

GFOCW: Questions answered by NCAT – May 2009

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Dataset

PPI

PPI number should have 20 characters but how should it be presented ie does it matter how it appears?

There are no restrictions, as long as the number is an20 (alphanumeric and 20 digits). We would however recommend that there are no spaces within the 20 characters as this has been shown to cause problems on some NHS systems.

We have heard that we do not have to upload the PPI even though the DSCN states that it is mandatory/ When I went onto the system the message came up that the PPI field must be blank or 20 digits. If it can be blank it implies that it is not mandatory. Please could you confirm whether this field is mandatory?

The PPI is a mandatory field within the CWT dataset and all mandatory fields are expected to be complete on the database by the end of the 25th working day after the end of a month or quarter.

In terms of how the CWT-Db will work when it is launched, a record would not be rejected if uploaded without a PPI but there may be repercussions for the internal processes of the CWT-Db to report on records correctly (eg. record matching) and if it is absent more local validation (probably manual) would be needed.

Although the PPI is a mandatory field the CWT-Db does not have checks and measures in place to ensure that this is included in every record at the point of upload. I understand that these validations have not been included in the system so that part-records can be uploaded. However, it is possible that in the future, actions such as audit of data completeness would be considered if there are concerns nationally that the mandate is not being followed.

In summary, if your local systems are not yet producing a PPI in the correct format then records uploaded without the PPI will not be rejected although this should not be encouraged and I do not know what action DH might take against Trusts not complying with the mandate.

Some staff have commented that their PAS systems produce a PPI that is less than 20 digits. Will this be rejected by CWT-Db?

The PPI **MUST** be a 20 digit alphanumeric number – the one used for monitoring and tracking patients on the 18w pathway. If the PPI is included within the CWT-Db record and is **NOT** 20 digits in length the record **WILL BE REJECTED** on upload.

We understand that some staff have commented that their PAS systems produce a PPI that is less than 20 digits. However, all organisations that are submitting the CDS (Commissioning Dataset) v6.0 to SUS and including the PPI are returning 20 digits. If they were returning less than 20 digits the CDS would be rejected at upload, which would impact on many areas including PbR. It is therefore likely that PAS systems

that only use an identifier of say 12 digits actually have a field length of 20 digits and export leading zeros (padding fields) upon export to pass the validation check. Local staff may not realise this if only the completed fields are displayed within the Trust.

If the PPI is accepted for the SUS upload it should be accepted for the CWTDb upload. The only problem will arise if, for any reason, local staff are manually inputting the PPI into the CWT-Db and cannot see the padding fields ie. if they can only see a 12 digit number.

In summary, if you are able to upload your PPI to SUS (even if you think it is only 12 characters) it should be OK as your local system is using padding fields (possibly behind the scenes) to ensure the PPI is actually 20 digits.

If a patient has been referred from an outside trust (therefore the date of referral and date first seen is at the first trust) how do we ensure that the PPI is transferred robustly?

There is an inter provider trust dataset that has been mandated for 18 weeks – this should ensure all the information required is transferred across.

Cancer Treatment Event Type

In the CANCER TREATMENT EVENT TYPE, there is Code 09 (Treatment for relapse of primary cancer (second or subsequent)) and Code 10 (Treatment for progression of primary cancer (second or subsequent)). What is the difference between relapse and progression?

I have sought advice from the national clinical lead on this and will respond when I have an answer. In the interim I suggest you ask your local clinician(s) whether a case is a relapse or a progression and use the appropriate code according to their advice.

If I enter the event type as 01 First Definitive Treatment for a new primary cancer, the database will not allow me to enter a metastatic site. However, if a patient has metastatic disease at diagnosis they may well be treated for both their primary disease and metastatic disease at the same time. There is no option here for First or Second treatments for a New Primary Cancer and associated metastatic disease. The database will only allow me to enter the metastatic disease if I list the primary as unknown and in many cases this is not accurate. Any ideas on how to get round this issue? Any guidance would be much appreciated?

If you 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 CWTDb 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.

Primary Diagnosis

Which clinical codes will be accepted by the CWT-Db?

Any ICD-10 code within the list published at:

<http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/clin coding> will be accepted by the CWT-Db system.

ICD10 field now needs 5 digits but not all codes are 5 digits ie. there remain some which have only 3 digits e.g. C61 - Prostate, C20 - Rectum. If the CSV spec specifies this field as AN5 will C61 which is AN3 be rejected by the system or does it have these codes listed as exceptions? how do we manage this?

The 5 digit code requirement in the CWT-Db is the maximum field length. We are aware that some ICD-10 codes do not breakdown to this level of detail and have therefore been retained at a three digit level (i.e. Cnn). The full list of codes the system will accept is available at:

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

Metastatic Site

Validation rules when uploading data do not allow you to enter treatment for a primary cancer if there is a metastatic site identified. This 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.

Tumour laterality

I am trying to establish a definitive rule for when we record tumour laterality. The obvious ones such as breast and lung are fine, but does ovary count as n/a - I read this in a cancer registry report - or should laterality be recorded? Also, what about head and neck cancers? Would it be correct to say we record tumour laterality (where known) for the following and n/a for everything else: breast, lung, kidney, testicle, tonsil, ovary(?).

You should record tumour laterality in all cases where it is applicable.

Source Of Referral for Outpatients

What sources of referral are permitted with a 2WW patient (not including breast symptoms) - is it still only codes 03, 92?

