

## Questions answered by NCAT – January 2010

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## **Two Week Wait (2ww)**

**If a GP sends a 2ww request for a patient but the wrong contact details are included for the patient, does the clock still start at receipt of referral or from when the correct details are received?**

The clock would start from receipt of the initial referral on the basis that it is not the patient's fault the GP enclosed incorrect details that led to a delay. The Provider will therefore have to absorb the delay unless the GP withdraws and re-refers. However, I would not advise that the Provider pressures the GP to re-refer as this would not be in the best interests of the patient - as far as they are concerned the clock is already running and their pathway should not be delayed further. I would like to add that this answer assumes the referral actually identified the correct individual by name.

**Can a telephone consultation be classed as 'first seen'?**

A telephone consultation is not considered DATE FIRST SEEN. This is expected to be when a patient is seen in clinic by a specialist most able to move forward on any diagnosis.

## **Symptomatic breast 2ww**

**Is the start date receipt of referral like a classic 62 day from a 2ww? Yes**

**Will the standard go live for patients who were first seen in Jan 2010 or patients who we receive a referral for in Jan 2010?**

You will start to be performance managed for those patients with a DATE FIRST SEEN from 1 January 2010 onwards.

**Is the operational tolerance going to stay at 93% or will it be adjusted once data is of better quality?**

*DH Advice: The Department of Health has no immediate plans to review this operational standard based on data currently available. As such we will be expecting performance to be compliant with this standard for patients seen after 31 December 2009.*

**If a trust fails to reach the 93%, but the breaches have consistently been due to patients choosing an appointment outside of the 2 week window what can we do?**

DH has set the operational tolerance at a level that takes into account the expected volume of breaches due to patient choice. If you have evidence that choice is a larger issue than this then I suggest you submit evidence to DH that they can consider if/when they review the tolerance.

**How can a trust ensure that they achieve this target if patient choice is an issue?**

You might want to focus on the communication between the GP and the patient ie what is the patient being told by the GP, do they know the importance of having a quick appt etc.

**Do symptomatic breast 2 week patients adhere to the same guidance as 2WW suspected cancers eg. for DNA's of their first appointment?**

The rules for 2ww and symptomatic breast 2ww are the same. If a patient DNA's the appointment that would be 'DATE FIRST SEEN' then the clock is re-set to when they re-book their appointment and the 2ww standard runs from then.

### **31d treatment (first or subsequent)**

**We have a patient who was discussed by the MDT and a decision for radiotherapy was made. Before the patient was seen by an oncologist she was reviewed on the ward by the hospital based specialist palliative care team and as such this was recorded as FDT. The patient was reviewed by an oncologist at a later date and it was decided she should be started on chemo prior to having any radiotherapy and this has now been recorded as a subsequent treatment. Was this correct?**

No. My understanding is that referral to SPC team can only count as FDT if no specific anti-cancer treatment is planned. This is not the case in your scenario as r/t was initially planned. In the end chemo was given so the decision to treat would change i.e. from DTT for r/t to DTT for chemo but the 31/62d clocks would stop at the chemo not the SPC.

**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 and, if so, is the modality surgery (due to the PICC line) 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.

**Does insertion of a VP (ventriculoperitoneal shunt) constitute FDT when hydrocephalus is due to a brain tumour?**

The enabling treatments that can be classed as FDTs are:

- colostomy for bowel obstruction
- insertion of oesophageal stent
- NSCLC stent
- ureteric stenting for advanced cervical cancer
- insertion of pancreatic stent if planned to resolve jaundice before the patient has a resection or starts chemotherapy. However, many clinicians agree that patients with mild obstructive jaundice (a serum bilirubin below 200 micromol/l) do not require biliary stenting before resection if surgery and imaging are planned within 7-10 days. If this is the agreed clinical practice locally then stenting for these patients will not count as the start of FDT

Other enabling treatments can only mark the end of the 62d period where a patient is having these prior to surgery. The scenario for this is where a patient is to have X enabling treatment and is admitted for this and remains an in-patient between this enabling treatment and the main surgery ie. if it takes place within the same hospital provider spell then the date of admission ends the 62 day period even though the enabling treatment was first within that spell.

**For patients that fall into the 'Active monitoring' group, do they only get uploaded for their first visit to the hospital where the watch and wait decision is made or at every subsequent visit?**

The end date is the date that this treatment approach is agreed with the patient. So, in effect, for active monitoring the start (DTT) and end date for the 31d period would be the same day. You do not need to upload for each visit.

