

Questions answered by NCAT – October 2009

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Two Week Wait (2ww)

How would NCAT describe a 'decision to refer' in terms of the 2ww standard?

This is the date on which:

- a GP or GDP decides to refer a patient urgently to secondary care with suspected cancer; or
- any health professional decides to make a referral to secondary care for breast symptoms that are not suspicious of cancer.

Please note this is not the date that starts the 2ww or 62d clock. From 1 Jan 09 the clock start has been receipt of referral ie the 'Cancer Referral to Treatment Period Start Date'

If a GP sends a 2ww referral where the patient has a known cancer diagnosis and the GP is requesting additional opinion and further treatment – does this apply as a 2ww referral?

This is not a 2ww referral for suspected cancer but a referral linked to the original primary cancer. Hence only the 31d subsequent treatment standard would apply. The exception would be if the GP suspected a new primary and was making an urgent 2ww referral on that basis.

If a patient is referred as a two week wait target referral but is admitted before the first appt this would usually then cancel out the two week wait appt and the patient would then be changed to routine – Is this still the case under the new standards?

See questions 5.6 and 5.7 in Version 6.5 of the GFOCW guide on the CfH website.

If a patient has had cancer treated, then X months down the line the GP refers the patient back for possible mets related to the primary using the 2WW referral route and mets is later confirmed (recurrence of a known primary) the patient would be covered by the 31D subsequent but would the 2WW also come into play or do we just accept that the GP has used this route for speed of access?

A GP can refer a patient under the 2ww with a suspected recurrence. If a recurrence was confirmed the 2ww standard would stand but the patient would NOT be covered by the 62d standard (this is only for new primaries). They would however be covered by the 31d subsequent treatment standard.

If a hospital receives an urgent referral facsimile at 0900 Jan 1st 2010 at what point does the hospital breach January 15th or January 16th?

Receipt of referral is day 0. The breach would therefore be 16 Jan.

If a facsimiles is received at 1200 or 1645 etc is that still classed as receipt of referral?

Yes.

If a pt is referred in as a 2ww LGI for rectal bleeding, no problems from that end, but the CT colonoscopy detects a gall bladder cancer incidentally, is this still part of that 2ww pathway, or can we close that record and commence a new pathway?

The receipt of the 2ww LGI referral would still mark the start of the 62 pathway which would end with the FDT for the gall bladder cancer. Although the gall bladder was an incidental finding it was found during the investigations as part of the LGI 2ww referral.

If a GP wanted to refer a patient but the next day that patient was going on holiday for three weeks, would they breach as the GP had made the decision, or would they be allowed a delayed decision to refer?

The clock starts upon receipt of referral not upon the date of the GP's decision to refer. If a patient cannot make themselves available for an appointment within 2 weeks despite having been given appropriate information, it is technically possible for a GP to defer making the referral until the patient is available for an appointment. The best interest of the patient should be at the forefront of the local policy. Ideally, the patient should be referred at the earliest opportunity because receipt of this referral flags to the receiving organisation that there is a potential cancer case on its way.

Some clinicians decide that a referral does not meet the 2 week rule referral criteria, contact the referrer and reroute the referral to what they consider an appropriate pathway. Is this legitimate practice?

No. 2ww referrals can only be 'downgraded' by the GP - if a consultant thinks the 2ww referral is inappropriate this should be discussed with the GP and the GP asked to withdraw the 2ww referral status.

We know that a consultant cannot refuse to see a patient referred via the 2WW route, no matter how inappropriate that referral – but where is the policy/guidance that confirms this please?

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, which is available at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4010373

"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."

Please note: The restriction on the referral being received with 24hours has been removed from the two week wait, to align with Chose and Book and 18-weeks. However, the restriction on the consultant's re-categorisation of these referrals remains current.

Previously the GP ordering of tests has been viewed as a way of by-passing targets and has not been practised. Given Professor Richards announcement about widening access to tests for GPs are we now able to allow this to happen? If so, if they have a test, ie colonoscopy, which yields a tissue diagnosis, would they still be classed as a suspected cancer, and come through the 2ww scheme?

DH response: On 29 September the Prime Minister announced plans to offer all patients in England access to tests which can confirm or exclude cancer within one week. Currently GPs can refer patients with suspected cancer to be seen by a cancer specialist within 2 weeks. Under the new plans, where the GP thinks that the risk of cancer does not justify a 2-week urgent referral to see a specialist, but there are symptoms which require investigation, the GP will be able to refer for the appropriate tests to be carried out within 1 week. In the great majority of cases, the tests will show that there is nothing wrong or a non-cancer problem which needs treating - but in the very small minority of cases which prove to be cancer, earlier diagnosis will increase the chances of curative treatment. Our aim is to start rolling this out from 2011-12 over a 5-year period. For the first two years, we plan to focus on the diagnostics associated with lung, colorectal and ovarian cancer – three of the biggest killers - with an expectation that people would know within two weeks whether or not they had cancer. This will be followed in the subsequent 3 years with a move towards people with all conditions that could possibly be cancer knowing the results of tests within, first, 2 weeks and, by the end of the 5-year period, within 1 week. There will always be exceptional cases where it will not be possible to get results as quickly as the normal turnaround period - for example where people have rare or complex cancers that are more difficult to diagnose. The National Cancer Director, Professor Mike Richards, will now work with the NHS, key stakeholders and the professions to ensure that this commitment to patients is successfully delivered. This work will include the confirmation of relationships between this commitment and existing access standards.