It is Codes 03,(General Medical Practitioner), Code 92 (General Dental Practitioner) or Code 12 (General Practitioner with Special Interest)

Multi Disciplinary Team Discussion Indicator

We've had a query on the MDT data items in the CWT dataset. The MDT data item in the dataset now states the following "Y - if the Cancer Care Plan was drawn up at a Multidisciplinary Team Meeting" What happens where there is a care plan drawn up before/after an MDT meeting but is not actually discussed at an MDT? For these patients it will look like they were not discussed at an MDT meeting in the upload, is this correct?

This data item is designed to capture the date of the MDT meeting where the care plan that was agreed was discussed. This may be one of many MDT meetings where an individual case is discussed. By omitting these data from the upload you are not saying the patient was not discussed, only that the agreed care plan was not discussed at an MDT meeting. This data item was introduced by DSCN 22/2002 and has not been changed during the upgrade to incorporate the CRS standards

A Trust was querying that where they have not actually discussed the care plan at an MDT it will look like the patient was not discussed. Is this a concern?

Whether patients are discussed at an MDT is one of the peer review measures, and is obviously a wider definition than the one used in the waits monitoring. The definition introduced by DSCN 22/2002 was purely to determine whether the episode/package of care we are collecting the waiting time data for had been discussed at an MDT. It may be the trust is wanting to monitor MDT activity to support the measures used for peer review.

Two week wait

Is the new methodology used for a TWW patient whose Date First Seen or whose Referral To Treatment date was in January?

Any patient with a DATE FIRST SEEN from 1 January 2009 onwards would be covered by the new counting methodology irrespective of when the decision to refer was made or when the referral was received.

PCTs want to set up a community based 2WW referral system for colorectal and urology patients. The GPs would refer directly to the community service and then refer into the secondary care service if further tests were required or cancer was proven. We are in a highly unusual position that we have 10 community hospitals so the plan would be for the patients to have all of their first appts (diagnostics) in the community. There would be exclusion criteria for those patients that medically could not be seen in the community. My questions are:

A - If the PCTs called the service and urgent referral service/screening service would that come under 2WW or would that come under the screening targets or even consultant up grade?

Yes it would come under the 2ww ie, the receipt of the referral from the GP to this service would be the start of the 2ww and the date first seen in that service would end the 2ww pathway

B - If it was called a suspected cancer referral service who would monitor the targets and up load them nationally and where would the monitoring sit if patients never came through the secondary care service, who would be responsible for those targets?

Responsibility for monitoring sits with the organisation commissioned to provide the service

C - If the PCTs are the provider for this service not secondary care and it is not called 2WW would those patients, proven with cancer get referred as an urgent and therefore be monitored under the 31 day target?

If the GP made an urgent referral to this service because they suspected cancer then this should be the 2ww referral – it would not be good practice to add an extra step in the process to avoid starting the 2ww and therefore the 62d pathway. If however a patient was referred to a community service without suspicion of cancer and cancer was diagnosed incidentally then yes they would just come under the 31d standard.

D - Alternatively if the diagnostic test is done and there is a high suspicion that this is cancer but only by clinical investigation should the patient then be referred via 2WW to the secondary care service?

If cancer was not initially suspected when a patient was sent to this community service but the suspicion was then raised then the GP could make a 2ww referral.

The key here is that if a GP is sending a patient to this service because they have a suspicion of cancer then that referral should be the start of the 2ww.

If a patient has had a previous cancer and is referred as a 2WW with a suspected second cancer, which is then confirmed, do they become a 31 day subsequent or stay on as a 2WW 62 day target.

If this is a new primary they stay on the 62d. If it is a recurrence they become a 31d subsequent ie the 62d standard does not apply to patients with a diagnosed recurrence.

Symptomatic Breast 2ww

Can you confirm that Breast Symptomatic Referrals will ultimately be monitored on the 62 Day Standard, but that this will not take effect until the two week standard is 'live' (Dec 2009)

That is correct.

Am I right in thinking that Trusts should be uploading data on the 2ww breast symptom referrals even though they won't be used for the Health Commission's 08/09 assessment?

Yes. Data on the symptomatic breast 2ww should have been collected locally from 1 Jan 09 and should be uploaded on to CWTDdb. This info will not however be part of the CQC (formerly HCC) assessment as the standard does not go live until the end of the year.

From the guidance it seems symptomatic breast patients are only subject to the two week rule and not to the 62 day standard. Please could you confirm that this is correct and that we won't be monitored on referral to treatment times for symptomatic breasts?

Patients on the symptomatic breast 2ww ARE on the 62d pathway if cancer is diagnosed. However, the 62d standard for these patients will not go live until the end of 2009 ie when the symptomatic breast 2ww goes live.

I'm not sure the date the 62 day standard for breast symptomatic referrals goes live – I presume it is Dec 2009 and hence outside the CQC assessment of performance for Q4. Could you possibly confirm?

You are right. As the breast 2ww does not go live until the end of 2009, the patients from the breast 2ww who are diagnosed with cancer will not be monitored against the 62d standard until the end of 2009.

We are being asked to upload data for all breast referrals as part of the big upload for Q4. Do we need to provide a breach reason for any 62D "breaches" ie routine breast referral, eventually treated outside 62 days given the standard is not yet live? Likewise there are a lot of 14-day breaches for these?

Yes. You need to complete the mandated dataset for breast 2ww referrals AND, for those that go on to be diagnosed with cancer, the mandated items for the 62d pathway. This would include breach reasons. However, although you need to collect this data from 1 Jan 09 and upload it to the CWTDdb from 30 April 09 you will not be performance managed on this until the standard goes live at the end of the year.

