

GFOCW: Questions answered by NCAT – June 2009

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Two Week Wait (2ww)

Why include patients who explicitly choose to breach within the remit of the 2ww?

This was a policy decision and is in line with 18w ie. it is recognised that some patients may choose NOT to accept the earliest appointments along their pathway. The policy decision was made that this should be handled via revised operational tolerances rather than 'clock stops' or exclusions.

Can 2ww referrals by GPs be deferred until the patient is available?

The referral should be made by the GP as soon as appropriate. DH has no plans to issue further guidance on this. Management of referrals between GPs and secondary care is a matter for local protocol/policy. The best interest of the patient should be at the forefront of the policy.

In essence, this is being left for local discretion. In an ideal world the patient should be referred at the earliest opportunity because receipt of this referral flags to the receiving organisation that there is a potential cancer case on its way. NICE referral guidelines for suspected cancer advise that *'adult patients who are being referred with suspected cancer should normally be told by the primary healthcare professional that they are being referred to a cancer service, but if appropriate they should be reassured that most people referred will not have a diagnosis of cancer, and alternative diagnoses should be discussed'*. If the NICE guidelines are followed it will hopefully encourage patients to accept the earliest appointment offered where possible.

In summary, we would not encourage delaying referrals but the management of referrals is a matter for local protocol.

Symptomatic breast 2ww

Does the symptomatic breast 2ww standard apply to patients referred for cosmetic breast work?

No. Cosmetic referrals are excluded.

Does the symptomatic breast 2ww standard apply to males?

Yes, it applies to males too.

Do all patients referred under the symptomatic breast 2ww standard have to be seen in a one stop diagnostic clinic within two weeks – is there any prescriptive directive?

Symptomatic breast 2ww referrals need to have a **DATE FIRST SEEN** within 2 weeks. What happens at that appointment is a local matter. Triple test is the gold standard for urgent breast 2ww referrals and may well be appropriate for some symptomatic referrals.

31d treatment (first or subsequent)

Do we have any guidance on what constitutes Combined Treatments?

For the purposes of the GFOCW dataset, combined treatments are: *treatments of different modalities combined in a way that they must be scheduled to take place together*. These should be regarded as single treatment package. Examples of combined treatment include: chemoradiation (where radiotherapy and chemotherapy are delivered within a strict schedule so that they interact to make both treatments more effective eg: weekly 5FU during radiotherapy for rectal cancer, radiotherapy given synchronously with cycle 4 of CMF for breast cancer), or pre-operative radiotherapy and intra-operative radiotherapy (where radiotherapy is given just before or during surgery to maximise the effect of both treatments). The definition of combined treatments EXCLUDES adjuvant therapies where each treatment can be scheduled separately eg: breast surgery followed by post-operative radiotherapy or chemotherapy for small cell lung cancer followed by consolidation radiotherapy.

Haematology patients who require auto or allografts require cycles of chemo prior to the transplant in order for it to take place. Would this be recorded as one treatment as it is a package and would the start date be the start of the chemo? Or would this be recorded as 2 treatments? If it is recorded as one treatment, which modality should it be recorded as anti-cancer drug, surgery or other?

I have been advising others to class this as a package for the time being where the pathway ends with the start of the chemo. The tumour specific guidance will include the definitive advice once I have it. In terms of coding, BMT is classed as surgery.

We wanted to know about how to report patients having allogeneic BMT – the patient receives cells from a donor and obviously this might involve a wait whilst identifying a donor. This would obviously run the risk of creating a breach...do you think that it would be appropriate (and right) to start the clock when a donor is identified?

DTT would be when the donor has been found and the patient agrees that they want to go ahead with that procedure.

Head and neck patients require dental clearance prior to commencement of radiotherapy can this be classed as the start of their treatment as they would not begin radiotherapy until this had been done and a period of healing has taken place.

Dental clearance prior to radiotherapy cannot be classed as FDT. I will be sending out the draft tumour guidance to the relevant national clinical leads shortly for comment and will check if the position needs to change on this but for the time being you will need to follow this advice.

I have just received GFOCW May Q&A answered by NCAT. It states that dental extractions can be used as FDT. Can you confirm that this is the definitive guidance? We have uploaded several patients as breaches who would not be under this guidance.

The advice I gave you initially was correct i.e. a dental clearance prior to radiotherapy cannot be classed as FDT. The advice in the May Q&A was wrong. I will send out a correction.

Corrected question from May Q&A:

In the original detail in the cancer waiting times documentation, enabling surgery was defined as first definitive treatment if it were part of a treatment package, The two most significant examples were the formation of a defunctioning colostomy prior to a patient receiving radical pelvic radiotherapy for colorectal cancer, the second is extraction of decayed teeth prior to head and neck radiotherapy. In both cases the radiotherapy process cannot commence until these have been carried out. In both cases not only can radiotherapy not be given but also the planning of treatment cannot commence until healing and surgical recovery are complete. I cannot find reference to enabling treatment in the newest documentation. Are you able to confirm that they do still count as FDT?

The above examples would not count as FDTs, Previous CWT guidance (version 5) stated that:

- Palliative interventions (e.g. formation of a colostomy for a patient with an obstructing bowel cancer) could be classed as an FDT. However, a palliative intervention is not classed as an FDT if active treatment is also planned. Therefore a colostomy prior to radiotherapy is not classed as an FDT;
- a dental clearance prior to radiotherapy cannot be classed as FDT.

The following enabling treatments can be classed as FDTs. This list is not exhaustive and may be added to as tumour specific guidance is finalised or local queries arise.

- 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.

I have today received GFOCW May Q&A. I note that there has been a complete about face in the answer previously provided about enabling treatments. Could you let me know the source of this most recent information please? Patients are unable to have colorectal radiotherapy in cases where they are required to have a defunctioning stoma formed in order to preserve the bowel during radical treatment. There is therefore a delay for the required surgery and the necessary post operative recovery before the radiotherapy planning can commence. Similarly if a patient with an oral cavity cancer requires radical radiotherapy and they have any dental decay, they must have dental extraction performed. This will prevent the construction of an immobilisation device for the patient, again until post operative healing has taken place. This means that radiotherapy planning cannot commence. On the basis of the answers provided on 13th may, we have continued to count these enabling treatments as FDT as indicated.

The change came about after someone highlighted the response given in the May Q&A was incorrect. I went back and checked version 5 of the CWT guidance (ie. the original documentation to which you had referred) and it stated that stomas can count as FDTs if palliative with no active treatment following and that dental extractions prior to r/t are not FDTs. I interpreted from your e-mail that this original guidance had said they were allowed but I should have gone back to check for myself. It was my mistake to tell you that they were FDTs. I have double checked with DH and they have confirmed the position is as set out in red in the corrected May Q&A. They have however confirmed that for the data you have already submitted (ie Q4) you would not need to correct this as you acted in good faith on the advice I gave. For Q1 you will however need to follow the correct advice. I do understand the point you make about patients not being able to proceed with the r/t until these procedures have taken place. Previously a medical suspension would have been allowed but under the new system the operational tolerance will be lowered to allow for this scenario.

