it is part of a wider package of care supporting a consultant led service.

The PCT is pushing for IS providers to be allowed to refer under the 2ww rule to the Trust and not have to send the patient back to the GP for 2ww referral. Please could you advise what organisations are classed as being part of the Independent Sector?

DH are looking into this as they advise that this issue is complicated. We will inform you as soon as we have heard from them.

2ww referrals for testicular cancer are subject to a 31 day wait for treatment, it has long been our local policy to arrange an outpatient appointment within 7 days. However, this does not happen if patients book via X Trust. While the 14 day target may be met, the last of these patients waited 12 days for his appointment. This obviously reduces the time we have available to ensure that the 31 day target is met.

The national standard is 14 days and that is all we monitor against. If you choose to have a tighter standard locally then you are free to do so but it would be for you locally to liaise with X Trust to see if you could get them to agree to work to your local protocol and/or provide you with additional information where they are not able to do so in any/all cases.

Can you clarify the position on repeat patient cancellations of first appointment - can pt be discharged back to GP after cancelling a first appointment several times?

A patient can be discharged back to the GP after multiple appt cancellations WITH THEIR (ie the patient's) AGREEMENT. A patient should not be referred back to the GP without their agreement because by cancelling (rather than DNA'ing) they have indicated a willingness to engage with the service.

A PT cancels 1st OPA twice then DNAs the 3rd date. Can clock be restarted to date PT rebooks appointment after DNA or is there no adjustment as PT cancelled before a DNA.

A DNA of a first appt will trump any patient cancellations that may have preceded it so you can reset the clock as you describe.

A patient is referred under TWW by a GP/GDP to a service which is not provided by the receiving organisation eg. sarcoma. The receiving organisation has a mechanism in place to ensure that the patient is referred to the appropriate Centre for that specialty before the referral is accepted and also before an appointment is booked with, or by, the patient. The GP is also contacted to inform them of the incorrect referral and we have a system in place to monitor these occurrences and report trends to the relevant PCT. Given that the criteria for a valid TWW referral have not been fulfilled is it permissible to treat the date of receipt of referral in the appropriate Centre as 'Day 0' for tracking purposes?

There should be referral protocols in place between primary and secondary care so that GPs know where to send eg. a suspected sarcoma. If they have sent a referral to the wrong trust you could liaise with the GP and ask them to withdraw the referral and re-refer the patient to the correct Trust (in line with the protocol). Receipt of the correct referral by the correct trust would then start the clock. If however, the initial trust has referred the patient on to the correct Trust the clock has started as the referral has been received and actioned.

With regards to downgrading/inappropriate referrals, if primary care and secondary care can locally agree what constitutes an appropriate referral does the consultant still need to contact the GP prior to downgrade? Eg, a GP refers a patient on a skin suspected cancer referral form stating the patient has a BCC, does the consultant need to contact the GP even though BCCs are not covered by cancer waiting times?

The GP has to be the one who downgrades the referral. In terms of BCC, the GP may have marked it as a BCC but may not be 100% sure hence referring it under 2ww. If it is confirmed that it is a BCC then the patient would not be covered by the 31 or 62d standards but would be covered by the 2ww standard unless the GP withdrew the referral.

Symptomatic breast 2ww

Can you clarify the position on repeat patient cancellations of first appointment for a symptomatic breast 2ww referral - can pt be discharged back to GP after cancelling a first appointment several times?

A patient can be discharged back to the GP after multiple appt cancellations WITH THEIR (ie the patient's) AGREEMENT. A patient should not be referred back to the GP without their agreement because by cancelling (rather than DNA'ing) they have indicated a willingness to engage with the service.

31d treatment (first or subsequent)

There is a patient who has come back after years only not with cancer at the initial site but mets from the primary in the lung. Does the 31 day subsequent cover treatment of the mets? The guidance talks about recurrence and progression. Is mets counted as progression?

Yes - Mets is classed as recurrence/progression.

Can you confirm that any patient treated for cancer will have either a 1st or subsequent target associated with their treatment?

Any patient treated for cancer would have a 31d period for their first treatment. Whether or not they will have 31d subsequent treatment periods depends on if they need further treatment. The majority probably will.

Please can you clarify what is classed as Surgery, Anti Cancer Drugs and Radiotherapy for the subsequent treatments 31 day standard.

Surgery: 01 - Surgery

Anti-Cancer Drugs: 02 - Anti-Cancer drug regimen (Cytotoxic Chemotherapy);
03 - Anti-Cancer Drug regimen (Hormone Therapy)
14 - Anti-Cancer Drug regimen (Other)
15 - Anti-Cancer Drug regimen (Immunotherapy)

Radiotherapy: 04 - Chemoradiotherapy
05 – Teletherapy (Beam Radiation excluding Proton Therapy)
06 - Brachytherapy
13 – Proton Therapy

If a patient is offered surgery and is given a TCI date & then decides that they would rather have chemotherapy: a) what happens to the original DTT for surgery; b) Is the Chemotherapy seen as a 1st treatment or a 31 day subsequent pathway?

The surgery did not take place so that 31 period does not need to be uploaded. A new DTT would be set for the chemo. There will be implications for the 62d pathway as the clock for this would continue to tick even though the patient changed their mind on their treatment

The chemo is seen as the first treatment as the surgery did not take place. The DTT is the date that the patient agrees a treatment plan for first or subsequent treatments within a Cancer Care Plan.

Rare cancers (childrens/testicular/acute leukaemia) referred by GP to 2WW have a 31 day target from Cancer Referral to Treatment Period Start Date. What happens to these rare cancers that come via other routes eg screening programmes and upgrades?

A consultant (or an authorised member of the consultant team) would be able to upgrade patients they suspected might have one of these cancers (childrens/testicular/acute leukaemia) but who had not been urgently referred with suspected cancer. The upgrade would be on to the 62 day period but it would be deemed as good practice for the locality to seek to deliver the treatment within 31 days where possible. This will not be monitored centrally against 31d though.

In terms of the 62d cancer screening programme:

- ◆ No children are seen by any of these 3 screening programmes
- ◆ It is unlikely that anyone will be urgently referred with suspected testicular cancer or acute leukaemia from one of the 3 screening programmes but, if they were, they would be on the 62 day period although, again, it would be deemed as good practice for the locality to seek to deliver the treatment within 31 days where possible. This will not be monitored centrally against 31d though.

Are there any specific rules/guidance on enabling treatments?