Symptomatic breast 2ww

Have you any advice on mitigating the effect of Choose & Book on performance for the Symptomatic Breast Referrals 2-week wait target? These patients may not consider themselves 'ill' or share our sense of urgency. With C&B they are even more free to exercise 'patient choice' and book appointments outside the target and there is virtually no time to compensate for this action.

For patients booking through CaB, the clock starts at the UBRN conversion. I understand that some patients may choose to wait some time before deciding to make their appointment and thus converting the UBRN. The key is to have a means by which appointment slots on CaB are only on offer within a 14 day period from the UBRN conversion date for these patients. I understand that this is how CaB should already be working for the urgent 2ww referrals and that some Trusts have already adopted this approach for symptomatic breast 2ww referrals.

I had understood that data on breast symptomatic 2ww should have been uploaded onto the Cancer Waiting Times Database (CWT-Db) from 30th April 2009. I took this to mean that it was mandatory for data for the month of May onwards to be uploaded onto the CWT-Db. Is that correct?

All data from 1 Jan 09 onwards needed to be uploaded if a 2ww symptomatic breast service had been commissioned. The 30th April 09 date related to when the CWT-Db was available to upload data onto ie. Jan, Feb and Mar data could not be uploaded until 30 April as the CWT-Db did not go live until that point.

An outpatient capacity planning model is available from the Intensive Support Team to help with preparation for meeting the new breast 2 week wait standard. Do you have any information on how to access this tool?

You need to e-mail cancer-waits@dh.qsi.gov.uk

DH will provide tool to you with appropriate background info/how to get support to use it etc.

31d treatment (first or subsequent)

We have a patient who is to be referred back to the GP for hormone treatment. How does the treatment part of the record get uploaded (assuming the GP gives the prescription)?

It is assumed that PCTs will upload this data rather than the individual GP practice. You would need to ensure that the PCT in question is registered to use the CWT-Db. Arrangements can be made for you to upload on their behalf if need be.

If a patient was scheduled for an operation in June, had a laparotomy but became unwell on the table and was closed with no resection, then proceeded to have a pacemaker before re-operation in September...how do we record this?

As the operation in June did not end with a treatment and you do still plan to treat (i.e. it wasn't an open and close because the tumour was inoperable etc) then you would need to class the FDT as the operation in September with no adjustments.

Do you think clearing a stent of tumour counts as a treatment?

If this procedure would be classed as 'debulking' the tumour then yes it would be classed as a 31d subsequent treatment.

Does lymph node excision count as treatment?

It depends. If lymph nodes excision is purely diagnostic/staging then not classed as treatment. However if it is to excise possible cancer then it could be a treatment.

Classic 62d (ie. from 2ww)

If a 2ww patient had a stent inserted at one trust followed by further surgery to the same site two months later at another trust, is the further surgery countable as a subsequent treatment or is it to be discounted - the stent insertion at the original trust being the FDT in this treatment package.

If the stent was the FDT then surgery at a second trust would be a subsequent treatment. However, you should be aware that a stent is not always classed as a FDT. A FDT is normally the first intervention which is intended to remove or shrink the tumour. Where there is NO definitive anti cancer treatment then a solely palliative intervention (e.g. stenting) would be counted as the definitive treatment with a small number of exceptions such as a stent to resolve jaundice before a pancreatic cancer patient has a resection or starts chemotherapy etc.

If a 62 day patient multiple DNAs in the diagnostic stage of the pathway can they be referred back to the GP?

A patient can be referred back to their GP after multiple DNAs (2 or more) if that is the local access policy.

The decision has been taken to monitor the progress of a lesion for the next few months - it is likely to be cancer but this has not been confirmed at this point. The surgeon noted that this patient: *'has asked to have the potential lesion in her caecum reassessed in a few months to see if it has progressed. The lesion is highly suspicious for malignancy but not definite on biopsy. She has long-standing UC and would need proctocolectomy and end ileostomy for which she is extremely reluctant. Only surveillance has been planned and if a cancer is definitely confirmed she will likely agree to surgery.'* Active monitoring seems most appropriate. Do you agree?

I do not agree that active surveillance/monitoring is appropriate in this scenario. For cancer waits, active surveillance is a legitimate treatment option. In this scenario the patient has not received a confirmed diagnosis of cancer yet so the active monitoring being suggested is NOT a treatment option. This scenario is one of diagnostic uncertainty. The 62 pathway remains open and the patient will breach if 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.

Would the following be examples of inappropriate policy - patient declines dates offered and requests delayed appointment. The start of the 62 day pathway is reset to the earliest date that the patient is available to attend for an appointment. The patient will be booked into the next available appointment following this date.

The start of the 62 day pathway cannot be moved in this way. The start of the 62d period is the receipt of the initial referral it is NOT the date a patient is available to attend an appointment. The only time the start can be re-set is if the patient DNAs their first o/p appt.

62d upgrade

What happens to a patient on a 62d consultant upgrade pathway who is admitted as an emergency prior to an appointment?

I have spoken to DH about this and they have advised that they need to think through the implications of this scenario. I will get back to you when I have their response.

62d Screening

What is the expectation for collection / submission of data in relation to the bowel screening patients, should we only be collecting information on patients who have a confirmed cancer via the screening program or is there an expectation we should track all patients who have a positive FOB and are referred.