Having said that, now that we have the 31d subsequent treatment standard the issue of enabling treatments does need to be reviewed i.e. should dental extraction as an enabling treatment be allowed as an FDT given that any follow on treatment will now be covered by a 31d standard etc. This is something that I will raise with the GFOCW Advisory Group when there is an opportunity but in the interim the ruling above should be applied.

We have a number of patients that enter trials and I think there is a good case for ensuring that we put ECADs in for these patients, particularly when, as part of the trials we know there will be a number of steps that they have to go through before having treatment that will always take more than 31 days. Can we use ECAD for these patients where appropriate?

If the treatment will be their first definitive treatment then an ECAD is not appropriate as a first definitive treatment must start with a decision to treat (DTT).

If the treatment within the trial is a subsequent treatment then an ECAD could be used – see v6.5 of the GFOCW guide on the CfH website for the full definition of an ECAD – in essence it is the earliest date that it is clinically appropriate for the next activity (that actively progresses a patient pathway) related to a treatment to take place.

There are a number of patients who we need to ensure are fit following surgery before they can have treatment, for example, breast patients where they need to be able to lift their arm to a certain degree. Can we utilise ECADs for these patients?

Yes – this is just the type of scenario that ECAD can address.

For treatments that run concurrently ie chemo and radiotherapy is this classed as 2 treatments or one?

Chemoradiotherapy is classed as one treatment and has its own code in the revised dataset (Cancer Treatment Modality – Code 04). The start date will be the date the first of these modalities is delivered. If they are on the same day it will be the one that is chronologically first that would mark the end of the 62d or 31d pathway.

Would we count a loop LLETZ procedure as a first treatment or is it diagnostic please? The guidance (version 5 page 18) mentions “diagnostic loop biopsy” but when you read about it on Cancer Research UK pages it seems to be thought of as a treatment. Also the way it is described when coded is Loop “excision” which sounds as if the intention is to remove the tumour cells as well as to diagnose.

As you say, original CWT guidance made clear that a purely diagnostic procedure does not count as treatment unless the tumour is effectively removed by the procedure. If the excision biopsy is therapeutic in intent (i.e. the intention is to remove the tumour) then this will count as first treatment, irrespective of whether the margins were clear. The answer to your query would therefore generally depend on the reason for the LLETZ ie therapeutic or diagnostic. If the intention was diagnostic but the biopsy was found to be malignant the procedure could count as first definitive treatment if the tumour had effectively been removed by the excision.

Can stenting be classed as a first treatment with any active treatment recorded as a subsequent treatment? Can you let me know if it will be applicable for all sites e.g. lung, UGI, LGI?

The general rule is that a stent can be classed as first treatment where the patient is unfit for other treatment. However, some tumour specific exceptions have been allowed e.g. insertion of a pancreatic stent to resolve jaundice before a patient has a resection or starts chemo.

Now that we have the 31d subsequent treatment standard the issue of enabling treatments needs to be reviewed i.e. should a stent as an enabling treatment be allowed as an FDT given that any follow on treatment will now be covered by a 31d standard. This is something that the GFOCW AG will need to consider but in the interim the general rule above should be applied.

Prostate cancer patients are currently being consented for radiotherapy at the time of starting hormones which is a 3 month course. They then have a CT after the three months of hormones before starting their RT, we are currently taking the CT date as their DTT as the date of consent would be 3 months prior! Is this correct?

If the CT scan is being used to assess if r/t actually needs to be given then this could in effect result in a second DTT.

If the CT scan is to confirm if the patient is fit enough to undergo r/t then the date of the CT could be the ECAD or it could be used to determine when the ECAD might be i.e. from the CT scan it might be that a decision is made that the patient would not be fit to start planning r/t for another 2 weeks in which case the ECAD would be set for CT date plus 14 rather than the CT date itself.

What is the difference between recurrence, relapse and progressive disease in terms of cancer waiting times standards: The definition of relapse and progression appear to be the same but there are two codes (one for each) in the CWT dataset to distinguish between them. Could you advise if there is a difference between the two and if so what it is please?

GFOCW guide v6.5 states that: "*A recurrence is where a patient has previously been informed that they are free of the disease. A relapse or progression of a disease is where this has not happened. Relapse and progression are terms more commonly associated with non-solid tumours (e.g. haematological malignancies) where it is more difficult to clearly identify if a neoplasm has been eradicated.*"

I have sought advice from the relevant national clinical lead on how to distinguish between relapse and progression. Apparently this is not straightforward. In the absence of more detailed guidance a clinical decision should be taken locally on the most appropriate categorisation and therefore which code to use.

62d (from 2ww)

A patient is on the 62d pathway and whilst there is diagnosed with another condition which needs treating/resolving before cancer treatment can be given (e.g. patient has had an MI or requires an urgent hernia operation) and this would necessitate a 2 or 3 month delay. Should Active Monitoring be instigated as a treatment for the cancer as the Consultant is still keeping the patient under review but is awaiting resolution of the other clinical issue?

This should not be classed as active monitoring. This would previously have been a medical suspension. We are handling this differently ie. instead of pausing the clock, the clock will continue and the patient will breach but the operational threshold will be lowered to allow for this.

Can you confirm that we should apply the following from CWT guide v5 to the current standard:

'2.9 Does the 62 day target apply when a patient is referred on suspicion of one cancer but is diagnosed with a different cancer?'

Yes, any patient who is referred as a suspected cancer and diagnosed with cancer should be monitored under the 62-day target from urgent referral to treatment. To meet this target trusts will require rapid handover arrangements between tumour groups where this situation can arise. Examples of the tumour groups where this may occur include:

- * Gynae/Colorectal (symptoms non-specific)*
- * Breast/Lymphoma (axillary lumps)*
- * Head and Neck/Lymphoma/Lung (neck lumps)*
- * Upper GI/Lower GI (symptoms non-specific)'*

Yes - this does still apply.

If patient is under 16 years of age and/or is a testicular patient or is an acute leukaemia patient and routinely referred (so not 2WW), what is the standard? Is the standard still 31 days from Cancer Referral to Treatment Period Start Date? Or is the standard the same as in routine referrals for other tumour sites ie. only the 31d standard from DTT?

If a patient under 16 years of age was routinely referred but was subsequently diagnosed with cancer as you describe they would not be covered by the 62d equivalent 31d standard. They would however be covered by the original 31d standard from DTT to treatment. Only those patients urgently referred with suspected cancer (childhood, acute leukaemia or testicular) are on the 31d (62d equivalent) pathway. However, a consultant (or an authorised member of the consultant team) would be able to upgrade patients they suspected might have one of these cancers but who had not been urgently referred. The upgrade would be on to a 62 day period but it would be deemed as good practice for the locality to seek to deliver the treatment within 31 days where possible. Achievement within 31 days will not, however, be monitored centrally – monitoring will be against 62 days for such an upgrade.

62d screening

Who issues the PPI number for patients on the 62d screening pathway?

The provider receiving the referral that would result in the patient being seen for the first time for a particular condition/ suspected condition.