There are a number of enabling treatments that are carried out prior to active treatment and the majority of these have NOT been able to be classed as first definitive treatments. The reasoning behind this has largely been that enabling treatments could thus end a 31 (and potentially 62) day period and the patients could then wait a long time for the active intervention that should follow as there would be no standard to cover this. For example, the general rule is that a stent can only be classed as first treatment where the patient is unfit for other treatment. However, some tumour specific exceptions have been allowed eg insertion of a pancreatic stent to resolve jaundice before a patient has a resection or starts chemo. Now that we have a 31d standard for subsequent treatments it would be useful to consider how enabling treatments are to be managed in case we get an increasing number of requests for exceptions and it becomes hard to justify why some enablers can count and others cannot. I would like to develop some clear rules/principles and I am going to the GFOCW AG about this on 22 September so I will hopefully have some clearer advice after that.

What is the position re GPs/PCTs uploading data to CWT-Db for drug treatments?

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 in this scenario. If, however, the GP prescribes the treatment or the prescription is sent to the GP for action the PCT should be recording the activity. It is not expected that GP practices will register to be able to use CWT-Db (unless they are very large) - it is expected that PCTs will register and upload data on behalf of their GPs when appropriate. If the PCT is in the provider code list at the acute provider then the acute provider could enter these data on that organisation's behalf, though it would not appear in the acute provider reports and the PCT would need to ensure they validate these data somehow as they would be published by DH and passed to the Care Quality Commission.

Combination treatments include radiotherapy combined with surgery especially for rectal cancer. Does this mean we code it as teletherapy as that is the initial treatment or should it be surgery as that is the main radical treatment?

Code it as the treatment that is given first in the sequence unless it is chemorad which has its own code.

Classic 62d (ie. from 2ww)

We have a patient on the 62 day pathway who has been diagnosed with cancer of the tongue, their treatment plan is to have a PEG fitted and then to have radiotherapy not surgery. As the patient would not be able to eat once the Radiotherapy starts, would the PEG count as first definitive treatment?

Date of admission for the PEG would be counted as the start date for FDT if the patient remained an in-patient between this date and surgery ie. if it is the same episode of care. The same would apply if they were to have radiotherapy as their treatment (rather than surgery) but only if the radiotherapy commenced during the same episode of care. Assuming that this would not be the case then PEG prior to r/t cannot be used as the FDT.

There are a number of enabling treatments that are carried out prior to active treatment and the majority of these have NOT been able to be classed as first definitive treatments. The reasoning behind this has largely been that enabling treatments could thus end a 31 (and potentially 62) day period and the patients could then wait a long time for the active intervention that should follow as there would be no standard to cover this. Now that we have a 31d standard for subsequent treatments it would be useful to consider how enabling treatments are to be managed in case we get an increasing number of requests for exceptions and it becomes hard to justify why some enablers can count and others cannot. I would like to develop some clear rules/principles and I am going to the GFOCW AG about this on 22 September so I will hopefully have some clearer advice after that. In the interim, PEG prior to r/t would NOT count unless r/t commenced during the same episode of care as the PEG.

62d Screening

General

We have to upload data on all urgent screening referrals even for patients who do not go on to be diagnosed with cancer. What use is the data on the patients who do not end up with cancer being put to?

At the present time DH do not use data uploaded on screening patients that were not diagnosed with cancer. There are also no reports on this cohort of patients available on the CWTDdb as yet. I am taking the issue of management of screening patients who are not diagnosed with cancer to the GFOCW Advisory Group on 22 Sept.

With the need to submit all screening referrals, will we be able to extract a report with any figures on this? I am looking at trying to reduce the time first seen, and this would be an ideal way to do it.

I don't think that there are any reports available (or planned for the foreseeable future) linked to those uploaded from the screening programmes that are not diagnosed/treated with cancer. A change request could be put in for this though for future updates of the cwtdb.

Response from DH: We have no concrete plans to implement reporting in this area, though recognise it is something that the NHS might wish us to do to support local performance management and service monitoring. Therefore, if you have any specific recommendations you would like to make regarding reporting in this area could I ask you to log it with CfH helpdesk, so any implementation can be properly investigated as a change request.

Cervical

We are picking up patients that have had a smear and are being referred into the trust by their GP rather than via the screening programme. Am I correct in thinking they wouldn't be put onto a 62 day screening pathway?

That is correct. If they are urgently referred via their GP they would NOT be in the 62d screening cohort. They would be in the classic 2ww/62d cohort.

If a patient is diagnosed with CIN II or CIN III , is this classed as cancer according to the standards and should it be uploaded as a cancer?

Unless CIN II or CINIII have a C code they are not classed as a cancer and are outwith the CWT standards after diagnosis.

We are told that patients diagnosed with CIN II and CIN III (severe/moderate dysplasia or dyskaryosis) are to be included in the standard. How do we record these patients on Open Exeter , there is no ICD code for these patients (our coding departments says they would code these patients as N87). Do we record these patients as C53.9 – Cervix, Uteri unspecified?

Patients urgently referred by the cervical screening programme with severe or moderate cytology are on the 62d pathway. If cancer is diagnosed and treated the ICD10 details would need to be uploaded. If cancer was not diagnosed then you would not need to upload the treatment part of the record so you would not need to upload the codes you are suggesting ie. where cancer is ruled out you only need to upload details up to DATE FIRST SEEN.

Can you clarify what an urgent referral from the screening programme means?

It refers to the data item 'Priority Type' which identifies the priority of the referral. Priority 2 is for urgent referrals and should be used for screening referrals coming on to the 62d pathway - see GFOCW guide v.6.5 part 6 on the CfH website for more details on this data item.

Screening patients are not 2ww referrals and therefore not on the classic 2ww/62 day pathway. Do we therefore need to do a 'consultant upgrade' i.e. step up all patients referred as priority type URGENT from screening so they get on a 62d pathway?

No. If the patient comes from the screening service as an urgent referral (priority 2) they are automatically on 62d pathway until cancer is ruled out so an upgrade is not necessary.

If a patient comes from a screening programme as a routine referral (priority 1) eg. for low risk cytology and cancer was then suspected they could be upgraded.

62d upgrade

No questions this month

Pauses

A patient is seen in clinic and given a diagnosis of Prostate Cancer. The patient agrees in clinic to have Radical Laparoscopic Prostatectomy. The patient was offered an operation date for 10/08/09 but declined as they wished to go on holiday first. Patient returns from holiday 20/09/09. Under CWT guidelines a 41d WTA can be made. The patient cannot be operated on straight away after returning due to being at high risk of DVT following a transatlantic flight. Can a further WTA be made?"