It is mandatory to upload data to the CWT-DB up until DATE FIRST SEEN for all patients urgently referred by the screening programmes i.e. not just those subsequently diagnosed with cancer. It is the responsibility of the Provider commissioned to provide this part of the screening pathway to code and record from the receipt of the referral (for the appt with the SSP to discuss suitability for colonoscopy) to date first seen.

We have noticed some bowel screening pts choose to defer their diagnostic colonoscopy for a number of weeks some of which turn out to have a cancer. If there is a significant delay in having the first test can these pts be removed from the fast track / 62 day reporting and counted against the 31 day only as they have chosen to wait so long or are they reported as such and are allowed for in the tolerance.

You cannot remove a patient from the 62d pathway because they choose to defer their colonoscopy appt for a number of weeks. The operational tolerances for all cwt standards have been set to take account of the likely volume of patients who will choose not to be seen/treated within the standard times or are not clinically fit to be seen within these timeframes.

Is there any news about reducing the data collection burden on trusts, especially around collecting the data on screening patients who do not have cancer?

In terms of screening, the GFOCW Advisory Group agreed that it was less of a burden to upload data on all the urgent screening referrals than to track the referrals and just upload for those diagnosed with cancer (assuming appropriate IT systems were in place). It was agreed that the decision should be made on the assumption that these systems were in place rather than being changed because of the impact on those Trusts that had not invested in better and more effective ways of working. The more general issues about burden vs benefit will be picked up as part of the ISB conformance review so there may be scope to submit to DH any concerns/evidence you have.

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

The GFOCW Advisory Group were advised by the National Screening Programme representative on the Group that the majority of patients under surveillance were having polyp management (preventative treatment) and the numbers with suspected cancer would be small. The Group agreed that the benefits of adding this small number of patients on to a 62d pathway were outweighed by the changes that would be required to the CWT-DB and potentially the dataset to implement this change. These patients will therefore not be on a 62d pathway but will be covered by the 31d first and subsequent treatment standards if they do go on to be diagnosed with cancer

Pauses

A patient was seen at X Trust but has opted to go to Y Trust for surgery as she has family near there. X Trust could have offered the surgery within the target time but Y Trust cannot. Could an adjustment be made for pt choice?

If you offered admitted treatment in X Trust and pt then asked to go to Y Trust to be closer to family then I agree that a reasonable offer of admitted treatment was rejected and a pause should be possible. If you offered the pt the choice of treatment at X or Y Trust and she chose Y Trust a pause would not be possible. Assuming the situation was the former, the issue is how long the pause should be. In theory it is from the appt date (TCI) the pt declined (or in your case the one you would have offered) to when they could make themselves available for treatment at Y Trust. Until there is central advice on what 'making self available' would mean in this type of scenario you will have to interpret that bit yourself.

Clinical trials - I am told that the SCRATCH trial requires a prolonged work-up period before treatment can commence, and may consequently breach. Patients are informed of this prior to giving consent, so have agreed to this delay. Can any kind of pause be taken?

No pause is possible in this scenario. I am not aware of this trial. If you have significant numbers of patients entered into it and the work-up genuinely takes a long time and this will adversely impact on your performance then you could consider making a case for extenuating circumstances to the CQC at the end of the year.

Patient was offered a TCI at one of our three sites, but declined as they wanted to attend a different site to the one offered. The treatment is for an inpatient admission. Please could you let me know if a pause would be applicable and were we would stop and restart the clock.

It depends... if the patient was told that 3 sites could provide the treatment and they then chose one that could not provide the treatment within the standard time then a pause is NOT allowed ie. a pause can't be used because of capacity issues locally. If, however, treatment was offered at site X and the patient enquired about alternative locations and then decided on one of them then yes a pause is allowed.

What is NCAT's view on holidaying patients?

The operational thresholds have been lowered to take into account that more patients will breach the CWT standards due to reasons of choice e.g. going on holiday.

Does NCAT know of a national DNA policy?

For cancer the national position is:

- Suspected cancer patients should not be referred back to the GP after 1st DNA of their first appointment.
- Suspected cancer patients can be referred back to their GP after multiple (2 or more) DNAs of any appt if this is the local policy.

The DH website has advice on management of DNAs in terms of the 18w standard.

A patient has a DTT and is scheduled for treatment, they call up and cancel their treatment planned within target and asked for it to be changed to a later date (which will make the patient breach their 62 day target) can we adjust for this as the patient has deferred?

No adjustment is allowed for a patient cancellation. The operational tolerance has been lowered to allow for more breaches due to patient choice

Is it incorrect to count cancellations of 2 week wait appts that occur within 24 hours of the appointment as a DNA?

It is incorrect. A cancellation is a cancellation irrespective of the notice given.

Breaches

We have a patient whose treatment plan is to have long course chemo RT. The chemo was prescribed at our Trust (patient went away with a prescription and was told to take the first dose on the day they start the RT). Patient received the RT part of their treatment at another Trust as we do not provide RT in our Trust. We have counted the day the patient went away with the prescription as their FDT start date. Is this correct and is it correct that the Trust who provided the RT claim no part of the treatment, as the start of this combined treatment package took place at our Trust?

