

## Questions answered by NCAT – November 2009

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

**If a GP refers a patient under the 2 week rule knowing that the patient will not be available within the next 14 days and provides a reference to this fact on the referral letter, could there be a local policy which allows the provider to acknowledge receipt of the letter when the patient becomes available ie. start the clock from that point?**

Receipt of referral marks the start of the 2ww pathway irrespective of what the GP has written on the letter. The operational tolerance for this standard takes into account that some patients will choose to wait longer. The policy suggested is not, in my view, in line with the GFOCW rules.

**If a patient is offered two appointments within the 14 day period and declines both, can a local access policy be agreed to stop and restart the 2ww clock at day 14 without informing the GP?**

The operational tolerance has been set at 93% to take into account the fact that some patients will choose to wait longer than 14 days so a person should not have their clock re-set because they choose not to accept 2 appointments offered within the 14d timeframe.

**Is referring a patient back to the GP on the basis of offered appointments that are declined acceptable?**

The operational tolerance has been set at 93% to allow for the fact that some patients will choose not to accept an appointment within a 14 day period. Referring a patient back to a GP should not happen because a patient chooses to decline an appointment. Referral back to the GP should only be a consideration after multiple DNAs or multiple cancellations of appointments. SHAs have been asked to ensure that local access policies in their areas are consistent with GFOCW rules.

**Is requesting that GPs remove patients off the 2WW pathway when they choose an appt outside of the 14 day period in line with CWT rules?**

I can confirm that it is NCAT's view that this approach is outside the GFOCW rules and I would advise this to the X SHA, Monitor etc if asked.

**Could you confirm whether the following is within the spirit of GFOCW rules?**

***“Patients who decline two offers of appointments will be informed that they are being referred back to their GP. However to prevent additional burden on the GP the Trust will automate the re-referral from the GP and therefore start a new pathway on behalf of the GP”***

I do not agree that this is within the spirit of GFOCW rules. These allow for a patient to be referred back to the GP:

- after multiple (2 or more) DNAs
- after multiple (2 or more) cancellations - with the patient's agreement

The 'rules' do not allow for a patient to be referred back to their GP because they have chosen not to accept 2 appointments that have been offered. The 2ww tolerance has been set at 93% to take into account that a proportion of patients will choose to wait longer than the standard time.

**In the instances where it is clear to the consultant that cancer is not the problem but the patient does require further secondary care input are we able to end the pathway based on the specialist consultant's opinion and continue on an 18 week pathway – i.e. without histopathology confirmation?**

The 2ww pathway would end at date first seen. If there is no cancer then there would be no DTT and therefore no 31d or 62d record to upload. There does not need to be a histopathological confirmation - the key is what has the patient been told ie if the clinician is confident to tell the patient that they do not have cancer without having pathology then that would end the 31/62d cancer pathways.

**A consultant yesterday saw a patient in clinic who had been referred as a two week-wait and when he saw them not only was he able to say the condition was not cancer but also that they didn't require any secondary care input at all. How is this managed?**

Patient only has a 2ww pathway (ie no 31d or 62d) as patient told they did not have cancer.

**If a GP sends a 2ww referral when the patient has a known cancer diagnosis because they want additional opinion and further treatment – does this count as a 2ww referral?**

There are different scenarios which result in different responses as follows:

- Scenario 1 - a GP sees a patient (does not suspect cancer) and sends them for some tests. The results of those tests raise the suspicion of cancer so the GP makes a 2ww referral;
- Scenario 2 - a GP sees a patient (does not suspect cancer) and sends them for some tests. The results come back with a diagnosis of cancer - the GP should make a direct referral to the appropriate consultant/service (ie. a 2ww is inappropriate as it is a confirmed not a suspected cancer). The patient would be on the 31d pathway only;
- Scenario 3 - a GP has a patient with a confirmed diagnosis for cancer who attends with some problem. The GP thinks this is related to the primary cancer. A 2ww is not appropriate as the referral is related to a diagnosed primary cancer. The GP should make a direct referral to the consultant/service already managing the patient. If the GP does a 2ww at this stage they could be asked to withdraw it by the receiving trust;
- Scenario 4 - a GP has a patient with a confirmed diagnosis for cancer who attends with another problem. The GP thinks this is another primary cancer. A 2ww referral is appropriate;

If any 2ww referral is not appropriate then the GP can be asked to withdraw it.

**If a patient is referred as an urgent suspected cancer referral when they already have a new pathological cancer diagnosis are they automatically removed from the 2WW or will the trust clinician have to discuss this with the referrer?**

They shouldn't be a 2ww referral as they already have a cancer unless it is a 2ww for a suspected new cancer. If a 2ww is made in this scenario then the GP can be asked to withdraw it. It must be the GP that does this.

**We know that a consultant cannot refuse to see a patient referred via the 2WW route, no matter how inappropriate that referral. What policy/guidance confirms this?**

The restriction that specifies that a consultant must see all referrals that are sent via the two week wait for suspected cancer was first introduced when the two week wait only covered suspected breast cancer. This guidance has remained current and now applies to all suspected cancer patients referred urgently by their GP (two week wait). Annex A of HSC 1998/242 specifies: "*It is the GP who decides in the light of the new national guidelines whether a patient needs to be seen "urgently" and requires a specialist outpatient appointment within the "two week" period.*"

This is further reinforced by the following text, which appears on page 2 of the document: 'Achieving the Two Week Wait Standard': "Q - *On receipt of the referral the consultant determines that the patient is not urgent and wishes to re-categorise as non-urgent. Is this permitted? A: No. It is the GP who determines whether or not a referral should be treated as urgent under the 'two-week standard'. All patients referred by their GP, within 24 hours of the decision to refer as urgent with suspected cancer, should be offered an appointment within 14 days of the GP's decision to refer, irrespective of whether or not the consultant regards the referral as urgent.*". This guidance is available at: [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4010373](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4010373)

The restriction on the referral being received with 24 hours has been removed from the two week wait, to align with Choose & Book and 18-weeks. However, the restriction on the consultants recategorisation of these referrals remains current. A GP can be asked to withdraw an inappropriate referral.