**If a patient is on active monitoring and monitored on say a six monthly basis, do we record each visit as a subsequent treatment?**

Active monitoring is the agreed 'treatment plan' - it doesn't matter how many visits that they then have under that plan it is covered by one 31d period.

**For a clinical trial can we upload chemo (or whatever the drug is) as first definitive treatment then the following surgery as a subsequent treatment?**

Yes, if that is what the trial protocol is.

**Are gamma knife treatments classed as surgery or radiotherapy or other?**

Technically, I think this is a type of radiotherapy. However, it does not fit any of the current radiotherapy categories so I would put it in "other" whilst we consider what is appropriate. DH would probably look to introduce a new treatment modality if there were a sufficient volume of cases.

**Classic 62d (ie. from 2ww)**

**Q - We have a patient (referred via the 2ww) who has received multiple tests but it is still inconclusive as to whether or not the patient has cancer. The clinical decision is to wait and see how things develop and to repeat tests at 3 monthly intervals. With regards to recording this patient:**

**a. do we leave the patient on the PTL until a diagnosis is found either way?**

Yes, although use of PTL is voluntary.

**b. is there a cut off for how long we leave the patient on an open pathway e.g six months, a year?**

No

**c. can we record treatment as active monitoring?**

No. Active monitoring is a treatment option and as such diagnosis has to have been made before its use.

**d. within the cancer database a diagnosis is needed to record treatment – what diagnosis would we record?**

The patient has not yet been diagnosed or treated so there is no treatment record to upload.

**e. do we remove the patient as no cancer found and put the patient back on a pathway if/ when a positive test comes back?**

This is only an option if the patient is informed that you do not think that they have cancer. As you have not confirmed this the patient is one of a number who have a long diagnostic pathway due to inconclusive tests etc. The operational standard has been reduced to take account of this.

**f. our PCT recommended removing the patient from the pathway – is this correct?**

I only agree if the patient has been informed that you do not think they have cancer.

## **62d upgrade**

**Patient referred to Upper GI team under 2WW at the beginning of November. Following a normal ultrasound and Gastroscopy the consultant responsible for the patient informed us at the beginning of December that the patient does not have cancer, we recorded the patient as no new cancer found and the patient's 62 day pathway therefore ended. Following a routine follow up at the end of December we were asked by the same consultant to put the patient on the Consultant Upgrade pathway as they now suspected cancer from a Lower GI perspective and had referred the patient for a Colonoscopy. Can you please confirm how we would record this patient if cancer is diagnosed. Do we record the patient under the original 62 day classic pathway or would we record them under the Consultant Upgrade pathway which started at the end of December?**

Record under 62d upgrade not original 62d pathway as this ended when patient told no cancer.

## **62d Screening**

**Does the bowel screening programme cover all of England?**

Yes

**Do all acute Trusts that offer cancer services get measured against the 62d screening standard even if a trust is not the screening centre within a region?**

The trust commissioned to provide the first part of pathway up to date first seen (for bowel screening, the appt with the specialist screening practitioner to discuss suitability for colonoscopy) is responsible for the first part of the 62d screening pathway.

The trust commissioned to provide the cancer treatment is responsible for this second part of the 62d screening pathway.

It is possible that that the same trust will be possible for both parts of the pathway.

If an acute trust is responsible for either part of these pathways then they are measured against this standard.

**Who is responsible for reporting on the cervical screening 14 d turnaround time standard and at what frequency?**

This is a screening standard rather than a cancer waits standard. *DH advice: The technical guidance supporting the vital sign has now been uploaded on to UNIFY. Data will be collected monthly, and NHS Cancer Screening Programmes are currently working on a system to do this which should be ready in time for the monitoring period beginning on 1st April. Data will be collected from the NHAIS system via CfH who will aggregate data for PCTs. Data will be available a month after the month end.*

## **Pauses**

### **How can we influence national thinking about the possibility of a 'pause' being allowed for patient choice?**

We are aware that there will be a proportion of patients that will choose to wait longer than the standard times. This has been taken into account in the operational standards that have been set. If you have evidence that patient choice is a bigger issue than has been allowed for then you could supply this evidence to DH as they keep all operational standards under review. Alternatively if you think there are issues specific to your Trust then you could make a case for extenuating circumstances to the CQC.

