CANCER WAITING TIMES (CWTs)

A GUIDE

(VERSION 8.0)

This document is to be used to support the monitoring and management of cancer waiting times from 01 July 2012 supporting the implementation of [insert ISB ref]
The document aims to provide answers to common questions about cancer waiting times requirements and seeks to ensure that staff from both informatic and clinical teams understand the cases they need to be reporting on.

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# CWTs – A GUIDE (VERSION 8.0)

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1. Introduction and Overview

Background

1) This document aims to provide answers to common questions about cancer waiting times standards and seeks to ensure that staff from both informatic and clinical teams understand the cases they need to be reporting on.

2) The Government’s document ‘Improving Outcomes: A Strategy for Cancer’ confirmed that cancer waiting times remain an important issue for cancer patients and that the NHS should continue to ensure that cancer services are delivered to patients in a timely manner. The standards that NHS Providers will be expected to meet are:

   a) Two weeks from urgent GP referral for suspected cancer to first outpatient attendance;
   b) Two weeks from symptomatic breast referral (cancer not suspected) to first outpatient attendance;
   c) One month (31 days) from decision to treat to first definitive treatment for cancer;
   d) One month (31 days) from decision to treat or earliest clinically appropriate date (ECAD) to subsequent treatment (surgery, drug or radiotherapy) for all cancer patients including those with a recurrent;
   e) Two months (62 days) from urgent GP referral for suspected cancer to first definitive treatment for cancer (31 days for suspected children’s cancers, testicular cancer, and acute leukaemia);
   f) 62 days from referral from NHS Cancer Screening Programmes (breast, cervical and bowel) to treatment for cancer;
   g) 62 days from a consultant’s decision to upgrade the urgency of a patient (e.g. following a non-urgent referral) to first treatment for cancer.

3) It is not expected that all patients will be seen and treated within these time frames. Some patients will choose to wait longer and others will not be clinically able to be seen/treated within these time frames. To take account of this, ‘operational standards’ have been set that allow for a proportion of patients to breach these standards due to medical reasons or choice. These operational standards are for all tumours taken together. Some tumour areas will exceed these standards, others (where there are complex diagnostic pathways and treatment decisions to make) are likely to be slightly below these operational standards. However, when taking a Provider’s casemix as a whole the operational standards should be achievable if Providers have streamlined and efficient patient centred pathways in place.

4) This guide aims to provide answers to common questions about cancer waiting times standards and seeks to ensure that staff from both informatics and clinical teams understand the cases they need to be reporting on.

5) All cancer waiting times standards set out in the NHS Operating Framework 2011-12 are being monitored through the national Cancer Waiting Times Database (CWT-Db). This document should be read primarily in conjunction with Data Set Change Notices (DSCN) 20/2008, 22/2008 and [DN: insert reference]. In addition, the National Cancer Waiting Times User Manual supports the Cancer Waiting Times Database.
1.1. **What are the cancer waiting times service standards the NHS needs to deliver?**

The cancer waiting times service standards are:

a) Maximum two weeks from:
   
   i) urgent GP (GMP or GDP) referral for suspected cancer to first outpatient attendance [*Operational Standard of 93%*];
   
   ii) referral of any patient with breast symptoms (where cancer not suspected) to first hospital assessment [*Operational Standard of 93%*];

b) Maximum one month (31 days) from:
   
   i) decision to treat to first definitive treatment [*Operational Standard of 96%*];
   
   ii) decision to treat/earliest clinically appropriate date to start of second or subsequent treatment(s) for all cancer patients including those diagnosed with a recurrence where the subsequent treatment is:
      
      (1) surgery [*Operational Standard of 94%*]
      
      (2) drug treatment [*Operational Standard of 98%*]
      
      (3) radiotherapy [*Operational Standard of 94%*]
   
   iii) Maximum two months (62 days) from:
       
       (1) urgent GP (GMP or GDP) referral for suspected cancer to first treatment (62 day classic) [*Operational Standard of 85%*];
       
       (2) urgent referral from NHS Cancer Screening Programmes (breast, cervical and bowel) for suspected cancer to first treatment [*Operational Standard of 90%*];
       
       (3) consultant upgrade of urgency of a referral to first treatment [*No Operational Standard as yet*];
   
   iv) Maximum one month (31 days) from urgent GP referral to first treatment for children’s cancer, testicular cancer, and acute leukaemia [*No separate Operational Standard – Monitored within 62 day classic*].
1.2. Which patients are included within the cancer waiting time service standards?

Cancer waiting times service standards are applicable to patients cared for under the NHS in England with ICD codes C00-C97 (excluding basal cell carcinoma) and D05 (All carcinoma in situ – breast). This includes those patients:

a) being treated within a clinical trial;

b) whose cancer care is undertaken by a private provider on behalf of the NHS ie directly commissioned by an NHS commissioner;

c) whose care is sub-contracted to another provider – including a private provider – (and hence paid for) by an English NHS provider i.e. commissioned by an NHS commissioner but subcontracted out by commissioned provider;

d) diagnosed with a second new cancer;

e) without microscopic verification of the tumour (i.e. histology or cytology) if the patient has been told they have cancer and/or have received treatment for cancer;

f) with any skin squamous cell carcinoma (SCC) ie. every SCC an individual skin cancer patient has will be covered by standards (previously only the first skin SCC was covered).

In terms of specific standards it should be noted that:

a) the **two week wait standard** can only apply to patients referred with a suspected cancer from Clinical Assessment Service – CAS (or walk-in centre) if the ‘triage’ GP or other health professional within the CAS (or walk-in centre) is acting on behalf of the patient’s GP and locally agreed guidelines are in place that authorise them to act in this manner.

b) The **one month (31 day) first and subsequent treatment standards** apply to:

   v) NHS patients with a newly diagnosed invasive cancer (localised or metastatic);

   vi) NHS patients with a recurrence of a previously diagnosed cancer (previously excluded from the treatment standard);

   vii) NHS patients (with a new diagnosis of cancer or a recurrence) regardless of the route of referral – this will include patients who may be diagnosed with cancer during routine investigations or while being treated for another condition (i.e. an ‘incidental’ finding);

   viii) Patients who choose initially to be seen privately but are then referred for first and/or subsequent treatments in the NHS.

c) the **two months (62 day) standard** applies to patients who are referred:

   i) through the two week wait referral route by their GP (GMP or GDP) with suspected cancer;

   ii) urgently from any of the three national cancer screening programmes (breast, cervical or bowel);

   iii) then upgraded by a consultant (or authorised member of the consultant team as defined by local policy) because cancer is suspected;

   iv) on suspicion of one cancer but are diagnosed with a different cancer.

In addition, patients who are referred by any relevant health professional because of breast symptoms (where cancer is not suspected) should be seen within 62 days – this will not be performance managed centrally at the present time, and does not
fall within the measures identified in the Operating Framework for the NHS in England 2011/12

1.3. Which patients are excluded from monitoring under these standards?

Any patient:

a) with a non-invasive cancer i.e:

i) carcinoma in situ (with the exception of breast (D05) which is included) – local systems will need to be in place to notify cancer registries of these other carcinoma in situ cases;

ii) basal cell carcinoma (BCC).

b) who dies prior to treatment commencing – local systems will need to be able to flag this and forward the information to cancer registries;

c) receiving diagnostic services and treatment privately. However:

i) where a patient chooses to be seen initially by a specialist privately but is then referred for treatment under the NHS, the patient should be included under the existing and/or expanded 31 day standard;

ii) where a patient is first seen under the two week standard, then chooses to have diagnostic tests privately before returning to the NHS for cancer treatment, only the two week standard and 31 day standard apply. The patient is excluded from the 62 day standard as the diagnostic phase of the period has been carried out by the private sector.

1.4 Can patients become ineligible for Cancer Waiting Times standards once referred?

Yes, for example, if they decide to pursue treatment privately.
2. Responsibility for meeting the service standards and submitting data

2.1. What are commissioners responsible for?

Commissioners are responsible for commissioning services in line with the two week, 31 and 62 day service standards for their patients and should monitor achievement of waiting times service standards for their managed population through the Cancer Waiting Times Database (CWT-Db).

Primary care organisations are also responsible for uploading data on to the CWT-Db to monitor the cancer waiting times service standards for cases where they are the service provider. The commissioners will need to be set up as a Provider on the CWT-Db to enable data to be uploaded by them. This process is started by contacting the Open Exeter Helpdesk on 01392-251289. Alternatively they can make arrangements for the NHS provider to upload on their behalf.

2.2. Who is responsible for meeting and returning data on the two week wait standards?

The Provider that is commissioned to deliver the activity (DATE FIRST SEEN) following an urgent GP (GMP or GDP) referral for suspected cancer or following referral of a symptomatic breast patient is responsible for meeting the two week wait standard. This Provider is also responsible for returning data on these patients up to the DATE FIRST SEEN (i.e. when the patient is seen for the first time by a consultant or member of their team or in a diagnostic clinic following receipt of the referral) to monitor the standard and to explain any breaches.

2.3. Who is responsible for meeting and returning data on the 31 day standards?

The Provider commissioned to deliver the first or subsequent treatment is responsible for meeting the 31 day service standard. This Provider is also responsible for returning data on these patients up to the TREATMENT START DATE (CANCER) to monitor the standard and explain breaches.

2.4. Who is responsible for meeting and returning data on the 62 day standards?

The Provider commissioned to deliver the first definitive treatment is generally responsible for meeting the 62 day standard. This Provider is also responsible for returning data on the patients it treats up to and including the TREATMENT START DATE (CANCER) to monitor the standards and explain breaches. However, some patients on the 62 day period are first seen at one Provider (including an NHS cancer screening service), and are then referred on to another Provider for treatment. In this case both Providers share responsibility for ensuring that their respective parts of the dataset are uploaded and for ensuring that the 62 day waiting time service standard is met.
2.5. **Who is responsible for activity (including breaches) and for recording it?**

Some questions have been raised about which Organisation Data Services (ODS) Site Code to record when a patient is first seen or receives treatment. In general this is straightforward:

- the organisation commissioned to provide the DATE FIRST SEEN is responsible for this activity including data upload; and
- the organisation commissioned to provide first or subsequent treatment(s) (TREATMENT START DATE (CANCER)) is responsible for this activity including data upload.

When reporting these data, DH apportion any activity 50:50 between the two providers identified in the patient record, irrespective of date upon which the Inter Provider Transfer took place or whether the patient breached the standard.

However, there are circumstances where you need to consider the commissioning route for the appointment/care provided in more detail. The diagrams that follow represent different scenarios for the 31 and 62 day service standards that could apply to the data stored on the CWT-Db reflecting ownership of commissioned activity.

The Provider responsible for recording the activity is outlined in **RED**.

**Scenario 1**

![Diagram of commissioning route](image)

In this scenario the patient is treated in an NHS Provider where this care is commissioned by an NHS Commissioner*. The patient will receive treatment/out-patient episode(s) under the care of a consultant who has a contract to provide session(s) at this NHS Provider. The activity and waiting time are recorded on the CWT-Db under the Site Code of the NHS Provider commissioned to provide care.

* An NHS Commissioner would usually be a PCT or Care Trust but could also be a consortium of PCTs/Care Trusts acting together, a Specialised Commissioning Group (SCG) acting on behalf of Commissioners or the National Specialised Services Commissioning Group which commissions services on a national basis for the population of England. Subject to the Health and Social Care Bill, clinical commissioning groups will become responsible for those services currently commissioned by PCTs and the NHS Commissioning Board responsible for commissioning of specialised services. During the transition to these new arrangements, PCT responsibilities will increasingly be devolving commissioning responsibilities to emerging clinical commissioning groups.
**Scenario 2**

In this scenario the patient is seen in an outreach clinic at Provider B, though the activity was commissioned from Provider A. The activity and waiting time is to be recorded on the CWT-Db under the Site Code of the NHS Provider that is commissioned to provide the service (NHS Provider A). This can be entered onto the CWT-Db as the Site Code of the Provider headquarters.

**Scenario 3**

This is the same as for scenario 2 but the outreach clinic is at a primary care trust site. Activity and waiting time is recorded under the NHS Provider commissioned to provide the service. This can be entered onto the CWT-Db as the Site Code of the Provider headquarters.
Scenario 4

In this scenario the consultant may be based at the NHS Provider, but also has a contract of employment (to provide sessions) at the NHS Primary Care Provider. The Primary Care Provider has been commissioned to provide the activity by itself or another commissioning organisation. The activity and waiting time are to be recorded on the CWT-Db under the Primary Care Provider Site Code.

Scenario 5

This scenario is the exact opposite of scenario 3. Here, the Primary Care Provider has had space made available to its staff in the local NHS Provider to provide the services it has been commissioned to provide. The activity and waiting times are to be recorded on the CWT-Db under the Site Code of the Primary Care Provider that is commissioned to provide the service.
**Scenario 6**

If one NHS Provider (A) subcontracts the activity to a second NHS Provider (B) the activity and waiting time is to be recorded on the CWT-Db by the Provider that was originally commissioned to provide the work. This activity is to be recorded under the Site Code of the administrative headquarters of NHS Provider A.

**Scenario 7**

This scenario is similar to scenario 6. The NHS Provider has taken out a sub-contract with a private provider. This activity is to be reviewed as if it was carried out by an NHS Provider. This activity and waiting time is to be recorded on the CWT-Db as if it was carried out by the Provider that was originally commissioned to provide the work. This activity is to be recorded under the Site Code of the administrative headquarters of this NHS Provider.