**When a patient cancelled their first & second CaB appointments and the Trust then received a direct referral from their GP you advised in July that 'assuming the GP referral was for the same condition I would advise taking the receipt of the GP referral as the start of the 2ww/62d pathway. The CaB route did not end up with a DATE FIRST SEEN so was an incomplete pathway that does not need to be uploaded to the CWTDdb.' Looking at this from another point of view, if the original referral had been made on paper rather than CaB we would not be permitted to adjust if the patient cancelled the first 2 appointments offered. Why would this be allowed because the cancelled appointments were made via CaB? Seems to be a double standard depending on route of referral?'**

From the information we had available it appeared that the patient was being re-referred (ie. a new referral) for the same condition (we do not know why) and therefore the new referral superseded the original referral. If however the GP had simply been writing with some additional information to supplement the initial referral then the initial referral would stand.

**The two week wait standard can only apply to patients referred with a suspected cancer from a Clinical Assessment Service (CAS) if the 'triage' GP or other health professional within the CAS is acting on behalf of the patient's GP. Locally agreed guidelines need to be in place to authorise them to act in this manner if this is desired. How do walk in centres fit in to this? Can they refer on a 2ww if the guidelines are there, or do they need to refer back to GP?**

A patient's own GP should make a 2ww referral or someone acting on behalf of that GP. I would suggest that you follow the same position as you have for CAS ie. walk-in centres can make 2ww referrals if acting on behalf of a patient's GP but locally agreed guidelines would need to be in place to support this. In the longer term I will raise this matter at the next meeting of the GFOCW advisory board in January.

## **Symptomatic breast 2ww**

**Can we refer symptomatic breast patients back to their GP if they are not available within 14d for an appointment?**

Once a referral has been received and the 2ww clock has started to tick the patient should not be referred back to the GP because they choose to be unavailable for an appointment within 14 days. The operational tolerance has been set at 93% to take into account that there will be a proportion of patients who choose to wait longer than the standard time.

**We allow direct GP referrals into radiology for symptomatic breast patients with the patient potentially referred directly back to the GP if the radiology is clear. Is that acceptable?**

As I understand it the breast cancer community has felt strongly for several years that direct GP access to mammography is a bad idea - because GPs could (understandably) misinterpret the implication of a negative mammogram. The "triple assessment" (clinical examination, imaging and biopsy) approach at a breast centre is much more reliable. This is one of the main reasons for advocating a '2 weeks for all' approach for patients with breast symptoms, which should be achieved by the end of the year.

**Do you know what the performance tolerance will be for breast 2ww when it starts?**

Yes, it has been set at 93%

**Will breast symptomatic patients be monitored on the 62 day target for our January compliance (i.e if a breast symptomatic patient breaches the 62 day target on 01.01.10 will it lower our 62 day compliance?) or will it be 62 days after the Breast standard target comes in?**

The symptomatic breast 62d is a separate cohort to the 62d classic. The 62d symptomatic breast standard will go live from 1 Jan 2010 ie. the same as the symptomatic breast 2ww standard. However, the 62d symptomatic breast standard is not being monitored centrally for the time being - DH is focusing on the cancer waits standards in the vital signs at the present time. We would, however, expect you to be keeping check on performance for this standard locally. DH will be including reports to help with this in the report suite available on the CWT-Db in due course.

**Can you confirm what 'month' we need to be recording symptomatic breast 2ww data from for reporting purposes. Is it December 2009 or January 2010?**

You should already be uploading data for this standard where services are commissioned as the mandate came in from 1 January 2009. The first month where you will be measured nationally (ie. when the standard is live) will be January 2010.

**For the symptomatic breast 2WW target we include all referrals from GPs and other relevant health care professionals with non-cancer breast symptoms. Should a patient referred from other health care professionals (e.g. an internal referral from another consultant) with suspicious cancer symptoms (not originally a suspected cancer referral from a GP) should be included in this target?**

I would class your scenario as a consultant upgrade (not a symptomatic 2ww breast referral) as cancer is suspected.

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

**Does the 31 day subsequent cancer treatments standard contain radiotherapy as well as drugs and surgery.**

The 31d subsequent treatment standard covers all treatment but is being phased in. The standard went live for surgery and drug treatments on 1 Jan 2009 but will not go live for radiotherapy and other treatments until 1 Jan 2011. Having said that, although the radiotherapy standard is not yet live (and is therefore not being performance managed) the data should still be being uploaded to the CWT-Db.

**Do the 31d standards for radiotherapy and other treatments go live in 2010 or 2011?**

The standards go live from 31 Dec 2010 so organisations will be measured against them from 1 Jan 2011 onwards.

**Is palliative chemotherapy or palliative radiotherapy classed as chemo or r/t or palliative care for 31d?**

Palliative treatments (surgery, radiotherapy or anti-cancer drug regimens) should be recorded against their respective 31d subsequent treatment standard.

In terms of supportive packages of care (excl the treatments above) then for the purposes of monitoring the 31-day subsequent treatment standard the supportive package of care (pain relief, transfusions etc) is considered as a whole. This means that whilst a patient may be receiving a range of supportive care if it is a single agreed package then the start of the package of care should be taken as:

- date of the delivery of the first episode; or
- the consultation that results in the referral to a non-NHS specialist palliative care service (that are not contractually obliged to return these data independently); or
- the consultation at which the patient receives a prescription.