Apparently on C+B the national codes that we use for symptomatic breast referrals aren't available ie code 16. This means that when GPs send the referral in, they aren't differentiating between 2ww and symptom referrals. Is this a

national problem and are there any timescales to make changes to C+B before we are monitored on this target in Jan?

We are aware of this issue but there is no short term solution to this problem. We would recommend that coding on local systems is completed on the basis of the content of the accompanying referral letter from the GP in the interim where possible. There is no timescale for resolving this yet.

Please can you tell me whether you consider GP requests for mammograms for annual follow up purposes to be re included as symptomatic breast referrals?

Breast 2ww is for symptomatic patients so if the patient is not symptomatic then they are not covered by the symptomatic breast 2ww. If the GP suspects cancer they should make an urgent 2ww referral.

Does the national team have a view or recommendation that GPs should refer using two separate proformas i.e. one for suspected cancer and one for symptomatic referrals or to amend existing 2ww proformas to capture both?

You do need to be able to distinguish between the 2 types of referral but how you do it is up to you. If you have an existing 2ww form that you can tweak that sounds like a good idea but whatever system works for you locally is ok.

Patient is referred as a 2ww symptomatic breast but is subsequently diagnosed with a lung primary. Am I correct in assuming this patient will stay on the 62 day pathway? Or is this not applicable until December 2009?

The patient would be on a 62d pathway BUT as the source of referral was initially symptomatic breast 2ww and this standard will not go live until the end of 2009 you will not be performance managed for the patient in question.

Are there likely to be any repercussions from DH/CAT with nil returns for breast 2ww which is not a live standard.

You are right it is not a live standard BUT the mandate was to collect the full CWT dataset from 1 Jan 09. DH will be checking whether or not the data was uploaded and are likely to report to SHAs where the mandate has not been met. Whether or not other action will be taken I don't yet know.

31d treatment standard (1st or subsequent)

Is the new methodology used for a patient whose Treatment Start Date is in January or whose Decision to Treat is in January?

Any patient with a TREATMENT START DATE (CANCER) from 1 January 2009 onwards would be covered by the new counting methodology irrespective of when the decision to treat was made.

What are the circumstances which could change a DTT date? E.g. if a patient agrees to have surgery but for whatever reason it is later decided that they will not have this but e.g. radiotherapy instead, would the original DTT date stand or would there be a new DTT date?

If the person decides they do not want the treatment originally agreed (which the DTT applies to) and therefore a different treatment is discussed and agreed, I would take the agreement for the treatment the patient goes on to have as the new DTT ie. for the 31d the DTT could be reset. However if this was the patient's first treatment the clock would continue to tick for the 62d even though the DTT was reset.

Has the radiotherapy DSCN been ratified i.e. do trusts need to have been collecting this dataset?

Yes.

Active Monitoring as a subsequent treatment: I was wondering if you could clarify the mechanics of classing active monitoring as a 31 day subsequent treatment. For instance using the example of a patient who has surgery (31day) then chemo (31day) then they would be under active monitoring, at the end of the chemo treatment. What would be the DTT and Treatment Date in this case; surely these would happen at the same time - and usually at the end of chemo treatment

Note from DH: Active monitoring could be a subsequent treatment, but you would only want to use it where the intention was for long term surveillance where the decision had been taken to monitor the progress of a specific condition. Examples of this include slow growing cancers where there is not an immediate problem and it is clinically appropriate to step back and monitor the situation until an active intervention is more appropriate. This category of treatment would exclude any ongoing assessments to determine fitness for a subsequent treatment (as this would be prior to the setting of an Earliest Clinically Appropriate Date). It would also exclude routine follow-up, as this is not intended as a treatment.

Does primary care activity/treatment need to be uploaded by GPs/PCTs?

It is expected that PCTs will upload on behalf of their GPs. However, it is possible for NHS Trusts to upload on behalf of PCTs if a formal agreement for them to do so has been entered in to.

Is a wide local excision for margins counted as a subsequent treatment even if no further tumour is found?

Yes

What is classed as 'other' treatments for the 2010 31d subsequent treatment standard?

It includes palliative care, active monitoring and anything else that doesn't come under surgery, radiotherapy or drug treatments such as light therapy.

If a patient is referred for surgery and considered to have either an extensive glioblastoma or cerebral lymphoma and has a debulking of the tumour mass (diagnosis then made as lymphoma) and surgery needs to be followed when fit enough by radiotherapy; which counts as first treatment, the debulking or the radiotherapy?

Debulking is a substantive cancer intervention and could count as the first treatment

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.

Does the 31d subsequent treatment standard apply to patients who have a subsequent treatment for a previous known cancer as opposed to having a treatment for a 2nd primary? Or does it apply to both groups of patients i.e. 31 subsequent treatment applies to patients with any previous cancer or a further new cancer.

This covers patients having subsequent treatment for a previous known cancer. In terms of a 2nd primary, the first treatment for the new primary is the first and anything else is subsequent.

How should mets be recorded and reported on?

Treatment of mets is classed as a subsequent treatment. The exception is mets with unknown primary where both a first and subsequent treatments can be recorded.

A patient has a breast primary 5 years ago and had treatment. She now has lung cancer and is due to have treatment - would that patient be a 31 day subsequent treatment. Or does the subsequent treatment target only apply for subsequent treatments of a previously known cancer?

If the lung cancer is a new primary cancer then it would be a 31d for first treatment followed by 31d subsequents if more treatments were required. If this was lung mets from the original breast cancer then it would be a subsequent treatment.

A Trust in our network is taking the 31d subsequent treatment standard as applying only to patients who have subsequent treatments for a previously existing cancer. We have applied it to patients who have had 1 cancer and now are having treatment for a different cancer.

