GFOCW: Questions answered by NCAT – July 2009

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Two Week Wait (2ww)

We have a patient who has cancelled their first choose and book appointment, then cancelled their second CaB appointment, then presumably went back to her GP as we received a referral from their GP and we booked an appt which the patient did attend. Did the 14 day/62 day clock start from the first UBRN/cancelled appt, the 2nd UBRN/cancelled appt or the GP referral?

Assuming the GP referral was for the same condition I would advise taking the receipt of the GP referral as the start of the 2ww/62d pathway. The CaB route did not end up with a DATE FIRST SEEN so was an incomplete pathway that does not need to be uploaded to the CWTDb.

If a consultant feels that a referral does not meet the 2WW criteria can the GP downgrade the referral following discussion with the consultant?

Yes, the GP can downgrade an urgent 2ww referral but a consultant cannot.

We have a patient who was referred as a 14 day wait under Colorectal and then a few weeks later referred again as a 14 day wait under Gynaecology. The patient has been cared for by both teams at the same time with a lot of joint team investigations. The patient now has a diagnosed cancer with an unknown primary. Which of the two tumour sites should I put the diagnosis under?

These would be 2 separate 2ww referrals with 2 separate PPIs. You have diagnosed primary of unknown origin and you need to link it back to one of the referrals. I would take a pragmatic decision based on clinical advice on which is most likely to have been the most relevant referral that resulted in the diagnosis ie. if diagnosis resulted from tests requested following gynae referral link it to that one etc. If it was a test that was jointly requested then you will just have to pick one of the two to link it to.

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.

One of the imaging depts in our trusts 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 p13 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 it is neither a clinic nor a consultant appt and so does not meet the above criteria. If the imaging appts are not the first seen date, then the dept are under no compulsion to offer an appt within 2 weeks. Please can you comment, as considerable work will need to be undertaken on local pathways.

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 see. *Note: DH have been asked to confirm this view – response awaited*

Symptomatic breast 2ww

Can you clarify whether non-urgent breast referrals (i.e symptomatic) should be treated the same as suspected cancer breast referrals in that a 2nd appt has to be given after a 1st DNA, or can pt be discharged after 1st DNA as 18 week rules?

The rules for the 2ww and the symptomatic breast 2ww are the same ie. you cannot send a patient back to their GP after one DNA.

Please could you confirm that the new breast symptom 2ww standard due to be implemented by the end of 2009 is for <u>all</u> breast symptoms referred by a GP not just those that are urgent.

The new symptomatic breast 2ww standard is not for all breast referrals. We now have two 2ww standards that are relevant to potential breast cancer patients as follows:

- the urgent 2ww standard is where the GP suspects cancer (this is the original CWT standard and remains relevant to suspected breast cancer referrals);
- the symptomatic breast 2ww standard is where the GP (or other relevant health professional) is referring a patient for breast symptoms but does not suspect cancer (this is the new GFOCW standard).

The symptomatic breast 2ww standard should ensure that all patients (men and women) with breast symptoms (where cancer is not suspected) are seen by a specialist within 2 weeks of a referral being received from their GP or other relevant health professional. The standard covers breast symptoms that a healthcare professional believes need to be seen by a specialist that are not covered by the NICE referral guidelines for suspected cancer. There are two types of breast referral that are excluded from the symptomatic breast 2ww standard. These are referrals:

- from family history clinics (unless a patient is symptomatic);
- for cosmetic breast surgery (such as enlargement or reduction).

The symptomatic breast 2ww standard is where the GP (or other relevant health professional) is referring a patient for breast symptoms but does not suspect cancer but does this relate only to urgent referrals by the GP / health professional or to all referrals?

All referrals that are made for breast symptoms where cancer is NOT suspected would be covered by the symptomatic breast 2ww standard (except cosmetic & family history referrals).

From the 1 Jan 09 the PRIORITY TYPE for referrals under the urgent 2ww or symptomatic breast 2ww standard should be Priority 3. This is the priority type for <u>any</u> 2ww referral. You should not be using Priority 2 (urgent) or Priority 1 (routine) for any 2ww referrals.

Query on patients who are referred directly to Radiology? X Hospital has a system in place to enable GP's to refer patients straight to test for some breast symptoms, with the results going straight back to the GP unless something suspicious is found, in which case the results would be forwarded to a Consultant within the Trust. We are unsure as to whether these patients should be treated and logged under the TWR for symptomatic breast patients?

The symptomatic breast 2ww standard is relevant when a GP or other relevant health professional refers a patient for breast symptoms but does not suspect cancer. The original 2ww is for urgent referrals where a GP suspects cancer.

If the patient is going 'straight to test' the receipt of the referral would mark the start of the 2ww period and the tests would count as the DATE FIRST SEEN thus ending the 2ww period ie. the patient is still covered by the standard even though they are going straight to test.

31d treatment (first or subsequent)

Is reversal of a stoma classed as a subsequent treatment.

No, it is not classed as a subsequent treatment.

Does a cardiac stent (an enabling treatment) class as a first treatment? Without it, no surgery was possible?

No, a cardiac stent is not classed as first treatment for cancer as it is treating a separate condition. Previously this would have been a medical suspension. You can no longer pause the clock for such suspensions, instead the operational tolerance will be lowered to take such instances into account. DH hope to issue the operational tolerances in mid-July.

We have a patient who was scheduled for 4 cycles of a particular chemotherapy treatment – with drug A. Patient commenced treatment and received 1 dose of chemotherapy. Prior to cycle 2 his disease has been noted as aggressively progressive and the treatment plan changed. The original Drug A has now been discontinued and the patient is to proceed to 6 cycles of Drug B. I was originally leaning towards a subsequent treatment record being generated for the change in chemotherapy drug, but now am not sure. Based on question G3.19 in GFOCW guide v6.5, theoretically we are still within the original course of treatment but the drug and number of cycles has been changed due to progressive disease. Please could you advise – should we have a first definitive treatment and a subsequent treatment for the drug change or not?

We need to take a pragmatic approach to this issue. If a patient is starting a new regimen then this would be a subsequent treatment. However, if you are modifying a regimen then this would not be classed as a new treatment. The GFOCW Advisory Board recently advised that the key should be whether a new consent form has been signed or not ie. if it has then this should be classed as a new treatment and therefore a new 31day period.

If a patient was first seen in 2002 for colorectal cancer and they come back in 2009 with cancer in the same area, are they treated as a subsequent treatment?

That is correct if it is a recurrence rather than a new primary.

Is there a stage at which it is assumed patients are 'cancer clear' i.e. after 10 years - if so, if the patient then did come back and cancer was found in the same area or as a secondary - would this be treated as a new or subsequent cancer?

There is no time limit. If the cancer is classed as a recurrence (whether after 1 year or 20+) then the 31d subsequent treatment standard would apply. The 62d standard would not apply for a recurrence. It will need to be a clinical decision whether it is a recurrence or a new primary.