*Note: The Private Provider in this example could be a Hospice.*
**Scenario 8**

In this scenario the patient is referred by NHS Provider A onto NHS Provider B for treatment. This is known as an ‘Inter-Provider Transfer (IPT) with the NHS Commissioner commissioning the whole pathway. If the patient was initially referred: as a two week wait referral with suspected cancer; as a two week wait referral with breast symptoms not suspicious of cancer; via the screening programmes; or on an RTT pathway and upgraded due to suspected cancer then they would be covered by the 62 day standard and both NHS Providers are jointly responsible for the activity and waiting time including the host provider of a NHS screening service. Both Providers will report their activity and waiting times for the same patient, ensuring the records are linked within the CWT-Db using the available online validation tools. If the patient was not initially referred into secondary care by one of the above routes, only NHS Provider B (i.e. the provider delivering the treatment) will report the patient under the 31 day standard.

**Scenario 9**

In some cases the initial activity (ie up to DATE FIRST SEEN) within a 62 day period (recorded as the CANCER REFERRAL TO TREATMENT PERIOD – i.e. from receipt of the original referral to first treatment) is provided by an NHS Cancer Screening Service. In these cases the host provider for the screening service should provide the required activity and waiting times data up until DATE FIRST SEEN.
Scenario 10

In some cases an NHS Commissioner will directly commission services from a private provider. The upload of data will depend on the contractual arrangements between the Commissioner and Provider.

If you have any other scenarios for which you require advice please send them to cancer-waits@dh.gsi.gov.uk
3. The Cancer Waits Service Standards in more Detail

Data to support the cancer waiting times service standards fit together along the following pathway:

Each of the cancer waits standards along this pathway is discussed in more detail in subsections 3.1 to 3.10. In addition, section 3.11 sets out how patients suffering a recurrence of cancer are covered by the cancer waits standards.
### 3.1. Two week wait from urgent GP (GMP or GDP) referral for suspected cancer

The period for this service standard is as follows:

![Diagram showing the two week wait process]

#### 3.1.1. When does the clock for the urgent two week wait start?

The starting point for this period is the receipt of the referral (recorded as the CANCER REFERRAL TO TREATMENT PERIOD START DATE). This original referral can be received either:

- Direct from the General Medical Practitioner/General Dental Practitioner (ORIGINAL REFERRAL REQUEST RECEIVED DATE); or
- via Choose and Book, in which case the UBRN CONVERSION (the Unique Booking Reference Number conversion date for an appointment) would mark the start of the period.

Receipt of referral is day 0 in the two week wait.

#### 3.1.2. If a referral is received at or after the end of the working day eg. 5pm, is that day still classed as the date of receipt of referral (ie the REFERRAL REQUEST RECEIVED DATE)?

Yes.
3.1.3. Can urgent referrals by a GP with a special interest (GPwSI) be included in the Two Week Wait data?

Only those referrals from a GP (GMP or GDP) are included within the two week wait cohort NOT those from a GPwSI (unless the GPwSI is acting in their capacity as the patient's own GP). If a GP refers a patient to a GPwSI and the GPwSI suspects cancer there are two options:

- GPwSI advises the patient's GP to make an urgent two week wait referral;
- GPwSI make a referral which can then be upgraded onto the 62 day pathway;

The SOURCE OF REFERRAL FOR OUTPATIENTS identifies whether a patient can be included within the two week wait cohort or not. Where a patient is referred by a GPwSI acting in their capacity as an ordinary GP the code 03 should be used and such patients are included in the two week cohort. Where a patient is referred by a GP acting in the capacity of a GPwSI, code 12 should be used and the patients are excluded from the two week cohort.

3.1.4. Can a clinician in a walk-in centre make a referral to a two week wait service?

A patient's own GP should make a two week wait referral. However, clinicians acting on behalf of that GP as supported by locally agreed protocols can make a two week wait referral on the GP's behalf. Given the nature of walk-in centres (ie. often used by a patient who is not able to get to their own GP practice for whatever reason) it is unlikely that agreements between walk-in centres and GP practices will be feasible.

3.1.5. If a patient is referred under an urgent two week wait to a provider that does not provide the service in question when does the cancer waits standard start?

There should be agreed referral protocols in place between primary and secondary care so that GPs know where to send patients. If they have sent a referral to the wrong provider that provider could liaise with the GP and ask them to withdraw the referral and re-refer the patient to the correct Provider (in line with the protocol). Receipt of the correct referral by the correct Provider would then start the clock. If however, the initial provider refers the patient on to the correct provider (for speed, in the best interests of the patient) the clock has started with the receipt of the initial referral as that referral has been received and acted upon.

3.1.6. When does the clock for the urgent two week referral stop?

The period end is when the patient is seen for the first time by a consultant (or member of their team) or in a diagnostic clinic following the referral receipt. This is recorded as DATE FIRST SEEN.

If cancer is excluded following DATE FIRST SEEN the period covering the 62 day standard (ie. the CANCER REFERRAL TO TREATMENT PERIOD) also ends at this point and the patient is either discharged or continues on a routine pathway as appropriate.

3.1.7. Can we stop tracking urgent two week referrals after the patient is first seen?

No. These patients need to be tracked from the receipt of the referral (the CANCER REFERRAL TO TREATMENT PERIOD START DATE ) until either:

- a cancer diagnosis is excluded (in which case they would either be discharged or moved onto routine tracking if treatment for another (benign) condition is required); or
• cancer is diagnosed (in which case the patient stays on tracking for the 62 day standard).

3.1.8. For those two week wait referral patients who do not go on to have a diagnosis of cancer, how is the 62 day period closed?

For those patients who do not have a diagnosis of cancer it will be assumed that if no subsequent 62 day period data is entered (ie. after DATE FIRST SEEN) that it was a non-cancer diagnosis. However, it is also assumed that you would want to close this record down locally. The data item CANCER OR SYMPTOMATIC BREAST REFERRAL STATUS supports local tracking. You could, for example, select Code 03 – ‘no new cancer diagnosis identified by Healthcare provider’. You can upload this data to the CWT-Db if you wish for completeness but if you do not the system will just take it that the pathway ended at DATE FIRST SEEN i.e. the patients did not end up with cancer and therefore did not carry on the 62 day period.

3.1.9. 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 the patient on an RTT pathway – i.e. without histopathology confirmation?

The two week wait pathway would end at DATE FIRST SEEN. If there is no cancer and the patient has been given a benign diagnosis (or confirmation that cancer is excluded) then there would be no Decision to Treat and therefore no 31 day or 62 day record to upload. There does not need to be a histopathological confirmation. The key is what the patient has been told i.e. if the clinician is confident to tell the patient that they do not have cancer without having pathology then that would end the 31/62 day cancer pathways.

3.1.10. What is a ‘decision to refer’ in terms of the two week wait standard?

This is the date on which:
• a GP (GMP or GDP) decides to refer a patient urgently to secondary care with suspected cancer; or
• any relevant health professional decides to make a referral to secondary care for breast symptoms that are not suspicious of cancer.

This is not the date that starts the two week wait or 62 day clock. The clock starts from receipt of referral ie the CANCER REFERRAL TO TREATMENT PERIOD START DATE.

3.1.11. Why collect the date of the GP’s decision to refer if it doesn’t start the cancer waits period?

The date of the GP’s decision to refer DECISION TO REFER (CANCER AND BREAST SYMPTOMS) can be uploaded to the CWT-Db where available to support the local management of referral processes eg. as a local lever to ensure referrals are made promptly. This data item cannot however be transmitted to the Provider via the Choose and Book system.

3.1.12. How will late referrals from GPs be managed

The data item for the GP’s decision to refer (recorded as DECISION TO REFER (CANCER AND BREAST SYMPTOMS)) can be used locally for monitoring referral practices. The CWT-Db includes a report that can be downloaded for local use showing, for example, the percentage of referrals made within 24 hours.
3.1.13. What if the referral letter from the GP is not attached or is not sent in promptly for cases coming through Choose and Book?

Providers are encouraged to run daily checks for missing referral letters, and follow these up with referring GP practices. The Choose and Book guidance makes clear that the duty of care remains with the practice and that, in the case of two week wait referrals, the referral information should be attached within one working day. The practice will therefore need to have systems in place to ensure that referral letters are sent promptly.

3.1.14. Will patients understand that it is an urgent referral for suspected cancer and that they need to make the appointment quickly?

GPs should use their clinical judgement to determine what to tell a patient and when but it is deemed good practice for a GP to ensure that a patient understands that they need to be referred urgently and for what reason where possible (as recommended in NICE referral guidelines for suspected cancer – see http://guidance.nice.org.uk/CG27). If the NICE guidelines are followed it will hopefully encourage patients to accept the earliest appointment where possible. It would also be helpful for a GP to reiterate the importance of keeping an appointment once it has been made.

3.1.15. How can we ensure patients make Choose and Book (CAB) appointments quickly – they may not share our sense of urgency?

For patients booking through CAB, the clock starts at the Unique Booking Reference Number Conversion (UBRN CONVERSION). The CAB two week wait guidance stresses the importance of an appointment being booked before a patient leaves the practice. However, it is possible that a patient may choose to leave the practice without an appointment and wait some time before deciding to make their appointment and thus converting the UBRN. It is for GPs to ensure that their patients understand the importance of making an appointment quickly and of keeping an appointment once made. It is suggested that appointment slots on CAB are only on offer within a 14 day period from the UBRN conversion date for these patients. This is how CAB should already be working for the urgent two week wait referrals.

3.1.16. What if a patient does not phone for a CAB appointment, who will follow this up?

The Choose and Book guidance makes clear that the duty of care remains with the practice. Practices should ensure that someone is responsible on a daily basis for monitoring the two week enquiry within CAB to follow up any patients who have not yet converted their UBRN into a booking.

3.1.17. If a patient chooses an appointment outside two weeks/declines an appointment within two weeks do they exempt themselves from two week wait and 62 day standards?

No. These patients would remain within the two week wait cohort (and the 62 day cohort if cancer is later confirmed). The operational standards that have been set take into account that a proportion of patients will choose to wait longer than the standard time and will therefore breach due to patient choice.
3.1.18. Is implementation of Choose and Book compulsory for urgent two week wait referrals?

No. Whilst we would encourage you to consider what benefits CAB could bring for urgent two week wait referrals there is no mandate from the Department of Health to use the system for the two week wait referrals.

3.1.19. Should a two week wait patient be able to use Choose and Book to book an appointment outside of two weeks?

This should not be possible. It is expected that Providers will make restrictions for clinic appointments for two week wait referrals by adapting local clinic rules within the Choose and Book system. Providers are recommended to set their polling range for any two week wait services to 15 days thereby ensuring that only 14 days worth of appointments are ever visible to referrers and patients.

3.1.20. If a GP knows a patient is not available for an appointment within a two week period should they: still refer so receipt of referral can start the clock or should they wait to refer until the patient would be available for an appointment?

Management of referrals between GPs and secondary care is a matter for local protocol/policy. The best interest of the patient should be at the forefront of the policy and it would be best for the patient to 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 and it minimises the risk of an intended referral being mislaid/forgotten. However, a GP can defer a referral if they think this is appropriate.

3.1.21. Are we required to offer a patient a choice of two appointments within the two week period?

No. For cancer a reasonable offer is classed as any appointment within that two week period.

3.1.22. What are the key principles for managing two week wait referrals?

- Management of referrals between GPs and secondary care is a matter for local protocol/policy within the overarching cancer waits rules and the 'spirit' of the rules.

- If a patient cannot make themselves available for an appointment within two 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 referral – a provider cannot refuse a referral.

- 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.

- If patients are given appropriate information about why they are being referred, the importance of being seen quickly (as advised in NICE referral guidelines for suspected
cancer) and the importance for the NHS of patients keeping appointments then the likelihood of patients accepting an early appointment and keeping it should increase.

- The operational standards for the two week wait commitments take account of the volume of patients likely to be seen outside of two weeks due to patient choice.

### 3.1.23. What are the rules/principles that need to be followed when setting up local access/referral policies for cancer waits?

Local access and referral policies should be in line with cancer waits rules and, where there is scope for local interpretation, they should also be in the ‘spirit’ of the rules. For example:

- Patients should not be referred back to the GP because they are unable to accept an appointment within two weeks i.e. once a referral has been received by secondary care it should not be returned due to patient unavailability;

- Two week wait referrals can only be ‘downgraded’ by the GP - if a consultant thinks the two week wait referral is inappropriate this should be discussed with the GP and the GP asked to withdraw the two week wait referral status – a GP should not be asked to downgrade a patient (or withdraw the referral) simply because they are unavailable to accept an appointment within two weeks;

- Patients should not be referred back to their GP after first DNA (Did Not Attend) of their first appointment;

- Patients can be referred back to their GP after multiple (two or more) DNAs if this is the agreed local policy;

- Patients should not be referred back to their GP after a single appointment cancellation;

- Patients should not be referred back to their GP after multiple (two or more) appointment cancellations unless this has been agreed with the patient – by cancelling an appointment a patient has shown a willingness to engage with the NHS.

### 3.1.24. What would be examples of inappropriate local access/referral policies?

It would be inappropriate to have a policy that refers a patient back to their GP because:

- they are not available for appointments offered within a two week period eg. for social commitment or other reasons – it is expected that a certain proportion of patients will choose to wait longer and the operational standard takes this into account;

- they have not made contact after a first DNA within a given time period – one might reasonably expect a Provider to make some attempt to contact the patient or the GP;

- they are not immediately fit for diagnostics/treatments needed – this would previously have been a medical suspension. The operational standard for the 31 day and 62 day standards takes this into account.

It would also be inappropriate to have a policy that ‘downgrades’ patients urgently referred by their GP, for example:
• if a consultant thinks that a two week wait referral is inappropriate it should not be downgraded but the GP could be asked to withdraw it;

• if the patient cannot ‘guarantee’ attendance for tests or treatment within a certain timescale the patient should not be downgraded – the operational standard takes into account that a proportion of patients will choose to wait longer than the standard time plus there is a pause allowed if a patient declines a reasonable offer of admission for treatment.