**Can you confirm that ECADs are only used for subsequent treatments and not FDTs**

That is correct.

**Is a list held nationally (or indeed anywhere else) of the procedures that we should expect to be included in the treatments we track for 31d?**

There is no nationally held list. In effect anything listed within the data item 'Cancer Treatment Modality' could be classed as a subsequent treatment and this includes the option 'other' so it can also include things that are not on that list!

v6.5 of the GFOCW guidance states that: '*A subsequent treatment could be:*

- *an anti-cancer treatment (curative or palliative) aimed at shrinking (or delaying the growth/spread) of the tumour/cancer;*
- *the provision of palliation for the symptoms resulting from the tumour/cancer (see G3.6);*
- *active monitoring (where no active or palliative treatment is appropriate); and*
- *symptomatic support by non-specialist palliative care teams (see G3.6).*

*An individual patient may receive one, or a combination of many of these interventions.'*

**If someone receives a course of BCG, say 6 installations. Then a year or so later they receive another 3 installations as maintenance, and then maybe a year later another course of 6, would they all be new subsequent treatments, or would they not classify as they had had that treatment previously?**

I think we need to take a pragmatic approach to this issue. The key should be whether a new consent form has been signed or not i.e. if it has then this should be classed as a new treatment and therefore a new 31 day period, if not then it is assumed that it is part of the same treatment package.

**A patient is having chemoradiotherapy. Both chemo and radio would normally start on the same day but we have a patient who is going to be having their Chemo at their local hospital and then Radiotherapy with us on a different date. Can you please advise how we should be recording the treatment for these patients ?**

If the patient is having chemoradiotherapy this is classed as a single treatment and the clock would stop when they had the first part of this ie. chemo in the scenario you describe. However I would refer you to the explanation of a combined treatment in v6.5 of the GFOCW guide Q3.32 to ensure that this is really a combined treatment. If there is likely to be a long wait for the r/t post chemo then it may not be.

**Did you get any clarification regarding enabling procedures i.e. defunctioning colostomy?**

The issue of enabling treatments was discussed at the last GFOCW Advisory Group meeting. It was noted that the last CWT guidance under the old rules (version 5) and GFOCW v6.5 included a small number of enabling treatments that could be classed as FDTs. Most others would have been classed as medical suspensions locally (eg. cardiac stents, dental extraction prior to r/t etc) and adjustments made.

When DH calculated the new operational tolerances it took into account the level of medical suspensions previously uploaded onto the CWT-Db. The reduced tolerance therefore already allows for breaches due to enabling treatments needed prior to FDT that were not covered by the older guidance. The group therefore advised that we should draw a line under the list of enabling treatments from the last national guidance issued prior to DH producing the operational standards and these should be the only ones that can be classed as FDTs. Any adhoc advice given since then adding enabling treatments to this list would be revoked on the basis that the operational tolerance allows for them.

In exceptional circumstances DH might consider a particular enabling treatment again. When v6.6 of the GFOCW guidance is issued in the new year it will include the list of enabling treatments that were accepted as FDTs under the original rules and therefore still remain as potential FDTs but you can look at these documents in the interim if you wish.

**Is there a list of enabling treatments that could be classed as FDTs?**

The enabling treatments that are set out in v5 as allowed as FDTs are:

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

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

**Please can you clarify how the 31d rare cancer standard is monitored?**

The 31-day rare cancer patients are included within the numerator and denominator of the 62-day all cancer National Statistics published by the Department of Health and all performance analyses and reports it shares with the NHS on a periodic basis.

These patients are separately reported within the Cancer Waiting Times Database, to enable your organisation to correctly manage these services to ensure that all patients within the Acute Leukaemia, Children's and Testicular Cancer cohorts, who are fit, able and willing to be treated receive that treatment within 31 days of the initial referral into secondary care.

The Care Quality Commission uses a dataset derived from these National statistics in their annual assessment so it is possible that they may also use data aggregated in this way. However, the dataset for the 2009/10 data year has not yet been commissioned by the Care Quality Commission, and DH therefore recommend that you discuss this with them ([performance.indicators@cqc.org.uk](mailto:performance.indicators@cqc.org.uk)) if you have queries.

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

**I just had a look at my networks Q1 & Q2 data and testicular cancers are not included in the 62 day report when you have previously advised they are part of the 62d denominator. Can you advise why?**

The 31-day rare cancer patients are included within the 62-day all cancer National Statistics published by the DH, and consequently will also be included in the dataset sent to the Care Quality Commission. These patients are separately reported within the Cancer Waiting Times Database as this is to enable your organisation to correctly manage these services to ensure that all patients within the Acute Leukaemia, Children's and Testicular cohorts, who are fit, able and willing to be treated receive that treatment within 31 days of the initial referral into secondary care.

**A 2 week wait patient has not been diagnosed with a cancer but the consultant wants to regularly review the patient, after a few months they are diagnosed with cancer. Is this still a 62 day patient? Is there any adjustment we can use?**

Yes this is still a 62d patient and no, an adjustment is not possible. In this scenario the patient has not received a confirmed diagnosis so it is a delay due to diagnostic uncertainty. The 62 pathway remains open and the patient will breach when cancer goes on to be confirmed. The operational tolerance for the 62d standard has been re-set to take into account that more patients will breach due to clinical reasons.