The other trust is correct.

62d standard (from 2ww)

Are rare cancers (eg testicular) which need to be treated within 31 days included in the 62-day denominator?

Yes. All urgent GP 2ww referrals are in the 62d denominator even though some of the rarer cancers actually need to be treated within 31 days.

If a treatment started and had to be abandoned because the patient became too ill to continue, could it still be counted as first treatment? I have a patient who went to theatre for his surgical procedure for cancer but unfortunately had a heart attack in the anaesthetic room, does this count as first treatment or will it be when he returns again to theatre sometime in the future?

If a patient started treatment but it had to stop then yes it would still be the FDT eg. started chemo but patient too unwell to complete course etc. However, the example given does not quite fit this scenario. To be classed as the FDT the admission has to be for the episode of care that ended with the treatment that stopped the 31d or 62d clock. The patient did not get to the treatment because they were taken ill prior to having the treatment agreed. For this patient the clock would continue, the patient would almost certainly breach BUT it would be an acceptable breach taken into account by the lower threshold that will be set because medical suspensions are no longer possible.

If a patient is referred as a 2WW for example as a suspected H&N cancer and after investigation is suspected as having a Haem cancer and is transferred to the Haem team, are we moving the patient across to the Haem team with the original 62 day target?

Yes, that is correct.

62d Screening

Can I just clarify when screening patients need to be uploaded to Open Exeter?

Providers commissioned to act as a screening centre need to upload data after the DATE FIRST SEEN.

Please can you confirm that it is the Trust who hosts the screening service who is responsible for uploading data on screening referrals up to the point that the patient is first seen (regardless of whether or not cancer is diagnosed).

It is the trust commissioned to host the screening service that is responsible for uploading data up to DATE FIRST SEEN irrespective of whether or not cancer is diagnosed.

We understand that we need to upload all screening referrals regardless of if they proceed on to a cancer diagnosis. We would like to know what the plans/timescales are for getting each of the national screening systems updated to be able to download this information in an appropriate format. This is a major overhead so want all the help we can get please?

Note from DH: The mandate to enter all screening data in DSCN 20/2008 is still current, therefore we are expecting this to be done either by withdrawing it from local systems or a national system. You will have to contact the national screening service direct for details as to the progress of any upgrades they may have made, however it may never be possible to implement a direct feed with no human intervention due to the need to validate performance data and accept it as correct.

Is there any news on whether you can access these data directly from the QA submissions generated by these centres already?

The bowel screening IT system (BCSS) has been able to produce reports since January. The reports come out either on paper or as a CSV file that can be manipulated in Excel (or similar). The same does not apply to the breast screening system yet but sites should be able to get ad-hoc reports using the Crystal report generator on request.

Is the bowel screening data being sent to you directly from screening centres or is the report produced available for trusts to then input into their CWT systems (eg Somerset) for monthly upload with the trust data?

It is available to the Trust if they wish to use it.

Looking at v6.5 it appears that the screening referral is triggered when a patient is referred for further assessment following an abnormal screen. The starting point is the date of the receipt of the referral by the Trust for further assessment. Is that right?

You are correct, the starting point for the three 62d screening pathways IS receipt of referral. For the individual screening programmes it is:

- ◆ Breast - Receipt of referral for further assessment
- ◆ Cervical - Receipt of referral for colposcopy appt
- ◆ Bowel - Receipt of referral for appt to discuss with ssp suitability for colonoscopy

Can you tell me whether Screening Leads have been contacted by CAT/DH to inform them of the requirement to submit data?

Not directly. Contact is via the national screening programme which has representatives on various national boards/groups linked to GFOCWs.

Cervical screening: if a patient's case is directly referred from cytology lab for a colposcopy appointment in Trust A but the patient decides they want an appointment at Trust B, who would be responsible for uploading the data from date the referral was received to date first seen?

The Trust where the patient is first seen (ie. the one commissioned to provide the service) should upload the data.

Am I correct in saying that a screening patient could have a different start date on their 18 week and their cancer pathway? For example a bowel screening patient, whose cancer pathway starts at referral for colonoscopy assessment, may then have a later start to their 18 week pathway when referred to a Trust for a colonoscopy?

No. If the patient has come through the screening programme as an urgent referral then the starting point would be the same ie. the receipt of the referral for the appt with the SSP to discuss suitability for colonoscopy would be the start of the 62d and, if the patient ended up with a non-malignant condition that needed treating, that would also be the start of the 18w pathway.

We have had 3 breaches in Qtr 4 in our 62 day screening standard, relating to 3 Lower GI patients who started their pathway in 08, sept, oct and nov, all of whom would have been 31day target patients once confirmed ca's. We were told that these had to transfer to 62day target patients once we hit Jan 09, and therefore we were pretty much onto a loser with these as they were so far into their pathway before being diagnosed. Could you confirm if this was the correct thing to do or should they have remained on the 31day pathway once they had their decision to treat/were given decisions to treat in January and the other Dec, all received treatment jan/feb 09.

You were correct. Anyone with a date first seen or a treatment start date from 1 Jan 09 onwards comes under the new standards. Therefore if someone from the screening route is diagnosed with cancer and treated post 1 Jan 09 they are under the new standard irrespective of whether the urgent referral was in Nov 08 etc. DH and the CQC are aware that some patients will be on a pathway that started under one set of rules and finished under another. The number of patients this will relate to should reduce from Q1 onwards.

Our plan is for those patients who are FOB +ve and colonoscopy -ve (and the symptomatic bit still needs to be resolved) to be internally referred for an UGI endoscopy. My query is, from a national CWTs perspective would the patient stay on the bowel screening monitoring until -ve colonoscopy and then would it be pragmatic to internally upgrade to a UGI 2ww?