It would also be inappropriate to have a policy that:

• introduces a new clock start for when the patient is available after they have been unable to accept offered appointments dates within two weeks of urgent referral;

• downgrades a patient from the 62 day standard to the 31 day standard only or to a routine pathway only because they are unavailable for non-admitted treatment for a period of time – the operational standard takes into account that a proportion of patients will choose to wait longer for treatment or will be unfit to start treatment at a given point in time;

• puts patients on pending lists for non-admitted treatment until they are available – the operational standard takes into account that a proportion of patients will choose to wait longer for treatment.

3.1.25. If a consultant feels that a referral does not meet the two week wait criteria can the GP downgrade the referral following discussion with the consultant?

Yes, the GP can downgrade an urgent two week wait referral (PRIORITY TYPE CODE 3) but a consultant cannot.

3.1.26. Where is the policy/guidance that states that a consultant cannot refuse to see a patient referred via the two week wait route, no matter how inappropriate that referral?

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 24 hours has been removed from the two week wait, to align with Choose and Book and RTT. However, the restriction on the consultant’s re-categorisation of these referrals remains current.

3.1.27. If a GP makes inappropriate two week wait referrals and direct feedback does not result in a change in practice what action can be taken?

You could report the matter to the appropriate commissioner. If the problem persists, each SHA has a Going Further On Cancer Waits lead that you could raise concerns with.

3.1.28. Can a diagnostic clinic/‘straight to test’ end the two week wait period?

Yes, if it is equivalent to when a patient would be first seen (recorded as DATE FIRST SEEN). For example an appointment for colonoscopy prior to seeing a consultant or an appointment for a chest x-ray before seeing a lung physician could be classed as the first seen date.

3.1.29. Is there any guidance on what can and can’t be classed as a diagnostic clinic?

No. Comprehensive central guidance on what does and does not constitute a diagnostic clinic which could end the two week wait is not planned. Decisions should be made locally within the general principles that:

• we would assume it to be a clinic where tests will be carried out as part of a clinical pathway that seeks to rule a suspected cancer diagnosis in or out prior to an appointment with the consultant (eg. straight to test for colonoscopy following two week wait referral for bowel symptoms);
• to be accepted as a diagnostic clinic/test the patient would be seen by a member of the consultant led team at the clinic in question; and that,
• the diagnostic test is appropriate for the pathway of care.

3.1.30. Could a blood test such as CA125 or a full blood count (FBC) be allowed as DATE FIRST SEEN for a GP two week wait referral patient?

Blood tests on their own (including the CA125 test and FBC) should not stop the two week wait clock. Although such tests could indicate heightened suspicion of cancer there are likely to be further investigations required.

3.1.31. If a patient Does Not Attend (DNAs) an appointment at a one stop clinic can a pause be used?

If the clinic would have been when the patient would be first seen (recorded as DATE FIRST SEEN) a pause can be used but not if the clinic would be after this point ie. following an outpatient appointment with the consultant.

3.1.32. Can GPs refer suspected recurrences under the Two Week Wait referral?

Yes. A GP can urgently refer a suspected recurrence. However, if the recurrence was confirmed the patient would not continue on the 62 day period. They would, however, be covered by the 31 day subsequent treatment standards.
3.1.33. Why include patients who explicitly choose to breach within the remit of the two week wait standard?

It is recognised that some patients may choose not to accept earliest appointments along their pathway or may choose to delay appointments or treatment. The policy decision was made that this should be handled via a combination of adjustments (DNA first out-patient appointment (OPA) for cancer waits) and revised operational standards i.e., the operational standard has been set to take account of the proportion of patients who will choose to wait longer than two weeks for an appointment.

3.1.34. Does the two week wait standard only apply to referrals received within 24 hours or is it all referrals?

No. It covers all urgent GP referrals for suspected cancer.

3.1.35. A patient is admitted as an emergency for another condition prior to their first seen appointment against a two week wait referral and cancer is ruled out during the emergency admission - how should this be recorded?

If a patient is an emergency admission prior to being seen for a two week wait appointment, and they are assessed as would have happened in the clinic they were waiting for and a benign diagnosis is given, then the date of the admission would be the clock stop for the two week wait. Subsequently the patient would (because of the benign diagnosis) be outside the scope of the 62-day standard, but the RTT pathway would still apply if they were not discharged.

3.1.36. A patient is admitted as an emergency for another condition prior to their first seen appointment against a two week wait referral and there are no investigations relevant to the two week wait referral during this admission - does this impact on the recording of the two week wait cancer wait?

If no investigation that could detect a cancer is carried out this admission is not equivalent to the DATE FIRST SEEN and the patient would stay on the waiting list for the relevant diagnostic clinic/ out-patient appointment.

3.1.37. A patient is admitted as an emergency for the same condition as their two week wait referral – the emergency admission is before their two week wait appointment – how should this be recorded?

Where a two week wait patient is admitted as an emergency for the same condition (i.e., related to the suspected cancer) before they are seen they should no longer be recorded against a two week wait standard. The emergency admission is the referral into the system and effectively supersedes the original referral. However, such a patient could be upgraded onto the 62 day period if a consultant or authorised member of their team suspects cancer is the cause of the admission.

3.1.38. What are “Interface Services”?

An interface service is defined as any arrangement that incorporates any intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care. This may include Clinical Assessment Services (CAS).
The definition of the term “interface service” does not apply to referrals to general practitioners with a special interest (GPwSI) for triage, assessment and possible treatment, except where they are working as part of a wider interface service type arrangement as described above.

A referral management centre or assessment service is a specific type of interface service that does not provide treatment, but accepts GP (or other) referrals and provides advice on the most appropriate next steps for the place of treatment of the patient. Depending on the nature of the service they may, or may not, physically see or assess the patient.

Referral management centres and assessment services should only be in place where they have clinical support locally and abide by clear protocols that provide benefits to patients. They must not be devices either to delay treatment or to avoid having clinical discussions with GP practices about good referral practice.

3.1.39. If a GP refers a patient to an “interface service” (or “referral management centre”) – the receipt of the referral to that service starts the RTT pathway, how does that fit with cancer waiting times pathways?

A referral to an interface service (as defined above) starts both an RTT clock and a cancer waiting times clock. The clock starts on the date that the referral is received by the interface service (recorded as the CANCER REFERRAL TO TREATMENT PERIOD START DATE).

3.1.40. A commissioner has commissioned an intermediary diagnostic & minor treatment NHS service. No suspected cancer patients should be referred there but if one slips through the net what action should be taken in terms of cancer waits?

If the GP suspects cancer they should make a two week wait referral. If not and they refer to an intermediary service and that service suspects cancer they can make a two week wait referral but only under the authority of the GP if there is a local policy to support this. The alternative is that as soon as a referral is received from an intermediary service with suspected cancer then a process is in place within the receiving Provider to upgrade the patient on to the 62 day period.

3.1.41. Can Independent Sector providers refer patients under the two week wait rule?

Independent Sector providers cannot refer patients under the two week wait rule at present.
3.2. **Two week wait to cover symptomatic breast referrals (cancer not suspected)**

The period for this service standard is as follows:

Note: The full list of potential referral sources for out-patients is included in the above diagram - breast referrals would not be expected to be made from all of these sources.
3.2.1. When does the symptomatic breast two week wait referral period start?

The starting point for this period is the receipt of the referral (recorded as the CANCER REFERRAL TO TREATMENT PERIOD START DATE) for an appointment in the appropriate breast clinic. The referral can be received either:

- direct from the General Medical Practitioner or other healthcare professionals who may see a patient with breast symptoms (see list in the diagram above for sources of outpatient referrals) – recorded as ORIGINAL REFERRAL REQUEST RECEIVED DATE;
- via Choose and Book, in which case the UBRN CONVERSION (the Unique Booking Reference Number conversion date for an appointment) would mark the start of the period.

Receipt of referral is day 0 for the symptomatic breast two week wait.

3.2.2. When does the symptomatic breast referral period end?

The period end would be when the patient is seen for the first time by a consultant or in a diagnostic clinic following the referral receipt. This is recorded as DATE FIRST SEEN.

If cancer is excluded following DATE FIRST SEEN the 62 day period (i.e. the CANCER REFERRAL TO TREATMENT PERIOD) also ends at this point.

3.2.3. Can we stop tracking symptomatic breast patients after the patient is first seen?

No. Symptomatic breast patients need to be tracked from the receipt of the referral (the CANCER REFERRAL TO TREATMENT PERIOD START DATE) until either:

- a cancer diagnosis is excluded (in which case they would either be discharged or continue on an RTT pathway if treatment for another (benign) condition is required); or
- cancer is diagnosed (in which case the patient stays on tracking for the 62 day standard).

3.2.4. Why do we need to continue tracking a breast symptomatic two week wait patient after DATE FIRST SEEN – most won’t have cancer?

About 50% of patients diagnosed with breast cancer do not come via the urgent two week wait referral route. About 20% of breast cancers are discovered following non-urgent symptomatic referrals. It is therefore recommended that you keep tracking the patients from the symptomatic route until cancer is ruled out and the patient informed of this because a proportion will have cancer and would benefit from the 62 day pathway.

3.2.5. How are ‘breast symptoms’ defined for the purposes of this standard?

These will be any breast symptoms (not covered in the NICE referral guidelines for suspected cancer) that a healthcare professional believes need to be seen by a specialist. This excludes referrals:

- from family history clinics (unless a patient is symptomatic);
- for cosmetic breast surgery (such as enlargement or reduction).
3.2.6. Why exclude referrals from family history/genetic services?

The standard is for symptomatic patients only. If, however, a patient is referred from a family history/genetic service with breast symptoms then they would be included within this two week standard.

3.2.7. Does the symptomatic breast two week wait standard apply to men?

Yes, it applies to men too.

3.2.8. What is the difference between an urgent breast two week wait referral and a symptomatic breast two week wait referral?

The urgent breast two week wait referral is where the GP suspects cancer. The symptomatic breast two week wait referral is where the GP (or other relevant health professional) is referring a patient for breast symptoms but does not suspect cancer.

3.2.9. Do GPs need to differentiate between urgent suspected cancer referrals and symptomatic breast referrals if both sets of patients need to be seen within two weeks?

Yes. It is still necessary to differentiate between the two patient cohorts to support monitoring of the NHS Operating Framework 2011-12. The differentiation might also help to monitor appropriateness of referrals and therefore identify any education needed about signs and symptoms of breast cancer amongst relevant healthcare professionals.

3.2.10. Do urgent two week wait and symptomatic breast two week wait referrals need to be uploaded separately onto CWT-Db?

No. All data can go in a single csv file, a separate upload is not required. Patients coming through the new symptomatic breast two week wait route can be distinguished from the suspected cancer breast two week wait route using the data item TWO WEEK WAIT CANCER OR SYMPTOMATIC BREAST REFERRAL TYPE where code 01 is ‘suspected breast cancer’ and code 16 is ‘exhibited (non cancer) breast symptoms – cancer not initially suspected’.

3.2.11. If a symptomatic breast patient chooses an appointment outside two weeks/declines an appointment within two weeks do they exempt themselves from the two week wait standard?

No. These patients would remain within the two week wait cohort. The operational standard has been set taking into account that a proportion of patients will choose to wait longer than the standard time and will therefore breach due to patient choice.

3.2.12. Is implementation of Choose and Book compulsory for symptomatic breast two week wait referrals?

No. Whilst we would encourage you to consider what benefits CAB could bring for symptomatic breast two week wait referrals there is no mandate from the Department of Health to use the system for these referrals.
3.2.13. Should symptomatic breast two week wait patient be able to use Choose and Book to book an appointment outside of two weeks?

This should not be possible. It is expected that Providers will make restrictions for clinic appointments for two week wait referrals by adapting local clinic rules within the Choose and Book system. Providers are recommended to set their polling range for any two week wait services to 15 days thereby ensuring that only 14 days worth of appointments are ever visible to referrers and patients.

3.2.14. What if the referral letter from the GP is not attached or is not sent in promptly for cases coming through Choose and Book?

Providers are encouraged to run daily checks for missing referral letters, and follow these up with referring GP practices. The Choose and Book guidance makes clear that the duty of care remains with the practice and that, in the case of two week wait referrals, the referral information should be attached within one working day. The practice will therefore need to have systems in place to ensure that referral letters are sent promptly.

3.2.15. What if a patient does not phone for a CAB appointment, who will follow this up?

The Choose and Book guidance makes clear that the duty of care remains with the practice. Practices should ensure that someone is responsible on a daily basis for monitoring the two week enquiry within CAB to follow up any patients who have not yet converted their UBRN into a booking.

3.2.16. How can we ensure patients make Choose and Book (CAB) appointments quickly – they may not share our sense of urgency?

For patients booking through CAB, the clock starts at the Unique Booking Reference Number Conversion (UBRN CONVERSION). The CAB two week wait guidance stresses the importance of an appointment being booked before a patient leaves the practice. However, it is possible that a patient may choose to leave the practice without an appointment and wait some time before deciding to make their appointment and thus converting the UBRN. It is for GPs to ensure that their patients understand the importance of making an appointment quickly and of keeping an appointment once made. It is suggested that appointment slots on CAB are only on offer within a 14 day period from the UBRN conversion date for these patients. This is how CAB should already be working for the urgent two week wait referrals.

3.2.17. Are internal referrals from other Consultants included under the symptomatic breast two week wait standard?

Yes. The symptomatic breast two week wait standard covers referrals from GPs and other relevant health professionals so there is a potential for referrals from secondary care if appropriate.