## **62d upgrade**

**A consultant upgraded a referral based on the GP letter but when the consultant (a different and more senior consultant) examined the patient it was clear that cancer was not the problem but something else. How is this managed?**

62d upgrade pathways are only uploaded IF a patient is treated for cancer. In this example the pt is told they do not have cancer and no cancer treatment is given therefore no 62d upgrade record is uploaded.

**A Trust within our Network has asked for a list of procedures that need to be followed in relation to the 62 Day Consultant Upgrade pathway. Is there a list of procedures for this pathway? If so, could you please supply them so I can pass them on?**

I'm not sure I understand the question. Policies for implementation of the consultant upgrade standard are being left for local determination ie. who can upgrade and the process that needs to be followed once a decision to upgrade has been made. Different Trusts have adopted different processes eg. some have fax numbers for consultants to fax upgrades too, some have an answer phone for consultants to leave messages on etc etc.

## **62d Screening**

*No questions this month*

## **Pauses**

**I understood no adjustments for DNAs in diagnostic phase but Oct Q&A mentioned a pt could be referred back their GP after multiple DNAs in the diagnostic phase?**

There IS only 1 adjustment associated with cancer DNAs ie. if a pt DNAs their first o/p then the clock is re-set to when they re-book. Multiple DNAs at any point in the pathway can result in a patient being referred back to their GP in line with local policy. This is not an adjustment as the existing pathway would end and the patient would need to be re-referred by the GP if still appropriate (as with 18w) starting a new pathway.

**Oct Q&A said: “No adjustment is allowed for a patient cancellation. The operational tolerance has been lowered to allow for more breaches due to patient choice”. V6.5 advises: “adjustments are allowed if a patient declines a treatment in an inpatient (ordinary admission or day case) setting provided the offer of admission was “reasonable”. Can you advise if we can adjust if a pt refuses a reasonable offer?**

Both are correct and do not, in my view, contradict. If you offer a reasonable appt of admitted treatment and this is declined a pause is allowed (V 6.5) If you offer a reasonable appt of admitted care, it is accepted and the patient then cancels at a later date a pause is not allowed as cancellations are accounted for in tolerances (Oct q&a). The key difference is that in one scenario the pt didn't accept the reasonable offer but in the other they did ie you have to accept something in order to cancel it at a later date.

**Patient had a treatment date for surgery, the Trust though wanted to bring the patient in earlier but because he was on Warfarin could not be brought in so he therefore breached. Is there any adjustment we can add for this?**

No. The operational tolerances take into account the fact that some patients may breach due to clinical reasons.

**With regards to putting in an adjustment for the first outpatient DNA for a 2ww patient, the adjustment is from the date of receipt of referral to the date the patient rebooks their appointment. If though the Trust rebooks their appointment do we use the date the Trust rebooked their appointment?**

If a patient DNAs their first o/p appt then the clock start is effectively re-set to the date that they rebook their appointment. This is the date the patient makes contact with the service. If the Trust sends out a letter with a new appointment date then the clock would re-start on the date the patient made contact to confirm that they were content with this new date rather than the date the letter was sent out.

**A patient is referred under the 2ww scheme, they are diagnosed with a cancer but are treated for a met prior to being treated for the primary. As they are likely to breach in this instance can we put a medical suspension in or patient pause?**

A pause is not possible for the scenario you describe.

**If a patient is offered a TCI date out of target and accepts and is then offered an earlier one and declines this can a pause be made in between the declined date and the date the patient could then make themselves available?**

No pause is possible. You offered a date and that was accepted. If you are later able to offer an earlier date you can do so but if the patient declines you cannot pause the clock.

## **Breaches**

**We have a patient that refused all treatment after first agreeing to surgery. Am I correct in assuming that although the patient refused all treatment in the end this case has to be recorded as a breach because he initially agreed to surgery and was given a TCI?**

It is not clear from the attachment that the patient has refused all treatment just that he has refused surgery it may be that there are other treatment options that could be discussed. In terms of the 31d, the DTT was for surgery and the patient changed their mind so a new DTT for a new treatment is needed (ie. the 31d surgery pathway is redundant and will not need to be uploaded). It could be that the new DTT is that all treatment is refused. In this scenario if the patient has genuinely refused all treatment it is likely that the 31d standard will therefore be met. For the 62d standard the clock would have continued to tick while the patient was considering surgery, decided not to have it and then decided what to have instead (possibly no treatment). It is possible that there will therefore be a breach of the 62d standard but the revision to the tolerance allows for these types of cases.

**If a patient declined all treatments offered and breaches the 62-day target, will the breach be include in the Trust's overall % performance?**

If Treatment Modality Code 98 has been used (i.e. decline all treatments) then this patient is not included within the Trust's overall performance.

**We have an issue with treatment breaches. The problem is that the patients are agreed and consented for Radiotherapy at another trust then come to us for 1st treatment. We do not find out about them until the day they arrive for treatment which is after day 31 (normally between day 40 and 50) As we are doing the treatment, we are liable for a breach but as we have no control over the pathway & feel this is unfair. Is there a way to re-allocate 31 day breaches or should these patients be reported as the other trust treatments?**

I am struggling with this at a general level ie. how can your trust not know that patients are turning up until the day they turn up for treatment? The fact that a patient is turning up expecting treatment (or planning) implies that the referring trust is able to book this patient into a clinic slot at your end and they must surely have agreement to do that and that must mean that someone at your end knows the patients has been booked in? I'm struggling to see/ believe that a r/t department would sit waiting to see who is going to turn up that day ie. not know who is expected to walk through the door? There seems to be a fundamental issue in the scenario you describe (unless I have misunderstood) with communication issues between trusts that need to be resolved here ie if other Trusts can make such DTTs and book patients in for r/t then you need to ensure that those trusts provide information in a timely manner in line with the interprovider transfer dataset.