The clock restarts when the patient 'makes themselves available again' which I take to be when the patient is back from their holiday. Any wait after that eg. due to risk of DVT would have been a medical suspension and therefore no pause is possible. However I will ask if DH agree or if we could argue that the patient has not 'made themselves available' until they had returned from holiday in a fit state ie back from holiday and dvt risk over.

Advice from DH: Risk of DVT would have been a medical suspension and therefore no pause is possible for this element on the pathway.

Patient has been diagnosed with cancer and wants time (approx 4 weeks) to consider whether they want to start treatment (chemo), which would be their first treatment. There are 3 possible outcomes and I would like to ascertain if there are any possibilities for pauses / suspensions:

a) Firstly, if the patient does decide to have chemo and is treated as an in-patient, could the Trust put a suspension in for the time the patient was 'considering' treatment?

No. There is no pause in this scenario. A pause is possible if a patient declines a reasonable appointment of admitted care. In your scenario they have not declined an appointment as they have not yet decided if they want that form of treatment. The operational standards for the cwt standards take account of the higher volume of patients being seen outside of the timescales due to patient choice factors.

b) Secondly, if the patient does decide to have chemo and is treated as an outpatient, could the Trust put a suspension in for the time the patient was 'considering' treatment

No. There is no pause in this scenario. The operational standards for the cwt standards take account of the higher volume of patients being seen outside of the timescales due to patient choice factors.

c) Lastly, if the patient decided not to have chemo, what options are there.

If the patient decided that they did not want any treatment then you would end the pathway on the date that this was agreed and record the CANCER TREATMENT MODALITY as Code 98 'All treatment declined' . If they agree to a different form of treatment then you would use the Decision to Treat date for the agreed treatment as the starting point for the relevant 31d standard. Unfortunately you cannot make any adjustments on the 62d pathway for a patient considering treatment X then declining and agreeing to treatment Y instead.

Pauses are allowed for admitted care but not for non-admitted. How should a Regular Day Admission/Attendance (RDA) for commissioning purposes be viewed in cancer waits and 18weeks. RDAs are never mentioned in CWT or 18w guidance possibly because the various national returns which are used to ratify data completeness for 18w are based on ordinary admissions and daycases only and RDAs aren't included .

Advice requested from DH.

For chemo a pause is allowed for daycase but not an outpatient appointment. Since mostly this categorisation is just due to the way Trusts classify the activity this is illogical. Can clearer rules be provided?

Advice requested from DH.

Breaches

If a patient DNAs their first outpatient appointment and then DNAs their second outpatient appt, can we put in an adjustment to cover both DNAs?

Yes. When a patient DNAs their first OPA the clock is reset to when they make contact to rearrange their appointment. If they DNA a second time the clock can be reset again as they still have not had their first appointment. If a patient does multiple DNAs of the first appointment (2 or more) then you can refer the patient back to their GP if that is in line with your local protocol. If however they DNA their first OPA, eventually attend but need a second OPA and DNA that then there is no pause for the DNA of that second appointment.

Our Trust is not designated as the screening centre but patients that have a positive FOB can be seen by the SSP at our Trust. We might then do the colonoscopy or the patient might go to the screening centre. If a patient breaches that had been first seen at our Trust, went to the screening centre for colonoscopy and then came back to us for treatment, would that be our breach?

If there is a breach it would be shared between the provider COMMISSIONED to provide the appt classed as 'date first seen' (ie the appt with the SSP to discuss suitability for colonoscopy not the colonoscopy appt) and the provider COMMISSIONED to provide the first definitive treatment. It may be the same provider that is commissioned to provide both parts of this pathway.

If a patient was first seen at the screening centre then came to us for their colonoscopy and stayed with us for treatment would we share a breach?

The DATE FIRST SEEN is the SSP appt. The colonoscopy is after the 'date first seen' and is not relevant in this scenario. If you were the treating trust ie COMMISSIONED to provide the first definitive treatment then you would share any breach with the provider COMMISSIONED to provide the SSP appt ie. Date first seen.

If a patient was first seen at the screening centre, had their colonoscopy there and then came to us for treatment would we share a breach?

The breach would be shared between the provider COMMISSIONED to provide the SSP appt ie. Date first seen and the provider COMMISSIONED to provide the first definitive treatment.

What would happen if there was a capacity issue at the screening centre for colonoscopy and the patient came to us for treatment after their 62 day breach date?

The Care Quality Commission has a repatriation policy for breaches where a provider receives a patient after day 62 ie with both CEs agreement the full breach can go back to the referring provider. However, at the present time this is only allowed when the late referral is due to administrative reasons and I am not sure that capacity would count as an admin reason. You would need to contact the CQC if you wanted to pursue this.

If we have a patient who is being suspended indefinitely from surgical treatment for a bowel cancer due to high portal vein pressures will it be a long breach for first treatment or would we record it as active monitoring/watch and wait?

You upload after he has the treatment and he would be a long breach.

If the patient with high portal vein pressure is being monitored symptomatically in the meantime (ie. prior to being fit for surgery), does this count as any treatment – eg. what if he had a TIPSS procedure, could this be seen as an enabling treatment?

I do not believe that symptom monitoring could be classed as a treatment in the scenario you describe. Also TIPSS (Transjugular Intrahepatic Portosystemic Stent Shunt) is used to treat the portal hypertension not the cancer so I do not believe that this can be used as the FDT either. Also, I understand that 18w classes FDT as '*An intervention intended to manage the patients disease condition or injury and avoid further intervention. It is a matter of clinical judgement , in consultation with the patient.*' I don't think TIPSS would be covered by this ie. it will not 'avoid further intervention'.

We have recently been receiving tertiary's from other trusts either after their breach date or with only days to go. The protocol for 62 day target patients is that any tertiary should be referred with a minimum of 31 days left on their pathway. In this instance, are we entitled to refuse to share half the breach?

The protocol you refer to of having 31days must be a local one as there is no national protocol setting out a specific point on the pathway at which referrals need to have been made to the tertiary provider. DH did some analysis on the older cancer waits data that indicated that referring on or by day 42 should normally give the treating trust time to treat the patient without breaching the standard. DH intend to re-do this analysis taking into account the new pause methodology to see if day 42 still stands. Either way day 42 only acted as a guide it was never a formal 'target' that could be used for breach reallocations.