If a patient needs to have dental clearance before radiotherapy can start is the date of dental clearance useable as the treatment start date as the patient can't have the Radiotherapy until this has happened.

Some interventions prior to anti-cancer treatments ie. 'enabling interventions' are classed as FDTs but dental clearance prior to r/t has never been classed as such. We are re-looking at the use of enabling procedures now that we have a 31d subsequent treatment standard but at the moment dental clearance cannot count as a FDT.

Could you give an example of a couple of enabling treatment that would count as FDTs

Examples of enabling treatments that can be classed as FDTs are:
• portal vein embolisation (PVE) performed prior to a patient going through liver resection
• staging laparoscopy to determine whether a patient is suitable for major UGI surgery (if the patient remained an in-patient between this date and surgery ie. if it is the same episode of care)
• mediastinoscopy/hysteroscopy/loop biopsy/removal of gynae polyps etc - if therapeutic in intent (i.e. the intention was to remove the tumour) then these would count as FDT irrespective of whether the margins were clear. If the intention was diagnostic but the tissue was found to be malignant the procedure could count as FDT if the tumour had effectively been removed by the excision.
• PEG prior to surgery for a head & neck cancer - 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 the main surgery ie. if it is the same episode of care.

A lady with a colorectal primary is treated at X Trust and is then seen by Mr A at Y Trust for a lung mets resection. Do we need to open a new referral or put pathology under colorectal referral?

The treatment of the lung mets would be a 31d subsequent treatment so a 31d record would need to be uploaded. You should use the same Patient Pathway Identify as created when the patient was initially referred and treated for the colorectal primary.

Should a patients started on thyroxine be classed as 31d period?

Yes - class this as a subsequent treatment.

If a patient is to receive a number of treatments within a clinical trial (including potentially a placebo) how should that be managed in terms of first and subsequent treatments for cwt standards?

If a patient has agreed to enter a national portfolio clinical trial (a National Institute for Health Research 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. For example:

- if the trial protocol sets out that first treatment could potentially be surgery or hormonal drug treatment or a placebo depending on the arm of the trial the patient was on it would not matter which of these treatments the patient received it would be classed as the FDT.

- if a second treatment could then be drug x or y or a placebo it would not matter which of these treatments the patient received it would be classed as a subsequent treatment.

Patients should be made aware if they may receive a placebo as part of their treatment within a clinical trial.

The cancer treatment modality for a placebo would be classed as ‘anti cancer drug regimen (other)’ for cancer waits reporting purposes assuming it is known which patient had received the placebo vs any other type of anti-cancer drug regimen such as cytotoxic chemotherapy. If it is a blind trial and it is not possible to identify which patient received which type of drug then the ‘anti cancer drug regimen (other)’ category would be used for each drug arm.

The POETIC study does not use a placebo. Patients must all be randomised ideally 14 days (absolute minimum 10 days) before the planned surgery date. This allows sufficient time for those allocated to receive perioperative treatment for treatment to have the chance of making a measurable impact on the tumour. Those not allocated to receive study treatment do not get placebo, but proceed to surgery as planned. Could you confirm that the above line to take does in fact cover POETIC?

The guidance does cover POETIC as it is not specific to trials that include placebo. Placebo was just part of an example given to explain the over-riding principle ie. whatever are the potential first treatments in the trial protocol are the potential first treatments for cancer waits. Whatever are the potential subsequent treatments in the protocol are the potential subsequent treatments for cancer waits. Sorry if the example confused things.

Classic 62d (ie. from 2ww)

A gentleman was referred under the 2ww pathway by his GP on 24/03/2009. He was referred with a skin lesion so was therefore classified under the skin site. He was seen by the consultant on 02/04/2009 and had the lesion excised on the 06/04/2009. When the histology report came back, it showed that the lesion consisted of a metastatic renal cell carcinoma (no renal cell carcinoma diagnosis was known). He was then referred to a Urologist on 30/04/2009 and is now awaiting palliative surgery (nephrectomy) for a right renal tumour with renal metastases after a complicated diagnostic pathway. The queries we have are:

a) do we keep him on the 62 day pathway from his original GP referral and keep him attached to the same cancer site (skin) even though he is now a urology patient, and count the palliative surgery as his first definitive treatment; or,

b) do we count the excision of his skin lesion as his first definitive treatment under his 62 day pathway, as this was a treatment for metastases, and then give him a new referral under a 31 day pathway as a consultant referral under the 'other referral source or urgency' category as a urology cancer site patient. The palliative surgery then being the first definitive treatment under that referral

I have discussed this scenario with DH and we have agreed that we need to take a pragmatic approach. We would advise that in this scenario the lesion excision (assuming that you removed the whole thing rather than just did a biopsy) be the first treatment ie. you assumed it was a skin malignancy and treated it as such. In terms of coding we would suggest using an Event Type of code 07 (first treatment of mets disease following an unknown primary) as you did not know the primary at the time of removing the lesion. In terms of coding we would suggest you code it as a secondary malignant neoplasm of the skin (ICD10 codes C79.2). Any treatment for the renal cancer eg. the surgery would then be classed as a 31d subsequent treatment.

We have had a patient who, during the 62 day pathway, DNAed two investigative appointments. GFOCW 6.5 states that a patient who refuses to have any diagnostic test(s) that will potentially diagnose their cancer has effectively removed themselves from the 62 day standard. Can multiple DNAs count as refusal of tests? The patient did eventually have a CT scan.

It is my view that a DNA is not the same as a refusal to have a test. It is not possible to refer a patient back to their GP after a first DNA of the appt that would have been DATE FIRST SEEN. However it is possible to introduce local policies to address multiple (2 or more) DNAs (be they DNAs of the first appt or multiple DNAs later down the pathway). This policy might include referral back to GP. In the situation you describe the patient has now had the diagnostic test so the clock would still be ticking until a non-cancer diagnosis is made or the patient has their first treatment for cancer.

62d Screening

General

Should individual Trusts be entering screening patients onto the CWTDb who are referred to them as part of the screening programme for colonoscopy, colposcopy or further breast assessment even if they do not end up with a cancer diagnosis?

It is mandatory to upload data up until DATE FIRST SEEN for all patients urgently referred by the screening programmes ie. not just those subsequently diagnosed with cancer.

Screening patients are not on a 14 day pathway up to DATE FIRST SEEN and if they do not have cancer they will not be on a 62 day pathway either. If we have to upload data on all screening patients what is this data used for?

The data of patients that do not go on to have a cancer diagnosis will not be used at a national level. A decision was taken by DH (supported by ISB) that it was less labour intensive for the screening services to upload the records for all the patients they see that were urgently referred to them with suspected cancer (eg. after positive FOB, with moderate to high risk cytology or concern following mammogram) than to ask screening centres to track patients and only upload records for those that went on to have a positive diagnosis.

You are correct that the screening referrals are not covered by the 2ww standard and there is no national target on time to first seen for screening patients that we will be monitoring centrally. There are internal waits standards within the screening programme for this period though.