On the specifics, the 31d standard is 'owned' by the treating provider and a breach CANNOT be shared. Therefore if an appropriate clinician is making the DTT in trust X but trust Y is commissioned to do the treatment then Trust Y is responsible for any breaches.

I think the issue here is not really about the 31d standard but the pathway and communication between trusts and the r/t centre.

**We are receiving tertiary referrals where we have no possible chance of treating the patient in the time remaining or indeed where the patient has already breached. I am acutely aware that patients delay their own pathway and therefore the referring Trust, through no fault of their own, are sometimes giving us half a breach. As a Urology specialist centre we receive referrals where pathways have had the 6 week clinical delay from TRUS biopsy to MRI so often the patient has breached before we receive the referral. As an Oncology centre if we receive patients that require radiotherapy/ chemotherapy we often do not get sufficient time left on the pathway to adequately plan treatments, this is across all sites. Advice has been that operational tolerances have been lowered but this is causing an unfair picture on our Trust because we are the specialist centre. I do not believe this was factored in. As example half a breach through no fault of our own means we would need a minimum 10+ extra treatments to cancel the affect. Do you have any comments?**

- A number of tertiary providers had a meeting with CQC to ask if they would reconsider their breach reallocation policy ie rather than just allow this if a referral is received after day 62 due to admin reasons they asked if other reasons such as choice could also be considered. I'm waiting to here the outcome of the CQC's considerations but understand that no changes are planned for this year
- Some trusts have pleaded extenuating circumstances to the CQC due to issues such as caseload and argued that their operational tolerance should be lower than the national one on that basis. CQC considered each case on its own merits.
- DH is aware of concerns and are carrying out some additional analyses to consider the impact on tertiary providers. The outcome is not yet available.

As soon as I have further info on bullets 1 and 2 I will let people know. Bullet 2 would be something for you to follow up with cqc if appropriate.

## **Performance management**

### **What action will be taken against Trusts with access policies outside CWT rules?**

If any trust has an access policy that is not within the GFOCW rules it will be for the SHA in the first instance (via PCTs for NHSFTs) to resolve this. If there are Trusts that refuse to bring policies in line with national rules then I am sure that the SHA GFOCW lead in question will raise this at the monthly meeting they have with DH and others (incl Monitor and CQC) to agree the most suitable way forward.

### **Q1 performance nationally shows quite a few Trusts with 99% performance and large numbers of referrals. I'd be very interested to know how they achieve these levels of performance as our Trusts are really struggling with patient choice?**

I have suggested to SHA leads that it would be worth looking at very high performing trusts (eg 5% over tolerance) so that we can learn lessons and/or challenge. The SHA leads are considering how best to address this.

### **Will Trusts with small screening numbers be excluded from the CQC ratings?**

DH advised: *The Care Quality Commission (CQC) do normally publish and apply a de minimis limit within their annual assessment process. Therefore it is reasonable to assume that any analysis incorporating this dataset will also be subject to such restrictions. Due to the independent nature of the CQC I cannot comment on what such a limit might be, however you might wish to address a query on this matter to: Performance.Indicators@cqc.org.uk.*

### **Are you aware of any publication from either DH or MONITOR that says that they will not be using Q1 2009/10 two-week data when they calculate our annual 2009/10 performance?**

Assuming this query is about the existing cancer 2ww, I am aware of no communication specifying this from DH. As far as we are concerned Q1 2009/10 has been published as national statistics and as such is a final record of the NHS activity in that period. However, whatever Monitor choose to do in their compliance framework is another matter. I would suggest that the FT contact Monitor direct to confirm how they will use these data.

### **We very occasionally report a patient (usually testicular) who falls into the "rare cancer" category. Due to the small numbers involved we have been reporting these in our 62 day figures but as a result we are getting queries with regard very slight discrepancies in the percentages between internal reports and results on OE. Could you advise me – are these figures (62 day/31 day rare) viewed completely separately by the CQC/DH or are they looked at together?**

DH advice is: *The 31-day rare cancer patients are included within the numerator and denominator of the 62-day all cancer National Statistics published by the Department of Health and all performance analyses and reports it shares with the NHS on a periodic basis. These patients are separately reported within the Cancer Waiting Times Database, to enable your organisation to correctly manage these services to ensure that all patients within the Acute Leukaemia, Children's and Testicular Cancer cohorts, who are fit, able and willing to be treated receive that treatment within 31 days of the initial referral into secondary care.*

**Am I correct in saying that the 31 day rare cancer patients are not included in the 62 day target reports that are accessible in the national waiting times database but are included in the 62 day all cancer national statistics published by the DH?**

You are correct.

**We have experienced a problem with the September Two Week Wait data (some was missing). Is there is anyway we could have this data included as it impacts on our performance?**

Once the cut-off for the quarterly reports has passed it is NOT possible to update/revise figures for the months within that quarter. It will not therefore be possible to revise your September figures. If a senior member of your Trust writes to DH (via Tim Hancox) setting out the issue that has arisen and the impact on your figures then DH will consider attaching a caveat to your data. I would also suggest that you consider writing to the CQC ([performance.indicators@cqc.org.uk](mailto:performance.indicators@cqc.org.uk)) to explain what has happened as there is a danger that you could fail any data completeness check that they carry out on the data.