3.2.18. Can a consultant upgrade a symptomatic breast two week wait patient referral?

No. An upgrade for symptomatic breast patients (who will have been referred with a PRIORITY TYPE CODE ‘03’ - two week wait) is not necessary. These patients would already be on a 62 day pathway if breast cancer is subsequently diagnosed.
3.2.19. What happens when a symptomatic breast two week wait patient is admitted with different symptoms (eg. cardiac or stroke) not related to the symptomatic breast referral?

The patient remains on the two week wait pathway. The operational standard has been set taking into account that a proportion of patients will breach due to choice and other reasons.

3.2.20. For those symptomatic breast referral patients who do not go on to have a diagnosis of cancer, how is the 62 day period closed?

For those patients who do not have a diagnosis of cancer it will be assumed that if no subsequent 62 day period data is entered (ie. after DATE FIRST SEEN) that it was a non-cancer diagnosis. However, it is also assumed that you would want to close this record down locally (same as for urgent two week wait referrals). The data item CANCER OR SYMPTOMATIC BREAST REFERRAL STATUS supports local tracking. You could, for example, select Code 03 – ‘no new cancer diagnosis identified by Healthcare provider’. You can upload this data to the CWT-Db if you wish for completeness but if you do not the system will just assume that the pathway ended at DATE FIRST SEEN i.e. the patients did not end up with cancer and therefore did not carry on the 62 day period.

3.2.21. If a patient is a two week wait symptomatic breast referral but is diagnosed with a different (ie. non-breast) cancer would the patient stay on the 62 day pathway?

Yes. The patient should remain on a 62 day referral to treatment pathway.

3.2.22. How should symptomatic breast referrals for under 16's be entered onto the CWT-Db?

There is no age restriction 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.

3.2.23. Do all patients referred under the symptomatic breast two week wait standard have to be seen in a one stop diagnostic clinic?

Symptomatic breast two week wait referrals need to have a DATE FIRST SEEN within two weeks. What happens at that appointment is a local matter. Triple test is the gold standard for urgent breast two week wait referrals and may well be appropriate for some patients in the symptomatic breast cohort.

3.2.24. Is it acceptable to 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?

The breast cancer community has felt strongly for several years that direct GP access to mammography is not a good 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 considered to be more reliable. This is one of the main reasons for advocating a "two weeks for all" approach for patients with breast symptoms.
3.2.25. If a GP requests annual follow up mammograms are these included as symptomatic breast referrals?

The symptomatic breast two week wait standard is for symptomatic patients so if the patient is not symptomatic then they are not covered by the symptomatic breast two week wait standard. If the GP suspects cancer they should make an urgent two week wait referral.
3.3. **Urgent GP (GMP or GDP) referrals for suspected cancer on to classic 62 day referral to treatment period (31 day referral to treatment period for suspected children’s cancers, acute leukaemia or testicular cancer)**

The period for this service standard is as follows (with the periods for the two week wait and 31 day treatment standards marked for reference).

![Diagram](diagram.png)

3.3.1. **When does the 62 day period from urgent GP (GMP or GDP) referral start?**

The starting point for this period is the receipt of the referral (recorded as the CANCER REFERRAL TO TREATMENT PERIOD START DATE). The original referral can be received either:

- direct from the General Medical Practitioner/General Dental Practitioner (ORIGINAL REFERRAL REQUEST RECEIVED DATE);
- via Choose and Book, in which case the UBRN CONVERSION (the Unique Booking Reference Number conversion date for an appointment) would mark the start of the period.

Receipt of referral is day 0 for the 62 day period.
3.3.2. When does the 62 day period from urgent GP (GMP or GDP) referral end?

The period end is the first definitive treatment – this is recorded as the TREATMENT START DATE (CANCER). This start date may differ slightly for different treatments. For example, it would be:

- the date the patient is admitted for an operation, for surgery – CANCER TREATMENT MODALITY code 01.
- the date the first drug in an agreed course is given, for ‘anti-cancer drug regimen (cytotoxic chemotherapy)’ – CANCER TREATMENT MODALITY code 02;
- the date the first fraction is given, for teletherapy (beam radiation excluding proton therapy) – CANCER TREATMENT MODALITY code 05.

3.3.3. Can the date of the GP’s decision to refer be collected locally?

Yes. The date of the GP’s decision to refer (DECISION TO REFER (CANCER AND BREAST SYMPTOMS)) can be recorded. This data item can be uploaded to the CWT-Db where available to support the local management of referral processes. This data item cannot however be transmitted to the provider via the Choose and Book system.

3.3.4. What if the referral letter from the GP is not attached or is not sent in promptly for cases coming through Choose and Book?

Providers are encouraged to run daily checks for missing referral letters, and follow these up with referring GP practices. The Choose and Book guidance makes clear that the duty of care remains with the practice and that, in the case of two week wait referrals, the referral information should be attached within one working day. The practice will therefore need to have systems in place to ensure that referral letters are sent promptly.

3.3.5. Will patients understand that it is a two week wait referral and that they need to make the appointment quickly?

GPs should use their clinical judgement to determine what to tell a patient and when but it is deemed good practice for a GP to ensure that a patient understands that they need to be referred urgently and for what reason where possible (as recommended in NICE referral guidelines for suspected cancer). If the NICE guidelines are followed it will hopefully encourage patients to accept the earliest appointment where possible. It would also be helpful for a GP to reiterate the importance of keeping an appointment once it has been made.

3.3.6. Should a two week wait patient be able to use Choose and Book to book an appointment outside of two weeks?

This should not be possible. It is expected that Providers will make restrictions for clinic appointments for two week wait referrals by adapting local clinic rules within the Choose and Book system. Providers are recommended to set their polling range for any two week wait services to 15 days thereby ensuring that only 14 days worth of appointments are ever visible to referrers and patients.
3.3.7. **What if the referral letter from the GP is not attached or is not sent in promptly for cases coming through Choose and Book?**

Providers are encouraged to run daily checks for missing referral letters, and follow these up with referring GP practices. The Choose and Book guidance makes clear that the duty of care remains with the practice and that, in the case of two week wait referrals, the referral information should be attached within one working day. The practice will therefore need to have systems in place to ensure that referral letters are sent promptly.

3.3.8. **What if a patient does not phone for a CAB appointment, who will follow this up?**

The Choose and Book guidance makes clear that the duty of care remains with the practice. Practices should ensure that someone is responsible on a daily basis for monitoring the two week enquiry within CAB to follow up any patients who have not yet converted their UBRN into a booking.

3.3.9. **How can we ensure patients make Choose and Book (CAB) appointments quickly – they may not share our sense of urgency?**

For patients booking through CAB, the clock starts at the Unique Booking Reference Number Conversion (UBRN CONVERSION). The CAB two week wait guidance stresses the importance of an appointment being booked before a patient leaves the practice. However, it is possible that a patient may choose to leave the practice without an appointment and wait some time before deciding to make their appointment and thus converting the UBRN. It is for GPs to ensure that their patients understand the importance of making an appointment quickly and of keeping an appointment once made. It is suggested that appointment slots on CAB are only on offer within a 14 day period from the UBRN conversion date for these patients. This is how CAB should already be working for the urgent two week wait referrals.

3.3.10. **Can tracking of patients stop after they have had their first treatment?**

If a single treatment modality was planned then tracking can stop after this treatment (after the TREATMENT START DATE (CANCER)). However, a patient may require subsequent treatments sometime in the future which would be covered by the 31 day subsequent treatment standard. A process therefore needs to be in place locally to ensure that these patients can be identified and tracking re-started when appropriate.

3.3.11. **Will end dates for treatments be collected?**

No. There is no central requirement to collect end of treatment or discharge dates for cancer treatment within the CWT-Db.

3.3.12. **How do we monitor a patient that refuses altogether the diagnostic test(s) that may diagnose cancer but continues to be cared for by the Provider?**

In effect the patient, by refusing the diagnostic test(s), has taken themself off the 62 day pathway. The Provider cannot deliver on a patient who is not prepared to "be on the pathway". If the patient agrees at a later stage to have the test(s) and is subsequently diagnosed with cancer, they can be monitored against the 31 day standard.
3.3.13. Does the 62 day period apply when a patient is urgently referred on suspicion of one cancer but is diagnosed with a different cancer?

Yes, any patient who is urgently referred by their GP for suspected cancer and is subsequently diagnosed with cancer (even if it is not the cancer initially suspected) should be monitored under the 62-day standard from receipt of referral to first definitive treatment. To meet this standard, Providers will require rapid handover arrangements between tumour group teams where this situation can arise. Examples of the tumour groups where this may occur include:

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

3.3.14. If a patient is referred in as a two week wait and a cancer is found incidentally that is unrelated to the referral, is this still part of that two week wait/62 day period?

Yes. The receipt of the two week wait referral would still mark the start of the 62 period which would end with the First Definitive Treatment for the incidental cancer. Although the cancer found was incidental, it was found during the investigations as part of the two week wait referral.

3.3.15. A two week wait patient is reassured at appointment that the risk of cancer is low but that the clinician wants to check progress in 3 months. At that time cancer is diagnosed. How should this be reported?

The key is what the patient has been told. If a cancer diagnosis has not been ruled out then the clock would continue to tick until a diagnosis is confirmed. From the patient’s perspective the interval between being referred and diagnosis would clearly be greater than 3 months and the waiting time reported should reflect this. The operational standard has been set to take such cases into account.

3.3.16. What enabling treatments can be classed as a First Definitive Treatment (FDT) and thus end the 62 day period?

The enabling treatments that can be classed as FDTs are:

- colostomy for bowel obstruction
- insertion of oesophageal stent
- non small cell lung cancer (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. Also, if the stent is needed because of the patient’s wait for treatment it cannot be classed as FDT.

Other enabling treatments can only mark the end of the 62 day period where a patient is having these prior to surgery within the same admitted care spell as that 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 i.e. 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.
3.3.17. Why can only such a small number of enabling treatments be classed as First Definitive Treatments?

There are a number of enabling treatments that are carried out prior to active treatment. The majority of these have NOT been able to be classed as first definitive treatments. In the past, the reasoning behind this was largely 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.

Under the old cancer waits rules (DSCN22/2002) a small number of enabling treatments could be classed as FDTs. These are set out in the question above. Other enabling treatments (for example dental extraction prior to radiotherapy) would have been classed as medical suspensions and adjustments used.

When DH calculated the operational standards it took into account the level of medical suspensions previously uploaded onto the CWT-Db. The operational standards therefore allow for the likely volume of breaches due to enabling treatments needed prior to FDT that were not allowed as FDTs by the older guidance (version 5 or earlier).

The last list of enabling treatments set out in version 5 of this guidance prior to DH producing the operational standards continue to be allowed as FDTs (see list above). In addition, enabling treatments can mark the end of the 62 day period where a patient is having these prior to surgery if the enabling treatment takes place within the same hospital provider spell as the surgery.

Any other enabling treatments are not classed as FDTs and the reduced operational standards takes this into account.

3.3.18. What do we do if we think an enabling treatment is being used differently to when the operational standard was set?

In exceptional circumstances DH might consider a particular enabling treatment again. Details would need to be sent to cancer-waits@dh.gsi.gov.uk setting out the procedure in question, what it is used for, how often and why its use has changed significantly since the operational standard (which was based on 2008 data) was set.

3.3.19. If a patient has had a previous cancer and is referred as a two week wait with a suspected second cancer which is then confirmed, is the patient on a 62 day period?

If this is a new primary they stay on the 62 day period. If it is a recurrence they are covered by the 31 day subsequent treatment standard only - the 62 day standard does not apply to patients with a diagnosed recurrence.

3.3.20. What is an orphan record?

An orphan record is when we have the part of the record up to DATE FIRST SEEN (for two week wait) and we have the part of the record up to TREATMENT START DATE (CANCER) (for 31 day) but the necessary data items to link the two together to make a 62 day period have not been entered onto the CWT-Db.
31 day referral to treatment standard for rare cancers (acute leukaemia, testicular and children’s cancers)

3.3.21. Do rare cancers (children’s, testicular and acute leukaemias) still need to be treated within 31 days of an urgent GP referral for suspected cancer?

Yes. Urgent GP referrals for suspected cancer should result in a 31 day period (rather than 62 day period) from receipt of referral if a patient is diagnosed with one of these 3 types of cancer. If a patient is not urgently referred but a consultant suspects one of these cancers they can upgrade. The upgrade would, however, be on to the 62 day period although we would recommend that you agree a local policy to treat such patients within 31 days if possible. Irrespective of your local policy you will be performance managed against 62 days for such upgraded patients.

3.3.22. How is the 31 day rare cancer standard monitored?

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, however, separately reported within the CWT-Db, 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 receipt of the initial referral into secondary care.

3.3.23. If a patient is under 16 years of age and/or is diagnosed with testicular cancer or an acute leukaemia after a routine referral (not two week wait), what cancer waits standard are they covered by?

Only those patients urgently referred with suspected cancer and diagnosed with a childhood cancer, testicular cancer or acute leukaemia are on the 31 day (62 day equivalent) pathway.

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

3.3.24. What happens if these rare cancers (childrens/testicular/acute leukaemia) come via a cancer screening programme?

No children are covered by any of the 3 NHS cancer screening programmes.

In addition, it is unlikely that anyone will be urgently referred with suspected testicular cancer or acute leukaemia from one of the 3 screening programmes but, if they were, they would be on the 62 day period although, again, it would be deemed as good practice for the locality to
seek to deliver the treatment within 31 days where possible. However, this will not be monitored centrally against the 31 day standard.

3.3.25. Is the accelerated 31 day standard (for acute leukaemia, testicular cancer and childhood cancers) based on the suspected referral or the final diagnosis?