Are there any reports in OE CWTDb that identifies screening patients once we have uploaded them?

The reports that will be provided on the CWT-Db only relate to those patients that came via the screening service and went on to have treatment for cancer ie. not everything you upload will feature in one of the reports To see all the patients that your screening service uploaded you would need to use the Download function.

With the need to submit all screening referrals, will we be able to extract a report with any figures on this? Happy to upload it, but would like to have a report to get some benefit from it. 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.

Note 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, so any implementation can be properly investigated as a change request. If you do want to raise a request for a change could you please do it via the CfH helpdesk.

Our thinking is that our 62 day screening activity volume reported on Open Exeter is low in Q4 and month 1 because there is no common PPI in use between all organisations. We think that there are probably a lot of orphan records (but can't see if this is the case as this function has been disabled on open exeter). Do you think that our assumptions are likely to be correct?

An orphan record is when we have the part of the record up to Date First Seen and we have the part of the record up to TREATMENT START DATE (CANCER) but we can't link the two together to make a 62d period eg. no PPI. If your screening providers have not uploaded the front end of the pathway at all there would not be an orphan record as only the 31d treatment record would be on the system. Either way – at a national level we believe that there is under-reporting on the 62d screening standard. From your point of view it could be because your screening centres are not uploading their part of the pathway at all or that they are uploading them without a PPI and hence creating orphan records

Breast

A patient has been referred from the breast screening service and discussed at the local breast MDT. It is however likely that the diagnosis will be lymphoma. If that is the case would the patient be on a 62 day screening pathway?

Yes. They would remain in the 62d screening cohort. The 62d cohort they are in is based on their source of referral in this case an urgent referral from the breast screening programme.

Cervical

The laboratory that recalls the cervical patients is a shared enterprise between 2 of our trusts (and located at Trust A). There seems to be uncertainty/dispute as to which organisation should be submitting the data for patients recalled from screening to a colposcopy appt. The scenario is that 2 lists of recall patients (who require a colposcopy appt) are produced for each trust (Trust A and Trust B) who hold colposcopy clinics. My understanding is that the data to be uploaded is based on the month in which the colposcopy takes place. Trust A therefore is indicating that it does not know when this appt takes place, at it is held at Trust B. Trust B maintains that the screening service is hosted by Trust A and therefore Trust A should upload the data. Both organisations would need to enter the data on Somerset prior to upload.

The Trust commissioned to provide the colposcopy appt should upload the data. If both Trust A and Trust B are commissioned to provide this service they upload their own data. If Trust A is commissioned but sub-contracts to Trust B it is still Trust A that has responsibility for ensuring the data is uploaded. The key is to identify the commissioning arrangement.

A cervical screening patient attends a colposcopy clinic but cannot proceed further at this point in time as she has recently had a termination of pregnancy (TOP) and a biopsy cannot be done until 4 weeks post procedure – can an adjustment be made to the waiting time or an ECAD set for 4 weeks after the TOP date?

An adjustment is not possible. A medical suspension would previously have been allowed but these are no longer possible. Instead the operational tolerance will take into account the fact that such pauses are no longer valid. In addition, as the patient is coming through the screening route on to the 62d pathway an ECAD is not appropriate. The clock start for a first treatment must always be a 'decision to treat' (DTT). An ECAD can only be an option to start the clock for a subsequent treatment.

A cervical screening patient attends a colposcopy clinic but cannot proceed further at this point in time as she is pregnant and cannot be biopsied or treated in pregnancy in line with national guidelines. She will therefore be seen at 28 weeks gestation and a biopsy arranged 3 months after delivery – can that date be defined as the ECAD for that patient?

The advice is the same as for the TOP ie. no pause allowed. Patient would previously have been a medical suspension but there will now be a breach and this will be covered by a lowering of the operational threshold. Again, the starting point for a first treatment has to be a DTT not an ECAD.

Please can you clarify how long cervical screening patients should wait for an appointment following an abnormal smear? Our colposcopy department are giving appointments within the following time scales and I need to know if this is acceptable: Borderline/mild – 5 week wait. Moderate – 4 week wait. Severe – 2 week wait.

The 62d screening standard is only applicable to patients with moderate or severe cytology. There are no national standards for the timescales for delivering the colposcopy as part of this standard. However, there are internal QA standards for the cervical screening programme. V6.5 of the GFOCW guidance that is available on the CfH website set these out. The relevant question is below for ease of reference:

Dc3.13 What are the internal waits standards for the cervical screening programme and how will they fit to a 62 day period?

The QA standards for colposcopy referrals are on pages 14-15 of screening publication no. 20 which can be found at: http://www.cancerscreening.nhs.uk/cervical/publications/nhscsp20.html. The standards include that at least 90% of women:

- *referred for colposcopy after one test reported as possible invasion should be seen urgently within two weeks of referral.*
- *referred for colposcopy after one test reported as glandular neoplasia should be seen urgently within two weeks of referral*
- *with a test result of moderate or severe dyskaryosis should be seen in a colposcopy clinic within four weeks of referral*

If these internal QA standards are met, the vast majority of patients diagnosed with cervical cancer via the screening programme would be able to receive their first treatment within 62days of the receipt of the referral if they were clinically fit and wanted to be treated within this timescale.

Bowel

We are experiencing several breaches of the 62 day pathway due to 'patient choice'. Several patients are being recalled to an appt with the CNS, but are choosing to defer this to a more convenient day, which ultimately results in a breach for those diagnosed with cancer. Can you confirm that the only time we can remove days is when patient DNAs - there seems to be some confusion that adjustments are possible. It would also be useful to know whether our local picture reflects the national one?

You are right the only pause here is for DNA of the first appt. I don't yet have info about the reasons for breaches on the 62d screening standard but will let you know if any patterns emerge.

The Hub at Trust X sees patients at X, Y and Z hospitals. Each of these sites has its own specific 5 digit site code which identifies it as part of the Hub – should this code be used in the Org First Seen box in Open Exeter CWT, or should it be the code for the Trust HQ?

Where a commissioned provider gives an outreach service and they have registered an office/ward/facility on one of another providers sites as being theirs with the ODS they should use that code. In your example, the main site code would be (for example) ABC11, but if you have registered the screening hubs rooms at B as (for example) ABC22 you should use that code, as opposed to your main site code or the site code of Trust B.

Some patients are coming up to 1 year surveillance – if a cancer is detected at this surveillance colonoscopy do I record it as a cancer identified through a national screening programme and, if so, what do I use as the clock start date?

If a patient has been informed that they do not have cancer but are being kept under surveillance then the original 62d screening period would have ended. If they come back for a surveillance colonoscopy and cancer is then suspected I have agreement from DH that this patient should be covered by the 62d screening standard. The starting point in this scenario will be receipt of the referral for the first appointment on this new 62d period. From the info you have given me this is likely to be the receipt of the referral for the surveillance colonoscopy but if the patient does have an appointment with an SSP prior to this it would be the receipt of the referral for that appointment. [Please note – following queries since this answer was given, it has been decided to take the issue of how patients on screening surveillance should be managed under cancer waits to the GFOCW Advisory Group on 22 Sept. The stated position may therefore change.]