In terms of breach reallocation, DH allocate a breach between the trust where the patient is first seen and the treating trust. The CQC have a slightly more detailed policy which allows for a middle trust to share the breach with the referring trust or indeed have the whole breach. Details are on their website. The CQC repatriation policy allows for the repatriation of breaches if a referral is made **on or after** day 62 provided that the delay was due predominantly to administrative reasons (not clinical reasons) and the CEs of both trusts agree. It has been suggested by some trusts that, given the change in adjustment methodology, there will be more referrals post day 62 due to patient choice and that it does not seem 'fair' for the receiving/treating trust to share this breach. They have asked if the CQC would consider reviewing their definition of 'admin' delays to take into account the changes to the pause methodology." CQC are considering this but have no plans to change the policy for the foreseeable future.

In summary local networks and trusts can agree a cut-off date to ensure that tertiary treating trusts are given sufficient time to treat them without breaching the target but this cut-off date will not be monitored nationally and cannot be used for breach reallocations. The CQC reallocation policy is there as a last resort where transfers take place on the breach date or after the breach starts for admin reasons.

Performance management

Have the 'under achieve' and 'fail' levels been set yet for the cancer targets - i.e. if you get less than 93% for the two week wait but more than say 90% would you under achieve rather than fail?

The Department of Health sets its overall operational standard and expects the NHS to meet this level. The concept of a 3 tier rating ie. achieve, under achieve or fail is only used in the CQC ratings. You might wish to redirect this query to them.

Will Trusts performance be rounded up or down to the nearest whole number?

The operational standards are in whole percentages, but the performance stats have a decimal point. The provider organisations would be expected to reach 93.0% to be marked as achieving the two week wait. 92.8% would show as failing to achieve.

Is the weekly cancer PTL mandatory for Trusts? Is there a DSCN planned? Is there a recommendation around how the PTL should be used?

The cancer PTL is not yet mandated. DH do intend to apply for a mandate but this is unlikely to happen until after the summer. In the meantime the PTL is available on the DH Unify system for use on a voluntary basis.

What will the operational standard be for the 31 Day rare cancers - *will it be 85% in line with 'classic' 62 day?*

There has never been an individual operational standard for the 31 Day Rare Cancers standard as the numbers involved are too small to reliably calculate one, or use it for performance management on a monthly/quarterly basis. However, these referral to treatment periods are a subset of the All Cancer 62-day standard, therefore DH will add them to the numerator and denominator for that standard and apply the 85% operational standard.

What will the operational standard be for the 31 Day Subsequent Treatment – other treatment standard?

The published operational standards relate directly to the current NHS Operating Frameworks and the Vital Signs monitoring, the composition and level of operational standards will be kept under review as is normal practice, but there is no immediate plan to introduce operational standards for areas not specified within Vital Signs.

Will there be an operational standard for 2ww symptomatic breast patients on the 62d pathway?

The operational standard for the 62-day symptomatic breast standard will have to wait as we do not have enough data to robustly calculate it. As a planning assumption in the interim you may wish to use the classic 62-day standard.

The number of screen-detected cancers treated at X Trust is very low (about 2 a month). MONITOR measure the targets against FTs every quarter, so with fewer than 10 cases per quarter, this means that even one isolated breach automatically means a breach of the 90% threshold. Our Performance team think that DH would normally make an exception for targets where such small numbers apply. Has there been any discussion about this? And do you know with whom we should raise this at DH please?'

DH Response: Firstly, when reviewing these data on a regular basis the Department of Health programme and performance teams do not usually apply a de minimis limit within their analytical outputs, this is because we choose to give the complete picture to the expert panel reviewing the data. The caveats to this however, are depending on the audience small cell count data may be suppressed. And the performance teams that review these data are aware of the effects that small numbers will have on reported performance and consider this before deciding to enact any interventions. Secondly, the Care Quality Commission (CQC) do normally publish and apply a de minimis limit within their annual assessment process. Therefore it is reasonable to assume that any analysis incorporating this dataset will also be subject to such restrictions. Due to the independent nature of the CQC I cannot comment on what such a limit might be, however you might wish to address a query on this matter to: Performance.Indicators@cqc.org.uk .

Dataset

PPI

For bowel screening, who generates the PPI - would it be the hub or the screening centre?

The PATIENT PATHWAY IDENTIFIER needs to be allocated by the organisation receiving the referral request which would result in the patient being seen for the first time for a particular condition/suspected condition. In terms of bowel screening that would be the provider receiving the referral request for the appointment with SSP to discuss suitability for colonoscopy. It is for the organisation in question to determine how to generate the PPI. Please also note that the Trust commissioned to provide the screening service MUST provide a PPI that is the same as that provided for the 18w pathway for this patient.

Could you confirm how we should upload recurrences that come to our trust via a 2 week wait referral in terms of PPI?

A patient can be referred under the 2ww route with a suspected recurrence but if a recurrence is confirmed they will then no longer be on the 62d pathway. They will only be on the 31d pathway.

My understanding is that the PPI would link appropriate periods together. In your example the PPI for the 31d subsequent treatment period would ideally be the same as that related to the initial primary cancer (assuming there was one ie. treatment took place post 1 Jan 09). Either way the CWTDb should not link the records to make a 62d period – see logic diagrams in the csv spec on the cfh website.

If you have a patient diagnosed with 2 cancers, one in the left breast and one in the right would they require 2 different pathway ID's?

My understanding is that if these are 2 separate primaries then yes they have 2 separate PPIs.

If we have two PPI numbers for each primary, they will only attend for one follow up for both. If they attend follow up on pathway X (for cancer X), but at follow up are diagnosed as needing further treatment for pathway Y (cancer Y) they will be on the incorrect pathway ID to record that subsequent treatment

There should only be 1 PPI for each primary. In your scenario there was a cancer in the left and the right breast. What I was saying was that if they were classed as different primaries (rather than say a primary in the left and a recurrence in the right say) then each one is a different condition and would have a different PPI ie there would be 2 PPIs, one for the primary in the left breast and one for the primary in the right breast. If a person needs a treatment that would treat both primaries at the same time there appear to be two options:

- ◆ record the 31d period against both PPIs
- ◆ pick one of the PPIs to record it against (it will just look like a person did not have so many 31d periods for one of the primaries.)

I will ask DH for advice.

DH have requested more details and will provide further advice on managing synchronous cancers..