Who would be responsible for uploading first seen and treatment part of the screening pathway?

Provider commissioned to provide the appt classed as **DATE FIRST SEEN** is responsible for uploading that part of the pathway and would share any breach.

Provider commissioned to provide the first treatment is responsible for uploading that part of the pathway and would share any breach.

It may be the same provider or 2 different providers.

We have come across instances where the screening host site have been uploading the treatment part of the pathway for some patients recording them as breaches when pts have been treated at a different Provider within standard causing a conflict of data uploaded.

The screening host should only upload the treatment part of the pathway if they were commissioned to provide the treatment.

Bowel

Recording cancer waiting times for bowel cancer screening is dependent on how a service is commissioned. Please can you confirm if the following is correct:

A) If X (as the Lead Provider) is commissioned from the National Programme but sub-contracts to Y, this means that X is the Commissioned Lead Provider and is therefore the host Provider specifically commissioned to provide the service and thus share any breaches with the treating Provider.

Correct

B) If X and Y were commissioned separately from the National Programme (with X merely taking the lead operationally), then both X and Y are host Providers and either can share a breach with the treating Provider.

Correct

C) Y will inform positive patients from screening populations A and B and these patients will be seen by an SSP based at Y Trust in a Clinic at Y. The patient will undergo Colonoscopy within Y Trust. If cancer is identified the patient will be MDT'd at Y and will be treated at Y. Who is responsible X or Y?

If Y is commissioned to provide the service this is their activity and any breach is theirs. If X is commissioned to provide the service but subcontracts to Y it is X's activity and breach (if there is one).

D) X will inform positive patients from the screening populations C and D and these patients will be seen by an SSP based at X Hospital. The patient will undergo Colonoscopy at X and if Cancer identified the patient will be MDT'd at X and will be treated at X. Who is responsible X or Y?

If X is commissioned to provide the service it is X activity and breach (if there is one). If Y is commissioned to provide the service but subcontracts to X it is Y's activity and breach (if there is one).

E) Unless absolutely necessary, we would envisage that at no time would a patient screened at either site be treated by the other provider if cancer is diagnosed – they will continue to be treated at the site they were screened unless having radiotherapy which would be undertaken at Trust Z. What happens about sharing then? Would the breaches be split 3 ways?

If a patient is treated elsewhere any breach is shared between the Provider commissioned to provide the appointment classed as **DATE FIRST SEEN** (in your case with the SSP) and the Provider commissioned to provide the resulting treatment.

Patient referred via bowel screening for a colonoscopy following positive FOB. Colonoscopy is negative/normal so patient would receive a recall a year later under the same referral. If they were then diagnosed with cancer under the original referral they would breach the 62d standard. Should the original referral be closed (no cancer diagnosed) following the normal colonoscopy and if cancer is diagnosed at recall a new referral generated as Consultant Upgrade, or should the diagnosis be recorded against the original referral as a breach?

DH has recently responded to a similar query on how to manage a patient with a positive FOB but a negative colonoscopy for the 62d standard. The response was as follows:

"A patient is placed on the 62-day pathway from a bowel cancer screening service when a referral for pre-colonoscopy assessment with a PRIORITY TYPE of "2" (urgent) is received by the local NHS provider commissioned to deliver these services within the bowel screening programme. They would remain on the fast-track pathway until a cancer diagnosis is excluded. This may be when a negative colonoscopy occurs, but would not be if there was still a suspicion of cancer. When cancer is excluded the patient remains on a RTT (referral to treatment pathway), but the target time expands from 62-days to 18 weeks.

It is important also to note that a 62-day pathway runs from referral to the first definitive treatment for any cancer in the range C00 to C97 or D05. Therefore, even if a patient was referred onto the pathway (at a pre-colonoscopy assessment) following a positive FOBT test the colonoscopy may

not be the definitive diagnostic test (there are other places the blood may have come from), therefore the patient will remain on the pathway until all suspicion of cancer is gone.

If a patient is removed from the 62-day pathway it will be because they are formally told of a benign diagnosis by the consultant (or member of the team) responsible for their care."

The key to your question is therefore what the patient was told i.e. if they are told that they do not have cancer but they will be kept under surveillance you can end the 62d pathway.

Patient is 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?

Further advice is being sought on this and the response should appear in the July Q&A.

Breast

Where is day 0 ie. when the pathway begins? Is it when we receive the referral from the host screening site - if not when/where does the pathway begin.

Day 0 is receipt of the referral for further assessment (ie. rather than placing women back on routine recall)

62d upgrade

No questions this month

Pauses

We have a query whether a pause can be made in the following scenario for a 31-day 1st treatment: *DTT 26/05/09 - Patient wanted to defer the start of treatment until the consultant returns from annual leave. Patient would have been able to start chemo on 11/06/09 if they had not deferred. The treatment is chemotherapy, which will be delivered as a day case.* Please let me know if it would be possible to 'pause' the clock in this case? If yes would the clock pause run from the 11/06/09 until the consultant returned from leave?

Having discussed this matter, and in this particular instance, we agree that a pause is possible i.e. the patient is declining a reasonable offer of an appointment to start treatment with another consultant. We agree that the patient would make themselves available again (and therefore the clock re-start) once the consultant is back from leave. [*Note: this advice applied because the chemo was an admitted treatment in this scenario*]

In view of the above, please confirm that when chemo is to be given as the first treatment and the patient declines, once a date has been made, that an adjustment can be made in all instances?

No, the response above did not mean that. For example, if the chemo was an outpatient appointment no adjustment could be made, also if the patient cancelled an appointment once a date had been made a pause could not be made etc. An adjustment can be made if a patient declines a reasonable appointment for admitted treatment. We do not have a definitive list of all the scenarios that might come under the heading of 'declining a reasonable appointment' – like 18w the overarching principles are set out but there is an element of local discretion about how this is implemented/interpreted. Some national guidance on pauses is available in v6.5 of the GFOCW guide on the CfH website and we will give additional national steers where we can/if it is appropriate.

Please clarify how to handle DNAs in relation to the 2ww standard?

Please see questions A4.4 - A4.10 in v6.5 of the GFOCW guide which is available on the Connecting for Health website at the following address:

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

In summary, if a patient DNAs their first appointment (i.e. what would be classed as the **DATE FIRST SEEN**) they should NOT be referred back to the GP. Cancer waits use a slightly different rule to 18w here. For suspected cancer patients the clock is re-set to when the patient re-books their appointment rather than the patient being sent back to the GP. Given the seriousness of the potential condition agreement was reached with the 18w team that for suspected cancer patients the patient should not be referred back to the GP after a single DNA but should instead be kept on active tracking. If, however, the patient has multiple DNAs (2 or more) of the first appointment they can then be referred back to the GP if that is in line with local policy/in the best interests of the patient.

If you are aware of any Trusts that are operating a policy of referring patients back to their GPs after a single DNA of the first appointment I would be grateful if you could draw to their attention that this runs counter to the GFOCW rules set out in GFOCW guidance v6.5 and as explained at GFOCW workshops hosted by SHAs in October 2008 and in Feb/March 09.