X unit uses the date of the surveillance colonoscopy as the referral date. They did say if they got somebody coming back for a flexi sig as a result of the colonoscopy, or they had to do another colonoscopy due to one being incomplete for whatever reason, then the referral date would remain as the 1st colonoscopy. Is that correct?

The receipt of the referral for the colonoscopy should start the clock for this surveillance patient rather than the date of the colonoscopy itself. If the patient did have an appt with an SSP prior to the surveillance colonoscopy it would be the receipt of the referral for that appt that would start the new 62d clock. [Please note – following queries since this answer was given, it has been decided to take the issue of how patient on screening surveillance should be managed under cancer waits to the GFOCW Advisory Group on 22 Sept. The stated position may therefore change.]

62d upgrade

No questions this month

Pauses

Apparently under 18weeks, if a patient is unfit for treatment, the clock stops and the patient is referred back to the GP until they are fit but there is no similar provision for cancer waits. Is this true?

No, this is not true. 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.

If the patient refuses an appt and is offered a replacement appt date within a reasonable timeframe which they also choose to defer further, I assume we could apply a pt pause for this element??

If a patient declines a reasonable offer of an appt for an admitted treatment a pause is possible.

Is the pause for DNA'ing the first appointment allowable to all potential cancer referrals i.e. 2ww plus screening referrals, upgrades and breast symptoms?

Yes, this pause is allowed for DNAing the appointment that would be classed as DATE FIRST SEEN irrespective of whether the patient is on a 62d screening, upgrade etc pathway.

I have mapped every breach since Jan at Trust X analysing the reason for breach and if it would have been a breach under the old system. I have done this to try and identify trends. It is interesting now that breaches are occurring because of pt DNAs and their unavailability which is frustrating for us, as before you could 'stop the clock' for this and it feels a bit unfair

The issue of DNAs is an interesting one. One of the issues that people have been feeding back to me is the need to do more locally with GPs about the info they give to patients about their referrals ie. If GPs were clearer to patients about why they were referring them, why it is important to be seen quickly, why it is important to keep appts etc this could reduce the number of DNAs.

Is there any expectation or policy on when and whether chemotherapy and radiotherapy are 'admitted' or 'non-admitted'?

There is no guidance on whether chemo or r/t are admitted or non-admitted.

DH Advice: We expect the recorded statistics to reflect the commissioned service. We have not specified what should be admitted or not as this is dependent on many factors such as case-mix, co-morbidities in patients, rurality of the provider.

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

The clock restarts when the patient 'makes themself 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.

Note - DH has been asked if they agree or if we could argue that the patient has not 'made themself available' until they had returned from holiday in a fit state ie back from holiday and dvt risk over. Response awaited.

Breaches

I am concerned about the deferment of appointments due to annual leave and other commitments. I have a patient on 62d tracking who has refused to come for a diagnostic test until after her holiday causing a month lost to the 62d pathway. She has also cancelled an offered date as it was inconvenient. Out of the 8 week pathway we will have lost 5 weeks due to patient cancellations or patient preference. This is not the only patient who has deferred appointments or diagnostics resulting in a severely reduced diagnostic and FDT time. Do we have the right to approach the GP to ask them to stand the patient down from the TWW / 62 day pathway?

If you think that a referral is inappropriate ie. the patient does not have a suspected cancer a GP can be asked to change the referral type but a consultant cannot downgrade a 2ww referral this has to be the GP's decision. I would not have thought a GP should be asked to downgrade a referral due to patient cancellations as the clinical need on which they based their referral would not have changed. However, if a patient has multiple cancellations it is possible to refer them back to their GP with their (the patient's) agreement if this is deemed to be in the best interest of the patient.

An increase in breaches due to patient choice is expected and that is why the operational tolerances will be lowered.

If you breach the 62d standard do you, by default, breach the 31d standard?

No. You may have delivered treatment within 31d of DTT but taken longer that 2ww to first see a patient, confirm diagnostics etc

Can we adjust for DNA's after a cancellation by the patient so long as these occur before the date first seen?

I can confirm that a DNA after a cancellation of the first appointment trumps the cancellation ie. the clock continued to tick after the cancellation then the patient DNAed so the clock can be reset for when the patient re-books their appt. I will add an additional Q&A to this effect in updated GFOCW guidance which will hopefully go out after the summer break.

Please could you help me out with a query regarding a patient who has potentially breached the 62 day target. This patient's target date was 21/7/09. She was admitted to the ward on 21/7/09 for surgery which would have been her 1st treatment date but she was discharged the day after as she had flu and no surgery could be carried out. The patient now has a new date for surgery in August which is passed her breach date. Because the patient stayed in overnight can I report this as 1st treatment and then the next surgery date in August report as a subsequent treatment?

The admission needs to end with the treatment to stop the clock. So you cannot class the admission in this example as the end of the period with the actual surgery as a subsequent treatment. This patient would have had an adjustment/pause under the old rules but under the new rules the operational tolerance is being lowered to account for more breaches of this nature.

Performance management

Currently, none of the trusts in X cancer network are submitting the weekly PTL data, but they are aware that they should be working towards this. Please can you tell me how far this has progressed, and whether there is a date when it will become mandatory?

DH has yet to submit the application to ISB to mandate the PTL. I will let you know as soon as I have any idea on timing but I would certainly not expect a mandated PTL during the summer.

Can you tell me when the PTL is likely to be mandatory and are there currently pilot sites submitting on a regular basis?

DH has yet to apply to mandate the PTL. They do still plan to but this is unlikely to be until the autumn. There are no formal pilot sites for the PTL. Any trust can upload data to the PTL on a voluntary basis and a number are doing do.

Is it still the case that the national averages issued after Q3 last year are the most up to date proxies for operational tolerances or is there an updated version we should now be using?

DH hope to publish the operation tolerances very shortly (ie before the end of the month).

Could you please advise me on an issue we are having currently with our PCT – despite meeting with them several times and explaining the new GFOCW targets to them at length they continue to want to measure us against the old targets of 100%, 95% and 98%, even though I have explained to them that we are being advised nationally to look at our figures against the national averages. I was wondering if you could please either send me anything you have confirming this position or pen me a response to state this.

I can confirm that the operational tolerances are being adjusted to take into account the change in pause methodology. This will almost certainly result in lower tolerances as the estimates of national performance published by DH alongside the Q3 data indicated. DH hope to issue the formal tolerances this month.