Two week wait cancer or symptomatic breast referral type

Please could you clarify something around Referral types for haematology and Urology please.

On the old cancer waits dataset there was no separate referral group for either acute leukemia or testicular, these were included under haematological and urological respectively. I believe that the shortened 31 day referral to treatment standard applied to both these rare cancer groups and was assigned retrospectively when the diagnosis was confirmed. The subset was therefore not identified until after the diagnosis and was not related to the referral type. Under the new system this seems to have changed but doesn't seem to be consistent in the dataset and reports ie:

In the dataset there are options for:

- ◆ Suspected haematological cancers (excluding acute leukaemia)
- ◆ Suspected acute leukemia
- ◆ Suspected urological cancers (excluding testicular)
- ◆ Suspected testicular

In the 2week wait reports there are options for:

- ◆ Haematological (excluding acute leukemia)
- ◆ Urological (excluding testicular)
- ◆ Testicular

Firstly, what's happened to the acute leukemias? I understand that clinically this group of patients should be referred directly and not under the 2ww anyway, but it appears in the referral types in the dataset but not in the reports.

Secondly, does the 31 day acute leukemia/testicular referral to treatment target apply to the referral type or to the diagnosis group.

Thirdly what standard applies if haematological or urological 2ww referrals are later diagnosed as acute leukaemia or testicular (31d or 62d)

Advice from DH:

The coding of acute leukaemia and testicular referrals was separate under DSCN 22/2008, and the coding structure has not been amended with the update to the DSCN 20/2008 definitions. Therefore the two week wait statistics should identify these referrals as being for different conditions to other haematological and urological cancers in a manner consistent with previous submissions.

The 31-day referral to treatment standard (for children's cancers, testicular cancer and acute leukaemia) is still defined by the ICD-10 or the age of the patient, this too is unchanged.

What has changed however is that these patients are now shown in a separate report to the bulk of the 62-day activity. This enables the system to show percentage performance of the 31-day standard for the first time.

Any patient with these specific diagnoses will be monitored against a 31-day referral to treatment standard, regardless of what was originally suspected at the point of referral. These patients will however also be included in the DH published statistics and annual assessment by the CQC for the all cancer 62-day wait (because they fall within the "all cancer" definition).

Primary Diagnosis (ICD)

There is (or has been) some ambiguity about the categorisation in CWT of ICD10 code C84 - Peripheral and cutaneous T-cell lymphomas - listed as haematological but analysed as skin, or something like that? Is this correct? Is this a known anomaly? What is the background? How should we look at the historical data? Will it be dealt with differently in the new CWTDb regime?

Advice awaited.

ICD10 code C01 (base of tongue) does not appear to be listed and therefore valid for use on CWT-Db. Can you please confirm what is happening with this?

This code has been omitted in error. We were notified of this a little while ago and I understand that DH is liaising with the developers to resolve this. I do not have a planned date for when this will be fixed I'm afraid.

Old guidance (V5) states that: 'Carcinoids of the appendix are coded as D37.3 and so are not reported for cancer waits, but carcinoids of any other site are coded to a C code in ICD10 and so are reported for cancer waits.' Is this still valid?

Yes. Only C codes are included with the remit of CWTs with the exception of breast cancer in situ which has a D code. I will recheck the pre-GFOCW guidance to see if there is anything we need to include from that in the GFOCW guidance for completeness.

Metastatic Site

Our Consultants feel that another field for 'metastatic disease at presentation' is needed. Is this possible?

If you have any specific recommendations that you would like to make about how we handle primary disease where metastatic disease is present at diagnosis in terms of the database/reporting could I ask you to log it with CfH helpdesk so any implementation can be properly investigated as a change request.

On page 9 of July Q&A there is reference to a patient ref as 2ww but found to have a mets diagnosis. The answer implies that the first treatment undertaken by Skin would be against the 62day target, with the palliative surgery in Urology a subsequent treatment - but should the patient be tracked on 62 at all, given that no new primary was found?

Yes because a mets of unknown primary IS covered by the 62d standard

Cancer Treatment Modality

If a combination treatment is radiotherapy combined with surgery do we use the code for teletherapy as that is the initial treatment or surgery as that is the main radical treatment?

Code it as the treatment that is given first in the sequence.

How should one classify argon beam therapy?

I have been advised that this is a form of laser treatment. There is not a code for this under CANCER TREATMENT MODALITY so you will need to use Code 18 (other treatment).

How should biological therapies be coded under GFOCW. Have there been any national discussions as to how these treatments would be coded?

We have not had any specific discussions. If you are unsure use Code 14 'anti-cancer drug regimen - other' unless you have local clinical advice that a certain treatment is more appropriate under a more specific category. I will raise this issue more generally when I have an opportunity.

Cancer Care Setting (Treatment)

Please could you confirm if our use of the CANCER CARE SETTING (TREATMENT) data item fits in with what is being done nationally. Our scenarios are:

- ◆ **Code 03 (out patient setting) when patient is given oral chemo**
- ◆ **Code 02 (day case) when the patient is admitted as a day**
- ◆ **Code 03 (out patient setting) for radiotherapy**

The care setting is not linked to the treatment modality and no efforts to link coding in this manner is being made nationally. It is perfectly appropriate to receive chemotherapy or radiotherapy in both the admitted or non-admitted environment. Therefore the CANCER CARE SETTING (TREATMENT) should be coded to reflect the care setting where the individual episode of care was delivered and what was commissioned by the patient's PCT.

What do we do with combined chemoradiotherapy? The patient is brought in as a day case for their chemotherapy and they then proceed to radiotherapy on the same day.

Code it as the treatment that is given first in the sequence.

Radiotherapy Intent & Priority

Please provide some clarification on what should be classed as:

RT Priority - "D" - elective delay (treatment delayed for clinical reasons)
RT Intent - "03" - Other

Advice requested..

Cancer Treatment Event Type

A patient has pulmonary metastases diagnosed at the time as the primary diagnosis - none of the options seem appropriate as the primary is known and this is not a recurrence of disease. The treatment is for the primary tumour and metastases at the same time.

Codes 03 to 06 are the ones to choose from. From the info I have I would choose code 05 - Treatment for a distant recurrence of cancer (metastatic disease) and class the treatment of the mets as a 31d subsequent treatment even though that treatment might be on the same day as the treatment of the primary.

Miscellaneous

Are you expecting the codings for margins to change and if so when?