We currently have a urology patient who has been offered an Open Prostatectomy well within his breach date but, has declined and wishes to wait for a Laparoscopic prostatectomy which will be after his breach date, are we able to remove time as 'patient pause'?

It depends! If you offered open and lap prostatectomies as both were clinically appropriate and the patient chose lap you could not pause the clock just because you do not have the capacity to provide the treatment within the timeframe. If you offered open prostatectomy as the most clinically appropriate option and the patient asked about lap which the clinician then thought was a suitable alternative then a pause would be possible as the patient declined a reasonable appt and requested something that was not originally offered. One could argue that the above could lead to patients only being offered treatments that a Trust can deliver on time. However it is assumed that clinical teams have the best interests of the patient as their priority at all times and would ensure that all clinically appropriate treatment options are considered.

Would the above advice change if the laparoscopic surgery is being offered at a non designated site?

The cancer waits admin rules remain the same. However, we would expect treatments offered to follow usual clinical practice safeguards. Offering treatment in a non-designated centre is not something we would therefore support.

What happens under 18-weeks rules if a patient delays (cancels, postpones, etc...) but does not DNA their 1st OPA, and is cancer is consistent with this?

If a patient cancels or delays their first OPA (ie. does not DNA) the 18w clock continues to tick. Cancer is consistent with this.

Breaches

We have a breast screening patient who has breached the 62 day target. The delay, as well as thinking time on part of the patient, was caused by trying to combine a theatre list with a breast surgeon (supplied by X) and a plastic surgeon (our plastic surgery services are provided by Y Hospital). The patient was operated on in X Hospital (the plastic surgeon also runs an outpatient clinic in X but all activity is credited to Y). As the treatment was half supplied by another hospital, although in our hospital, can half the breach be given over?

A breach can be shared between the Trust commissioned to provide the out patient part of the pathway (**DATE FIRST SEEN**) ie. the host screening centre and the Trust commissioned to provide the treatment episode. If, for some reason, you had 2 trusts directly commissioned to provide the treatment episode ie one for the anti-cancer surgery and one for the cosmetic surgery it would be the former that would share the breach.

If a 2 week wait patient does not attend their first OPA because they are an inpatient for another condition would this be classed as a breach?

If they DNA'd their first appointment you can use the pause irrespective of the reason for the DNA. If they did not DNA i.e. you were informed that they could not attend because they were currently an inpatient for another condition the clock would continue to tick as a pause is not possible. The patient may well then breach but the operational tolerance is being lowered to take into account these types of scenarios.

Am I right in thinking that the CQC will still only consider reallocating cancer waits breaches if a patient has been referred to the treating trust after the 62nd day? The reason I ask is that the DH seems to be suggesting that cancer networks can decided locally what date should be taken as the cut-off, eg any referral after day 52 or 42 etc.

The CQC approach remains that reallocation becomes a possibility if the patient has been referred to the treating trust after day 62 (and the delay was for predominantly administrative reasons). I think what DH are saying is that local networks and trusts are advised to agree a cut-off date to ensure that tertiary treating trusts are given sufficient time to treat patients without breaching the standard. An analysis undertaken under the old pause methodology indicated that referring on or by day 42 should normally give the treating trust time to treat the patient without breaching the standard. So the idea was that trusts put processes in place which reduced the likelihood of breaches in the first place, and the CQC reallocation policy is there as a last resort where transfers take place after the breach starts. DH intend to redo this analysis taking into account the new pause methodology to see if day 42 remains the date for referring to give the best chance of treatment within standard.

Under the extended CWT standards we have seen an increase in the number of patients referred on or after day 62 (because of waiting time adjustments being stripped out) and are therefore requesting more reallocations of breaches. However, numerous trusts are refusing to accept the reallocations quoting the CQC rule around administrative delays in patient pathways. My query is around the validity of this rule now that all adjustments have been removed - surely the removal of adjustments should also apply to reallocation of breaches - meaning that a late referral for any reason is the responsibility of the referring organisation, not just when administrative delays were experienced? It seems unfair to penalise the treating trust when patients have already breached prior to referral. We are unable to know what our true level of performance is until we get this issue resolved.

This issue has been raised with CQC who will keep it under review but for the time being the position is unchanged.

Advice from CQC: Thank you for getting in touch and sharing your concerns - we really appreciate being informed, and sharing your experiences as trusts in similar positions seems like a good approach. NCAT did raise this recently with us, although it has been difficult to consider our response without a full understanding of the Q4 data and the impact of the change in clock rules - and indeed without knowing the proportion of your requests for reallocation which the referring trusts are refusing.

We are happy to look further into this and consider whether a) it would be appropriate for delays other than admin to qualify, and b) whether referrals to the treating trust before day 62 could qualify, but we don't think it would be possible to incorporate any changes into the policy for 2008/09, because of the time it will take to analyse this and get it approved, and when the policy and forms for 2008/09 have already been published. As you know, up to now the Commission has taken the view that neither change should be made, but we do acknowledge that the new clock rules could potentially have an impact on this.

Performance management

Is there any indication of when the new operational standards may be published?

The Department of Health is aiming to have the development work for operational standards completed by mid July, this will enable to Care Quality Commission to use them in their assessment should they wish to do so.

What are your reporting plans for the various 62d standards?

For the 62d standard (from 2ww, screening, upgrades – and from end 2009 symptomatic breast) they are classed as separate standards and will have separate tolerances. DH has no plans to merge these into a composite 62d standard. You will need to check the CQC website for how they plan to use 62d data. In addition you should note that the 62d screening standard will NOT separate out patients from the various screening programmes.

How we are being nationally measured on the 31 day target and the 62 day target ie. will there be separate targets set for all the types of second and subsequent treatment (surgery, drug, radiotherapy, other) and each of the 62d standards or will they all be combined into a single target? On Open Exeter, the final monthly reports that are shown are split down - the 31 by first and then subsequent treatments and the 62 day target by screening and then the original 62 day target patients etc. Are we measured by looking at the total or each individual part?

For the 31d standards (FDT, subs drug, subs surgery, subs radiotherapy and subs other) they are separate standards and DH will issue separate tolerances. The results for 31d drug and 31d surgery will however be fed into a larger 31d indicator given that they were both due to be delivered by the end of 2008. Whether or not r/t and other treatments will eventually be merged into a larger indicator post 2010 is not yet known.

For the 62d standard (from 2ww, screening, upgrades – and from end 2009 symptomatic breast) they are classed as separate standards and will have separate tolerances. DH has no plans to merge these into a composite 62d standard.

You will need to check the CQC website for how they plan to use the 31d and 62d data.

Will there be a separate target for symptomatic breast referrals, or will these be combined with the existing 2WW for suspected cancer referrals?

They will be kept separate.

Will there be separate tolerances for each of the three screening programmes (breast, bowel and cervical)?

No. There will be a single tolerance for the 62d screening standard.