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 receipt of 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. Following this there are three scenarios that may occur associated with further cancer suspicions:

- The patient remains in secondary care on a continuing 18-week RTT pathway. If the condition they were referred to secondary care was subsequently diagnosed as cancer, the first definitive treatment episode for this would be recorded as a separate 31-day treatment episode. This is because the patient was formally removed from the 62-day pathway at the point they were given a formal benign diagnosis (or were told it was definitely not cancer) by the responsible clinician. This pathway would not be subject to a consultant upgrade;
- The patient remains in secondary care on a continuing 18-week RTT pathway for their benign condition, however during further diagnostic tests a separate condition that may be cancer is identified by the clinical team. At this point a new RTT pathway begins when the patient is referred to the appropriate service to investigate this. The date of this referral is the date of the consultant upgrade and the start of both a new 62-day clock, and a new 18-week RTT period. It is important to note that the RTT clock for the original condition still keeps running and this possible cancer represents a new pathway; and
- The patient is discharged to primary care at the point at which the suspicion of cancer is removed. Any subsequent referral back to secondary care for the same condition would either be an urgent referral for suspected cancer (PRIORITY TYPE "3"), an urgent GP referral for a condition other than cancer (PRIORITY TYPE "2") or a routine referral (PRIORITY TYPE "1"). If the new referral back in is not an urgent GP referral for suspected cancer it could be subject to a consultant upgrade.

62d upgrade

We have had numerous patients that have been upgraded in MDT meetings and then seen later the same day in clinic. We are unable to count these patients currently as consultant upgrades as the upgrade date is the same as the DTT.

Can you suggest how we handle this group of patients?

DSCN 20/2008 – pg 17 of 58 - states that the upgrade must be on or before the DTT. Therefore in your scenario the upgrade is ON the same day as the DTT which is allowed ie. upgrade is made in the morning so 62d clock starts to tick. A clinic is held in the afternoon and a DTT reached so the 31d clock starts to tick in effect shortening your 62d pathway to 31d also. As the 31d clock would start at DTT, assuming you met this standard you would, by default, also meet the 62d upgrade.

Is it right that upgrades to the 62 day pathway cannot occur after the patient has been discussed at the MDT?

That is not correct. An upgrade can occur after an MDT as long as it was not the MDT where the care plan that was agreed was discussed.

Patient had hip operation and over admission period a possible lung cancer was suspected and the patient referred to lung team. The patient was then referred on to GI team as suspicious of a GI cancer and is now being tracked by GI team. Should this patient be considered as 2WW, Consultant upgrade or how should we record the source of referral and priority for them?

The patient is not a 2ww as they were not referred urgently by a GP with suspected cancer. It sounds more like a consultant upgrade at the point that the consultant suspected the lung cancer assuming they upgraded the patient at that point (which they should have done under the new system). If, however, the referral to the lung team was not an upgrade and the lung team suspected a GI cancer and referred the patient's case on to the GI team one would hope they did an upgrade. If not and the patient is now with the GI team and a diagnosis is not yet confirmed but cancer is still suspected then I hope a consultant there has upgraded. If no upgrade has yet taken place it sounds like some local publicity of the upgrade standard and the mechanism for upgrading locally etc is needed to ensure any patient with a suspected cancer benefits from the faster pathway..

If a patient is referred from one MDT to another MDT, without a specific consultant upgrade form being completed, and they weren't a screening/2ww patient. Can this inter MDT referral count as a consultant upgrade for the purposes of CWT?

If a patient had been considered at an MDT I would assume that was usually because there was a suspicion of cancer (although I accept that that might not always be the case) and hopefully the patient would have been upgraded prior to that point. If not and the MDT suspected a cancer (albeit one for another MDT to consider) then a consultant (or appropriate member of team) would I hope upgrade the patient being referred. If you want to agree a local policy that a referral from one MDT to another with a suspected cancer should automatically be classed as an upgrade you could do so but some authorisation for the upgrade would be needed and you need to collect the equivalent of the consultant upgrade date eg. the MDT meeting date in the scenario you describe.

Pauses

If a patient has a combination of cancellations/DNAs how should the 2WW be calculated? Here is a scenario: Referral received 05/11/08; Patient cancelled 19/11/08; Patient DNA'd 21/01/09; Appt rebooked on 22/01/09; Patient cancelled 04/02/09; Patient first seen 25/02/09

A DNA will trump any cancellations that take place before it and reset the 2ww clock to when the patient rebooks the appt after the DNA. The clock in this scenario therefore runs from 22/01/08 to 25/02/09 ie. reset after the DNA but do not stop the clock for the second of the cancellations (ie. the one after the DNA).

We would like some advice on whether it is considered OK to discharge a patient undergoing investigations for a suspected cancer back to the referring GP if they DNA two subsequent appointments. I understand that under the 18 week rules this is possible if there is a clear local policy on this, would this be the same for 62 day pathway cancer patients can the policy be applied to both?

You cannot refer a patient back to their GP for DNA'ing their first appointment but you can introduce a local protocol for managing multiple (2 or more) DNAs and this might include referral back to the GP. If the patient has multiple DNAs for appointments further down the pathway (after the first appointment), I believe the same applies ie. you can have a local policy to manage these which might include referral back to the GP if that is deemed to be in the patient's best interest.

I have a patient who made a decision to treat for surgery but then requested 4 weeks to allow him to lose more weight, it was the patient's decision and because it was not going to effect the patients condition the surgeon was happy for him to delay. Would we say this breach was patient choice or could we adjust on the basis that the patient was making himself unavailable for the op?