The issue here is whether this is genuinely chemoradiation. For the purposes of the GFOCW dataset, combined treatments such as chemorad are treatments of different modalities combined in a way that they MUST be scheduled to take place together. These should be regarded as single treatment package. An example of combined treatment includes chemoradiation where radiotherapy and chemotherapy are delivered within a strict schedule so that they interact to make both treatments more effective (eg: weekly 5FU during radiotherapy for rectal cancer, radiotherapy given synchronously with cycle 4 of CMF for breast cancer). The definition of combined treatments EXCLUDES adjuvant therapies where each treatment CAN be scheduled separately (e.g. chemotherapy for small cell lung cancer followed by consolidation radiotherapy).

If the patient in your scenario is genuinely having a combined treatment (as described above) then the date the chemo prescription was given (as this is an oral chemo) stops the clock.

A breach is shared by the provider commissioned to first see the patient and the provider commissioned to carry out the treatment - in terms of a combo treatment if two Trusts split the combo treatment ie one did chemo and one did r/t it would be the Trust commissioned to deliver the first part of the combo treatment , in your example, chemo that would share any resulting breach.

Please clarify the shared breach arrangements for trusts hosting a bowel cancer screening programme. As an example, we host a screening service which covers three trusts. SSP appointments are held in all three Trusts but resulting colonoscopies can only be carried out in one of these Trusts. Soon all 3 Trusts will be able to offer colonoscopies. If cancer is found patients are referred to their nearest organisation for onward management. To date we have assumed shared responsibility for patients who are referred onto other Trusts, however when colonoscopies are being performed in all 3 sites will we still remain responsible for a shared breach?

If there is a breach it would be shared between the provider COMMISSIONED to provide the appt classed as 'date first seen' (ie the appt with the SSP to discuss suitability for colonoscopy not the colonoscopy itself) and the provider COMMISSIONED to provide the first definitive treatment. It may be the same provider that is commissioned to provide both parts of this pathway. v6.5 of GFOCW guide includes a number of commissioning scenarios e.g. if Trust A is commissioned to provide the SSP appt but sub-contracts to Trust B it is still Trust A that has responsibility for ensuring the data is uploaded and for sharing any breach.

A patient was referred to a Trust via Breast Screening in July. A biopsy revealed she had stage 2 breast cancer, requiring treatment (surgery advised). The patient does not speak English and her adult daughter acted as interpreter. The Trust planned to get the patient in again with a professional interpreter but the patient went off to Algeria before this could be arranged. She was due to return in September but in fact has gone on to the USA and may return sometime in the new year. Does her 62-day screening pathway stay open and for how long - presumably the DTT has not yet been reached?

The scenario you describe implies that, due to patient choice, the 62d screening standard will be breached as no pause is possible. The 62d pathway would remain open until either the patient is seen again and treatment agreed or there is some form of contact to confirm that the patient will not be returning/receiving treatment. There is no cut-off date for how long you need to keep the record open. As the patient has not received treatment the second part of the record will not have been uploaded so a 62d pathway will just not be created.

We have patients who are being seen in oncology for subsequent treatments of radiotherapy however they have holidays booked and the oncologists are happy to delay the r/t until after they return. They cannot start a treatment package before going on holiday as there would be a break between fractions. These patients are therefore breaching their 31 day standard as these are outpatient treatments. We are recording these patients as breaches, using the 'other' option as the reason and explaining in the breach comments that it was due to holiday. Is this correct?

Yes that is correct. As this is non-admitted treatment there is no pause.

What is the CQC breach reallocation policy?

The CQC have advised: For patients who are referred from one provider trust to another, the patient and any breaches of the target time are automatically shared between the trust where the patient is first seen and the trust where they are first treated on a 50:50 basis. This is to stimulate joint working between trusts to provide timely treatment to patients. The cancer waits database does not collect data on referral dates between trusts that could facilitate a more sophisticated division of responsibility and the collection of the extra data would be burdensome to both trusts and the data collection infrastructure.

However, when a patient is referred from one trust to another after the two month (62 day) target time has already been breached, the Care Quality Commission will consider reallocating the patient and breach from the treating trust in the following circumstances:

- 1. The main reason for the delayed referral was non-clinical (e.g. administrative) problems in the first trust (clinical exceptions to the two month target are allowed for in the indicator thresholds).*
- 2. The trusts' Chief Executives agree that this reallocation is appropriate. The Care Quality Commission expects any disputed requests for reallocation to be settled locally.*

For the purposes of requests for reallocation of breaches, the referral date is defined as being the date when the referral was received by the trust treating the patient (i.e. not including any delays between receipt and agreement to treatment). Please note that any changes will be reflected in the data and assessments made by the Care Quality Commission, but not in the data published by the Department of Health.

Below is a link to the documentation required to request the reallocation of a breach as described above. Please note that despite the reference to 2008/09 we are still accepting this form which is due to be updated shortly.

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

Performance management

Trusts achieving 100% compliance with the 2WW target may be artificially inflating the national performance figure and making those who are complying with the rules look poor in comparison. What is being done about this?

We have suggested that SHA GFOCW leads pay particular attention to those providers performing very highly for 2ww. We may be able to learn positive lessons from some that we can share. For others, SHAs may need to consider appropriateness of access policies. The operational standard was set taking a whole range of data into account including (as I understand it) at least a year's worth of data under the old system. DH will keep operational tolerances under review and we have suggested to SHA GFOCW leads that they stress the need for performance to reflect the TRUE position if we are to have appropriate operational tolerances. If you have local concerns please liaise with your SHA GFOCW lead.

Some Trusts are concerned about end of year performance - is there any news on CQC thresholds for performance yet?