Why are the palliative treatment patients being included in the calculations for the 31 day subsequent treatment reports if only surgery and chemo are live standards for this year? I also understand from the network that radiotherapy patients are also being included. Will this be taken into account later?

DH response: *"The reports show all modalities, a total and the "groups" that are live this year. The NHS can therefore see performance against the current standards, and manage implementation of the future standards against VS trajectories."*

For 62d operational tolerance, some Trusts are working on the 86% which was in Mike Richards' Dec 08 letter while others believe that DH has increased this to 88%. Could you let me know which it is at present 86% or 88%?

The answer is that it is neither! DH has not yet set a tolerance. The figure in Mike's letter was an estimate based on an older quarter of data. The figure in the DH document is a 'guesstimate'. Either can be used as a proxy if you wish. The actual tolerances are expected to be available in mid July.

When calculating compliance rate should the tertiary referral count as a full treatment or a part treatment on the 62 day targets?

Performance figures appear under the accountable provider ie. if the provider was commissioned to see the patient (**DATE FIRST SEEN**) and treat the patient (**TREATMENT START DATE (CANCER)**) the 'whole' patient is recorded against their organisation. If they were only responsible for one part of the pathway (i.e. just **DATE FIRST SEEN** or just **TREATMENT START DATE (CANCER)**) then they will be responsible for 0.5 of the patient i.e. performance is apportioned.

Therefore for a 62d standard the tertiary provider would only be responsible for 0.5 of the patient (assuming that the patient was first seen elsewhere). In terms of the 31d standard (for first or subsequent treatments) the treating provider is the accountable provider for the whole pathway i.e. breaches are not shared.

Where the first treatment is showing as commenced but there are no treatment details, how are subsequent treatments recorded?

Subsequent treatments are individual 31d periods. It is therefore possible to upload details for a 31d subsequent treatment period even if the details for the first treatment period have not been uploaded.

Why doesn't the CQC 2ww indicator construction separate out Q1-3 and Q4 as they have done for 31d and 62d?

This is a point you will need to raise with the CQC.

Who are performance figures recorded against for breast screening? Scenario: A patient is referred to X breast screening unit, where they are first seen. They are then sent to Y Trust for treatment. Would Y, on behalf of X, upload up to date first seen along with the treatment data? And, under whose performance figures would this patient be recorded?

My understanding was that X provides screening but that the host Trust is Y. I also understand that X hospital is not located within the Y Trust.

If Y is the host provider commissioned to provide the breast screening service then they are responsible for uploading the data up to **DATE FIRST SEEN**. X can only upload data on behalf of Y if they are authorised to do so (ie. if it is part of their contract).

If Y has been commissioned to provide the treatment they are responsible for uploading this activity.

Performance figures would appear under the accountable provider ie. if the provider commissioned to both to see the patient (**DATE FIRST SEEN**) and treat the patient (**TREATMENT START DATE (CANCER)**) then the 'whole' patient is recorded against their organisation. If they were only responsible for one part of the pathway (i.e. just **DATE FIRST SEEN** or just **TREATMENT START DATE (CANCER)**) then they will be responsible for 0.5 of the patient i.e. performance is apportioned.

Please could you confirm that the CQC take their cut of data each quarter as opposed to monthly? I am asking because we have an issue with another trust submitting our treatments with different PPI's and dates - including breaches. These were submitted hours before the APRIL 09 deadline closure and we only had time to trace the issues, not to resolve them. This is being addressed now, but I was seeking confirmation that if the data is amended to reflect the correct pathways that this amended data would be collected by the CQC.

The CQC use the quarterly data (at the end of the reporting year) not the monthly data although I understand that they can request access to a particular month's data if there are any concerns. In terms of the problem you have with the April data you should have time to correct it for Q1.

Dataset

NHS Number

How do we handle patients treated in England whose care was commissioned by a Welsh LHB?

Response from DH; All patients treated within the English NHS should be reported. Those whose care is commissioned by a Welsh LHB can be removed from the statistics reported to the CQC as their NHS Number can be used to identify the commissioning LHB.

What does the English NHS mean for cancer waits?

English NHS in this context refers to Health Care Provider Organisations within England who are treating PATIENTS with cancer (where the PATIENTS have NHS NUMBERS which exist on the Patient Demographic Service database, and which can be used within the National Cancer Waiting Times Monitoring Data Set for transmission purposes) who may have been referred from outside England.

What about patients that are not residing in England (eg. Brits in Spain, the in Scottish, Welsh and those from Northern Ireland)?

Anyone treated in England with an acceptable NHS number can be uploaded onto the CWT-DB.

Cancer Or Symptomatic Breast Referral Patient Status

In Patient Status there does not appear to be an opportunity to record '*Diagnosis of new cancer confirmed, treatment planned*' so I have assumed that this is left in the '*not planned stage*' permanently. Is that correct?

Response from DH:

*If a patient has been diagnosed with cancer, but no course of treatment has been agreed the **CANCER OR SYMPTOMATIC BREAST REFERRAL PATIENT STATUS** should be recorded as: 10 Diagnosis of new cancer confirmed - first treatment not yet planned. This will remain the case until their NHS treatment is planned, at which point their status becomes: 11 Diagnosis of new cancer confirmed - English NHS first treatment planned .*

Primary Diagnosis (ICD)

Now that we are recording the ICD10 code to the 4th digit, if a patient is diagnosed with 2 different foci of breast cancer - one in the upper inner quadrant (C50.2) and one in the lower outer quadrant (C50.5) of the same breast, would we just record one of these or both bearing in mind that the treatment would most likely be a mastectomy so Decision to Treat and Treatment Dates would be the same?

If there were 2 breast referrals (ie 2 different PPIs) leading to the diagnosis of two primary cancers then you could have separate records one for each of the primaries and they would both end on the same day ie. with the same operation. However, it is more likely that this was a single referral that has resulted in cancer being found in 2 sites. It is not possible to record 2 ICD10 codes so I think (for this rare occurrence) you will need to either pick one of these sites and record it or code it as breast cancer with site unspecified. I have asked the NCIN if they are content with this given implications for cancer registration and will let you know if they advise differently.

If a patient has an unknown primary and is recorded as ICD10 code C80 because they have some form of treatment but then subsequently have another diagnostic test at some point afterwards which identifies the primary site, should we change the ICD10 code or not?

No, you do not need to change the ICD10 code. The correct ICD10 code can be used for any 31d subsequent treatments that follow but you would not need to retrospectively change the ICD10 code for a record that had been completed (ie FDT given for mets of unknown primary) as the ICD10 code was unknown at the time.

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

Advice has been sought and a response should be available in the July Q&A

What ICD10 code do you use when treating an unknown primary?

If you are treating mets of an unknown primary you would use codes C78.0-C79.8 ie. whichever is relevant to the mets site you are treating.

If you are treating the unknown primary (eg. with palliative treatment) you would use code C80 which is for malignant neoplasm without specification of site.