Is there any update on the Operational tolerances for the CWT standarads

Professor Sir Bruce Keogh, NHS Medical Director, wrote out to SHA, NHS Trust and PCT Ces on 30 July setting out details of the operational standards for existing and new commitments for cancer waiting times. These operational standards take into account the fact that for any given period there will be patients unavailable, because: they elect to delay (patient choice), are unfit, or it is clinically inappropriate to treat them within the commitment. The operational standards are summarised below:

Commitment (As specified in published National Statistics data - where applicable)	**Operational Standard**
62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	85%
62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	90%
31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	96%
31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	98%
31-Day Wait For Second Or Subsequent Treatment: Surgery	94%
31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	94%
All Cancer Two Week Wait	93%
Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	93%

Note: An operational standard for the commitment of a maximum wait of 62 days for first treatment for those patients who are upgraded with a suspicion of cancer by the consultant responsible for their care has not been provided. This is because not enough patients have benefited from the implementation of this service yet to provide enough data for a robust calculation of an operational standard. This work will be undertaken as soon as this is possible.

How will these operational standards be used?

The Department of Health will use these operational standards as part of the assessment of deliverables with the NHS Operating Framework, and in its work to support the implementation of the Cancer Reform Strategy within the NHS. DH recommend that these operational standards are used locally within the NHS to inform the development of services and the monitoring of Service Level Agreements.

Is there any update on how the CQC will use Q4 data?

The CQC confirmed to SHAs yesterday that they will not be using the Quarter 4 waits data in their 2008/09 indicators for the annual health check. As a result, a revised indicator construction has been agreed with the Department of Health which will apply with immediate effect to both acute trusts and PCTs and will cover only Quarters 1 to 3. The revised constructions have been published on the CQC website and I understand that the CQC has written to all PCT and acute trust Chief Executives to advise them of the changes.
The CQC website is as follows:
http://www.cqc.org.uk/guidanceforprofessionals/healthcare/nhsstaff/annualhealthcheck2008/09/qualityofservices/existingcommitmentsandnationalpriorities.cfm
From here you can follow the links for different trust types, and then the separate indicators are under the 'national priorities' heading.
If you have any queries these should be directed to the CQC at
performance.indicators@cqc.org.uk

I've been informed about a possible problem with the definitions used on the CQC website for the 2009/10 assessment for the breast symptoms 2 week standard which seems to suggest that 2 week breast symptoms is only for patients referred urgently by GP whereas all the other guidance would suggest it's all breast referrals regardless of urgency or source.Can you clarify please? That page also seems to suggest the 2ww and breast symptoms will be combined into one figure for overall performance. I didn't think this was happening as there are different thresholds for each standard??

Note from DH: The issue that you raise is correct, this has been passed to the CQC for them to investigate.

Dataset

PPI

Trusts are saying that for screening activity they 'can't' generate PPIs and so they think that a great number of screening cases are in open exeter as orphan records. Does this sound right?

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 screening that would be the provider receiving the referral request for:

- Further assessment – breast
- Appointment with SSP to discuss suitability for colonoscopy – bowel
- Colposcopy appointment – cervical

It is for the organisation in question to determine how to generate the PPI but it is something they need to do.

As I understand it the same PPI needs to be used by all organisations that have a hand in the patients treatment pathway e.g. host org of the breast service and then the treating trust (otherwise the treating trust is likely to record under a 31 day pathway?).

Correct – the same PPI should be used

X and Y have agreed on a PPI format (screening number plus the date of day zero on the 62 day pathway and however many '0's to pad the reference), our intention is to communicate out to all receiving Trusts that they should use this PPI when treating breast screening cases.

This will only be Ok if the host provider has agreed that this PPI will also be the 18w PPI for this pathway/condition. If not, 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.

Our thinking is that our 62 day screening activity volume reported on Open Exeter is low in Q4 and month 1 because there is no common PPI in use between all organisations. We think that there are probably a lot of orphan records (but can't see if this is the case as this function has been disabled on open exeter). Do you think that our assumptions are likely to be correct?

An orphan record is when we have the part of the record up to Date First Seen and we have the part of the record up to TREATMENT START DATE (CANCER) but we can’t link the two together to make a 62d period eg. no PPI. If your screening providers have not uploaded the front end of the pathway at all there would not be an orphan record as only the 31d treatment record would be on the system. Either way – at a national level we believe that there is under-reporting on the 62d screening standard. From your point of view it could be because your screening centres are not uploading their part of the pathway at all or that they are uploading them without a PPI and hence creating orphan records

I would like to confirm that the PPI that we are using at our trust is ok in terms of CWT guidance please. Our PAS does not have an 18wk PPI. We therefore had to devise a mechanism to generate one. We decided to concatenate our hospital number (max 10 chars) with the referral date (no delimiters - 6 chars) and the tumour site code (2 chars). Any shortfall in the 20 digits is then dealt with by padding the PPI with zeroes from the left. This allows for more than 1 urgent GP referral on the same day to a different tumour site. We have been using this since Oct 2008; a trust that we transfer patients to for their first treatment is saying that our PPIs are incorrect and that they can't use them. They believe that the first 5 characters of the PPI should be the provider code. We have other trusts with the same PAS that do not appear to have any issues with our PPIs. I have been asked by our PCT to clarify with you that our method of deriving the PPIs is acceptable. Our PPI together with the PPI issuer does fully identify the pathway and it seems unnecessary to duplicate the issuer by adding this to the beginning of the 20 character PPI leaving 15 characters for the PPI itself.

The first 5 characters of the PPI DO NOT have to be the provider code. You can create a PPI how you want, however, the PPI MUST be the same as that used for 18w. If your PAS does not generate a PPI and you are creating your own PPI it is important that this is also the 18w PPI. If it is not and the 18w team are creating their own PPI you need to use that one.

I have been informed that nationally, all referrals to palliative care are to be given a new PPI number. However, for our own purposes, referrals to palliative care (which in this line of work are quite common) need to be retained on the original PPI number that they came across with. So for instance if a 2ww pt was referred in with a PPI of 456789 (i know it's not 20 digits), and had surgery, they would be on the one pathway. If they had palliative care as 1st or subsequent treatments, then we are required to create a new PPI nationally, but retain the original PPI nationally (for Open Exeter).

I have raised this with the 18w team in DH. They have said that it would be useful to know where you got this info/advice from as it doesn't sound right. They have advised that in the original policy decision phase there were 2 options:

i) to give each RTT period a unique identifier
ii) to give each pathway a unique identifier

The 2nd option was chosen. This means that there can be multiple RTT periods within a single pathway and that the pathway has a unique identifier. This should be applicable to all RTT pathways and they cannot think of any good reason why cancer pathways would differ from RTT pathways as most cancer pathways are RTT pathways anyway. So in summary:

a) they are not sure where the advice came from
b) it doesn't sound right because the data dictionary design allows a single pathway (with unique identifier) to have multiple RTT periods associated with it.

Organisation Codes

The Hub at Trust X sees patients at X, Y and Z hospitals. Each of these sites has its own specific 5 digit site code which identifies it as part of the Hub – should this code be used in the Org First Seen box in Open Exeter CWT, or should it be the code for the Trust HQ?