You haven't missed anything. As I understand it CQC will assume that you are working to the DH operational standards but when they have data they will consider if they will use these and also what thresholds they will set for almost achieved, failed etc.

We are keen to know how a “fail to achieve” will be assessed?

You would need to contact the CQC about this via Performance.Indicators@cqc.org.uk

Can I just clarify, if the patient who declined treatment breaches the 62-day target, will the breach be include in the Trust's overall % performance?

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

In the August Q and A edition, there is a section regarding CQC reallocations that states day 62 is the earliest time for a reallocation. Should this not be day 63?

I have double checked and you are correct.

Do you have any feedback on data completeness for the live and non-live standards?

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.

Dataset

Delay Reasons

Please could you clarify when to use Code 08 'Delay due to referral between trusts' as a breach code? We have several patients who breach their 62 day target as a result of them being referred over to us late. When agreeing a breach reason with the referring hospital they are giving us their reason for the delay and we are incorporating it into the breach comment however they are questioning us using the 08 as they feel as they have given a legitimate reason for the delay. From our point of view the patient has not been treated in time because of the late referral regardless of the reason. Please can you confirm which is the correct position?

Code 08 'delay due to referral between trust' is for use where the delay is due to admin reasons (ie in line with the CQC breach reallocation policy) for example a patient was missed off a list etc. It is not for issues such as patient choice and delays because patient unwell etc.

Two week wait cancer or symptomatic breast referral type

How should symptomatic breast referrals for under 16's be entered onto the cancer waiting times database.

There is no age specification for this standard. For an under 16 with breast symptoms that were not suspicious of cancer you would use a 'Two Week Wait Cancer or Symptomatic Breast Referral Type' of Code 16 ie 'exhibited (non-cancer) breast symptoms - cancer not initially suspected'. Code 02 ie. 'suspected childrens cancer' would only be used if an urgent referral was being made because the breast symptoms made the GP suspect cancer.

Primary Diagnosis (ICD)

Myeloid dysplastic syndrome, is likely to be coded as D464 or D469. Is this a recordable cancer? I only ask as the pt is having chemo, and treatment regime similar to that for AML.

No - only D code in scope is breast in situ.

We are reporting an increase in the number of primary peritoneal carcinomas. How do we code this in ICD10 please? We have been using C48.2 but this is categorised as "Sarcoma" and not "Gynae" in the ICD10 tables. Is that right?

I agree that C48.2 should be used to code primary peritoneal carcinomas and that this is currently categorised as sarcoma.

Categorisation of primary peritoneal carcinoma as sarcoma rather than gynaecology is disappointing (less than 5% are sarcoma) – there are raising numbers of these cases. Under reporting the CWT records for the Gynaecology team is annoying them. Now that we're recording ICD to 4 digits for all cancers would it be possible to re-categorise C48.2 to Gynaecology rather than Sarcoma?

NCIN are looking in to this and we will try to get this re-categorised as gynae. I am not sure how long this will take but NCIN are on the case.

Metastatic Disease

Please confirm if I have the recording of mets correct based on the following theoretical pathway:

- 01/07/09 – 2ww referral received – setting 62 day target as 01/09/09
- 07/07/09 – Patient first seen (Closing the 2ww period) 2ww First seen details uploaded to CWT as normal

- 20/08/09 – Confirmation of cancer – Lung primary
- 24/08/09 – Staging tests have identified cord compression from bone mets – emergency treatment required
- 24/08/09 – Emergency radiotherapy for cord compression for bone mets

Subsequent Treatment Details loaded to CWT with Decision to Treat 24/08 and Treatment Start date 24/08

- Diagnosis – C34.3 Lung primary – with 01-Bone Metastatic site
- Treatment Event Type - 05 Treatment for distant recurrence of cancer (metastatic disease)
- Treatment Modality – 05, Teletherapy
- Radiotherapy Intent – 01 Palliative
- Cancer Status – 21 Subsequent Treatment commenced

Monitored against 31 day subsequent treatment target only

- 31/08/09 – Patient recovered from Radiotherapy – to proceed to Chemotherapy for treatment of the lung primary
- 04/09/09 – PICC line insertion for Chemotherapy
- 06/09/09 – Chemo commenced

62 day treatment breach uploaded to CWT – with Decision to Treat 31/08 and Treatment Start date 06/09

- Diagnosis - C34.3 Lung Primary – Metastatic Site details removed from 62 treatment upload record
- Treatment Event Type – 01, First Definitive Treatment on new Primary
- Treatment Modality – 02, Anti Cancer drug regimen

62 day Treatment Breach Reason and Comment uploaded

Cancer Status 08 – First Treatment Commenced

Monitored against 62 day treatment and 31 day first definitive treatment targets

Future – All further treatments uploaded as subsequent treatments – whether for the mets or the primary or BOTH

I think that you have cracked the logic/system although I'm not sure if one of the examples used within it is correct ie. I'm not sure if managing spinal cord compression in your example is actually a subsequent treatment. If this is just treating the symptom of bone mets it would not be a subsequent treatment but if it was also treating the mets in some way (e.g. contributed to debulking etc) then it would. Either way a technicality - you have the process right.

Source of Referral for Outpatients

What is the source of referral for subsequent treatments that follow straight on from the FDT and also those that may be some time later i.e. should this data item relate to the initial referral or something else?