Metastatic Site

When would the ICD10 code for metastases be used in place of the primary code? All guidance produced suggested that the ICD10 code for the primary diagnosis should always be recorded (unless C80 – unknown primary) but the codes C78 - C79 are valid for reporting for cancer waits. Where a patient is treated for primary and then mets this is fine but one example we have is a colorectal patient referred to a tertiary centre for treatment to lung mets following treatment in the DGH for colorectal primary. If as the guidance suggests the original primary should be recorded then why are the codes C78 - C79 included and when would they be used?

Response from DH: Where it is primary Lower GI with lung mets the ICD-10 code used should be that of the lower GI cancer with the mets given as lung mets for any subsequent treatments.

From validation of upload data, it appears you are not allowed to treat for primary cancer if there is a metastatic site, which doesn't make sense. A lot of patients have metastases as well. Please advise why this isn't allowed.

You can treat a primary where there is mets you just don't upload the detail of the mets on the first treatment record. If mets details were included on the record for a known primary it would not be clear if the treatment being reported on the CWTDdb was for the first treatment of the primary or for treatment of the mets. Therefore, for first treatment of a primary you don't include the metastatic site. However you could upload a 31d subsequent treatment record related to the metastatic site if a treatment was delivered. You are not the first to raise the logic of this approach and it may be something that could be reviewed at a later date.

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 has been sought and a response should be available in the July Q&A.

Cancer Treatment Modality:

I have been asked how to classify, for CWT, treatment using radioiodine. Can you clarify whether this is 'Cancer Treatment Modality' 04 (Chemoradiotherapy), or 18 (Other Treatment) or something else? And does it count as 'chemotherapy' (live target) or 'RT and Others' (2010)?

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 would need to go to ISB) it should be coded as 'other treatments' ie. code 18. As such it will come under the 2010 31d standard for 'other treatment'.

How should I code Bone Marrow Transplanatation?

It should be coded as surgery ie. code 01.

CWTDb

We are currently uploading our April patient information. We uploaded our breast information, and the information was processed and accepted. However, when running the preview reports, it is showing 0 patients, but other 2ww patients we have uploaded are showing. Is there a problem with the system in some form?

You need to report this to the Open Exeter helpdesk. We do not have sufficient access to be able to assist you with this sort of problem. The phone number for the helpdesk is: 01392-251289.

When some Trusts in X SHA are uploading data on Open Exeter they are getting no error message but then finding that not all the data was in the report. Have any other SHAs raised this?

You need to report this to the Open Exeter helpdesk. We do not have sufficient access to be able to assist you with this sort of problem. The phone number for the helpdesk is: 01392-251289. No SHA has mentioned it to me though some NHS Trusts in different parts of the country have raised issues about uploads not equalling what they expected. Some have found that they uploaded incorrect info; others have logged issues with helpdesk for investigation.

For subsequent 31-day treatments we can analyse Trusts or PCTs by Tumour Type OR by Treatment Group, but we cannot analyse by BOTH Tumour Type and Treatment Group. This means we cannot analyse the treatment modalities by tumour type - e.g. I cannot tell our Urology NSSG whether their cases/breaches (Trust or Network) were surgical, drugs, RT, palliative or 'other'. In fact I cannot even group these according to the separate targets - surgery + drugs ('live', accountable) or RT + other (not yet 'live' or accountable) - though I CAN do this at Trust/PCT level for all cancers.

The reports are going to be a simplistic high-level overview. We anticipated that networks, PCTs and SHAs will want to drill down into the dataset to look at the performance of individual services. However due to the small numbers in some cases and inconsistent service configurations nationally it was decided that this type of work is best done by local analysis using the anonymised download function.

In the Treatment Group reports, national average comparison figures are only provided for each modality/group category, and not in the clusters we will be performance managed ie. not aligned to the standards

Note from DH: The reports produced identify performance in a manner consistent with the dataset that is passed to the CQC for their annual assessment, and that which is published by the Department of Health at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_099885

Both of these datasets identify separate lines for each of the 31-day subsequent treatment standards, even though they are used in aggregate indicator. It should be noted that the CQC 31-day indicator includes all 31-day standards, not just those in Vital Signs, and that a reporting methodology that supported Vital Signs and the CQC requirements had to be developed.

There are some refinements that would be useful, such as: provider codes (Trust First Seen, and Trust First Treating) on Commissioner/PCT exception reports - otherwise one has to download the case data and trawl through it to find out that a Trust from some other Network failed to deliver for one of our residents); and provider codes and Tumour Types on 2ww exception reports - otherwise it is virtually impossible to map them to individual services. I'm sure we will think of more!

Note from DH: As always there will be a continual evolution of the reports and functionality, which will begin once all of the initial development work, has been finished and the full functionality of the system has been restored. If you have any specific suggestions there is a change request form on the CfH website.

What reports will be available from CWT-Db?

There follows the list of reports that will be available on the CWT-Db once it is completed. If any report you think is necessary does not appear on the list you can submit a change request to the Open Exeter helpdesk. Your request will be given consideration in the coming months i.e. once the full system is up and running DH/CfH will be able to consider such change requests.

- Report 1.1 – the Cancer Two Week Wait Report;
- Report 1.2 – the Breast Symptom Two Week Wait Report;
- Report 1.5 – the Two Week Wait Referral Management Report;
- Report 2.1 – the 31-Day First Treatment (Tumour) Report;
- Report 2.2 – the 31-Day First Treatment (Treatment Group) Report;
- Report 2.7 – the 31-Day Subsequent Treatment (Tumour) Report;
- Report 2.8 – the 31-Day Subsequent Treatment (Treatment Group) Report;
- Report 3.1 – the Cancer Plan 62-Day Standard (Tumour) Report;
- Report 3.2 – the Cancer Plan 62-Day Standard (Treatment Group) Report;
- Report 3.7 – the Cancer Plan 31-Day Rare Cancer Standard Report;
- Report 4.1 – the CRS 62-Day Screening Standard (Tumour) Report;
- Report 4.2 – the CRS 62-Day Screening Standard (Treatment Group) Report;
- Report 5.1 – the CRS 62-Day Upgrade Standard (Tumour) Report;
- Report 5.2 – the CRS 62-Day Upgrade Standard (Treatment Group) Report;
- Report 6.1 – the Commissioner Based Cancer Two Week Wait Report;
- Report 6.2 – the Commissioner Based Breast Symptom Two Week Wait Report;
- Report 6.5 – the Commissioner Based Two Week Wait Referral Management Report;
- Report 7.1 – the Commissioner Based 31-Day First Treatment (Tumour) Report;
- Report 7.2 – the Commissioner Based 31-Day First Treatment (Treatment Group) Report;
- Report 7.7 – the Commissioner Based 31-Day Subsequent Treatment (Tumour) Report;
- Report 7.8 – the Commissioner Based 31-Day Subsequent Treatment (Treatment Group) Report;
- Report 8.1 – the Commissioner Based Cancer Plan 62-Day Standard (Tumour) Report;
- Report 8.2 – the Commissioner Based Cancer Plan 62-Day Standard (Treatment Group) Report;
- Report 8.7 – the Commissioner Based Cancer Plan 31-Day Rare Cancer Standard Report;
- Report 9.1 – the Commissioner Based CRS 62-Day Screening Standard (Tumour) Report;
- Report 9.2 – the Commissioner Based CRS 62-Day Screening Standard (Treatment Group) Report;
- Report 10.1 – the Commissioner Based CRS 62-Day Upgrade Standard (Tumour) Report; and
- Report 10.2 – the Commissioner Based CRS 62-Day Upgrade Standard (Treatment Group) Report;
- Report 13.1 – The Referral to Decision to Treat Report (Tumour); and
- Report 13.2 – The Referral to Decision to Treat Report (Treatment);
- Report 14.1 – The Referral to Decision to Treat Report (Tumour); and