This data item does not appear in the CWT dataset so I am not aware of any proposed changes to it, my colleagues at NCIN will be more up to date on this.

CWTDb

Some of the reports produced by CWT-DB do not look correct – can you investigate?

If you have concerns with how tables are reporting data you should first re-check the data and if you still have concerns you should report them to the CfH helpdesk – this is because neither DH nor NCAT have access to the level of data necessary to investigate your concerns.

If you have suggestions for how tables could be improved etc these should also be logged with the CfH helpdesk as CfH will start to collate service request change notices which can be considered in due course – they should also be able to alert us if something you are suggesting should actually be happening already ie. if there is an error.

We will consider all recommendations for change requests when we have delivered the core functionality we have committed to.

There is no report for the 62 day target for symptomatic breast referrals.

The 62-day symptomatic referral to treatment report is under development, but as the standard is not live other reports have been prioritised ahead of it;

The monthly reports are only available from March i.e. no Jan or Feb data

We are currently reviewing the release policy for new reports, but at present we have no plans to fill in all the gaps (e.g. Jan and Feb data) as there is no version controlled dataset held, and to reconstruct them from the dataset held at the specific points in time would be a disproportionate amount of work.

On all the 31 day treatment reports, consultant upgrades are missing from the breakdown of referral types.

Consultant Upgrade is not a source of out patient referral for this dataset this is why it is not on the 31-day reports. We will need to look at this when the current workplan has been implemented. I cannot give exact timescales. At present CfH have enough work ensuring that the CWT-Db is returned to a service level equivalent to that which was previously decommissioned. The work plan for this is likely to take most of the remainder of this year.

We understand that if a patient is admitted for surgery the admission date stops the clock and if the operation is not in fact performed the clock would need to restart. The X system stops the clock on admission but if we then add that the operation was not performed the patient is still included in the waiting times figures. Could you please clarify if this should be the case?

The date of admission for the provider in-patient care spell that included the treatment episode is the one that would stop the 31 or 62d period. If a treatment episode does not occur you cannot count the related admission. It does not therefore look like the X system is operating correctly in the example given. I would suggest that you advise your contact at X of this but let me know if you would prefer me to. [*Note: X have since confirmed that they are addressing this*]

For all patients booked via X Trust, there is no obvious audit trail to indicate whether a patient was offered an earlier appointment which was refused. While knowing that a patient has chosen to wait longer than 14 days does not affect our performance as the clock does not stop, it is essential information in enabling us to understand whether our capacity for symptomatic breast referrals is adequate. We are unable to see whether a significant number of patients breach because they choose to do so, rather than because of a Trust problem. Do you know of any way in which we can resolve either of these issues?

Data item 'DELAY REASON REFERRAL TO FIRST SEEN (CANCER OR BREAST SYMPTOMS) enables you to identify from a list of options an overarching reason why (after any pauses have been removed) a delay/breach occurred ie. why the health care provider was unable to provide an appointment date within the service standard of 2 weeks. DFor example:

- 01 Clinic cancellation
- 02 Out-patient capacity inadequate (i.e. no cancelled clinic, but not enough slots for this patient
- 03 Administrative delay (e.g. failed to be rebooked after Did Not Attend, lost referral)
- 99 Other reason

If patient choice is the reason for a delay then code 99 'other reason' would need to be used.

We have been asked if some additional options could be included such as patient choice to aid analysis of breach reasons locally. DH will consider this further. If it is deemed appropriate, the GFOCW technical user group will be asked to consider supporting a change request to the system (and to the wider data dictionary) to add in new options. Such change requests can start to be considered once the system is fully up and running – the timescale for this is still to be confirmed. You may wish to submit your own data change request on this matter via the CfH helpdesk to ensure that DH has a sense of the volume of people who would support such a change.

In addition the data item "DELAY REASON COMMENT (FIRST SEEN) is a free text comment field to describe why the maximum 2 week wait standard has been breached. The aim of these additional comments should be to provide enough information to help identify issues/problems that need to be resolved locally and you may want to liaise with X Trust if you do not think that they are providing sufficient information in this field for your needs.

In summary, the CWTDdb should be able to provide you with some information to identify the reason for any breaches but you would need to follow this up locally if you do not think the fields are being completed in a way that is useful to you locally. In terms of changes to the national database, you might want to submit suggestions via the CfH helpdesk.

Our Trusts are missing the orphan records report and would like to know when it will be available again. Do you have any news on this?

I cannot say for definite but DH inform me it is an early phase three deliverable. I don't yet have timings for this phase.

If one of our patients goes to another hospital for treatment but is treated by our Consultant at that hospital, can you confirm if we should be completing the treatment details.

The provider commissioned to provide the treatment should upload that part of the record. If Trust Y is commissioned to provide the treatment they should upload the data. Trust X would upload data if they were commissioned to provide the treatment but, for example, offered an outreach service at Trust Y or subcontracted the activity to Trust Y. v6.5 of the GFOCW guide sets out various commissioning scenarios which you might find helpful (pgs 7-11). The key is the commissioning arrangement being used in your scenario.

Tumour-specific

Bladder

We are a little unsure about reporting bladder transitional cell carcinoma in situ on Cancer Wait Times. Could you confirm if we should be reporting In situ in the bladder?

In situ bladder cancer is currently excluded from cwt standards. This is however being reviewed and may change in the future.

Bowel

I have concerns about colostomy not being accepted as FDT before r/t. A colostomy is surgery requiring inpatient stay and healing/recovery time plus patient acceptance etc. This will make starting radiotherapy within both 31 and 62 day targets almost impossible.

There are a number of enabling treatments that are carried out prior to active treatment and the majority of these have NOT been able to be classed as first definitive treatments. The reasoning behind this has largely been that enabling treatments could thus end a 31 (and potentially 62) day period and the patients could then wait a long time for the active intervention that should follow as there would be no standard to cover this. Now that we have a 31d standard for subsequent treatments it would be useful to consider how enabling treatments are to be managed in case we get an increasing number of requests for exceptions and it becomes hard to justify why some enablers can count and others cannot. I would like to develop some clear rules/principles and I am going to the GFOCW AG about this on 22 September so I will hopefully have some clearer advice after that.

My understanding was that colostomy is allowed as FDT if this enabling intervention is part of the 'planned treatment package' agreed with the patient or for palliation patients unfit for active treatment. I will double check this at the 22 Sept meeting and then clarify things.