The data item 'Source of referral for Outpatients' is not applicable to subsequent treatments. In GFOCW guide v 6.5 part 6 there is a table on pages 56-58 which sets out each data item in the cwt dataset and clarifies which are mandatory/optional or n/a and for who.

Priority Type

What is the priority type for subsequent treatments that follow straight on from the FDT and also those that may be some time later i.e. should this data item relate to the initial referral or something else?

The data item 'Priority Type' is not applicable to subsequent treatments. In GFOCW guide v 6.5 part 6 there is a table on pages 56-58 which sets out each data item in the cwt dataset and clarifies which are mandatory/optional or n/a and for who.

Pt admitted as an emergency admission (not for cancer) but when visited on ward there is a suspicion of cancer - assuming this is a Consultant Upgrade what priority do we use (1,2,3)?

I would advise using Priority 2.

A GP has referred a patient for an X-ray, the result shows possible mets, the GP refers the patient as a 2WW, mets confirmed, patient will have RT (elsewhere) and chemo here - how do we record the priority of this patient?

The Priority would be code 3 as the GP made a 2ww referral after suspecting metastatic cancer. If mets was confirmed the patient would only be covered by the 31d subsequent treatment standard as mets is classed as a recurrence. The exception would be if it was mets of unknown origin in which case the 62 standard would still apply.

Cancer or Symptomatic Breast Referral Patient Status

An urgent screening referral goes on to be diagnosed with a recurrence rather than a new primary. Treating centre has noticed that referring provider coded the 'Cancer or Symptomatic Breast Referral Patient Status' as Code 03 ie. 'no new cancer diagnosis identified'. As they were diagnosed with a local recurrence should this not have been set to one of the codes 15-21 as appropriate?

I agree this is a recurrence so codes 15-21 should have been used as appropriate. Code 03 is for no new cancer and that can mean no new primary or no new recurrence. You can correct this code on the system - it will have no impact on reports CWTDb produces.

For a first definitive treatment followed by a subsequent treatment it has been suggested (locally) that the 'Cancer or symptomatic breast referral patient status' should show the *current* status of the patient (i.e. 21) even on the FDT details (rather than 8) - is that correct or does it not matter either way?

The 31d subsequent treatment period is a separate record on the CWTDb and would have its own 'patient status' code ie. the 'patient status' code for the FDT would not be changed on the CWTDb it should stay related to the FDT.

Could you confirm what cancer status you would recommend to record those patients with pTas? I know they are not included in CWT currently but would like advice on whether to record them locally as no cancer diagnosed or cancer confirmed.

Unless there is an ICD10 C code for the condition it is not covered by the 31d or 62d CWT standards and a treatment record should not be uploaded to the CWT database (exception breast cancer in situ). If a patient is a 2ww referral then the record up to date first seen would be uploaded and if a pTa was then diagnosed the treatment part of the record would not be needed so you would not need to upload any info after date first seen. The national system has not been designed to cater for the scenario you then have locally. You could record the status on your local system as no new cancer diagnosed but then, if your local system allows, include the ICD10 code so that locally you can see that it was in fact an in situ cancer. Not sure if that helps but in essence it is up to you how you manage this locally as nationally this info is not required.

CWTDb

We want to put in a change request for the open Exeter system to request a report view where for an indicator you could view all providers for a SHA. Is there a form/document template to complete?

Advice from DH: You need to contact the Open Exeter helpdesk they will be able to give you an address to e-mail a change request to. This will then go to the developers and DH for consideration. You will however also get a standard response detailing that no change requests will be processed (unless they are very urgent) until the upgrade of the system has been completed.

Tumour-specific

Bladder

If a patient has pTa they are not within in the remit of GFCOW standards. If at resection it IS found to be a bladder cancer would treatment of that cancer be a subsequent treatment?

If the patient has pTA they are not within in the remit of GFCOW standards. If it is a bladder cancer a resection would be classed as a subsequent treatment assuming you have a new DTT.

Is the resection in this scenario a TURBT? If so, as I understand it the usual circumstance is that a patient will have their first TURBT and then have planned surveillance cystoscopy 3 to 4 months later and possibly 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 to when it was resected (possibly the same day). A less common scenario is that a planned second (rarely third or more) TURBT is done usually at 6 week intervals after the initial one. The national clinical lead for urology advises that this should be outside the 31 day standard but I have yet to get sign off for this. I would therefore suggest you make a local decision as to whether you would class this latter scenario as a subsequent treatment or not.

Breast

If a patient has chosen to have mastectomy with immediate reconstruction (Hosp A) and then changes her mind and wishes to have mastectomy only (Hosp B) can the DTT be updated?

In the scenario you describe, the patient is agreeing to a different treatment plan ie. mastectomy without immediate reconstruction. I would therefore say the DTT was when they agreed to this different plan.

Gynae

If a patient has a subsequent treatment and this is reported as benign do we still report it. Several gynae patients have complete removal of the cancer but then go on to have hysterectomy and the histo comes back clear. Do we still record this treatment?

If this was part of treatment of cancer (e.g. to ensure that no traces remained) then yes, it would be classed as a subsequent treatment even if the margins etc came back as clear.

Is a metastatic pleural effusion/pleurodesis a subsequent treatment? The example is a Gynae patient who has already had surgery and debulking surgery for her gynae cancer. In a recent admission she was found to have a pleural effusion, which was drained and found to be metastatic.