The 31-day referral to treatment standard (for children's cancers, testicular cancer and acute leukaemia) is defined by the PRIMARY DIAGNOSIS or the age of the patient. These patients are shown in separate reports to the bulk of the 62-day referral to treatment activity.

3.3.26. What standard applies if haematological or urological two week wait referrals are later diagnosed as acute leukaemia or testicular ie, the 62 day or accelerated 31 day standard?

Any patient with these specific diagnoses (testicular cancer or acute leukaemia) will be monitored against a 31-day referral to treatment standard, regardless of what was originally suspected at the point of urgent two week wait referral. These patients are also included in the DH published statistics for the all cancer 62-day wait (because they fall within the "all cancer" definition).
3.4. **Screening referrals on to 62 day referral to treatment period**

3.4.1. **Are people with suspected cancer from any screening programme covered by this standard?**

The extended 62 day standard relates to the three national cancer screening programmes only:

- the national breast screening programme;
- the national bowel screening programme;
- the national cervical screening programme.

If anyone is suspected of having cancer during any other screening programme then this suspicion could be notified to their GP who could initiate an urgent referral for suspected cancer. Receipt of this referral (the ORIGINAL REFERRAL REQUEST RECEIVED DATE or the UBRN CONVERSION if Choose and Book is used to make the appointment), is recorded as the CANCER REFERRAL TO TREATMENT PERIOD START DATE and would trigger both the two week wait standard and, if cancer was diagnosed, the 62 day standard. Alternatively a consultant upgrade of a PRIORITY TYPE CODE 1 referral from a screening programme would be possible – this is only expected from the cervical screening programme.

3.4.2. **Is the screening service responsible for reporting on patients?**

All screening services are hosted by an NHS provider which is commissioned for the service. It is the commissioned provider that is responsible for reporting data.

3.4.3. **What is the priority type code for referrals from the screening programmes?**

All breast and bowel referrals from the screening programmes are potential cancer and would therefore be PRIORITY TYPE CODE 2 referrals.

All cervix referrals grade moderate or worse would be PRIORITY TYPE CODE 2 referrals if referrals are direct from the laboratory. If the laboratory does not make direct referrals then the GP should make a PRIORITY TYPE CODE 3 (two week wait) referral for cervix grade moderate or worse.

3.4.4. **Do PRIORITY TYPE CODE 1 referrals from the screening programmes need to be uploaded on to the CWT-Db?**

Such referrals are only expected from the cervical screening programme (ie. for low grade cervical screening referrals). They do not need to be uploaded onto the CWT-Db. A consultant (or authorised member of their team) could upgrade such a referral if they suspected cancer.
3.4.5. Screening patients are not two week wait referrals and therefore not on the two week wait/62 day period - do we need to do a ‘consultant upgrade’ to ensure the patient is on the 62 day period?

Breast, bowel and moderate or worse cervix patients would be PRIORITY TYPE CODE 2 referrals. Such referrals from the screening programmes are automatically on a 62 day period until cancer is ruled out so an upgrade is not necessary. If a patient comes from the cervical screening programme as a PRIORITY TYPE CODE 1 referral for low risk cervical cytology and cancer was then suspected they could be upgraded.

3.4.6. When does the 62 day standard start for the three cancer screening programmes?

The clock start is receipt of referral (day 0) which for the individual screening programmes, means as follows:
- breast - receipt of referral for further assessment (i.e. not back to routine recall);
- bowel - receipt of referral for appointment to discuss suitability for colonoscopy with a specialist screening practitioner (SSP);
- cervical - receipt of referral for appointment at colposcopy clinic.

3.4.7. Are patients on the 62 day screening standard covered by the two week wait standard?

No. The two week standard does not apply to the 62 day screening patients cohort. The two week wait standard only applies to urgent GP (GMP or GDP) referrals with suspected cancer and any symptomatic breast referrals where cancer is not suspected.

For screening referrals there is no national standard on time to DATE FIRST SEEN that will be monitored centrally. There are, however, internal waits standards within the NHS cancer screening programmes. The relevant internal screening service standards are as follows:

- breast – a minimum standard of >=90% of women attending an assessment centre within three weeks of attendance for the screening mammogram;
- bowel – a specialist screening practitioner appointment should be offered within two weeks (14 calendar days) from the date that the FOBT (faecal occult blood test) kit was read;
- cervical – at least 90% of women referred for colposcopy after one test reported as possible invasion or after one test reported as possible glandular neoplasia should be seen urgently within two weeks of referral;
- cervical – at least 90% of women referred for colposcopy with a test result of moderate or severe dyskaryosis should be seen in a colposcopy clinic within four weeks of referral.

If these internal QA standards are met, the vast majority of patients diagnosed with cancer via the screening programmes would be able to receive their first treatment within 62 days of the receipt of the referral if they were clinically fit and wanted to be treated within this timescale. The data items related to the two week wait standard (e.g. date first seen, relevant adjustments etc) do, however, still need to be uploaded. For example, adjustments in the first part of the pathway may be relevant to the calculation of the 62 day period.
3.4.8. Does the two week wait adjustment for DNA of first out-patient appointment apply to patients who come via a screening route even though the two week wait standard does not apply to them?

Yes, even though patients coming through the cancer screening programmes are not covered by the two week wait standard, the adjustment for DNA of first out-patient appointment would be included within the calculation of the 62 day referral to treatment period.

3.4.9. What is classed as DATE FIRST SEEN for the three cancer screening programmes?

The DATE FIRST SEEN for the individual screening programmes, is as follows:

- breast – first attendance for assessment in breast screening;
- bowel – first appointment with specialist screening practitioner (SSP) to discuss suitability for colonoscopy;
- cervical – first colposcopy appointment.

3.4.10. Who would be responsible for uploading the screening part of the 62 day period?

The Provider commissioned to provide the appointment classed as DATE FIRST SEEN is responsible for uploading that part of the pathway and would share any breach:

- for breast screening – it is the Provider commissioned to provide the screening centre that is responsible for uploading data on the first part of the pathway up to and including DATE FIRST SEEN;
- for bowel screening – it is the host Provider commissioned to provide the specialist screening practitioner (SSP) appointment to discuss suitability for colonoscopy that is responsible for uploading data on the first part of the pathway up to and including DATE FIRST SEEN;
- for cervical screening – it is the Provider commissioned to see the patients for their colposcopy appointment that is responsible for uploading the data up to and including DATE FIRST SEEN.

It is possible to distinguish between patients seen at a provider in its capacity as a screening host from those seen in its capacity as a conventional provider by the SOURCE OF REFERRAL FOR OUTPATIENTS data item within the patient record. If the Provider is seeing a patient in its capacity as a host for the screening service the referral source would be code 17 which identifies it as a referral from a national screening programme.

3.4.11. Do private providers carrying out screening services for the NHS cancer screening programmes have to record/report data on waiting times?

It depends upon the commissioning arrangement. If they are sub-contracted from the NHS Provider then the NHS Provider remains responsible for the data (see diagrams in Part 2).
3.4.12. **When should data on screening patients be uploaded to the CWT-Db?**

The mandate is for all records where DATE FIRST SEEN has been reached to be uploaded. Uploads should therefore be done at or soon after DATE FIRST SEEN. Organisations should not wait until later on the pathway as, for example, the treatment may be at another organisation that is relying on your upload at DATE FIRST SEEN to complete a 62 day referral to treatment period.

3.4.13. **Are Providers expected to upload to the CWT-Db all tracked screening referrals even if cancer is not diagnosed?**

It is mandatory to upload data up until DATE FIRST SEEN for all PRIORITY TYPE CODE 2 referrals from the screening programmes ie not just those subsequently diagnosed with cancer.

3.4.14. **Wouldn’t it be less of a burden on Providers only to collect the data on screening patients who go on to be diagnosed with cancer?**

The GFOCW Advisory Group consider that, with appropriate local systems in place, it is less of a burden on local management to upload data on all PRIORITY TYPE CODE 2 referrals from the screening programmes than to track all patients referred and just upload those subsequently diagnosed and treated for cancer.

3.4.15. **If we have to upload data on all screening patients what is this data used for?**

The data on patients that do not go on to have a cancer diagnosis will not be used by DH. A decision was taken by DH in 2008 (supported by ISB) that it was less labour intensive (with appropriate local IT systems in place) for the screening centres to upload the records for all the patients where they make PRIORITY TYPE CODE 2 referrals than to ask screening centres to track patients and only upload records for those that went on to be diagnosed with cancer.

3.4.16. **Are there any reports on the CWT-Db that identify screening patients once we have uploaded them?**

The reports available on the CWT-Db only relate to those patients that came via the screening service and went on to have treatment for cancer ie. not everything uploaded will feature in one of the reports. To see all the patients that a screening service uploaded you would need to use the download function to give data for local analysis.

3.4.17. **Is it acceptable for the screening services to upload 62 day screening patients after they have received their diagnosis to minimise the number of records that need to be saved on local systems?**

No. This is not an acceptable approach. The receipt of the referral (recorded as CANCER REFERRAL TO TREATMENT PERIOD START DATE) and the DATE FIRST SEEN will need to be uploaded to the central database irrespective of whether or not cancer is subsequently diagnosed. Delaying upload until a positive diagnosis is confirmed or otherwise is not relevant. Concern about the capacity of a local database needs to be resolved locally. Also, there is local evidence from NHS Improvement that proactive management of the patient pathway from the start is more efficient than retrospective management as is being proposed.
3.4.18. Would it be possible to introduce autoclosure of records?

Automatically defaulting status fields on dormant records is not considered good information practice.

3.4.19. Do screening services share breaches?

Yes. The host provider commissioned to provide the screening service can share breaches with another Provider involved in the 62 day period.

3.4.20. Who is responsible for issuing a Patient Pathway Identifier (PPI) for patients on the 62 day screening pathway?

It is the responsibility of the organisation receiving the referral request that would result in the patient being seen for the first time for a particular condition/suspected condition to allocate the patient pathway identifier (PPI). It should be noted that the screening host needs to upload data to CWT-Db from receipt of referral (CANCER REFERRAL TO TREATMENT PERIOD START DATE) to DATE FIRST SEEN for all PRIORITY TYPE CODE 2 referrals (i.e. not just those for whom cancer is confirmed) and this would include the PPI. All RTT periods should have a PPI and the cancer period must have the same PPI as that used for the related RTT period.

3.4.21. How does patient choice apply to patients coming through the screening programmes?

A host screening provider is responsible for its patients up to the point of diagnosis of cancer. The screening programmes make automatic referrals for appointments (with the exception of some cervical screening referrals which come via the GP) patients receive an appointment automatically with no element of choice for date, time or location. However, a number is provided so that, if the appointment or location is inconvenient, the person can request a change. The screening programme would then try to accommodate the patient’s wishes for, for example, an alternative provider where possible e.g. closer to work than home. If a cancer is subsequently diagnosed, treatment is usually offered at one of the screening centre’s local providers. If a patient requests an alternative provider every effort is made to meet this request as it would be for cancer patients coming via other routes.

*Each of the three national cancer screening programmes are discussed in turn below.*
3.5. Breast Screening

The period for this standard is as follows:

3.5.1. When does the 62 day referral from breast screening programme to treatment period start?

The starting point for this period is the receipt of the referral for further assessment. This is recorded as the CANCER REFERRAL TO TREATMENT PERIOD START DATE – the ORIGINAL REFERRAL REQUEST RECEIVED DATE is the data item from the NHS dictionary that would populate this field. In the breast screening programme this referral is both made and received within the screening service, which is hosted by a local provider. Receipt of referral is day 0.

3.5.2. Do we need to record when a patient is informed about their appointment?

No – upload on to the CWT-Db is from the receipt of the referral for the appointment for further assessment. You don’t need to record when the referral was made.

3.5.3. Should the first or second read of the mammogram trigger the referral for further assessment?

The referral is triggered when the reader(s) decide to recall the woman for further assessment (rather than return her to routine recall) and that referral has been received. When the referral is made depends on the local protocol – the protocol could be to recall on the basis of one reader’s recommendation or following consensus/arbitration.

3.5.4. Why not start the 62 period from the date of the first read?

A service request (i.e. a request for the provision of care services for a patient) is needed to initiate receipt of a referral. The date of the first read and the resulting decision by a ‘reader’ that a person needs referring is not a recordable activity within the NHS.
3.5.5. When does the 62 day referral from breast screening programme to treatment period end?

If the patient is diagnosed with cancer, the end point for this period is the first definitive treatment. This is recorded as the TREATMENT START DATE (CANCER). This start date may differ slightly for different treatments. For example, it would be:

- the date the patient is admitted for an operation, for surgery – CANCER TREATMENT MODALITY code 01;
- the date the first drug in an agreed course is given, for ‘anti-cancer drug regimen (cytotoxic chemotherapy)’ – CANCER TREATMENT MODALITY code 02;
- the date the first fraction is given, for teletherapy (beam radiation excluding proton therapy) – CANCER TREATMENT MODALITY code 05.

If a cancer diagnosis is ruled out the patient would either be discharged or continue on RTT tracking if treatment for another (benign) condition is required – in this case the CANCER REFERRAL TO TREATMENT PERIOD would end at DATE FIRST SEEN.

3.5.6. Does the receipt of the referral relate to a referral to a clinician or to an assessment clinic?

Referrals are made to the assessment clinic within the screening host not to a specific consultant. In effect the screening centre is referring a patient to itself. Such clinics do not need to register to use the CWT-Db in their own right as data entry would be carried out via the host provider of the screening service.

3.5.7. How can patients seen at a provider in its capacity as a screening host be distinguished from those seen in its capacity as a conventional provider?