- Report 14.2 – The Referral to Decision to Treat Report (Treatment);
- Report 12.1 – the Network Provider Total Cancer Two Week Wait Report;
- Report 12.2 – the Network Provider Total Breast Symptom Two Week Wait Report;
- Report 12.3 – the Network Provider Total Two Week Wait Referral Management Report;
- Report 12.4 – the Network Provider Total 31-Day First Treatment (Tumour) Report;
- Report 12.5 – the Network Provider Total 31-Day First Treatment (Treatment Group) Report;
- Report 12.6 – the Network Provider Total 31-Day First Treatment (Treatment) Report;
- Report 12.7 – the Network Provider Total 31-Day Subsequent Treatment (Tumour) Report;
- Report 12.8 – the Network Provider Total 31-Day Subsequent Treatment (Treatment Group) Report;
- Report 12.9 – the Network Provider Total 31-Day Subsequent Treatment (Treatment) Report;
- Report 12.10 – the Network Provider Total Cancer Plan 62-Day Standard (Tumour) Report;
- Report 12.11 – the Network Provider Total Cancer Plan 62-Day Standard (Treatment Group) Report;
- Report 12.12 – the Network Provider Total Cancer Plan 62-Day Standard (Treatment) Report;
- Report 12.13 – the Network Provider Total Cancer Plan 31-Day Rare Cancer Standard Report;
- Report 12.14 – the Network Provider Total CRS 62-Day Screening Standard (Tumour) Report;
- Report 12.15 – the Network Provider Total CRS 62-Day Screening Standard (Treatment Group) Report;
- Report 12.16 – the Network Provider Total CRS 62-day Screening Standard (Treatment) Report;
- Report 12.17 – the Network Provider Total CRS 62-Day Upgrade Standard (Tumour) Report;
- Report 12.18 – the Network Provider Total CRS 62-Day Upgrade Standard (Treatment Group) Report;
- Report 12.19 – the Network Provider Total CRS 62-day Upgrade Standard (Treatment) Report;
- Report 12.20 – the Network Commissioner Based Total Cancer Two Week Wait Report;
- Report 12.21 – the Network Commissioner Based Total Breast Symptom Two Week Wait Report;
- Report 12.22 – the Network Commissioner Based Total Two Week Wait Referral Management Report;
- Report 12.23 – the Network Commissioner Based Total 31-Day First Treatment (Tumour) Report;
- Report 12.24 – the Network Commissioner Based Total 31-Day First Treatment (Treatment Group) Report;
- Report 12.25 – the Network Commissioner Based Total 31-Day First Treatment (Treatment) Report;
- Report 12.26 – the Network Commissioner Based Total 31-Day Subsequent Treatment (Tumour) Report;
- Report 12.27 – the Network Commissioner Based Total 31-Day Subsequent Treatment (Treatment Group) Report;
- Report 12.28 – the Network Commissioner Based Total 31-Day Subsequent Treatment (Treatment) Report;
- Report 12.29 – the Network Commissioner Based Total Cancer Plan 62-Day Standard (Tumour) Report;
- Report 12.30 – the Network Commissioner Based Total Cancer Plan 62-Day Standard (Treatment Group) Report;
- Report 12.31 – the Network Commissioner Based Total Cancer Plan 62-Day Standard (Treatment) Report;
- Report 12.32 – the Network Commissioner Based Total Cancer Plan 31-Day Rare Cancer Standard Report;
- Report 12.33 – the Network Commissioner Based Total CRS 62-Day Screening Standard (Tumour) Report;
- Report 12.34 – the Network Commissioner Based Total CRS 62-Day Screening Standard (Treatment Group) Report;
- Report 12.35 – the Network Commissioner Based Total CRS 62-day Screening Standard (Treatment) Report;
- Report 12.36 – the Network Commissioner Based Total CRS 62-Day Upgrade Standard (Tumour) Report;
- Report 12.37 – the Network Commissioner Based Total CRS 62-Day Upgrade Standard (Treatment Group) Report;
- Report 12.38 – the Network Commissioner Based Total CRS 62-day Upgrade Standard (Treatment) Report

Tumour-specific

Do we have any idea of when the Cancer Site Specific Information might be issued?

Lung, bowel, breast and brain almost finished and drafts of most others ready to go to relevant clinical leads for comment. Subject to what responses I get back and when I should be in a position to start releasing some of the guidance around the end of June. However, the tumour specific guidance will not change any rules/principles that are in the overarching guidance (v6.5). It will simply give examples of how these rules etc apply in different areas. If you have any tumour specific queries in the interim feel free to send them to me.

Bladder

Can I have an update about carcinoma in situ bladder cancer and whether they could be accepted as cancer for the purpose of waiting times?

Bladder carcinoma in situ is outside the scope of the CWT standards at the present time although the inclusion of in situ cancers in general is being reviewed. If approved for inclusion, this would not be immediate as DH would need to secure approval for the wider collection and amend the CWTDb system to allow the data to be accepted.

The May Q&A clearly states that ALL pTa Urology tumours are regarded as non reportable (currently) and that this is under review. Is there a distinction made for the WHO 2004 high or low grade classification? It appears that clinically these may follow different pathways and that patients with a pTa high grade tumour may be treated the same as a patient with an invasive tumour. Question – should any pTa tumours of WHO 2004 classification high grade be uploaded to Open Exeter?

Unless there is an ICD10 C code for the condition it is not covered by the CWT standards and a record should not be uploaded to the CWT database. There are plans to expand the system to accept pTa but this will not be possible for some months. When the change is made I will ensure that we are clear whether all pTa are included or only certain grades.

Breast

Now that we are recording the ICD10 code to the 4th digit, if a patient is diagnosed with 2 different foci of breast cancer - one in the upper inner quadrant (C50.2) and one in the lower outer quadrant (C50.5) of the same breast, would we just record one of these or both bearing in mind that the treatment would most likely be a mastectomy so Decision to Treat and Treatment Dates would be the same?

If there were 2 breast referrals (ie 2 different PPIs) leading to the diagnosis of two primary cancers then you could have separate records one for each of the primaries and they would both end on the same day ie. with the same operation. However, it is more likely that this was a single referral that has resulted in cancer being found in 2 sites. It is not possible to record 2 ICD10 codes so I think (for this rare occurrence) you will need to either pick one of these sites and record it or code it as breast cancer with site unspecified. I have asked the NCIN if they are content with this given implications for cancer registration and will let you know if they advise differently.