- Drainage of a pleural effusion – only a FDT if no further anti-cancer treatment is planned
 - Pleurodesis - only a FDT if no further anti-cancer treatment is planned.
- Pleural aspiration or drainage (for pleural effusion) or pleurodesis (surgical or medical) could be counted as a subsequent treatment but, if it is part of a palliative support package the start of the package of care would 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; or the consultation at which the patient receives a prescription so unless either of these procedures was the first episode they are unlikely to be counted. If they are not part of the package and a new DTT is made they could be counted as a subsequent treatment.

Head & Neck

Patient treated for thyroid cancer receives thyroxine immediately following surgery - is this recorded as a subsequent treatment - it happens within the same episode?

There can be multiple episodes within a care spell so it could be possible for the thyroxine to be classed as a 31d subsequent treatment. However, if the surgery/thyroxine is classed as a combined treatment (as described in GFOCW v6.5) it would be a single treatment ending with admission for the surgery.

We have a patient who has had radioiodine treatment (we think patients usually only have one dose of this). The patient has subsequently come back to MDT and the decision has been to give another dose of radioiodine. Would you record this as a subsequent treatment or would this be a continuation of treatment as the patient has already received this treatment previously?

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 required to prepare for treatment by having injections of recombinant human TSH in addition to hormone withdrawal treatment in order to obtain higher potential uptake at treatment. Would these injections be the start of treatment as it is required as part of this package or would the clock not start (i.e. ECAD) until the patient had received these injections?

If these 'preparations' are to mitigate the effects of the treatment once it starts then they are NOT counted as part of the treatment. However, if they are integral to the treatment itself i.e. facilitate the effectiveness of the treatment then yes they would be part of the package. Is this in effect a combined treatment as described in GFOCW guide v6.5 Q3.32 i.e. treatments of different modalities combined in a way that they must be scheduled to take place together. If this is the case the injections would be the start of treatment.

Haematology

Patient X is diagnosed with lymphoma in 2008 and is put on a treatment plan of Active Monitoring. In 2009, he is referred back in by his GP due to swelling in lymph nodes in his groin. These are investigated and the patient is offered radiotherapy which he rejects and active monitoring is continued. Should this be recorded as a new subsequent treatment, or is it a continuation of his previous treatment?

One could argue that the patient is just continuing with the agreed treatment plan of active monitoring but it sounds like there was a further discussion about treatment options, radiotherapy was proposed and the patient declined so that there was 'in theory' a second DTT via active monitoring. I would take a pragmatic view ie. if the patient re-consented to active monitoring I would take it as a second DTT ie a 31d subsequent period, if not, I would take it as a continuation of the original treatment ie no new 31d subsequent treatment period.

A patient who has been referred to the sarcoma team has gone on to have surgery but the diagnosis is unclear at this point. After surgery the patient has been diagnosed with a haematological cancer. In the past we have not counted the surgery as the 1st treatment as this is not a treatment that we would use for haematology. Please clarify if this is correct.

The answer really depends on the scenario. For example:

- if a patient had a lump which was a suspected sarcoma and there was surgery to remove it and this showed that it was actually a lymphoma then this would still be the FDT
- if a patient had a lump which was a suspected sarcoma and there was surgery to remove it and this showed that it was actually a metastases then I would class the surgery as a FDT of a mets of unknown origin with all haematological cancer treatments then subsequents to that (assuming the mets came from that)
- if a patient had a lump which was a suspected sarcoma and there was surgery to remove it and it turned out to be something benign but at the time blood tests or something else showed up a haematological cancer then the first treatment for the haematological cancer would be the FDT as the surgery treated a non-cancerous condition.

Can total body radiation prior to Bone Marrow Transplant be classed as FDT?

For a patient who is having a bone marrow transplant and is admitted before for conditioning e.g. whole body RT we have been classing this as the first treatment on the basis that it generally takes place as part of the same admission.

Lung

How should we record late stage lung cancer patients who have palliative symptom control whilst considering their treatment options?

Palliative symptom control would only be classed as treatment if no active cancer treatment is planned. In your case, treatment options are still being considered. If an active treatment is decided on then that treatment would be the FDT not the previous symptom control. If it was decided that a supportive package of care was the way forward this would be considered as a single agreed package and the start of the package of care would 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 ; or the consultation at which the patient receives a prescription. It might be possible in this scenario to argue that the symptom control was the date of the delivery of the first episode.

What if a lung cancer patient dies between palliative symptom control and any planned anti-cancer treatment? Would the palliative treatment be the FDT as no further treatment will follow or should the patient simply be removed from the dataset because they died before (anti-cancer) treatment could be delivered?

If a patient dies before treatment there would be no record to upload.

In a tertiary referral of a lung cancer patient, who is responsible for any delay/breach caused because the patient failed to give up smoking when advised - the unit or the centre, or both?

This is a shared breach between the provider commissioned to first see the patient and the provider commissioned to treat the patient. The patient was advised to give up smoking and it was their choice not to follow this advice.

Prostate

Is radiotherapy to a male patient to prevent or reduce breast growth and tenderness caused by prostate cancer treatment reportable as a 31d subsequent treatment?

I have never heard of radiotherapy to the breast area being used in this way to treat/prevent gynaecomastia. It is my view that radiotherapy to treat symptoms brought about by another treatment or as a prophylactic treatment would not be classed as 31d subsequent treatment but I will seek clinical advice. Clinical advice has since been received: I have been advised that this is an enabling treatment to allow hormone therapy to start and, in itself, it is not a cancer treatment. This cannot therefore be classed as the FDT. It is up to you if you wish to class it as a subsequent treatment but I do not think this is necessary.