These patients can be distinguished by the SOURCE OF REFERRAL FOR OUTPATIENTS data item within the patient record. If the Provider is seeing a patient in its capacity as a host for the screening service the referral would be code 17 which identifies it as a referral from a national screening programme.

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

The quality assurance (QA) standards for breast screening are in Table 1 on page 7 of publication no.60 which can be found at: http://www.cancerscreening.nhs.uk/breastscreen/publications/nhsbsp60.html. The standards include, for example, a minimum standard of >=90% of women:

- sent their screen results within two weeks;
- attending an assessment centre within three weeks of attendance for the screening mammogram;
- for whom the time interval between non-operative biopsy and result is one week or less;
- for whom the time interval between the decision to refer to a surgeon and surgical assessment is one week or less.

If these internal QA standards are met, the vast majority of women diagnosed with breast cancer via the screening programme would be able to receive their first treatment within 62 days of the receipt of the referral for further assessment.
3.5.9. When does data on screening patients need to be uploaded to CWT-Db?

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

3.5.10. Which Provider is responsible for uploading data on screening referrals up to the point that the patient is first seen?

It is the Provider commissioned to host the screening service that is responsible for uploading data up to DATE FIRST SEEN irrespective of whether or not cancer is diagnosed. For breast screening this is the appointment for further assessment following a screening mammogram. The SOURCE OF REFERRAL FOR OUTPATIENTS data item will make it possible for the host Provider to see waiting times for patients it has seen in its capacity as a screening provider separate from those patients it has seen as a conventional Provider.

3.5.11. Will screening units share breaches if the 62 day standard is not met?

Yes. The screening Provider commissioned to provide the first part of the 62 day screening pathway is responsible for the pathway up to DATE FIRST SEEN (ie the appointment for further assessment after the initial mammogram). It is possible that the screening Provider will go on to treat the patient but it is also possible that the patient could be referred to another Provider for treatment. If the latter, all activity would be shared following the normal process for multi-provider pathways.

3.5.12. If cancer is not diagnosed whose responsibility is it to let the screening programme know to put the women back on routine recall?

The patient would still be within the screening programme so it would be their own processes that would do this.

3.5.13. If a breast screening patient with a previous left breast cancer is screened and a new cancer is detected on the right side, how should this be handled?

If the cancer diagnosed was a new primary then they would be on a new 62 day referral to treatment screening pathway. If it was a recurrence of the original cancer they would be on the 31 day subsequent treatment pathway.

3.5.14. A patient has been referred from the breast screening service but the diagnosis is likely to be lymphoma – is this still a 62 day screening pathway?

Yes. The patient would remain in the 62 day screening cohort. The 62 day cohort the patient is in is based on their source of referral (in this case a PRIORITY TYPE CODE 2 referral from the breast screening programme) and not the type of cancer ultimately diagnosed.

3.5.15. If the breast screening service identifies a patient with breast symptoms but they do not suspect cancer, can they make a symptomatic breast two week wait referral?

Yes. If the screening service identifies breast symptoms but cancer is not suspected they should make a two week wait symptomatic breast referral (PRIORITY TYPE CODE 3) in line with the symptomatic breast two week wait standard which is explained in more detail in section 3.2.
3.5.16. How do patients get offered choice of provider if they are referred directly from a screening centre?

Because the breast screening programme make automatic referrals for appointments, patients receive an appointment automatically with no element of choice about date, time or location. However, the person is provided with a number and can request a change if the appointment or location is inconvenient. The screening programme would then try to accommodate the patient’s wishes for, for example, an alternative provider where possible e.g. closer to work than home. If a cancer is subsequently diagnosed, treatment is usually offered at one of the screening centre’s local providers. If a patient requests an alternative provider every effort is made to meet this request as it would be for cancer patients coming via other routes.

3.5.17. How many patients are expected to come through the breast screening route onto the 62 day pathway?

In England around 75,000 women a year are referred for further assessment following an abnormal screen. Of those around 13,500 would turn out to have cancer. The number of women referred through this route would be expected to increase over the next few years with both the increase to the aging population and planned expansions to the breast screening programme.
3.6. **Bowel Screening**

The period for this standard is as follows:

- **Abnormality spotted in FOBT sample** → **Automatic referral made by screening service** → **ORIGINAL REFERRAL REQUEST RECEIVED DATE** → **DATE FIRST SEEN** → **DECISION TO TREAT DATE** → **TREATMENT START DATE (CANCER)**

**NEW 62-DAY WAIT**

3.6.1. **When does the 62 day referral from bowel screening programme to treatment period start?**

The starting point for this period is the receipt of the referral for an appointment with the Specialist Screening Practitioner (SSP) to discuss the patient’s suitability for a colonoscopy. This is recorded as the CANCER REFERRAL TO TREATMENT PERIOD START DATE and it is the ORIGINAL REFERRAL REQUEST RECEIVED DATE that is the data item from the NHS dictionary that would populate this field. In the bowel screening programme this referral is made by the screening hub and received by one of the screening centres which is hosted by a local provider. Receipt of referral is Day 0.

3.6.2. **Do we need to record when a patient is informed about their appointment?**

No – upload on to the CWT-Db is from the receipt of the referral for the appointment with the specialist screening practitioner to discuss suitability for colonoscopy. You don’t need to record when the referral was made.

3.6.3. **Is it the result of the Faecal Occult Blood (FOB) test or colonoscopy that triggers the referral from the bowel screening service?**

It is a positive FOB test result that will trigger the referral (service request) from the screening hub (see 3.6.5) and receipt of that referral by the screening centre for an appointment with the specialist screening practitioner (SSP) marks the start of the 62 day period. This should be recorded as the CANCER REFERRAL TO TREATMENT PERIOD START DATE and it is the ORIGINAL REFERRAL REQUEST RECEIVED DATE that is the data item from the NHS dictionary that would populate this field.
3.6.4. Why is a positive FOB test the trigger rather than colonoscopy?

The intention of this standard is for patients coming through the bowel screening programme to be on an even footing with those coming through the existing urgent GP two week wait referral route with suspected cancer. The standard will start from receipt of referral following a positive FOB test rather than following a positive colonoscopy to pick up patients at higher risk of having bowel cancer at the earliest stage possible. The positive FOB is an indicator of higher risk and would ensure such patients are treated equitably with those referred with warning signs via the two week wait route. If we waited until the colonoscopy then we would almost be at the point of diagnosis when the 31 day standard would start and would gain little extra benefit for the patient.

3.6.5. What FOB results trigger a referral from the Hub for an appointment with the specialist screening practitioner to discuss suitability for a colonoscopy?

A FOB kit will include six samples of faeces. A strong positive result is classed as five or more of the six samples including traces of blood. This would initiate a referral to discuss suitability for colonoscopy.

A weak positive result would be classed as four or less of the six samples including traces of blood. This would result in the person being sent a new kit to repeat the test. If the second kit:

- provides a strong positive result then a referral would be made;
- provides a second weak positive result (i.e. four or less of six samples including traces of blood) then a referral would be made;
- provides a negative result (i.e. none of the six samples including traces of blood) then the patient would receive a further kit. If this sample:

  - is negative then they would return to standard recall in two years time;
  - is also weak positive it means the person had a sequence of: weak positive, negative and weak positive results which would result in a referral.

A referral to discuss suitability for colonoscopy is therefore made after the following:

- a first strong positive result;
- a second weak positive result (i.e. two kits returned each with four or less out of 6 samples positive);
- a sequence of weak positive, negative, weak positive results.

The test which finally results in the referral being made is known as the index test.

3.6.6. If a patient has a positive FOB but there are no clinics available for the Hub to book does the clock start?

No. The clock starts at receipt of referral within the host Provider. However, to ensure no patients are on a pending list in the hub (i.e. with no clock start), screening centres have been advised to have specialist screening practitioner (SSP) slots available on the Bowel Cancer Screening System for at least six weeks ahead (the internal Bowel Cancer Screening Programme standard is to book within two weeks). This should ensure that the programme hub can always book an SSP appointment (i.e. to start the clock) even if they then go back and change the date of the appointment.
3.6.7. Can the clock start on the day the Hub identifies the index test indicating referral is needed and/or the Hub makes the clinic appointment rather than receipt of referral by the Provider?

All calculated waiting times for RTT and cancer referral to treatment periods begin with the receipt of a referral, which constitutes the service request. This is what is defined in DSCN 20/2008 and consequently what has been entered into the NHS Data Dictionary for these services. It is what we expect to be collected and returned to the CWT-Db. It may be that the receipt of the referral is the same date the Hub identified the index test etc because of the automated central infrastructure available to the local services, but this date must be checked locally to ensure that it is truly the receipt date and to guarantee accuracy of reporting.

3.6.8. When does the 62 day referral from bowel screening programme to treatment period end?

If the patient is diagnosed with cancer, the end point for this period is the first definitive treatment. This is recorded as the TREATMENT START DATE (CANCER). This start date may differ slightly for different treatments. For example, it would be:

- the date the patient is admitted for an operation, for surgery – CANCER TREATMENT MODALITY code 01;
- the date the first drug in an agreed course is given, for ‘anti-cancer drug regimen (cytotoxic chemotherapy)’ – CANCER TREATMENT MODALITY code 02;
- the date the first fraction is given, for teletherapy (beam radiation excluding proton therapy) – CANCER TREATMENT MODALITY code 05.

If a cancer diagnosis is ruled out the patient would either be discharged or continue on RTT tracking if treatment for another (benign) condition is required – in this case the CANCER REFERRAL TO TREATMENT PERIOD would end at DATE FIRST SEEN.

3.6.9. How do you stop the pathway for patients who refuse to have an appointment with the screening service practitioner after a positive FOB test?

Data is not uploaded onto the CWT-Db until DATE FIRST SEEN (which is the appointment with the SSP). If this appointment is refused a record is never uploaded onto the central system. It will be for local determination how best to close the record on local systems.

3.6.10. If a patient is FOB positive and colonoscopy negative but has symptoms that still need to be resolved would they stay on the 62 day bowel screening pathway?

Yes, they would remain on the 62-day pathway until a cancer diagnosis is confirmed or excluded. If a patient is removed from the 62-day pathway it will be because they are formally told of a benign diagnosis by the consultant (or member of the team) responsible for their care.
3.6.11. How are patients coming up to one year bowel screening surveillance – this managed under cancer waits?

Patients under surveillance are having polyp management – they do not have cancer and are not expected to have cancer – they are on a preventative pathway and, as such, are not covered by the 62 day waits standard.

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

There are two internal QA waiting time standards for positive FOB tests:

- A specialist screening practitioner (SSP) appointment should be offered within two weeks (14 calendar days) from the date that the FOB test kit was read:

- The colonoscopy appointment should be offered within two weeks (14 calendar days) of the SSP assessment.

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

3.6.13. The internal QA standard within the bowel screening programme is that the colonoscopy should be performed within two weeks – what if the patient doesn’t want to be seen that quickly?

This is their choice and no adjustments to the 62 day period can be made for this. However, the operational standard takes into account that a proportion of patients will choose to wait longer than the standard time.

3.6.14. In some parts of the country there are a number of Providers in an area that could perform the colonoscopy as part of the screening programme – who is responsible for reporting on the patients?

The Provider that was commissioned to provide the service classed as DATE FIRST SEEN would report on the patients. For bowel screening DATE FIRST SEEN is the appointment with the specialist screening practitioner (SSP) to discuss suitability for colonoscopy not the date of the colonoscopy itself. The date of the colonoscopy is not relevant to the cancer waits upload unless the first definitive treatment took place during this procedure in which case it would be regarded as the TREATMENT START DATE (CANCER) ending the 62 day period.

3.6.15. Can the colonoscopy take place at a local Provider’s colonoscopy clinic rather than one within the screening programme?

If a patient is suitable for a colonoscopy this would be offered in a clinic that is part of the screening programme. Only clinics accredited to the screening programme can be used.
3.6.16. The 62 day bowel screening pathway is less efficient than the 62 day pathway for bowel patients coming through the two week wait i.e. patients urgently referred by their GP with suspected bowel cancer could go ‘straight to test’ for colonoscopy – the pathway for screening patients is slower as they need to have an appointment to discuss suitability for colonoscopy prior to this test – why is this?

Patients coming through the screening programme have not been to a doctor with symptoms that they are concerned about (as someone referred under the two week wait standard would have been). It is therefore right that they are managed differently i.e. offered additional ‘counselling’ prior to progressing to a colonoscopy. In addition the screening programme has internal standards for the timing of stages in the process – if these are followed it would allow time for first treatment within the 62 day period for patients where cancer was diagnosed who were clinically able and wanted to be treated within this timescale.

3.6.17. How can patients seen at a Provider in its capacity as a host for a screening service be distinguished from those seen in its capacity as a conventional NHS provider?

These patients can be distinguished by the SOURCE OF REFERRAL FOR OUTPATIENTS data item within the patient record. If the Provider is seeing a patient in its capacity as a host for the screening service the referral would be code 17 which identifies it as a referral from a national screening programme.

3.6.18. When does data on screening patients need to be uploaded to CWT-Db?

Providers commissioned to act as a screening centre need to upload data after the DATE FIRST SEEN (ie. appointment with SSP to discuss suitability for colonoscopy).

3.6.19. Which Provider is responsible for uploading data on screening referrals up to the point that the patient is first seen?

It is the Provider commissioned to host the screening centre that is responsible for uploading data up to DATE FIRST SEEN irrespective of whether or not cancer is diagnosed. For bowel screening this is the appointment with the specialist screening practitioner to discuss suitability for colonoscopy.

3.6.20. Can we access data directly from the Bowel QA submissions generated by the Hubs?

The Bowel Cancer Screening System (BCSS) has been able to produce reports since January 2009. The reports come out either on paper or as a CSV file that can be manipulated locally. These are available for providers to use if they wish.