Where a commissioned provider gives an outreach service and they have registered an office/ward/facility on one of another providers sites as being theirs with the ODS they should use that code. In your example, the main site code would be (for example) ABC11, but if you have registered the screening hubs rooms at Trust B as (for example) ABC22 you should use that code, as opposed to your main site code or the site code of Trust B.

Primary Diagnosis (ICD)

When patients decide to have their treatment privately so cancer status is 7 or 18 should the primary diagnosis be recorded or does this not matter?

In theory you would not need to upload a treatment record for this patient as the episode did not end with a treatment. However, if you want to close the record you could use treatment modality 'all treatments declined' in which case you would need to complete the other mandated data items for the 31d period such as ICD10.

I need to record a first treatment for sarcoma of the lungs but there is no option for sarcoma in the primary diagnosis drop down selection.

Note from DH: The scope of the cancer waiting times standards are defined by ICD-10, the full code list is available both within the system and online at:
http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/clincoding
This code list includes all forms of sarcoma within the range C00-C97 (cancer), therefore the correct coding option should be available. If your pathology lab/clinical coders have attached an ICD-10 code outside this list we would be interested to know what it is, otherwise please select the most appropriate from the list.

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 a the historical data? Will it be dealt with differently in the new CWTDb regime?

Advice on this question from the June Q&A is awaited.

Metastatic Site

Where a patient is referred as a two week wait, has a known primary and is found to have metastatic disease how should we be entering them? We can't say they have mets and an unknown primary because that is not true but if we omit the metastatic site to get around the validation, we are losing potentially valuable information on that patient. Are we meant to close down the 62 day pathway (because the patient is being treated for metastatic disease) and open a subsequent treatment 31 day pathway instead? The patient will therefore never have been recorded as receiving a first treatment. This is all very unclear and I think we need guidance?

Treatment of Mets has to be classed as a subsequent treatment if the primary is known. The 31d subsequent treatment of the mets is a separate record. It can be uploaded before the 31d first treatment record for the primary has been uploaded as treatments do not need to be uploaded sequentially. If you are saying that the patient needs the treatment for the Mets BEFORE the treatment of the primary cancer you can upload a 31d subsequent treatment record even though it took place ahead of the first treatment but if the patient is on a 62d pathway for the primary cancer that subsequent treatment would NOT stop the 62d clock. If you are saying the patient will be treated for the primary cancer first then the mets will be treated, we are aware that for the first treatment record we will not have the mets details - this is something that we can review but for the time being that is the position. The mets details will be on any 31d subsequent treatment records for this patient with this condition – the PPI would be the same for the first and subsequent treatment records.

A patient is diagnosed with primary and mets:
a) is the patient on 62d pathway for primary and a separate 31d pathway for mets?

Yes. Treatment of the primary is on the 62d standard and treatment of the mets would be a 31d subsequent treatment.

b) the patient is treated first for primary then mets – do you upload 62d pathway for primary and mets record and then upload a separate 31d pathway for treatment of mets?

Upload the 62d for the primary without the detail about the mets plus a 31d record for a subsequent treatment of the mets.

c) 31 day start date for mets would be a DTT which may be the same as the 62 day DTT or ECAD?

31d for the first treatment of primary would have to be a DTT. 31d for a subsequent treatment of a mets could be a DTT or an ECAD.

d) 62 day record is uploaded onto Exeter when completed, upload of 31 day record is separate until that treatment has also been completed.

The 31d record is separate so can be uploaded before the 62d record is complete.

e) the patient is treated first for mets followed by primary - the mets treatment clock start is DTT, upload as a separate record without reference to the primary. The 62 day clock is paused and restarted on the first clinically appropriate date for treatment after the treatment for mets is complete (ECAD) – record uploaded without reference to the mets.

Mets treatment clock can be DTT or an ECAD as it will have to be classed as a subsequent treatment if the primary is known. The 31d subsequent treatment of the mets is a separate record. It can be uploaded before the 31d first treatment record has been uploaded as treatments do not need to be uploaded sequentially. If you are saying that the patient needs the treatment for the mets BEFORE the treatment of the primary cancer and you are therefore pausing the 62d clock that is incorrect. You cannot pause the clock. Medical suspensions no longer apply, the operational tolerance will be lowered to take into account of this. Also the 31d part of the 62 day pathway ie for first treatment has to start with a DTT, it cannot start with an ECAD. You can upload a 31d subsequent treatment record even though it took place ahead of the first treatment.

A patient is given first treatment at a highly symptomatic secondary site, the CWTdb does not pull this through into 'first treatment' from the cancer status where the cancer treatment event type is not 'first treatment for primary cancer' or 'first treatment for mets following unknown primary'. How should we account for the patients receiving appropriate and timely care for the disease they have presented with and will our commissioners/SHA be expecting to review our data completeness targets in light of this?

Treatment of Mets has to be classed as a subsequent treatment if the primary is known. The 31d subsequent treatment of the mets is a separate record. It can be uploaded before the 31d first treatment record for the primary has been uploaded as treatments do not need to be uploaded sequentially. If you are saying that the patient needs the treatment for the Mets BEFORE the treatment of the primary cancer you can upload a 31d subsequent treatment record even though it took place ahead of the first treatment but if the patient is on a 62d pathway for the primary cancer that subsequent treatment would NOT stop the 62d clock. DH has not yet set a national data completeness measure.

Cancer Treatment Modality

What is the treatment modality code for Radio Iodine therapy?

Radioiodine is a radioisotope therapy and a new category would be needed to correctly code it. In the interim (as a new code will not be possible for some time) it should be coded as 'other treatments' ie. code 18. As such it will come under the 2010 31d standard for 'other' treatment.

Should thyroxine be classed as 'anti-cancer drug (hormone)'?

Yes - class this as a subsequent treatment and as an 'anti-cancer drug (hormone)'.

How would you record radioiodine thyroid ablation?

Yes, class it as 'other treatments' ie. code 18.

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 on this question from the June Q&A is awaited.

Cancer Treatment Event Type

I would be grateful for more information on the meaning of the following codes:

06 - Tx for multiple recurrence of cancer (local and/or regional and/or distant)
07 - 1st tx for metastatic disease following an unknown primary
08 - Second or subsequent tx for metastatic disease following an unknown primary
09 - Tx for relapse of primary cancer (second or subsequent

Advice from NCIN:

- ***06 Tx for multiple recurrence of cancer (local and/or regional and/or distant)** – this is a patient e.g. a breast patient who presents or is treated for a cancer which has spread in more than one way.*
- ***07 1st tx for metastatic disease following an unknown primary** – this is the patient who presents with secondary metastatic disease, for whom the clinical team do not know where the site of the primary is. The site of the primary may become apparent after treatment or not at all whilst the patient is alive.*
- ***08 Second or subsequent tx for metastatic disease following an unknown primary** – this is also the patient who presents with secondary metastatic disease, for whom the medics do not know where the site of the primary is. The site of the primary may become apparent after a second or subsequent treatment or not at all whilst the patient is alive.*

- ***09 Tx for relapse of primary cancer (second or subsequent**) – as haematological cancers do not spread in the same way as solid tumours, haematologists consulted during the development of GFOCW advised including this category.*

What is the difference between local, regional and distant disease?