If the surgeon did not think the weight loss was necessary prior to the op then I would think that you could pause because the patient declined a reasonable offer. However if the surgeon suggested it would be useful, though not essential, to lose weight and the patient decided to do this I don't think a pause would be possible. Tim - what do you think please about this scenario? *Note from DH: This would not be cause for an adjustment to the waiting time as it is not a patient initiated pause.*

Under 18 weeks, when a patient is listed for organ transplant writing to the GP informing them of the listing acts as a stop for 18 week tracking. Now that we are aligning 18 week and cancer tracking, can we record a similar stop for the cancer tracking? If not, liver transplants will always breach.

In terms of an organ transplant the DTT would be the date the organ became available and the patient agreed to proceed. In reality they would then always meet the 31d but are likely to breach the 62d if that is their FDT. The clock does not stop but the tolerance will be lowered to allow for this.

If a patient is offered open prostatectomy, but would prefer laparoscopic op at a later date, can an adjustment be made?

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.

Is there any more guidance on managing pauses for patient choice of consultant?

Note from DH : Any guidance on what constitutes choice and how it should be recorded would need to map across to 18-weeks, we are not currently in a position to do this.

Breaches

Is there any circumstance in which a 31 day standard breach (1st definitive treatment or subsequent) would be shared?

My understanding is that the treating trust is responsible for the whole breach. *Note from DH: There are no circumstances where a 31-day breach will be shared between two providers.*

Is there any guidance on shared breaches when there are more than 2 trusts in the pathway i.e. if a trust is involved in the diagnostic phase but not the referral or treatment stage?

The Care Quality Commission (CQC), formerly the Healthcare Commission, have some guidance on this on their website as they have introduced a new repatriation of breaches policy which allows a middle trust in a pathway to share part or all of a breach under certain circumstances. See

http://www.cqc.org.uk/db/documents/Reallocation_form_200904291418.doc

Performance Management

What would happen to Trusts that fail to upload all the data. I've heard rumours that not only will it affect their Q4 performance, but they will fail the whole year. Is this true?

I am not aware that DH or the CQC have made any decisions about what action to take against trusts that fail to upload all their data. The best advice I can give is try not to be one of them so you don't need to find out!

Don't agree with the change to methodology

We understand that changing the performance calculation methodology is challenging for health care providers, but believe that, in the longer term, this will be beneficial. The new reporting methodology, also used for the 18-week standard, shows the complete elapsed care time and moves us from a system of retrospective adjustments, which is time-consuming and difficult to explain to either clinicians or patients, to one that allows for patient choice, co morbidities that may make cancer patients unable to access faster treatments and the complexity of some care pathways by lowering the tolerances.

How will new operational standards be set?

DH will work closely with the Care Quality Commission (CQC) and Monitor to develop the new operational standards. This work will be informed by expert clinical advice as well as by the ongoing performance and service provision data produced.

How will trusts be monitored, and by whom? Will they be looking to achieve DH standards or CQC or both? Will you be excluding those standards not yet 'live', and how will these be weighted?

NHS Organisations will be performance managed against live standards and Vital Signs trajectories (where applicable), which may include progress towards implementation of future standards. No data relating to standards for implementation at the end of 2009 or 2010 has so far been requested by the CQC for this year's assessment. Should you have further queries about what is included in that assessment I would recommend you contact performance.indicators@cqc.org.uk

What is the potential to upload information again and have the reports re-run in an error is found locally

My understanding from DH is that it will NOT be possible to re-run the reports but that they can include a footnote to the published stats to explain that there has been an error with the data for your Trust. I understand that you should also report this issue to the CQC so that they can decide how to handle it within their assessment process.

Additional note from DH: It is the responsibility of the provider trust to ensure that correct information is supplied for the purpose of performance management and performance assessment within the given timescale, and consequently this information

will not be changed. Unfortunately, it is not possible to alter any provider, national, SHA, network or PCT extracts/reports after the CWT-Db has generated them. This is because these data have already been published within the NHS as part of an automated process on the day following the deadline, i.e. the CWT-Db will already have posted details of any reported activity to the commissioning PCT and SHA, your local SHA (if different) and your cancer network. In addition these patients will be recorded in multiple places within the aggregate commissioner and provider datasets that the CWT-Db generates for the Department of Health. Therefore a regeneration of reports would mean that the strict version control is lost as the new reports would not match the data held on the CWT-Db which relates to a snapshot of the database at 1300hours on the 19th of May. I hope this clarifies the reason why we are unable to accept an amendment to these data via the CWT-Db. If you still have outstanding concerns about the non-inclusion of your statistics in these reports, and any future consequences we would recommend that you discuss these with the Care Quality Commission at the earliest opportunity.

What data will go into the public domain? And will it be accompanied by explanations for the perceived 'drop' in performance? Will trusts be able to see this before it is released?

Data on all live standards on a provider basis is preannounced for publication on 29 May 2009. We are aware that this will show a reduction in calculated performance, however this potential reduction was previously notified to the public in the form of an impact assessment published alongside Q3 data. This impact assessment can be found at: <http://www.performance.doh.gov.uk/cancerwaits/>

Please could you confirm the national guidelines for cancer performance at the current time in absence of the national targets

No national guidelines have been issued by the cancer policy team . The latest info were the estimates based on the Q3 data which were as follows:

2ww - 93.3%
31d - 97.5%
62d - 84.7%

These are the best proxies for what the region might be in but are no guarantee. You are correct that there have been no estimates for where a threshold for the new gfoCW standards might be?.