Haematology

For patients with liquid cancers (eg. Acute Myeloid Leukaemia), could we count a blood transfusion as a first treatment (particularly as the patient is very ill and not suitable for any other treatment)? Also, would we then count any further blood transfusions as a subsequent treatment? Which Treatment Modality would a blood transfusion come under?

If a patient is not planned to have active anticancer treatment (eg. chemo or r/t) then a blood transfusion would count as FDT and would be recorded as a palliative care treatment (eg for chronic lymphocyte leukaemia). In all other circumstances the blood transfusion would NOT count as FDT.

Palliative treatments can count as subsequent treatments so a blood transfusion would be covered by the 31d subsequent treatment standard. However an agreed 'package' of palliative care would only count as one treatment with the first treatment in the agreed pally care package marking the end of the 31d period. So, if the transfusion was part of an agreed package of pally care it would be part of a single 31d period for that package that would end when the first treatment in that package starts. If not then it would be a 31d period in its own right.

Head & Neck

We have a patient on the 62 day pathway who has been diagnosed with cancer of the tongue, their treatment plan is to have a PEG fitted and then to have radiotherapy not surgery. As the patient would not be able to eat once the Radiotherapy starts, would the PEG count as first definitive treatment?

Date of admission for the PEG would be counted as the start date for FDT if the patient remained an in-patient between this date and surgery ie. if it is the same episode of care. The same would apply if they were to have radiotherapy as their treatment (rather than surgery) but only if the radiotherapy commenced during the same episode of care. Assuming that this would not be the case then PEG prior to r/t cannot be used as the FDT.

There are a number of enabling treatments that are carried out prior to active treatment and the majority of these have NOT been able to be classed as first definitive treatments. The reasoning behind this has largely been that enabling treatments could thus end a 31 (and potentially 62) day period and the patients could then wait a long time for the active intervention that should follow as there would be no standard to cover this. Now that we have a 31d standard for subsequent treatments it would be useful to consider how enabling treatments are to be managed in case we get an increasing number of requests for exceptions and it becomes hard to justify why some enablers can count and others cannot. I would like to develop some clear rules/principles and I am going to the GFOCW AG about this on 22 September so I will hopefully have some clearer advice after that. In the interim, PEG prior to r/t would NOT count unless r/t commenced during the same episode of care as the PEG.

Prostate

Would TURP be classed as a FDT?

As I understand it, TURP can be classed as FDT if performed to debulk a tumour or if carried out for benign disease and cancer found incidently. I am seeking views from the GFOCW Advisory Group (on 22 September) about handling enabling treatments more generally.

Would you class TURP as a subsequent treatment if it is only being performed to help a patient urinate?

Palliative treatments can count as subsequent treatments so TURP would be covered by the 31d subsequent treatment standard. However an agreed 'package' of palliative care would only count as one treatment with the first treatment in the agreed pally care package marking the end of the 31d period. So, if TURP was part of an agreed package of pally care it would be part of a single 31d period for that package that would end when the first treatment in that package starts. If not then it would be a 31d period in its own right.

GP's should refer a patient to a Trust if a patient has a consistently high PSA over two tests or an extremely high result after one test. In most circumstances GPs are referring patients on the 2ww pathway after one moderately high PSA when they should repeat the test again. What action should we take?

Inappropriate referrals should be addressed locally ie. a consultant could speak to the 'offending' GP(s) or you could notify the PCT or SHA if you have significant concerns about inappropriate GP referrals more generally.

If the patient has come in with only one moderately high PSA, the consultant will usually repeat the PSA test in 8 weeks time unless it is extremely obvious it is prostate cancer. The consultant leaves eight weeks between tests to ensure that the patient does not have any infection that can lead to the PSA rising.

Once the clock has started to tick it is not possible to pause the clock because the patient needs to wait (for clinical reasons) between tests.

The result of the second PSA test can lead to the following decisions:

- 1. If the patient's PSA result has greatly reduced and the prostate feels benign then the patient will be 'not cancer'.**
- 2. If the patient's PSA result is much higher than before, they will have a prostate biopsy.**
- 3. If the patient's PSA is still at similarly high level or has a family history of prostate cancer then for good clinical practice a third PSA needs to be undertaken, which will be done in 6 – 8 weeks time.**

For option three the consultant cannot categorically say that the patient does or does not have cancer. This leaves three options:

- 1. Leave the patient on tracking (but they will inevitably breach)**
- 2. Take the patient off as 'Not Cancer' (but don't know this is the case at this point)**
- 3. Classify the third PSA as surveillance; take patient off tracking as 'Treated'.**

What would you advise?

If there is diagnostic uncertainty the patient stays on tracking and will be an expected breach. The patient would only come off tracking if they were informed that they did not have cancer. This would be a clinician's call ie. are they prepared to tell a patient that they do not have cancer. In general terms the new operational standards reflect the changes that have been made to the pause methodology and are lower as a result.

Skin

A patient has a skin lesion excised at the GP surgery which is confirmed on histology as a malignant melanoma. The GP then makes a 2ww referral. The patient is seen within 2 weeks and listed for a wider excision. Histology shows no residual malignancy. How should this all be recorded on cancer waits?

A 2ww referral is made when a GP suspects cancer. In the scenario you describe it appears that a cancer has been diagnosed/treated prior to the referral. I'm not therefore sure if/how the 2ww/62d applies. To me the wider excision was a subsequent treatment (even though it came back clear) but sequentially it appears to be the first treatment after the 2ww referral. I have asked DH to advice. **DH advice awaited**

With regards to downgrading/inappropriate referrals, if primary care and secondary care can locally agree what constitutes an appropriate referral does the consultant still need to contact the GP prior to downgrade? Eg, a GP refers a patient on a skin suspected cancer referral from stating the patient has a BCC, does the consultant need to contact the GP even though BCCs are not covered by cancer waiting times?

The GP has to be the one who downgrades the referral. In terms of BCC, the GP may have marked it as a BCC but may not be 100% sure hence referring it under 2ww. If it is confirmed that it is a BCC then the patient would not be covered by the 31 or 62d standards but would be covered by the 2ww standard unless the GP withdrew the referral.

Recurrences

If a patient has been previously diagnosed and treated for cancer and has a check cystoscopy booked for 3 months time where a recurrence is diagnosed and resected at the time of the investigation, is this a breach of 31d ie. decision to treat was when the cystoscopy was booked 3 months previously?