Advice from NCIN: Local would be a recurrence very close to the site of the original primary, regional spread in, for example, the case of a breast patient may be to the axilla, supraclavicular or inter-mammary nodes, and distant would be metastatic spread to somewhere like the liver, brain, lung, etc.

CWTDb

How long does it take to upload records to CWT-Db?

This is dependent on:

- the number of records in the upload;
- the number of those records that contain NHS numbers that are not in existing records;
- the bandwidth available at the provider;
- the number of records in the queue from other providers;
- the demand on the central PDS system at any given time; and
- the availability and amount of traffic on the N3 NHS-Net at any given time.

For symptomatic breast pts with no cancer suspected, can you confirm that even if these are referred in as routine or urgent, that they go on Open Exeter as two week waits.

Note from DH: Two week wait services should be expanded to include patients referred for non-cancer breast symptoms. We expect referral protocols from primary care (including CaB) to reflect this and ensure that referrals are to two week wait services, and the appropriate steps to notify patients of this at the time of referral are taken. These patients should therefore be given a PRIORITY TYPE of "Two Week Wait" (code 3). This priority type is distinct from (urgent-code 2 and routine-code 1) in that it is partly related to the waiting time standard the service must reach, not exclusively the clinical priority (which may also be very high).

We expect these services to be coded on the Cancer Waiting Times Database as PRIORITY TYPE 3 (Two Week Wait), however this will only occur when the service is offered. If your local two week wait service is not yet in place you will not be recording these patients as such, However from the 31st of December we will expect all patients to be coded with a PRIORITY TYPE of 3, because from this date you must be meeting this commitment for all patients. We would of course recommend that you establish these services as early as possible to give enough time to develop to reach the required performance level.

We are still unable to obtain information on Open Exeter around the provider responsible for any breaches. This information was available on the old database. We raised this as an issue when the quarter 4 reports were available from Exeter and received the following response: '*Further to the log you raised above regarding reports on the CWT system. Please note that due to the time constraints under which we developed the new version of the Cancer Waiting Times Database (to comply with DSCN20/2008), we were not able to develop all of the reports that were in the old system in time for the release that went out yesterday. There are a number of reports that are still to be developed, but at present we do not have a planned release date. The best we can say is that they will be along later in the year.'* **This is causing us problems when we try to identify why and where our breaches are happening. Can you advise when this information will be available?**

I have double checked with DH and I'm afraid that it is still not possible to give a timescale for this. DH and CfH are still finalising the work schedule/priorities for the coming months. As soon as we have more details I will make them available. Sorry I can't be of more help.

How can we lobby for missing reports to be a priority?

I am, by way of this e-mail, copying your request to Tim Hancox at DH. Tim is liaising with CfH to prioritise the next stages of their work programme. He will no doubt give this request due consideration but will need to balance it with other considerations. As soon as I have an update on the cwt-db work programme I will share it.

My understanding is that where a patient has been first seen and diagnosed at one trust (X) and then transfers to another Trust (Y) for actual treatment, that first treatment should be recorded onto Open Exeter by Y as they are the provider commissioned to carry out the treatment, even though, under Improving Outcomes Guidelines (IOG), a Consultant from X travelled to Y to carry out the actual treatment i.e. surgery.

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

It has been suggested that the organisation code recorded on Open Exeter can be split between the location of where the treatment took place ie "11" for X plus ABC (for Y) as it was a Trust Y treatment. The code would then be entered as ABC11 – I must admit to never having heard of this "splitting of codes" before so would be very grateful for some clarification?

The code should be that of the organisation of the health care provider where a patient receives a treatment which ends a 62 and/ or 31 day period(s) (ie. the organisation where the TREATMENT START DATE (CANCER) takes place). This code can be found in the Organisation Data Service (ODS) tables on nww. The link is as follows:
www.connectingforhealth.nhs.uk/systemsandservices/data/ods/data-files

Codes can be 'split' as suggested. For example, if 'AnyTrust' is commissioned to provide a service and uses facilities at site of 'AnotherTrust' they could register a facility with ODS at that site. Then, if they provided say an outreach service at that site they could put that site code (eg. 55) on their main code (eg. XYZ). For example, If 'AnyTrust' register a ward at 'AnotherTrust' as one of their sites with the ODS and are given a code of say 55 for that site and then 'AnyTrust' were commissioned to provide a service that they carried out at that site they could use the code for 'AnyTrust' eg. XYZ plus the site code 55. Therefore the 5 digit code would be XYZ55

In the mandatory fields specified in Part 6 of V6.5 and DSCN the 1st column 'HCP where patient is first seen following a referral rqst with priority 3 or urgent referral from cancer screening service' the field Two week wait cancer or symptomatic breast referral type is shown as being mandatory. However, in the cross validation rules, rule number 3 (currently disabled) states that if the above field is not blank then the priority must be 3. For screening patients where the priority is meant to be 2, how can the field then be mandatory unless the validation rule is permanently disabled?

The cross validation rule was disabled because of the error you have noted so it will not be re-enabled in its current form. It will be replaced by a correct validation rule. I have no timescale for when this will happen yet though.

Tumour-specific

General

Previous advice has been that we should record re-excisions for breast even if there is no cancer identified in the re-excision sample. Does that apply to other cancers such as skin, urology, gynaecology etc?

Yes. If a decision is made to re-excise eg. to ensure margins are clear that would count as a subsequent treatment even if no further cancer was found.

Breast

If a patient is diagnosed with cancer and the treatment is discussed for mastectomy but the patient declines as they wish to have immediate reconstruction surgery, this is agreed and the patient undergoes a sentinel node biopsy prior to the reconstruction which is part of the treatment plan. As cancer is already diagnosed would this be classed as the FDT or would this still be part of the diagnostic/planning phase?

Sentinel Lymph Node Biopsy is a diagnostic/staging procedure and cannot be classed as the FDT

The POETIC study does not use a placebo. Patients must all be randomised ideally 14 days (absolute minimum 10 days) before the planned surgery date. This allows sufficient time for those allocated to receive perioperative treatment for treatment to have the chance of making a measurable impact on the tumour. Those not allocated to receive study treatment do not get placebo, but proceed to surgery as planned. Could you confirm that the advice that a national portfolio clinical trial protocol will determine which treatments are classed as first or subsequent treatments respectively and they will be assigned as such under cwt standards covers POETIC?

The guidance does cover POETIC as it is not specific to trials that include placebo. Placebo was just part of an example given to explain the over-riding principle ie. What ever are the potential first treatments in the trial protocol are the potential first treatment for cancer waits. Whatever are the potential subsequent treatments in the protocol are the potential subsequent treatments for cancer waits. Sorry if the example confused things.

Head & Neck

Could you clarify whether tonsillectomy can be considered FDT when a patient then goes on to have post op chemoradiotherapy. We have considered it so but oncologists are now unsure?