Patients receiving brachy require a Volume Study prior to implantation of low-dose Radiotherapy seeds. We would like confirmation as to which portions of a cancer pathway for such patients are (a) Decision to Treat and (b) Anti-Cancer Treatment. Can you offer guidance, to assist us with clarifying this matter?

I would class the volume study as part of the prep and the admission date for the implantation of the seeds as the start of the treatment.

For patients who require 3 months of hormone prior to radiotherapy, we have been working out their treatment date and ensuring r/t planning is commenced prior to this date (i.e not waiting until the end of 3mths then planning). The GFOCW guidance says if pts are fit for r/t planning this would be ECAD date, however in our scenario pts are being prepared for their treatment but can't start until the end of 3 months. Please can you clarify the position.

For the radiotherapy dataset (RTDS) care record, the ECAD is used as the start date for the radiotherapy pathway. It will be the same date as the DTT date unless there is a previously agreed and clinically appropriate period of delay prior to the commencement of the activity in the care pathway. This will be the date on which it is clinically appropriate to:

- commence radiotherapy preparation; or,
- commence the radiotherapy itself, if preparation and treatment are to be carried out at the same time

In situations where radiotherapy must be delivered on a specific date in order to be scheduled with other therapies, the ECAD will be the date on which the radiotherapy must be delivered).

I would say that your situation is in line with the final line above i.e. where the r/t must be delivered on a specific date to be scheduled with other therapies (in your case after hormones) i.e. your ECAD would be the end of the 3 month period of hormones

There appears to be a rumour floating around that in Urology an adjustment can now be made between TRUS and MRI for patients who have both procedures to allow for recovery time so the MRI can be viewed correctly. What is the official line on this issue.

I can confirm that no adjustment is allowed for this recovery period. I can also confirm that the operational tolerances were revised to take into account the higher proportion of patients that would breach the standards due to clinical reasons and/or choice.

Skin

We often treat skins patients at local community hospitals which are closer to them, so we offer them a choice of location. In some cases they have to wait longer for an appointment at the community hospital. As I understand it we can only have a pause if the patient asks for treatment at another Trust, rather than if they are offered treatment at another Trust. Could you please clarify this point?

If you offer treatment at a range of providers (as you describe) and the patient picks one of these and it cannot offer an appt within the standard time NO pause is allowed. If you offer treatment at the same range of providers but the pt asks to go to a different provider that you had not offered, perhaps because it was closer to their family etc then you could pause the clock (if the treatment was admitted care) as the patient has declined a reasonable appt of admitted care that you have offered.

Upper GI

Patient has been referred with recurrent GIST and also has liver mets, do we count GIST under GFOCW?

Gastrointestinal stromal tumours (GISTs) that are described as malignant, invasive or having metastases coded to the relevant 'C' code for the part of the GI tract involved are within the remit of GFOCW standards. However, as it is a recurrence it would only be covered by the 31d subsequent treatment standard as would any treatments of the liver mets.

If we do not count GIST, do we count the treatment for the liver mets of a GIST patient instead?

GISTs that are coded as borderline using the relevant 'D' code are not covered by the GFOCW standards. I was not aware that non-invasive D code 'cancers' could spread ie. if they spread they would no longer be a D code. If you think someone can have a D code cancer with mets let me know as I will need to seek clinical advice on how this scenario is managed under cancer waits.

I would like to be able to use the CWT data to validate case ascertainment in the National Oesophago-gastric Cancer Audit. The audit is collecting data on patients diagnosed with invasive epithelial cancer of the oesophagus, gastro-oesophageal junction (GOJ) or stomach (ICD10 codes C15 and C16) aged 18 years or over.

Patients with high-grade dysplasia, endocrine tumours or gastro-intestinal stromal tumours (GISTs) were not included. It would be very useful if I could have the most recent 12 months data. Please could you advise on how I would go about obtaining the data and any additional information that you require.

DH Response: I'm sorry to say that I'm not sure if I can help you with this. As a matter of routine the Department of Health does not have access to datasets broken down by ICD-10 from the Cancer Waiting Times Database (CWT-Db). This is because of the small cell counts, and risk of disclosure when this condition is considered alongside the other disaggregating factors in the dataset we receive. Currently we receive a routine dataset that is disaggregated by: Tumour Group (e.g. "upper gastrointestinal"), care setting (e.g. "admitted care"), provider and treatment modality. The security policy covering access to these data does not allow a lower level of disaggregation, except for ad-hoc datasets for specific analyses where the risk of disclosure has been assessed. Therefore in order to meet the requirements of your data request we would need to specify and request an ad-hoc query, this however may take some time and I'm not sure what level of urgency you have. Alternatively, if you were after statistics for the period prior to 31-December 2008, these have all been made available to cancer registries, so it may be possible for you to source the statistics you require via the National Cancer Intelligence Network.

Miscellaneous

Who are the members of the GFOCW AG?

If you want the full membership you would need to contact DH but in general terms the group is chaired by the National Cancer Director and includes members from NCAT, DH (cancer policy, performance), NCIN, NHS Improvement, NHS Screening programmes plus NHS colleagues including clinicians and GPs.

Useful Links:

CWT Stats:

http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationsStatistics/DH_099885

CQC Indicators Constructions:

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

GFOCW guidance:

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

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
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