### **If a patient cancels their first offered appointment, re-books it, but then DNA's the new date, can the clock be reset?**

Yes. DNA trumps the cancellation i.e. clock is re-set to when patient re-books after the DNA.

### **If a patient states at an appointment that they are unavailable for a set period of time (e.g. on holiday) before a reasonable date has been offered, is it legitimate to pause the clock if an appointment could have been offered during those times?**

Yes. Where a patient makes themselves unavailable for admission for a set period of time then this may mean that offering actual dates which meet the reasonableness criteria would be inappropriate (as the provider would be offering dates that they know the patient can't make). In these circumstances the clock can be paused from the date of the earliest reasonable offer that the provider would have been able to offer (for admitted treatment). The clock would restart when the patient can made themselves available again.

### **If we have offered a patient a TCI date but later are able to offer an earlier appointment which they refuse, is a pause possible ie. could the patient be classed as having refused a reasonable offer?**

Part of being 'reasonable' is that the patient is consulted and listened to during the process of agreeing an appointment and it is not about 'doing things' to the patient. In this scenario the patient has been consulted and agreed a TCI. If an earlier TCI then comes up but the patient declines (for whatever reason) it does not seem reasonable to introduce a 'pause'. The patient had agreed a TCI and was waiting for admission/treatment – it is not acceptable to then say they declined an alternative appointment offered after one they had agreed.

### **What actions can be taken if a patient has multiple cancellations of their first appointment?**

By contacting the service to cancel/rebook etc the patient is showing an interest in staying in contact with the NHS and therefore in their treatment/tests. It would not therefore be appropriate to refer these patients back to their GP unless this was discussed and agreed with them as the most appropriate course of action. It would be deemed good practice for the Trust, when in contact with the patient, about re-booking (after multiple cancellations) to try and establish if there is any problem. It is possible to refer the patient back to the GP, but this action should be taken with the knowledge and agreement of the patient.

## **Breaches**

**We have a patient that was referred to us as a Haematological 2ww with splenomegaly and lymphadenopathy. A Lymph node biopsy suggested metastatic cancer. A CT suggested that this was from testicular origin. The final diagnosis is Azzopardi tumour following Germ Cell markers. This is therefore, coded as a Testicular cancer. Although the patient was treated within 46 days it appears as a 31day breach. Is this correct as the original referral would have been on a 62 day pathway. We could not have anticipated this would be a testicular cancer and therefore on a 31 day pathway. Do we have to record a breach?**

I'm afraid that this is a breach. The ICD 10 code will determine whether the patient is on a 62d or accelerated 31d pathway. In your scenario the patient was a 2ww referral on the 62d pathway but the ultimate diagnosis means that that they ended up on the 31d pathway. There is no operational standard for this 31d standard as the numbers are too small. It is therefore performance managed as part of the wider 62d standard which has an operational standard of 85%.

**Could you advise me on a patient who is breaching and is out of our control. A patient is due to have pre-operative radiotherapy at XX followed by surgery at YY. The patient has to have surgery the week after radiotherapy. The surgeon is away on annual leave and the trust operating have offered a new surgery date with a different surgeon (which is in time of the standard). However, the patient has deferred this until his named clinician is back off annual leave. The means that we cannot treat in time with radiotherapy. This is a clear patient choice decision - is there anything we can do with this breach?**

I have consulted my colleagues at DH and there are no adjustments possible and the patient would breach.

**We have a couple of patients who were referred to us in Oct / Nov as breast symptomatic. We did offer them a 1<sup>st</sup> appointment but not within 14 days. The patients subsequently all cancelled various appointment offers to the extent that they were all first seen after 1<sup>st</sup> jan 2010 when the new target came in. Is the breach reason 'lack of capacity' or patient choice please?**

*Advice from DH: The delay reason within the dataset should relate to the primary reason why the patient breached. If it was due to no clinic slots being available due to capacity that should be recorded, irrespective of whether there were further delays through choice. However, you might want to add the subsequent cancellation in the free text fields.*

## **Performance management**

**How do we manage the reporting of cancer patients which have either had their appts/treatments cancelled due to the adverse weather - would we be allowed under these exceptional circumstances to put in an adjustment?**

There are no adjustments possible. If a Trust considers that its performance has been impacted by the adverse weather conditions then it would need to make an extenuating circumstances application to CQC. In addition, a Foundation Trust might want to consider liaising with Monitor. At a national level, DH has no plans that I am aware of to suspend performance standards due to adverse weather conditions. Management is a decision for SHAs, but DH would only expect standards to be suspended in a sustained and serious emergency situation. This is unlikely to be considered for occasional periods of snow and ice.