3.6.21. Will screening units share breaches if the 62 day standard is not met?

Yes. The screening Provider commissioned to provide the first part of the 62 day screening pathway is responsible for the pathway up to DATE FIRST SEEN (ie. an appointment with the specialist screening practitioner (SSP) to discuss suitability for colonoscopy). It is possible that the screening Provider will go on to treat the patient but it is also possible that the patient could be referred to another Provider for treatment. If the latter, all activity would be shared following the normal process for multi-provider pathways.
3.6.22. **Does the Hub share any breaches?**

No. The Hub is not reported within the cancer waiting times dataset. The 62 day clock starts at receipt of referral for the SSP appointment by the host Provider. The host Provider is responsible for uploading the data up to DATE FIRST SEEN. The treating Provider (which may be the same Provider) is then responsible for uploading the data related to the first treatment if cancer is diagnosed. If the 62 day standard is breached then the breach is shared if the host screening Provider is different from the treating Provider.

3.6.23. **How do patients get offered choice of provider if they are referred directly from a screening centre?**

Because the bowel screening programme makes automatic referrals for appointments, patients receive an appointment automatically with no element of choice for date, time or location. However, the person is provided with a number and can request a change if the appointment or location is inconvenient. The screening programme would then try to accommodate the patient’s wishes for, for example, an alternative provider where possible e.g. closer to work than home. If a cancer is subsequently diagnosed, treatment is usually offered at one of the screening centre’s local providers. If a patient requests an alternative provider every effort is made to meet this request as it would be for cancer patients coming via other routes.

3.6.24. **The Hub sends a letter to the patient with an appointment that makes it clear that the appointment can be re-booked if it is not convenient – is it appropriate to actively encourage patients to change the appointment?**

The letter should provide details of how to change an appointment if it is not convenient etc. The letter needs to strike a balance i.e. not actively encouraging a change but making clear it is possible. The National Screening Programme is content that the balance is correct.

3.6.25. **Some bowel screening patients choose to defer their diagnostic colonoscopy for a number of weeks. Can they be removed from the 62 day pathway?**

No. You cannot remove a patient from the 62 day screening pathway because they choose to defer their colonoscopy appointment for a number of weeks. The operational standards for all cancer waits 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.

3.6.26. **How many patients are expected to come through the bowel screening route onto the 62 day pathway?**

It is expected that around 30,000 patients will come through the bowel screening route with around 3-3,500 of these having cancer and therefore proceeding as part of the 62 day standard.
3.7. Cervical Screening

The period for this service standard is as follows:

3.7.1. When does the 62 day referral from cervical screening programme to treatment period start?

The starting point for this period is the receipt of the referral for a colposcopy appointment. This is recorded as the CANCER REFERRAL TO TREATMENT PERIOD START DATE. In the cervical screening programme, the referral can be received either:

- direct from the screening laboratory (this would be the ORIGINAL REFERRAL REQUEST RECEIVED DATE) – these patients would be part of the 62-day screening cohort;
- via the General Medical Practitioner (this would be the ORIGINAL REFERRAL REQUEST RECEIVED DATE) - these patients would be part of the 62-day cohort from urgent GP referrals;
- via Choose and Book (this would be UBRN CONVERSION, the Unique Booking Reference Number conversion date) - these patients would be part of the 62-day cohort from urgent GP referrals.

Receipt of referral is Day 0. It is recommended that, wherever possible, local processes enable referrals to be received direct from the screening laboratories. This removes an unnecessary step in the process which will save time. It also means that patients will be more accurately assigned to the 62 day screening cohort and there will be more flexibility for the colposcopy clinics in their appointment planning.
3.7.2. How are indirect cervical screening referrals (i.e. via GPs) recorded?

If a laboratory sends screening results back to the GP then it is for the GP to refer the patient for colposcopy. If the patient had moderate or worse cytology then the GP should make a two week wait referral. If the patient was subsequently diagnosed with cancer they would be on the 62 day pathway from a two week wait referral (i.e. not part of the 62 day screening cohort). The choice of referral mechanism used is for local determination between commissioners and the screening service but it is expected that, over time, laboratories will increasingly be encouraged to make direct referrals for a colposcopy appointment. If a GP did not make an urgent referral it would be possible for an upgrade on to the 62 day period – the patient would then, if cancer was diagnosed, be part of the 62 day consultant upgrade cohort.

If the GP sends the referral (rather than the laboratory) this will be identified via the data item SOURCE OF REFERRAL FOR OUTPATIENTS i.e. Code 03 (General Medical Practitioner) will be used rather than Code 17 (National Screening Programme).

3.7.3. If reports from the screening laboratories go back to the GP it adds delays into the 62 period. How can this be avoided?

It is strongly recommended that, wherever possible, local processes enable referrals to be received direct from laboratories rather than via GPs to avoid unnecessary delays and to enable more efficient clinic management. The maximum 14 day turnaround time (from date of test to date of receipt of result letter), implemented from 2010, should facilitate changes to local processes.

3.7.4. What will be the impact of the two week turnaround for results?

This should act as an incentive to streamline the whole process including moving to direct referral for colposcopy from the laboratory rather than via the GP.

3.7.5. When does the 62 day referral from cervical screening programme to treatment period end?

If the patient is diagnosed with cancer, the end point for this period is the first definitive treatment. This is recorded as the TREATMENT START DATE (CANCER). This start date may differ slightly for different treatments. For example, it would be:

- the date the patient is admitted for an operation, for surgery – CANCER TREATMENT MODALITY code 01;
- the date the first drug in an agreed course is given, for ‘anti-cancer drug regimen (cytotoxic chemotherapy)’ – CANCER TREATMENT MODALITY code 02;
- the date the first fraction is given, for teletherapy (beam radiation excluding proton therapy) – CANCER TREATMENT MODALITY code 05.

If a cancer diagnosis is ruled out the patient would either be discharged or continue on RTT tracking if treatment for another (benign) condition is required - in this case the CANCER REFERRAL TO TREATMENT PERIOD would end at DATE FIRST SEEN.
3.7.6. When does data on screening patients need to be uploaded to CWT-Db?

Providers need to upload data after the DATE FIRST SEEN (ie. the colposcopy appointment).

3.7.7. Which Provider is responsible for uploading data on screening referrals up to the point that the patient is first seen?

It is the Provider commissioned to carry out the DATE FIRST SEEN (ie. colposcopy appointment) that is responsible for uploading data up to DATE FIRST SEEN irrespective of whether or not cancer is diagnosed.

3.7.8. Do ‘routine’ cases (PRIORITY TYPE CODE 1) from the cervical screening programme need to be uploaded on to the CWT-Db?

No. Such referrals only need to be reported on CWT-Db if they are subsequently upgraded and diagnosed and treated for cancer. These can be defined as borderline and mild dyskaryosis.

3.7.9. If a patient is directly referred from the cytology laboratory for a colposcopy appointment in Provider A but the patient decides they want an appointment at Provider B, who would be responsible for uploading the data?

The Provider where the patient is first seen (ie. the one commissioned to provide the colposcopy appointment) should upload the data.

3.7.10. Which abnormalities are included within this standard?

All patients with moderate or worse cytology will be included within the 62 day screening period. This includes the following cytology categories:

- Possible invasive cancer;
- Possible glandular neoplasia;
- Severe dyskaryosis;
- Moderate dyskaryosis.

These referrals for colposcopy indicate at least cervical intraepithelial neoplasia (CIN) or a suspicion of cancer.

3.7.11. Why include moderate dyskaryosis – few of these patients will have cervical cancer?

Changes were being considered to the pathology recording of dyskaryosis – severe and moderate may be overlapping categories in the future. To take into account this proposed change both categories of dyskaryosis are included within the 62 day screening standard.
3.7.12. **What are the referral priorities for different abnormalities?**

Referrals direct from the cervical screening service should be identified as follows:

- Moderate or worse cytology (i.e. abnormalities within the scope of the standard) – should be referred with a PRIORITY TYPE CODE 2 (urgent),
- Low risk cytology (i.e. abnormalities not covered by this standard – cancer not suspected/likely) – should be referred with a PRIORITY TYPE CODE 1 (routine) and patients would be covered by the RTT pathway. These routine referrals could be upgraded to the 62 day period if a consultant (or authorised member of the team) suspected cancer.

3.7.13. **How long should cervical screening patients wait for a colposcopy appointment following an abnormal cervical screening test?**

The 62 day screening standard is only applicable to patients with moderate or severe cytology. There are no national standards for the timescales for delivering the colposcopy as part of this standard. However, there are internal Quality Assurance standards for the cervical screening programme.

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

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

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

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

The other internal screening standard is that at least 90% of women with an abnormal test result should be seen in a colposcopy clinic within eight weeks of referral. This standard covers borderline and mild dyskaryosis. These would be routine referrals (PRIORITY TYPE CODE 1) that would be on the RTT pathway although it would be possible for a consultant to upgrade them on to the 62 day pathway if cancer was suspected.

3.7.15. **Can a consultant (or authorised member of the consultant team) upgrade a routine referral (PRIORITY TYPE CODE 1) from the cervical screening programme onto the 62 standard?**

Yes, if they suspect cancer.
3.7.16. What is the status of women referred after persistent low grade cytology?

These women would be referred as PRIORTY TYPE CODE 1 (routine) and would be covered by the RTT pathway. These routine referrals could be upgraded to the 62 day standard if a consultant (or authorised member of the team) suspected cancer.

3.7.17. How are persistent ‘inadequate’ tests managed in terms of the 62 day standard?

If tests are inadequate it would not have been possible to have identified moderate dyskaryosis or worse at cytology. The patient would therefore be a routine referral (ie. not on the 62 day screening pathway) but could be upgraded by a consultant (or authorised member of the team) if appropriate.

3.7.18. Where does the colposcopy appointment sit in the 62 day screening pathway for patients with a moderate or severe cytology?

If a patient is a PRIORITY TYPE CODE 2 referral from the cervical screening programme with moderate or severe cytology then they are on the 62 day pathway. Receipt of the referral for the colposcopy appointment would mark the start of the 62 day period and the first definitive treatment would mark the end of the 62 day period and also the end of the 31 day period for the first treatment.

The colposcopy appointment itself will generally be the DATE FIRST SEEN unless for any reason the patient sees a consultant first but that is not generally the case. The colposcopy is part of the diagnostic process aimed at confirming whether or not a patient has cancer. It is possible for the first definitive treatment to take place at the same time. For example, if a biopsy is taken during this procedure, the excised tissue was found to be malignant and the tumour had effectively been removed by the excision. However, it is not always possible for the first treatment to occur at this appointment.

3.7.19. How can patients seen at a Provider in its capacity as a host for a screening service be distinguished from those seen in its capacity as a conventional NHS provider?

These patients can be distinguished by the SOURCE OF REFERRAL FOR OUTPATIENTS data item within the patient record. If the Provider is seeing a patient in its capacity as a host for the screening service the referral would be code 17 which identifies it as a referral from a national screening programme.

3.7.20. Will screening units share breaches if the 62 day standard is not met?

Yes. The Provider commissioned to provide the first part of the 62 day screening pathway (the colposcopy clinics) is responsible for the pathway up to DATE FIRST SEEN. It is possible that this Provider will go on to treat the patient but it is also possible that the patient could be referred to another Provider for treatment. If the latter, all activity would be shared following the normal process for multi-provider pathways.
3.7.21. How do patients get offered choice of provider if they are referred directly from a screening laboratory?

Where the cervical screening programmes makes automatic referrals for colposcopy appointments direct from the laboratory no element of choice for date, time or location is included. However, the person is provided with a number and can request a change if the appointment or location is inconvenient. The screening programme would try to accommodate the patient’s wishes for, for example, an alternative provider where possible e.g. closer to work than home.

Where the results are sent via the GP (a slower pathway which is not recommended) an element of choice may be possible, especially if the patient uses Choose and Book to make the appointment. If a cancer is subsequently diagnosed, treatment is usually offered at one of the screening centre’s local providers. If a patient requests an alternative provider every effort is made to meet this request as it would be for a cancer patients coming via other routes.

3.7.22. How many patients are expected to come through the cervical route onto the 62 day standard?

In England around 40,000 women are expected to be referred after a single occurrence of potentially significant abnormality. While the majority of these come through direct referrals, in a few places they may still come via the GP or CAB if direct referrals from the laboratories are not in place. Of the 40,000 referrals around 1,000 are likely to have cervical cancer and around 200 other gynaecological or urogenital cancers.
### 3.8. Consultant upgrade on to a 62 day referral to treatment period

The period for this service standard is as follows:

1. **18 WEEK PERIOD**
   - **REFERRAL TO TREATMENT PERIOD START DATE**
   - **DATE FIRST SEEN**
   - **TREATMENT PERIOD START DATE**
   - **TREATMENT START DATE**

2. **62 DAY UPGRADE**
   - **CONSULTANT UPGRADE DATE**
   - **DECISION TO TREAT DATE**
   - **CANCER TREATMENT PERIOD START DATE**
   - **TREATMENT START DATE (CANCER)**
   - **62 DAY UPGRADE/TREAT WAIT**

#### 3.8.1. Where does the 62 day period from an upgrade start?

The starting point for this 62 day period is the date on which the consultant (or an authorised member of the consultant team, as defined by local policy) decides to upgrade the patient. This is recorded as the CONSULTANT UPGRADE DATE.

#### 3.8.2. Why doesn’t the 62 day period start with receipt of the upgrade given that the other 62 day periods start at the receipt of a referral?