DH has issued a document (The NHS Performance Framework: Implementation Guidance, April 2009) which includes thresholds for the new vital signs GFOCW standards – what is their status?

I have discussed this with the DH cancer policy team and the figures in this document, as the footnote to the relevant table states, are 'subject to decisions on revised cancer waits op standards' ie. these are just 'guesstimates' from the DH performance team – if you wish to use them as proxies you can but they are not based on any firm data and there is no guarantee that the actual threshold will be at the levels shown.

Would you be able to confirm which category these treatments would fall under please so we can determine which of the ‘go live’ dates apply?

- a. **Chemoradiotherapy - would this be recorded as anti-cancer drug (2008), radiotherapy (2010) or other (2010)?** Radiotherapy
- b. **Would you add a treatment record for both the chemo and the radiotherapy in chemoradiation?** No it is classed as one treatment, see cancer treatment modality code 04.
- c. **If the chemo and radiotherapy started on different dates, would you record the start dates as the same or different, using the actual dates the drug or fractions were given?** The start date is when the first of the two treatments started.
- d. **Brachytherapy - would this be classed radiotherapy or other?** Radiotherapy
- e. **Radio Frequency Ablation (RFA) - would this be recorded as surgery or other?** Other
- f. **High Intensity Focussed Ultrasound (HIFU) - would this be recorded as other?** Yes
- g. **Cryotherapy - would this be recorded as other?** Yes
- h. **Proton Therapy - would this be recorded as other?** No, Radiotherapy
- i. **Light Therapy (including Photodynamic Therapy and Psoralen and Ultra Violet A (PUVA) Therapy) - would this be recorded as other?** Yes
- j. **Hyperbaric Oxygen Therapy - would this be recorded as other?** Yes

On reviewing the CQC website, and their explanation of how trusts will be measured against the 31 Day standard, it indicates that first treatments and subsequent treatments are likely to be rolled together to produce one indicator for the 31 Day standard. Obviously, Open Exeter produces reports that split the data into First and Subsequent treatments, and then at Inpt and Outpt levels. Has their been any news on liaison between DH/CAT and CQC re standards. Are there likely to be differences between those operational standards set by DH and those set by CQC?

Note from DH: The indicator was agreed between the DH and the CQC, all 31-day standards will be rated as a combined indicator, however there will be relative weightings between the different component parts to ensure that one part is not swamped in the statistics by a part with greater patient numbers. Obviously this means that the traditional operational standard cannot be applied to the whole year, however this approach means that all aspects of the cancer waiting times standards can be combined in a balanced and appropriate manner. There will be differences between how the data is used between DH and CQC, mainly because DH is responsible to parliament and the public on these standards, and the CQC is looking for a more rounded approach to assessment covering the whole of a healthcare providers processes.

CWTDb

Could you let me know the upload dates please?

The dates are available on the cfh website at:

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

Could you let me know the upload deadline times and if there is a link which states what they are.

We have not yet set the specific times of the upload deadline, this (as always) will be determined by the fact that an earlier close is required when there are software updates to be installed. The recommendation has always been to ensure data is uploaded several days in advance of the deadline to give adequate time for validation to be completed.

To summarise our Network's provider performance I have to specify separate reports for each Trust for each target, whereas for Commissioner data one single report per target yields data for EACH PCT AND the Network aggregate. (Network summaries by provider, please?) To extract my Network's performance on each target and for all Trusts/PCTs I had to generate 63 separate reports - and that was still not a full definitive set of permutations! More reports are coming, we just ran out of time. There will be around 50 in total.

For subsequent 31-day treatments (and probably for 1st definitive ones too, but I haven't checked) 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 decision was taken by the expert group to keep the numbers of patients in each report line meaningful. It aligns with how we will publish these data. Further reports will actually break the treatments down by modality, rather than groups.

In the Treatment Group reports, the National Average comparison figures are only provided for each modality/group category, and not in the clusters we will be performance managed on - i.e. a weighted average of Surgery PLUS Drugs, and a weighted average of RT, Palliative and Others – why?

These reports mirror the dataset that DH is intending to publish on 29 May 2009.

31 Day First treatment and Subsequent treatments are separate reports - do you intend to roll them together to produce a new combined report in order to cover the combined indicator for CQC?

There is no intention to develop a report to mirror the CQC indicator as the relative weightings are not fixed (as far as the independent CQC have informed us) and will always be subject to change. The requirement will always be on trusts to deliver the required standards, no matter how they feed into a wider assessment.

In their current format, we cannot differentiate between treatment modalities for the different tumour sites - ie radiotherapy subsequent treatments incorporated with those modalities that are 'live' standards. NSSGs will need to know their compliance. Cancer Centres will be seen as performing badly compared to the acute trusts that do not deliver radiotherapy.

The reports available break down performance by tumour or modality, to break down by both would mean very small cell-counts, which would degrade the value of the report and/or infringe patient confidentiality. It is because of this some organisations have access to anonymised data for local analysis in a secure manner.

Will Jan & Feb's reports on National CWT-db be made available at any point?

DH has confirmed that for Q4 only quarterly statistics will be available ie. they will not be releasing Jan, Feb data retrospectively. Monthly data will be available to you as a matter of course from Q1 ie. starting with April 09.

There is data for March available on the system, did they give reasons why they don't think Jan & Feb's data is needed in report format?

No. I think they have had to take a pragmatic decision in terms of time and priorities.

What Cancer Network reports will be available?