**Are there likely to be adjustments to the tolerance levels when figures for a complete year are known if it is shown that a high proportion of breaches are caused through patient choice?**

*DH Advice: The Department of Health has no current plans to alter its published operational standards within the year 2009/10, though these are always kept under review to ensure they reflect service patterns and current treatment practices. If you have a specific issue relating to the case mix of your organisations for the 2009/10 data year I would suggest that you ask the provider in question to raise the issue with the Care Quality Commission as part of their annual assessment process.*

**Do you know what the cut off point for the CQC and Open Exeter is for small numbers for tumour groups? I thought it used to be 20 per quarter but I'm not sure if it's changed at all?**

DH don't set a minimum figure but take small numbers into account at meetings etc. CQC will set a minimum number but they haven't yet for this year.

## **Dataset**

### *Waiting Time Adjustment (First Seen)*

**When I try to enter the 'WAITING TIME ADJUSTMENT (FIRST SEEN)' there are only 2 options ( 3 DNA and 9 No adjustment). It is not possible to enter 'patient's choice' - what is the best way forward in this case?**

You are only allowed an adjustment for a DNA. You would therefore have to select option 9 i.e. no adjustment to waiting time for the data item 'WAITING TIME ADJUSTMENT REASON (FIRST SEEN). However, if you breach the 2ww standard you can then explain that this is due to patient choice as follows:

DELAY REASON REFERRAL TO FIRST SEEN (CANCER OR BREAST SYMPTOMS) - select code 99 i.e. 'other reason'

DELAY REASON COMMENT (FIRST SEEN) - explain the reason eg.. multiple patient cancellations.

### *Miscellaneous*

**I understood that a diagnosis date (providing cancer is confirmed) is the date the diagnostic test was taken, not the date the results had been made available. (i.e. once path is ready) Please can you confirm that this is still correct?**

We don't use the diagnosis date in the cancer waits dataset so I don't know the answer to this. The best place to look is the NHS Data Dictionary (which will include the definition you should use). This is available on the connecting for health website. (<http://www.connectingforhealth.nhs.uk/systemsandservices/data/nhsdmds/dmd>) .

## **CWTD**b****

### **What data should be recorded on patients admitted as an emergency prior to surgery now that the system validation has been changed to only allow CANCER TREATMENT PERIOD START DATES that are on or before TREATMENT START DATE (CANCER)?**

A problem has arisen for patients admitted as an emergency to hospital where, during the admission, a DTT is reached that the patient should have surgery. The surgery takes place during that same admitted period. This results in the 31d period start point being sequentially after the 31d period end point as the DTT would be the start and the admission date (before the DTT) would be the end point. Previously this was allowed but new validation rules will only allow CANCER TREATMENT PERIOD START DATES that are on or before TREATMENT START DATE (CANCER). DH has issued the following advice:

*DH Advice: Some cancer patients are admitted as emergencies and remain as an inpatient until they receive treatment, as the date of admission is counted as the TREATMENT START DATE (CANCER) for surgical interventions the following scenarios should be considered when reporting this activity:*