A patient is having bilateral revision of mastectomy scars. Would this be classed as a subsequent treatment for breast cancer or is this merely cosmetic?

Reconstruction and cosmetic procedures are not covered by the 31d subsequent treatment standard. Bilateral revision of mastectomy scars is a cosmetic procedure and therefore is not covered by the 31d subsequent treatment standard.

Change from May Q&A

May Q&A: POETIC trial requires breast cancer patients to have 2 weeks hormone (Aromatase Inhibitor) treatment, prior to the planned surgery. In the past, hormone therapy for breast cancer patients has not been counted as first treatment, but can you tell me whether this planned 2 weeks of treatment prior to surgery would now count as first treatment? Answer: I have been advised that the use of Letrozole prior to surgery is part of the clinical trial but should not be regarded as first treatment as one third of patients will be getting a placebo not the active drug.

New Query - why should the drug treatment not be regarded as the First Definitive Treatment given that there are two arms of the trial in a ratio of 2:1 with no placebo.

- **Group 1** Peri-operative therapy with an Aromatase Inhibitor (choice of AI =anastrozole or Letrozole) and excisional surgery 10-14 days later
 - **Group 2** No peri-operative therapy and excisional surgery 10-14 days later
- The trial is the *treatment option* for the patient so should be counted as first treatment'

This raises wider issues about managing clinical trials within cancer waits. Therefore, further advice has been sought and the advice has been revised. It is now advised that you should allow the hormonal treatment and the placebo arm of this trial to count as first treatment. It is noted, for example, that in blinded trials it would not be possible at the time of treatment to know who got which drug etc. The surgery in this trial should count as a 31d subsequent treatment.

Head & Neck

Head and neck patients require dental clearance prior to commencement of radiotherapy can this be classed as the start of their treatment as they would not begin radiotherapy until this had been done and a period of healing has taken place.

Dental clearance prior to radiotherapy cannot be classed as FDT. I will be sending out the draft tumour guidance to the relevant national clinical leads shortly for comment and will check if the position needs to change on this but for the time being you will need to follow this advice.

Haematology

Haematology patients who require auto or allografts require cycles of chemo prior to the transplant in order for it to take place. Would this be recorded as one treatment as it is a package and would the start date be the start of the chemo? Or would this be recorded as 2 treatments? If it is recorded as one treatment, which modality should it be recorded as anti-cancer drug, surgery or other?

I have been advising others to class this as a package for the time being where the pathway ends with the start of the chemo. The tumour specific guidance will include the definitive advice once I have it. In terms of coding, BMT is classed as surgery.

Prostate

Prostate cancer patients are currently being consented for radiotherapy at the time of starting hormones which is a 3 month course. They then have a CT after the three months of hormones before starting their RT, we are currently taking the CT date as their DTT as the date of consent would be 3 months prior! Is this correct?

If the CT scan is being used to assess if r/t actually needs to be given then this could in effect result in a second DTT.

If the CT scan is to confirm if the patient is fit enough to undergo r/t then the date of the CT could be the ECAD or it could be used to determine when the ECAD might be i.e. from the CT scan it might be that a decision is made that the patient would not be fit to start planning r/t for another 2 weeks in which case the ECAD would be set for CT date plus 14 rather than the CT date itself.

Sarcoma

Kaposi sarcoma (malignant tumour arising from blood vessels in the skin) is rare in the western world except for patients with Aids. As a centre for HIV care, we are finding some such patients with Kaposi Sarcoma (through our pharmacy reporting chemotherapy infusions). Please can you confirm that cancer services should be tracking and reporting these as they are having chemotherapy treatment in my Trust?

I can confirm that Kaposi's sarcoma is included within the remit of cancer waits and patients with this condition should be tracked against the relevant cancer waits standards.

Would Kaposi sarcoma be recorded as Skin, Sarcoma or a Haematology malignancy? Our haematologists deal with the cases but the diagnosis C46 ICD code is included under Sarcoma but CWT guide version 4-5 pg 23 has the query under Skin Please can you clarify?

I have looked at the ICD10 codes listed on the CfH website and C46.0 through to C46.9 are all related to Kaposi sarcoma and seem to be categorised as sarcoma. If you have any doubts I suggest you speak to your clinical coders.

Skin

Multiple Squamous Cell Carcinoma: Would we record these as a first definitive treatment when first diagnosed and then subsequent treatments for each lesion removed thereafter, or would this be a new first definitive treatment for each lesion?

In theory:

- if a second/third SCC is classed as part of the same condition ie. considered to be a recurrence then its treatment would be under the new 31d subsequent treatment standard.
- If it was classed as a new primary ie. not a recurrence it would be a new condition with a new PPI (if it came via 2ww etc) and would be under the 31d first treatment standard.

Whether or not an SCC is classed as a new primary would need to be a local clinical decision for now. It might be easier for each SCC to be classed as part of the same condition so the same PPI would apply and additional SCCs would always be classed as 'subsequents' but I need to get advice from the national clinical leads as to whether or not this is an acceptable approach.

If a patient has multiple SCCs requiring treatment that can be carried out as part of the same appointment I would advise that this be classed as one 31d period.

Malignant Melanoma - Would we record these as a first definitive treatment when first diagnosed and then subsequent treatments for each lesion removed thereafter, or would this be a new first definitive treatment for each lesion?

The same principles apply as for SCCs above.

It sometimes occurs that a patient will have lesions removed and will then be referred for Radiotherapy. We are working along the lines that the radiotherapy would be subsequent treatment – even though it may treat more than one area previously excised?

Agree that r/t is a subsequent treatment. If there is more than 1 PPI for the lesions (ie. if they had come in under different 2ww referrals etc) but the r/t is treating more than one of the excised areas I would take a pragmatic decision and just count the r/t as one treatment and link it to one of the PPIs only.

Granulosa cell tumour

Would it be possible to let me know whether a “granulosa cell tumour” is countable for CWT? Usually when in doubt we have a look into the histopathology to see how the tumour behaves etc but in this case I am still not sure. Our coders have coded it as benign but the trackers are treating it as a countable cancer?

Advice has been sought and a response should be available in the July Q&A

Miscellaneous

Three of our Trusts have merged into one from 1st April 09. In the raw data it is still possible to distinguish between the constituent elements (all three still have separate comprehensive cancer services, and will have for the foreseeable future) because they each have new 5 char provider codes. However, it would seem likely that, in the reports, they will be aggregated together and it will be impossible to analyse them separately without cross-checking with the download files, which will be very time-consuming. Can you offer any helpful advice here?

Advice from DH: The reports will continue to be maintained at the accountable level which unfortunately means they will not help your situation. Within the operating policy of the CWT-Db any analysis at a sub-provider level is to be carried out at a local level from the anonymised downloads (within local data protection governance), and not included in the aggregate reports due to the increased risk to patient confidentiality.

Do you know when the final version of GFOCW's version 6.4 is to be produced - currently we are using the draft version?

Version 6.5 has been on the CfH website for many months – see the Connecting for Health website:

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

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