Cancer networks will continue to receive access to reports similar to SHAs to support the performance management function where it has been delegated to them by their local SHA. Unlike the SHA reports these will not be generated from mapping tables produced by the ODS. These reports will be based around the organisational relationship tables produced and maintained by NCIN. Using these tables the CWT-Db system will need to grant network users access to the following reports for organisations within their boundaries:

- 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);

Those reports marked in BOLD for Acute Providers and PCTs should be available to cancer networks on day one.

In addition to these reports, networks will require access to an aggregate summary for each line, the summary reports are:

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; and

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; and

Report 12.38 – the Network Commissioner Based Total CRS 62-day Upgrade Standard (Treatment) Report.

Tumour-specific

Urology

Do planned 3-monthly TURBTs count as subsequent surgical treatments for Bladder cancer?

The usual circumstances are that a patient will have their first TURBT and then have planned surveillance cystoscopy 3 to 4 months later and repeated for many years. At some of these, tumour will be found and a TURBT performed either on the day or subsequently. I would expect the waiting time to commence from the day tumour was identified eg. at the cystoscopy. A less common scenario is that a planned second (rarely third or more) TURBT is done usually at 6 weeks after the initial one. The national clinical lead for urology advises that this should be outside the 31 day subsequent standard.

Patient has had urology surgery (this is 1st Definitive treatment) and then then returns some time later for mitomycin. Is this a subsequent treatment that needs to be tracked and reported?

Advice from the national clinical advisor on urology is that mitomycin is essentially adjuvant chemotherapy and hence we should track the time from decision to treat/ECAD to first dose of the course just like other chemotherapy.

UGI

Under 18 weeks, when a patient is listed for organ transplant writing to the GP informing them of the 'listing' acts as a stop for 18 week tracking. Now that we are aligning 18 week and cancer tracking, can we record a similar stop for the cancer tracking? If not, liver transplants will always breach.

In terms of a transplant the DTT would be the date the organ became available and the patient agreed to proceed. In reality they would then always meet the 31d but are likely to breach the 62d if the transplant is their FDT due to the potentially long wait for an organ to become available. The clock does not stop but the tolerance will be lowered to allow for this.

Is there any further advise from CAT re urology pTa recording for the cancer waits?

pTa remains excluded but is under review.

Breast

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?

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.

NOTE: The above advice was revised in June. The current position is 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

Stent for carcinoma of the oesophagus has been overgrown. Laser treatment arranged - would this be a subsequent treatment?

Advice from the national clinical lead is that the laser treatment is treating the cancer so should be covered by new 31d standard.

Miscellaneous

I've been asked to advise one of our PCTs if there is any change - or need to change - those aspects of their contract with a local provider relating to CWT and GFoCW, and Cancer Registration. Reading through it I cannot see (or am unaware of) any points that have changed - except that the target thresholds are unknown, and the 25, 20, 15 days turnaround change is 'on hold' as it has not been mandated by a DSCN or ROCR notice - though this is already covered in the wording or the existing variation.

You are right that the target thresholds have not yet been set and that the upload dates remain at 25 for the time being. Other things to ensure are that the contract includes all the standards ie. Old and new including working towards implementation of the breast 2ww and 31d subsequent treatment standards for r/t or other treatments and that all systems are fully compliant with the DSCN. Possibly not appropriate for the contracts but an issue which is causing concern is the PPI - ie. 18w IT systems need to produce an AN20 digit PPI which the CWTDb would then use and some are not doing so. If the contract included full compliance with the DSCN that might help.

There was a plan (set out in the National Contract) to reduce the time interval for submitting the national CWT dataset to the CWT-Db from within 25 operational days of the end of the month to 20 and ultimately 15 operational days. Is there any idea when this will happen?

No not yet. It will stay at 25 for the foreseeable future. The long term aim remains, however, to reduce the time interval for uploading to the national dataset to within 15 operational days.

A PCT has commissioned an intermediary NHS service for diagnostic and minor treatment purposes. Technically no suspected cancer patients should come through this service but it is always possible that patients with suspected cancer could slip through the net and, for example, a skin lesion removed and found to be either a CWT tracking requirement. The intermediary service does not provide any data for Open Exeter, what happens to the FDT recording in this instance?

If the GP suspects cancer they should do a 2ww referral. As I understand it if the intermediary service can make a referral under the authority of the GP then it could make a 2ww referral if cancer was suspected. The alternative is that as soon as a suspected cancer referral is received by the intermediate service then a process is in place locally to upgrade the patient on to the 62d pathway.

We have a batch of about 15 patients who were referred from the GP to primary care services for their date first seen however the database will not accept the organisation code of the PCT services. As this affects our denominator please could you advise what we should do?

It sounds like the PCTs may not be registered to use the system and should contact the cfh helpdesk to resolve this ASAP.

Patient goes to their GP as an NHS patient and the GP offers them a choice of provider and they choose a private hospital. If they opt for a private establishment who should be tracking and reporting these patients through their cancer pathway ie. has the patient technically chosen private treatment or should they be treated as an NHS patient who is being seen in a 'peripheral' setting??

If the patient is opting to pay for themselves ie a private patient then they are opting out of the 2ww and the 62d. If however they come back into the NHS for treatment then they would be on the 31d pathway for either a first or subsequent treatment depending on which they were coming back for. If however the NHS has commissioned the private hospital to see patients ie. the patient is still an NHS patient then the 2ww and the 62d would still apply. Who is responsible for collecting and uploading the data depends on the commissioning arrangement eg. if the NHS Trust has subcontracted the activity to the private hospital the activity and waiting time is to be recorded on the CWT-Db by the Provider that was originally commissioned to provide the work ie. the NHS trust The GFOCW guide v6.5 on the Cfh website includes different commissioning scenarios.