- *If a CANCER TREATMENT PERIOD START DATE was determined prior to the emergency admission for the admitted period within which the surgical intervention took place that date should be recorded on the Cancer Waiting Times Database in all instances;*
- *If the surgical treatment being recorded is a first definitive treatment (CANCER TREATMENT EVENT TYPE 01 or 07) and a DECISION TO ADMIT DATE exists on the hospital PAS and the admission episode was for the condition that the TREATMENT START DATE (CANCER) relates to, then the DECISION TO ADMIT DATE should be recorded as the CANCER TREATMENT PERIOD START DATE and will be on or before the TREATMENT START DATE (CANCER);*
- *If the surgical treatment being recorded is a first definitive treatment (CANCER TREATMENT EVENT TYPE 01 or 07) and no DECISION TO ADMIT DATE exists on the hospital PAS due to the emergency nature of the admission with the patient having no prior communication with the provider for this condition i.e. no DECISION TO ADMIT DATE exists on PAS, and the admission episode was for the condition that the TREATMENT START DATE (CANCER) relates to, then the CANCER TREATMENT PERIOD START DATE should be the same date as the TREATMENT START DATE (CANCER);*
- *If the surgical treatment being recorded is a first definitive treatment (CANCER TREATMENT EVENT TYPE 01 or 07) and the original admission was not for the specific condition that the TREATMENT START DATE (CANCER) relates to, then the CANCER TREATMENT PERIOD START DATE should be recorded as the same date as the TREATMENT START DATE (CANCER). This will provide the same output as was generated from the Cancer waiting Times Database prior to the implementation of DSCN 20/2008 as all negative waiting times were previously rounded to zero in the reports; or*
- *If the surgical treatment being recorded is not the first definitive treatment (CANCER TREATMENT EVENT TYPE is not 01 or 07) and an Earliest Clinically Appropriate Date (ECAD) is being used to populate the field CANCER TREATMENT PERIOD START DATE, the CANCER TREATMENT PERIOD START DATE and the TREATMENT START DATE (CANCER) should be recorded as being the date of admission as it is assumed that the patient became fit for their next activity during the same hospital care spell.*

## **Tumour-specific**

### *Bladder*

**Patients that are referred into our Trust and are then diagnosed with a Bladder TCC are tracked as a 'No cancer'. Is this correct?**

Only a urological condition with an ICD10 C code is within the remit of cancer waits. At present bladder cancer in-situ/pTa etc are not within the remit of cancer waits.

**A patient attends Urology with a suspected recurrence of their bladder tumour, they have surgical resection (TURBT) and the histology comes back as negative - will we record this as a subsequent treatment?**

TURBT if intended to de-bulk the tumour/suspected recurrent tumour (rather than just for diagnostic purposes) would be a subsequent treatment even if margins came back clear.

### *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 this a subsequent treatment?**

I have agreed with DH that, as the oophrectomy is replacing hormone treatment which was classed as a subsequent treatment, the surgery should be classed as a subsequent treatment.

**I understand that the POETIC trial involves randomised Letrozole vs Placebo. This delays the treatment by a week to 10 days. Does this count as a first definitive treatment as it precedes surgery, or can we apply a pause? Also, would we count the surgery as part of the clinical trial?**

If a patient has agreed to enter a national portfolio clinical trial then the trial protocol will determine which treatments are classed as first or subsequent treatments respectively and they will be assigned as such under cwt standards. So, in theory a placebo or letrozole before surgery could be classed as a first definitive treatment if that is part of the trial protocol. Patients should be made aware if they may receive a placebo as part of their treatment within a clinical trial. The surgery would then be a subsequent treatment.

**Our IT system does not class the Poetic trial as a treatment – how do I manage this?**

When you say your IT system doesn't class it as a treatment I'm not sure I understand what you mean. Poetic would not be listed in its own right. Under cancer treatment modality you pick whatever the treatment is within the trial protocol ie surgery, chemo etc. For a placebo you could use the option for drug (other). You would then ensure that the clinical trial data item said yes.

*Children & Young People*

**Under the 2ww, children's cancer is clearly identified in the data from Open Exeter. Apart from this standard, what other standards exist for paediatric cancers?**

Children are covered by the following cancer waits standards:

- Urgent 2ww referral for suspected cancer
- 31d from receipt of 2ww to treatment (ie. Equivalent of 62d for adults)
- 31d first and subsequent treatments
- 62d upgrade.

*Head & Neck*

**A head & neck patient is discussed at MDT and a decision made that chemoradiotherapy in form of IMRT should be given. The patient is seen in clinic to consent and the decision is made to give a single dose of chemo as in-patient and then for chemoradiotherapy (IMRT) concurrent as day case in twelve weeks time. Do we treat this as: different treatments, 1<sup>st</sup> line chemo and subsequent chemoradiotherapy; 1<sup>st</sup> line chemo subsequent RT; or just first line chemoradiotherapy?**

I'm minded to advise chemo is FDT and chemoradiotherapy is subsequent treatment on the basis that if the pt is to wait 12 weeks for the chemoradiotherapy then the initial chemo can't be part of the chemoradiotherapy. This advice is based on the assumption that the admitted chemo being given first is a genuine treatment option and not being given as a means to stop the 31/62d clock because of delays for chemoradiotherapy.