**In 2005, a number of completeness targets were issued to Trusts around cancer waiting times activity which CQC monitored as part of the Annual Health Check. Are there any plans to revisit this?**

DH has looked at data completeness for some of these standards, particularly working with the Care Quality Commission as an estimate of the quality of the dataset is an integral part of their annual assessment. Obviously the Care Quality Commission reserve the right to apply any completeness measure they deem appropriate, but DH has considered the following mechanisms, and consider them to be robust enough to share:

- all cancer 2ww - where we would expect a submission of data each quarter that is at least 90% of the average quarter from the previous year;
- all cancer 31-day FDT - where we would expect a submission of data each quarter that is at least 90% of the average quarter from the previous year;
- 62-day classic - where we would expect a submission of data each quarter that is at least 90% of the average quarter from the previous year;
- breast symptom 2ww - we would expect 15 referrals to yield one case of diagnosed cancer that is subsequently treated.
- 31-Day subsequent radiotherapy - we assume that there will be 190 new courses of radiotherapy per million population per month, and that 82% of these will be subsequent treatments.

Obviously there are some assumptions in these models that local service patterns and reconfiguration may invalidate. However DH consider these robust enough to support local performance management. They would not however consider these processes robust enough for a complete audit, and would always recommend an audit against local systems, e.g. PAS or Radiotherapy V&R machines.

Other areas DH has looked at are using screening service data (KC53 and 63 returns) to assess completeness of screening pathway data, though this is complicated by the fact that not all PCTs run call/recall at the same time; and using HES data to calculate average yields for subsequent surgery. However, they do not consider these robust enough to be shared.

If you need more information my colleagues at DH are best placed to help.

## **Dataset**

*Two week wait cancer or symptomatic breast referral type*

**Please can you confirm that a symptomatic breast 2ww referral should NOT have the Referral Type set to "Suspected children's cancer" if the patient is under the age of 16 at receipt of referral?**

You are correct.

*Primary Diagnosis (ICD)*

**Can you clarify whether cervical cin3 are included in cancer waits or not?**

We have no D codes in the database for gynaecological cancers.

*Cancer Treatment Modality*

**Can you elaborate on Specialist Palliative Care?**

This is palliative care delivered under the management of a consultant in palliative medicine

**Can you elaborate on Active Monitoring (excluding non-specialist Palliative Care)?**

This is where a diagnosis has been reached but it is not appropriate to give any active treatment at that point in time but an active treatment is still intended. The patient is therefore monitored until a point in time when they are fit to receive or it is appropriate to give an active treatment. It is not to be used for thinking time. For example, if a prostate patient is offered a range of treatments and wants to take a couple of weeks to think about the options this is NOT active monitoring. However, if a prostate patient has a 'pussycat' tumour that is not causing any significant problems and they decide that they don't want to pursue active treatment immediately but have the cancer kept under check by repeat PSA etc this would be active monitoring. Whilst a patient is being actively monitored they may receive symptomatic support.

**Can you elaborate on Non -specialist Palliative Care (excluding Active Monitoring)?**

This is palliative care (excl active monitoring) given under the management of a consultant other than a consultant specialising in palliative medicine

*Cancer Treatment Event Type*

**A patient with recurring cancer could undergo subsequent treatment. Typical example may be a recurring breast cancer treated with surgery first and then radiotherapy. Which Event Type should it be please?**

Treatment of a recurrence is always classed as a subsequent treatment (even if it is the first treatment of that recurrence) on the basis that the first treatment would have been to the primary cancer at some point in the past. The Event Type would therefore be code 03-06 as appropriate.

**A patient is referred under the 2ww scheme, they are diagnosed with a cancer but are treated for a met prior to being treated for the primary. Do we record as treatment for a met ie. Cancer Treatment Event Type 05 and when they go on to have primary treatment is this 01?**

Yes, Code 05 is appropriate. Treatment of mets with a KNOWN primary has to be classed as a subsequent treatment even if it takes place at the same time or before treatment of the primary. It cannot therefore be classed as the FDT and end the 62d pathway. It does not matter that sequentially it took place before treatment of the primary in terms of the CWT-Db ie. you do not need to upload the treatment records sequentially. You would upload the first treatment for the primary (Code 01) as normal once it had taken place and this would end the 62d pathway.

*Miscellaneous*

**Do you know if there is an up to date list of referral codes for GPs? Not the urgent referral type, but the coding for the symptoms that sits behind this ie the codes the GPs have for referring patients in based on criteria, eg rectal bleeding, loose motions etc?**

I'm not sure that I understand the question. This is not part of the CWT dataset. It sounds like you are referring to READ codes (ie coding structures used within primary care) which map to OPCS4, ICD10, SNOMED. This is not within my remit. I suggest you liaise with Ally Butler (Head of Datasets team at the Information Centre) on [ally.butler@ic.nhs.uk](mailto:ally.butler@ic.nhs.uk) as a starter. Hopefully she can point you in the right direction.

**Can you please confirm to me if the actual date of diagnosis is the histology report date or the date the test was taken? There are a number of Trusts within our network using different dates, and I said I would clarify this for them all.**

The date of diagnosis is not used within the cwt dataset so I'm afraid that I don't know. You would need to check the data dictionary for the definition.

**CWTDdb**

**What are the reports on Referral to Decision To Treat for (reports 13.1 and 13.2). Are they for our own use?**

They are to support local service improvement and pathway redesign if necessary.

## **Tumour-specific**

### *Bladder*

**Should Intravesicle chemotherapy following TURBT count as a 31d subsequent treatment in 2 scenarios:**

**1. When given in the form of Mitomycin-C within 24 hours of TURBT as a single dose**

If this is classed as a combined treatment then the drug treatment would NOT be classed as a subsequent treatment. Combined treatments are described at Q3.32 in GFOCW guide v6.5 as '*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. An example 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 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.*' I have sought clinical advice on your scenario and have been advised that this could be classed as a combined treatment and therefore the drug element would not be a subsequent treatment.