If the tonsillectomy excised or debulked the tumour with therapeutic intent then it would count as FDT.

Prostate

We are monitoring a significant number of Prostate breaches in our Network, although I see that national figures reflect a similar pattern. At our recent Tumour Group it was discussed whether it was good clinical practice to send patients straight to MRI after biopsy, when it was likely that the MRI would not yield images of sufficient quality to enable meaningful diagnosis. The consultants were discussing whether it was considered good practice to reduce the pathway in this area in order to meet the 62 day standard?

There are no plans to issue guidance on the time between these 2 procedures (biopsy and MRI). However, we are aware of the biopsy/MRI issue for prostate and DH has taken this into account in the operational thresholds they have set. These thresholds are for all tumours taken together ie. it is expected that some tumour areas such as breast will be able to exceed this level of performance and others, such as urology, might be lower.

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

As I understand it TURP is an operation to remove some of an enlarged prostate gland. In the scenario you describe I imagine it is debulking the tumour (which is classed as a subsequent treatment) even though the motivation is to aid urinary function. However, I am not a clinician and I will double check with the national clinical lead for you. In the interim I would class it as a subsequent treatment but until there is definitive guidance you need to make a local decision on this.

Is TURP classed as a subsequent treatment if it is only being used to help a patient urinate – part II?

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 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.

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. *Advice from DH awaited.*

Miscellaneous

There are issues about the availability of the Nanocolloid drug used in Sentinel node imaging scans – without resolution this will impact on the 31 day and 62 day targets. Could you please help me to understand the following: 1) The likely DH position on the monitoring of the targets in advent of the issue not being resolved in time. 2) If the targets are to be amended, how should we highlight these patients on the Cancer reporting mechanisms. In addition, could you highlight any areas on your websites that would provide us with regular information on the position of the negotiations as we need as an organisation to be able to look at alternative treatments if, this is not likely to be resolved in the near future.

I can confirm that DH is aware of this issue and is liaising with the MHRA about this. It is hoped that a solution will be found before supplies run out so there is no specific advice in relation to CWTs at this time but it will be produced if the position changes. The contact in DH if you require an update is: Mohammed.Adrish@dh.gsi.gov.uk on 0113 2545274.

What happens to Welsh patients and are they included in the final reports. Also if they are, can a report be run to extract Data specifically relating to Welsh Patients.

Provider reports include Welsh patients. Provider reports broken down by commissioner (when available)will distinguish treatment commissioned for patients by Welsh LHBs from that commissioned by PCTs.

Is there any national patient information that explains cancer waits and targets?

There isn't anything targeted at patients but it is on my list of things to do.

Swine Flu

We have had patients cancelling planned treatment as they have confirmed swine flu, am I correct in assuming we will not be able to apply a pt pause for this?

That is correct. No pause is possible.

Is there anything formal to circulate on the effect of swine flu on cancer waits standards?

Note from DH: Information on suspending or modifying operational or financial target requirements is set out in paragraph 3.2.18 of 'Pandemic influenza: Guidance on preparing acute hospitals in England'. This guidance is available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080754 Currently, providers should continue to report waiting times as per published rules and keep their SHAs closely informed of any developments.

Local Access Policies

We have been trying to unpick a lot of the differing approaches between organisations regarding access policies post GFoCWs. We would appreciate your views as to what you think are reasonable interpretations of GFoCWs as locally we are concerned about referrals back to the GP and 'step down' options that don't seem within the spirit of the rules.

I discussed this issue at the SHA leads meeting and it was agreed that Trusts should have access policies that are in line with the GFOCW rules (and the 'spirit of the rules'). I agreed to produce some advice for SHAs which they would then share with their Trusts and PCTs as they saw fit. I go on leave in about an hour so I won't have time to do this until the middle of August but, for your information, the types of things I am likely to include in it are as follows:

Rules/Principles within which a local access/referral policy must sit

Local access/referral policies should not conflict with the rules/principles for cancer waiting times. Relevant rules/principles are as follows:

- Patients should not be referred back to the GP because they are unable to accept an appointment within 2 weeks ie. once a referral has been received by secondary care it should not be returned due to patient unavailability;
- 2ww referrals should not be 'downgraded' - if a consultant thinks the 2ww referral is inappropriate this should be discussed with the GP and the GP asked to withdraw the 2ww referral status;
- Patients should not be referred back to the GP after 1st DNA;
- Patients can be referred back to their GP after multiple (2 or more) DNAs if this is the local policy;
- Patients should not be referred back to the GP after a single cancellation;
- Patients should not be referred back to the GP after multiple (2 or more) cancellations unless this has been agreed with the patient;

Example of Local Access/referral policies that may not be in keeping with the GFOCW rules or the 'spirit' of the rules:

- referring a patient back to their GP because:

- they are not available for appointments on offer within a 2 week period eg. for social commitment or ill health or other reasons– it is expected that a certain proportion of patient will choose to wait longer and the operational tolerance will be lowered to take that into account;
- they DNA their first appointment date – referral back to the GP should only be considered after multiple ie. 2 or more DNAs;
- they cancel one or more appointment - by contacting to cancel an appointment the patient is engaging with the service so should not be referred back to the GP unless this is with their agreement;
- they are not immediately fit for diagnostics/treatments needed – this would previously have been a medical suspension. The operational tolerance for the 31d and 62d standards will be lowered to take account of this;

- they have not made contact after a first DNA within a given time period (eg. 7 days) – one might reasonably expect a Trust to make some attempt to contact the patient or the GP.

- ‘downgrading’ patients, for example:

- referred under the 2ww by a GP inappropriately – the GP should be asked to withdraw an inappropriate referral in this scenario;
- from the 62d standard to the 31d standard only or to 18w pathway because they are unavailable for non-admitted treatment for a period of time – no pause is allowed if a patient is unavailable for an offer non-admitted care but the tolerance will be lowered to take into account the increase in volume of breaches due to patient choice;
- unless they can ‘guarantee’ attendance within a certain timescale – the operational tolerance will allow for more breaches due to patients choosing to wait longer than 31d/62d for their treatment;
- by putting them on pending lists for non-admitted treatment until they are available – the operational tolerance will allow for more breaches due to patients choosing to wait longer than 31d/62d for their treatment;

Please note the above on local access policies has not yet been agreed by the SHAs.

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

CWT guide V5 – link:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063067

Annex A

Abbreviations/Acronyms used in July Q&A

18w	18 week standard
2ww	Two week wait standard
31d	31 day standard
62d	62 day standard
Appt	Appointment
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
MHRA	Medicines & Healthcare Products Regulatory Agency
MRI	Magnetic Resonance Imaging
ODS	Organisation Data Service
OE	Open Exeter (ie where the CWTDB is located)
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
TOP	Termination of Pregnancy
TURP	Transurethral Resection of the Prostate
TWR	Two Week Wait
Tx	Treatment
BRN	Unique Booking Reference Number
METS	Metastatic Disease