**A head & neck patient had a biopsy, a polypectomy and tonsillectomy to determine diagnosis. The histology came back as cancer and the tonsil was excised but incomplete as no clear margins. There is some discrepancy as to whether we can class this tonsillectomy as first treatment or not. The head and neck team are saying no as this was for diagnostics only and margins were not clear. Please can you clarify?**

If the tonsillectomy debulked or excised the tumour (rather than just being a biopsy for diagnosis) then it can be classed as FDT even though the margins were not clear. Any additional excision etc would be a subsequent treatment.

*Prostate*

**I am concerned that 'active surveillance' is being used differently across the country for cancer – please can you clarify when it should and shouldn't be used?**

Active Monitoring/Surveillance in terms of cancer waits is where a diagnosis has been reached but it is not appropriate to give any active treatment at that point in time but an active treatment is still intended. The patient is therefore monitored until a point in time when they are fit to receive or it is appropriate to give an active treatment. It is not to be used for thinking time or to address capacity issues that mean the proposed active treatment will not be available in 31/62 days. For example:

- if a prostate patient is offered a range of treatments and wants to take a couple of weeks to think about the options this is NOT active monitoring.
- if a prostate patient is offered a range of treatments, selects brachytherapy and has to wait for this procedure it is not appropriate to say the patient is on active monitoring.

However, if a prostate patient has a 'tumour that is not causing any significant problems and they decide that they don't want to pursue active treatment immediately but have the cancer kept under check by repeat PSA etc this would be active monitoring.

**Patient referred in on 2ww for bladder cancer, nothing found but PSA taken and then investigated for prostate cancer. Could the original referral for suspected bladder cancer be closed and a new non-urgent opened for the prostate cancer?**

No, the investigations are part of the same referral. If prostate cancer is diagnosed this would need to be treated within 62d of receipt of the referral for suspected bladder cancer.

*Skin*

**A GP excises a Skin SCC. It is discussed at our Skin MDT as it appears on pathology as a “positive” diagnosis. The decision at MDT is that further treatment is required. The patient is then referred into the Trust on 2ww and receives a “subsequent” treatment. This subsequent treatment is then hung from the 2ww referral which I assume is not acceptable to Open Exeter. How should such cases be handled?**

A subsequent treatment cannot follow a 2WW referral. The treatment in question would be a standalone 31d period and would not be linked to any related 2ww referral ie. no 62d period should be created.

**GP excises skin lesion, cancer confirmed, GP makes 2ww referral as patient will require more treatment – how do we manage this?**

It is my view that the GP did the first treatment and anything else is subsequent but we need advice from DH on how to handle this as a 2ww referral was made AFTER the first treatment. DH have been asked to advise on the following handling options:

- class first treatment AFTER receipt of 2ww referral as the first definitive treatment and the one which will end a 62d period even though sequentially it was not the patient's first treatment for the skin cancer.
- class the treatment by the GP as the first treatment and advise that the treatment date can be before the date of receipt of referral (if the CWTDb will accept this).
- class the treatment by the GP as the first treatment and advise that the treatment date should be recorded as the same as the date of receipt of referral (if the CWTDb will accept this).
- some other option.

## **Miscellaneous**

**If a patient is referred in on one pathway, no cancer is found in that area but an incidental finding raises the possibility of cancer on another pathway how is this managed – do we close the original 2ww referral and start a new non-urgent referral based on the incidental finding or leave the original referral open and the diagnosis reflects where the cancer is?**

If a patient is a 2ww breast referral, breast cancer is ruled out but lymphoma, for eg, is diagnosed during the investigations the pt would continue on a 62d pathway which started with suspected breast cancer and ended with treatment for lymphoma.

If a patient is a 2ww breast referral, breast cancer is ruled out and the pt is discharged but is later re-referred (non 2ww) with other symptoms and cancer is diagnosed this would be an incidental finding and only the 31d standard would apply.

### **When will the updated GFOCW guide be out?**

v6.6 should be out spring 2010.

## **Useful Links:**

*CWT Stats:*

[http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationsStatistics/DH\\_099885](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://www.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
CDS	Commissioning Dataset
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
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
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
TIPSS	Transjugular Intrahepatic Portosystemic Stent Shunt
TURBT	Transurethral Resection of Bladder Tumour
TURP	Transurethral Resection of the Prostate
TWR	Two Week Wait
Tx	Treatment
UBRN	Unique Booking Reference Number