The decision to book in a cystoscopy is not a DTT in this scenario. If a patient had a check cystoscopy and something was found at the cystoscopy that needed treatment then I would take the DTT to be the date of the cystoscopy as that was when the decision to carry out some form of treatment was made. If the treatment was carried out during the cystoscopy then, in effect, the DTT and start date for treatment would be the same day.

Miscellaneous

Do you have or can you point me to any national or international statistics that would have been used by the Department to initiate CWT in the first place? eg cancer rates, treatment rates, timings, numbers etc?

This predates me but I understand that there was an audit around 1997 that showed

- Variations in cancer waits between cancer types & between those referred urgently and non-urgently by GPs
- Only 63% of urgently referred pts seen at a hospital within 2wks
- Interval between referral and 1st treatment generally shortest for breast and longest for urological cancers
- Even among patients urgently referred a significant minority waited at least 4 months for treatment

Additional info from DH

The document that we use as a baseline for the two week wait, and that was used as evidence for the waiting times section of the NHS Cancer Plan was an investigation by the Health Services Management Centre at the University of Birmingham. The details are:

*Title: Cancer Waiting Times Audit: Final Report
Authors: Prof. P Spurgeon and Dr F Barwell
Date: March 1999*

DH communications have indicated that 100% of patients that are eligible for treatment for cancer under the 18 week rule should be treated if fit and willing. What patients are then ineligible?

See v6.5 of the gfoCW guide (on CfH website) page 5 para 10 sets out those patients excluded from the cwt standards.

Can a patient become ineligible once referred?

Yes, for example, if they decide to pursue treatment privately.

In the 18 week standard patients can come off their pathway for many reasons - do these reasons apply to cancer patients?

The majority of reasons for a patient coming off a pathway will apply to 18w and 62d pathways alike such as a patient dying or declining treatment. The main exception in cancer waits is if a patient DNAs their first outpatient appt ie. for cwt you cannot refer back to GP - due to the potentially serious nature of the suspected condition these patients are kept on tracking after their first DNA.

I realise that there are tolerances set to take into account patient fitness etc but in 18 weeks a patient not fit for treatment would end their pathway. If patients are truly matching the 18 week pathway should we not take this into account?

This is not correct. I have checked with the 18 weeks team in DH and they have confirmed that under 18 weeks, if a patient is not fit for treatment, the default should not be to automatically stop their clock and refer them back to the GP; it will depend on the circumstances as follows:

- if they become temporarily unfit during their wait but are likely be fit for treatment in future, the clock should continue to tick and this should be considered within the tolerances under clinical complexity;
- If they become permanently unfit for treatment, then it is likely that a decision not to treat would be made, the clock would stop and the patient would be referred back to primary care;
- If a patient is admitted to hospital and then deemed temporarily unfit for treatment, their clock should continue to tick unless a clinical decision is made that the patient is unsuitable for surgery and they are discharged back to primary care or a decision is made not to treat;
- If a patient isn't fit at the start of their pathway, then they should not be added to the waiting list in the first place.

As you will see the only scenario under 18 weeks where the patient could be referred back is if they become permanently unfit for treatment. In the case of cancer the patient is still likely to require palliative care which can be classed as a FDT or a subsequent treatment.

A patient is referred as a routine referral to Gynae and after tests etc there is no Gynae issue but the Gynae team believe there may be a lung issue (ca not suspected) and do an internal referral to Lung team. After tests lung team believe there may be cancer:

A . Do we use Source of Referral and priority for the referral to the Lung team and would/should this referral have the same PPI as the Gynae referral?

In the scenario you give the patient was a routine gynae referral NOT a 2ww referral so they would be on the 18w pathway. Once referred to the lung team cancer was suspected. The consultant upgrade could be used at this point to get the patient on a 62d pathway or if the diagnosis is already confirmed and a DTT made then the patient would just be on the cancer 31d pathway not the 62d. I don't think the PPI would need to change. The original 'Source of Referral for Out-patients' would be used ie. to the gynae clinic and if a lung cancer is diagnosed the ICD10 code would be uploaded giving the resulting condition so the correct condition would eventually be linked to the initial PPI. *DH advise – that the PPI would be different ie. one for a suspected gynae condition and one for lung condition.*

B. If cancer was suspected at any stage before the patient attended the MDM for the lung referral, then can you confirm if this should be a Consultant Upgrade?

Ideally yes.

C. If lung ca was suspected by the gynae team can you confirm if this should also be a Consultant Upgrade and which Source of Referral and priority should be used, those for the initial referral or for the referral from Gynae to Lung team

Ideally an upgrade should be made. The source of referral and priority would remain those that the patient came in with under the initial referral (on 18w pathway).

D. If gynae team had suspected gynae ca but then diagnosed it was not ca and sent on to lung team would both the following be Con Upgrade:

i) Gynae team suspected lung ca

Yes ideally upgrade as they suspected some form of cancer

ii) Gynae team thought lung issue but not ca but later diagnosed as lung ca before MDM?

No upgrade as no suspicion of cancer. If cancer later diagnosed patient on 31d FDT standard.

E. In the above two cases which Source of Referral and priority should be used?

The source of referral and priority would remain those that the patient came in with under the initial referral (on 18w pathway).

Can you just clarify one more thing relating to the situation in Dii when the answer is a 31 day and not a Consultant upgrade are you saying that it is only an upgrade if the first team (Gynae) suspect cancer but not if the lung team suspect cancer, even if before the MDM for the lung?

In the scenario you described the gynae team did not suspect cancer so would not upgrade. They referred to a lung team. The lung team CAN upgrade if they suspect cancer. The gfoCW guide v6.5 part 6 sets out the point after which an upgrade can't be made ie: an upgrade must be on or before:

- A DDT has been agreed;
- The MDT where the care plan that was subsequently agreed with the patient was discussed.

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
Appt	Appointment
BCC	Basal Cell Carcinoma
CaB	Choose and Book
CA125	Cancer antigen 125 (a blood test)
CfH	Connecting for Health
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
LHB	Local Health Boards
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
PDS	Personal Demographics Service
PPI	Patient Pathway Identifier
Pt	Patient
PTL	Priority Target List
r/t	Radiotherapy
RTT	Referral to Treatment Time
SSP	Specialist Screening Practitioner
TCI	To Come In Date
TIPSS	Transjugular Intrahepatic Portosystemic Stent Shunt
TOP	Termination of Pregnancy
TURP	Transurethral Resection of the Prostate
TWR	Two Week Wait
Tx	Treatment
UBRN	Unique Booking Reference Number