**2. When given in the form of 6 doses of Mitomycin-C for a fixed tumour where complete resection not performed.**

In view of the above the clinical advice is that the drug treatment in this scenario WOULD be a subsequent treatment.

### *Brain & CNS*

**Are we supposed to be tracking grade 1 and 2 / meningioma / benign tumours?**

Grade 1 & 2 brain tumours (generally considered benign) are outside the CWT remit.

**Are there any plans to incorporate benign brain tumours (grade 1 & 2 ) into CWTs?**

No plans to include them as yet.

### *Haematology*

**If a patient has been diagnosed with a lymphoma and is treated for this and then later is found to have transformed, should this be considered a progression or a new primary cancer? For example, a patient diagnosed with a follicular lymphoma that later transforms to a diffuse large B cell lymphoma (DLBCL).**

I would class this as a progression so any new treatments would be subsequents.

*Head & Neck*

**A Head & Neck patient was referred to us for chemotherapy, but needed to have a PEG tube inserted before the chemotherapy could commence. We have put his first treatment as the start date of his chemo with us, and the referring trust are putting his first treatment as the date of the insertion of his PEG tube with them. Can the insertion of a PEG tube count as a first treatment in this instance?**

PEG (percutaneous endoscopic gastrostomy) is not generally classed as an FDT. There is an exception for PEG prior to surgery where the date of admission for the PEG can be classed as the FDT if the patient remained an in-patient between this date and the main surgery ie. if it is the same episode of care. In your scenario I think that you are correct ie the chemo not the PEG ends the 62d pathway in this scenario.

*Lower GI*

**We have a LGI patient who has bone mets and they have had a vertebroplasty and we want to know if we can class this as first treatment for surgery. Basically they have had a kind of 'cement' injected into their spine to fuse a break that has occurred due to the mets.**

Treatment of mets (where the primary is known) are always classed as subsequent treatments. They can sequentially take place before the treatment of the primary but they CANNOT be classed as FDT for the primary.

*Lung*

**Would a VATS biopsy (Video Assisted Thoracic Surgery) counts as first definitive treatment for lung?**

If a procedure could be considered as debulking a tumour then it can be classed as FDT but not if it is just taking a small biopsy for diagnostic purposes.

*Prostate*

**We have a patient who is having Radiotherapy to his breasts to Prevent or Reduce Breast Growth and Tenderness from his Prostate cancer (Prophylaxis). Is this reportable?**

I have received clinical advice on this query to the effect that such r/t is an enabling treatment to allow hormone therapy to start and is not in itself a cancer treatment. In this instance it is not therefore reportable.

**X trust has informed me that if a patient is diagnosed with prostate cancer on biopsy and then six weeks later has a MRI, we can take active surveillance as the first definitive treatment (after the biopsy) and the treatment he receives after the result of the MRI, as subsequent treatment?**

This is not correct. Active monitoring/surveillance is where a diagnosis has been reached but it is not appropriate to give any active treatment at that point in time but an active treatment is still intended. The patient is therefore monitored until a point in time when they are fit to receive, or it is appropriate to give, an active treatment. It is not to be used for thinking time or to wait needed between procedures in the diagnostic pathway. For example, if a prostate patient is offered a range of treatments and wants to take a couple of weeks to think about the options this is NOT active monitoring. However, if a prostate patient has a 'pussycat' tumour diagnosed that is not causing any significant problems and they decide that they don't want to pursue active treatment immediately but have the cancer kept under check by repeat PSA etc this would be active monitoring. Whilst a patient is being actively monitored they may receive symptomatic support.

**It is accepted that different tumour sites will have different performance against the 62d standard. For prostate some Trusts are using MRI as a triage test in their prostate pathways rather than the traditional pathway of PSA, TRUS guided biopsy then MRI. Some Trusts are reporting that the triage route takes longer than the traditional pathway and pauses are needed. Is this acceptable?**

As I understand it the standard pathway for patients with suspected prostate cancer is PSA followed by TRUS guided biopsy followed by MRI. I am not aware of the pathway whereby MRI is being done before biopsy as a triage test (but that does not mean it is inappropriate). The question implies that, although, reducing the number of biopsies patients are still likely to breach 62d. I can't see how this would lead to an increase in breaches unless there were MRI capacity issues locally or patients wanted thinking time eg. to consider treatment options etc following diagnosis. I will seek clinical advice on this pathway but even if it is appropriate I don't see that any pauses would be allowed.

### *Upper GI*

#### **Patient required duodenal stenting prior to starting chemotherapy - is this classed as a treatment?**

There is no definition of an enabling treatment. The key is how we define a first definitive treatment and how an enabling treatment would fit within that. The definition of FDT that has been used for many years for cwts is as follows: *'The first definitive treatment is normally the first intervention which is intended to remove or shrink the tumour. Where there is no definitive anti cancer treatment almost all patients will be offered a palliative intervention (e.g. stenting) or palliative care, which would be counted as the definitive treatment.'*

There are a number of enabling treatments that are carried out prior to active treatment which do not fall within these definitions. The majority of these have NOT been able to be classed as first definitive treatments. The reasoning behind this has largely been that enabling treatments could thus end a 31 (and potentially 62) day period and the patients could then wait a long time for the active intervention that should follow as there would be no standard to cover this. The last CWT guidance under the old rules (version 5) included a small number of enabling treatments that could be classed as FDTs. Most others would have been classed as medical suspensions locally (eg. stents, dental extraction prior to r/t etc) and adjustments made. When DH calculated the new operational tolerances it took into account the level of medical suspensions previously uploaded onto the CWT-Db. The reduced tolerance therefore allows for breaches due to enabling treatments needed prior to FDT that were not covered by the older guidance. The general rule is that a stent can only be classed as first treatment where the patient is unfit for other treatment.

In your scenario the patient is having palliative chemotherapy and the stent is being classed as part of palliation. For the purposes of monitoring the 31/62d standards, supportive packages of care are to be considered as the whole. This means that whilst a patient may be receiving a range of treatments (e.g. stent and chemo etc), if it is a single agreed package then the start of the package of care should be taken as:

- date of the delivery of the first episode; or
- the consultation that results in the referral to a non-NHS specialist palliative care service (that are not contractually obliged to return these data independently); or
- the consultation at which the patient receives a prescription.

If the stent was part of an agreed single package as described above then it can be FDT. If not then the general rule is a stent is not an FDT.

### *Urology (general)*

#### **Q .Should we be tracking and reporting on Grade 1 and Grade 2 histology Urology cancers**

PTa and in situ urological cancers are excluded.

## **Miscellaneous**

**If a patient's DTT is in the private sector but treatment is in the NHS, how would you record the DTT? The patient does not have a NHS clinic appointment and is not discussed at MDT before treatment as the private clinician and NHS clinician are the same person.**

You have a scenario where a private patient has a DTT but then decides to be treated in the NHS. The issue is whether or not the DTT (and therefore the clock start for the 31d period) is that made in the private sector. My view is that it should NOT be and that a further DTT would need to be made in the NHS. The complication arises because the clinician seeing the patient in private practice is the same one that will be treating the patient in the NHS and hence it does not appear a good use of time to have an additional consultation in the NHS to agree the treatment again. My view is that the DTT would be the point at which the NHS provider is notified that the patient is being transferred back into the NHS and that the clinician has already agreed with patient the course of action.

*DH added: 'The DTT should be reached somewhere along the pathway of care the patient is following whilst in NHS care. Therefore I agree with NCAT and I would expect the DTT to be at the point where they agree the care package with the consultant treating them within the NHS, this may be acting on the advice received from the private provider.'*

**We've had a question in from a system supplier relating to commissioning dataset information from hospices. I would assume that hospice data is excluded from CDS activity particularly in relation to 18 weeks RTT (and CWT) as the target times are focussed on time from diagnosis to first definitive treatment. We are also thinking that hospice care wouldn't normally be included in CDS as it is not generally NHS commissioned care. Is that correct?**

*DH Advice: 'For the purposes of cancer waiting times, if a patient was transferred to a local voluntary hospice for a palliative treatment and no active treatment was planned, then the date of the referral to the hospice would count as the start date of the treatment. This would be recorded by the NHS organisation that had made the decision to transfer the patient to the independent palliative care provider. As far as the inclusion of this activity in the CDS, this would probably depend on the contractual arrangements with the provider. However I would suggest that you direct this query to datastandards@nhs.net for a definitive answer.'*

**When will the definitive guide to GFOCW be available, is there any chance this could be categorised by tumour group and are there any plans to produce a guide as to what exactly is required for each data item?**

There will never be a definitive guide as it is constantly evolving. The current guide is v6.5 which is on the cfh website. An updated version should be out early next year along with a series of tumour specific cwt guides. There is already a document which goes into the dataset in more detail setting out what is required. It is a document that sits alongside v6.5 of the guide on the cfh website from memory it is part 6.

## **Useful Links:**

*CWT Stats:*

[http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationsStatistics/DH\\_099885](http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationsStatistics/DH_099885)

*CQC Indicators Constructions:*

<http://www.healthcarecommission.org.uk/guidanceforhealthcarestaff/nhsstaff/annualhealthcheck/annualhealthcheck2008/09/qualityofs/nationalprioritiesacuteandspecialisttrusts.cfm>

GFOCW guidance:

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

**Abbreviations/Acronyms**

18w	18 week standard
2ww	Two week wait standard
31d	31 day standard
62d	62 day standard
AML	Acute Myeloid Leukaemia
Appt	Appointment
BCC	Basal Cell Carcinoma
CaB	Choose and Book
CA125	Cancer antigen 125 ( a blood test)
CfH	Connecting for Health
CDS	Commissioning Dataset
CNS	Clinical Nurse Specialist
CWT	Cancer Waiting Times
CWTDb	Cancer Waiting Times Database
DH	Department of Health
DNA	Did Not Attend
DSCN	DataSet Change Notice
DTT	Decision to Treat
ECAD	Earliest Clinically Appropriate Date
FDT	First Definitive Treatment
GFOCW	Going Further on Cancer Waits
GP	General Practitioner
HCP	Health Care Provider
ISB	Information Standards Board
LGI	Lower Gastro Intestinal
LHB	Local Health Boards
METS	Metastatic Disease
MHRA	Medicines & Healthcare Products Regulatory Agency
MRI	Magnetic Resonance Imaging
ODS	Organisation Data Service
OE	Open Exeter (ie where the CWTDB is located)
OPA	Outpatient Appointment
PCT	Primary Care Trust
PDS	Personal Demographics Service
PET	Positron Emission Tomography
PPI	Patient Pathway Identifier
pTa	a low grade bladder tumour
Pt	Patient
PTL	Priority Target List
r/t	Radiotherapy
RTT	Referral to Treatment Time
SSP	Specialist Screening Practitioner
TCI	To Come In Date
TIPSS	Transjugular Intrahepatic Portosystemic Stent Shunt
TOP	Termination of Pregnancy
TURBT	Transurethral Resection of Bladder Tumour
TURP	Transurethral Resection of the Prostate
TWR	Two Week Wait
Tx	Treatment
UBRN	Unique Booking Reference Number