There is no formal process by which the receipt of an upgrade could be measured i.e. it is not like the receipt of a referral for an appointment which would be generated by a service request. The decision has therefore been taken that the date of the decision to upgrade should start the process as it should be possible to introduce local systems to enable this date to be captured. It will be recorded as the CONSULTANT UPGRADE DATE and marks the start of the 62 day period for upgraded patients.
3.8.3. Why not start this 62 day period from the receipt of the original referral which the consultant then went on to upgrade?

At the point the original referral is received (recorded as the REFERRAL TO TREATMENT PERIOD START DATE on an RTT pathway) cancer is not suspected and it might be a few weeks before a consultant (or authorised member of a consultant team) decides to upgrade the patient onto a faster pathway. It is not appropriate to calculate a timed 62 day period from this point (i.e. retrospectively starting the clock from the original referral) as the patient was not on a faster pathway at that point.

3.8.4. Where does the 62 day period from an upgrade end?

If the patient is diagnosed with cancer, the end point for this period is the first definitive treatment. This is recorded as the TREATMENT START DATE (CANCER). This start date may differ slightly for different treatments. For example, it would be:

- the date the patient is admitted for an operation, for surgery – CANCER TREATMENT MODALITY code 01;
- the date the first drug in an agreed course is given, for ‘anti-cancer drug regimen (cytotoxic chemotherapy)’ – CANCER TREATMENT MODALITY code 02;
- the date the first fraction is given, for teletherapy (beam radiation excluding proton therapy) – CANCER TREATMENT MODALITY code 05.

If a cancer diagnosis is ruled out the patient would either be discharged or continue on RTT tracking if treatment for another (benign) condition is required. In this case the CONSULTANT UPGRADE DATE would not be recorded on the CWT-Db as this date is only uploaded following a TREATMENT START DATE (CANCER).

3.8.5. Is data on all upgraded patients uploaded onto the CWT-Db?

No – only data on those patients that go on to be diagnosed with and treated for cancer after an upgrade need to be uploaded.

3.8.6. If a patient is upgraded but cancer is not diagnosed do you have to report on this patient eg. to determine appropriateness of upgrades?

No. There is no national requirement to collect this information but it can be collected locally to aid local awareness and education about appropriateness of upgrades.

3.8.7. Who can upgrade a patient?

A consultant or an authorised member of the consultant team (as defined by local policy) can upgrade a patient if cancer is suspected. The ultimate responsibility for upgrades rests with the consultant responsible for the care of the patient, who will have delegated his/her authority by local agreement. The upgrades could come from any part of the health service not just from consultants and teams that most commonly see cancer patients. It is therefore important that local policies are agreed and processes in place to publicise and operate the upgrade system locally.
3.8.8. Are upgrades restricted to consultants within cancer Multi-Disciplinary Teams (MDTs)?

No. Any authorised member of a consultant team can initiate an upgrade so upgrades could come from any part of the health service not just from consultants and teams that most commonly see cancer patients. There can of course be local upgrade policies so it might be possible to restrict upgrades locally if this is deemed appropriate. The adopted protocol has been left entirely to local determination. This is due to the differing practices across different specialties and organisation in the NHS. Asking everybody to conform to a single process would not be feasible or desirable.

3.8.9. Can there be an upgrade from any source of referral?

Yes, with the exception of:

- two week wait referrals for suspected cancer;
- two week wait referrals for breast symptoms (not suspicious of cancer);
- urgent screening referrals

These are exceptions because the patient would automatically be on a 62 day period if cancer was diagnosed.

3.8.10. If a patient is already in hospital (i.e. as an in-patient) can a consultant still upgrade them?

Yes, the original source of the referral would be based on the SOURCE OF REFERRAL FOR OUT-PATIENTS codes.

3.8.11. Where within the RTT period can an upgrade take place?

Examples of when the upgrade might take place include:

- on reading the referral letter;
- after seeing the patient for the first time;
- after seeing test results (before or after seeing the patient);
- after discussing the patient’s case at a multidisciplinary team meeting.

An upgrade must be on or before a decision to treat a patient has been agreed (i.e. before the DECISION TO TREAT DATE recorded as the CANCER TREATMENT PERIOD START DATE (if recorded). It must also be on or before the multidisciplinary team meeting where the care plan that was subsequently agreed with the patient was discussed i.e. the MULTIDISCIPLINARY TEAM DISCUSSION DATE (CANCER) (if recorded).

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

No, that is not correct. An upgrade can occur after an MDT meeting as long as it was not the MDT meeting where the care plan that was agreed with the patient was discussed.
3.8.13. Can a patient be upgraded and have a Decision To Treat (DTT) made on the same day?

Yes. DSCN 20/2008 states that the upgrade must be on or before the DTT. Therefore an upgrade ON the same day as the DTT is allowed. For example, an upgrade could be made in the morning and the 62 day clock starts to tick. A clinic is then held in the afternoon where a DTT is reached and the 31 day clock starts to tick in effect shortening the 62 day pathway to 31 day also.

3.8.14. Is an upgrade possible if a recurrence is suspected?

No. The upgrade to the 62 day standard is intended for suspected new primaries only. However, if a consultant (or an authorised member of the consultant team) wishes to upgrade a patient they suspect may have a recurrence it would be good practice for the locality to ensure the patient is diagnosed and receives their treatment as quickly as possible. This will not, however, be monitored centrally. Patients with suspected recurrent cancer will be covered by the 31 day standard for subsequent treatments if the recurrence is confirmed.

3.8.15. Are acute leukaemias, testicular cancers and children’s cancers (which currently run on a 31 day period from urgent referral to treatment) included in the upgrade standard and, if so, would that put them on a 31 day or 62 day period from the point of upgrade?

A consultant (or an authorised member of the consultant team) would be able to upgrade patients they suspected might have one of these cancers but who had not been urgently referred on to a 62 day period. The upgrade would be on to the 62 day period but it would be deemed as good practice for the locality to seek to deliver the treatment within 31 days where possible. The 31 day timescale will not, however, be monitored centrally.

3.8.16. Can a consultant upgrade a two week wait symptomatic breast referral?

No. An upgrade for symptomatic breast patients (who will have been referred with a PRIORITY TYPE CODE 3 – two week wait) is not necessary. These patients would already be on a 62 day period if breast cancer is subsequently diagnosed.

3.8.17. Can a consultant downgrade inappropriate urgent referrals from GPs/GDPs?

No. There are no plans to introduce downgrades. Any evidence of inappropriate referrals would need to be managed locally. For example, a consultant could ask a GP to withdraw an inappropriate two week wait referral.

3.8.18. When does the patient find out that they have been upgraded as a suspected cancer?

This is a matter for clinical judgement in the same way as it is when a GP makes an urgent referral for suspected cancer. It would be good practice to ensure that a patient understands why they are being upgraded where possible.
3.8.19.  Do patients get any choice about service provider if they are upgraded?

Patients can decline any appointment and seek an alternative (including an alternative provider). However, the importance of speed in diagnosing and treating a potential cancer should be explained to patients as a factor to consider.

3.8.20.  How can we ensure that patients have a choice of provider if they are upgraded?

This is for local decision. In some ways it is no different than how you would ensure choice for any patient having any diagnostic or treatment episode.

3.8.21.  Should a network/SHA make a consultant upgrade protocol mandatory?

It should not be necessary to mandate a protocol. However, it would be helpful for networks/SHAs to ensure that clinical teams have considered how they are going to manage the consultant upgrade process locally. If there are no local protocols then by default only the consultant(s) will be able to upgrade within individual teams.

3.8.22.  Who collects the upgrade dates?

They should be uploaded retrospectively by the provider delivering the treatment. It is for localities to determine processes to facilitate this.

3.8.23.  How do upgrades and shared breaches work?

If the upgrade took place in a different Provider to the one carrying out the treatment then it is possible that the breach would be shared. It would be shared between the provider where the CONSULTANT UPGRADE DATE takes place and the provider commissioned to carry out the treatment (TREATMENT START DATE (CANCER)) respectively.

3.8.24.  Will DH set a level for the proportion of upgrades it is expecting to take place or an operational standard?

There are no plans to do either of these although DH will continue to consider how it supports the NHS in this area.

3.8.25.  Do 62 day upgrade patients have to be seen within the two week wait standard?

The two week standard does not apply to the 62 day upgrade patients. The two week wait standard only applies to urgent GP (GMP or GDP) referrals for suspected cancer or symptomatic breast referrals where cancer is not suspected. However, the data items related to the two week wait standard (e.g. DATE FIRST SEEN, relevant adjustments etc) do still need to be uploaded. For example, adjustments in the first part of the period may be relevant to the calculation of this 62 day upgrade period.

3.8.26.  Can an adjustment for a DNA be used for upgraded patients?

The only time this adjustment could be used for upgraded patients is if the patient is upgraded BEFORE they are first seen e.g. after consultant reads the referral letter etc and they then DNA their first appointment. If a patient had already had 1-2 outpatient appointments prior to upgrade then no adjustment would be possible for a DNA.
3.8.27. What local processes should be in place to ensure that patients who may have been routinely referred by their GP but then require ‘upgrading’ are discussed with the practice, if necessary?

It is for local determination how best to educate GPs about the signs and symptoms of cancer. It might be useful to consider locally both the conversion rate of urgent two week wait referrals to cancer diagnosis as well as the proportion of non-two week wait referrals that were upgraded and feedback to primary care any lessons in terms of signs and symptoms to look out for.

3.8.28. We have a patient who had an internal referral upgraded - this was received two days before a GP two week wait referral was received for the same patient. How do we record this patient?

If the two referrals are for different conditions then they would be different pathways with different PPIs. If the 2 referrals are linked to the same condition, you could ask the GP to withdraw the two week wait referral on the grounds that the patient has already been fast-tracked internally.

3.8.29. Should all suspected cancers that are not already on a 62 day period be upgraded, or just those that a consultant specifically says should be?

If a consultant or an authorised member of their team (as set out in local protocol) suspects cancer then they can upgrade the patient. Upgrading is not compulsory and we have no way to mandate it. It would be good practice to ensure that consultants locally are aware that they can now upgrade patients and should make use of this option if they suspect cancer if this would benefit their patients by ensuring they are on a faster pathway.

3.8.30. Is there a definitive way of capturing the information on upgrades?

The key data item is the CONSULTANT UPGRADE DATE – you will need a means locally to capture this date. The date of receipt of the original referral is also needed as this is required for monitoring purposes i.e. to ensure two week wait and urgent screening referrals are not upgraded.

3.8.31. A consultant upgrades a referral based on a GP letter but when a different and more senior consultant examines the patient it is clear that cancer is not the problem. How is this managed?

62 day upgrade periods are only uploaded if a patient is treated for cancer. In this example the patient is told they do not have cancer and no cancer treatment is given therefore a 62 day upgrade record is not uploaded.
3.9. **31 day standard for first definitive treatment (FDT)**

The period for this service standard is as follows:

- **CANCER TREATMENT PERIOD START DATE**
- **DECISION TO TREAT DATE**
- **TREATMENT START DATE**

3.9.1. **What is classed as a First Definitive Treatment (FDT)?**

A treatment is: “An intervention intended to manage the patient’s disease, condition or injury and avoid further intervention. It is a matter of clinical judgement, in consultation with the patient.” For cancer waits a first definitive treatment is further defined as the start of the treatment aimed at removing or eradicating the cancer completely or at reducing tumour bulk.

3.9.2. **Where does the 31 day standard for a first definitive treatment start?**

The starting point for this standard is the date that a patient agrees a plan for their treatment. This is recorded as the CANCER TREATMENT PERIOD START DATE and can be populated using the data item DECISION TO TREAT DATE (DTT) as shown in the NHS Data Dictionary.

3.9.3. **What counts as a DTT i.e. is it the date the treatment is agreed with the patient or the date the consent form is signed?**

The DTT is the date the patient agrees a treatment plan. The date the patient signs the consent form may, depending on administrative procedures locally, take place some days after the DTT. It is therefore advised that the face to face (or telephone) meeting where the treatment plan is agreed is classed as the DTT not the date the consent form is signed.

3.9.4. **How will agreement of a treatment plan taken outside the clinic setting e.g. via a phone call be managed?**

The 31-day period starts on the date the care plan was discussed and agreed with the patient. The date could be based on a phone call rather than an appointment if appropriate. Either way the date would be recorded as the CANCER TREATMENT PERIOD START DATE and can be populated from the data item DECISION TO TREAT DATE from the data dictionary.
3.9.5. Can a DTT date be changed?

Yes. If a patient decides they do not want the treatment originally agreed (which the DTT applies to) and therefore a different treatment is discussed and agreed then agreement for the treatment the patient goes on to have would be the new DTT i.e. for the 31 day standard the DTT could be reset but, as it is the patient's first treatment, the clock would continue for the 62 day standard.

For example, if a patient is offered surgery and is given a To Come In (TCI) date & then decides that they would rather have chemotherapy:

- the surgery did not take place so that 31 day period does not need to be uploaded;
- a new DTT would be set for the chemotherapy and this is classed as the first treatment as the surgery did not take place;
- the DTT is the date that the patient agrees a treatment plan for chemotherapy;
- this would have implications for the 62 day pathway as the clock for this would continue to tick even though the patient changed their mind about surgery.

3.9.6. Why does the 31 day standard start from the decision to treat rather than the diagnosis date?

In some cancers it is common for the diagnosis to take place after first treatment. For example, in testicular cancer, orchidectomy is counted as the first definitive treatment, although definitive diagnosis will be obtained from this operation. The start date for monitoring this standard therefore needs to be the one that is meaningful for patients. The DECISION TO TREAT DATE (recorded as the CANCER TREATMENT PERIOD START DATE) is the date of the consultation in which the patient and clinician agree the treatment plan for first (and/or subsequent) treatments.

3.9.7. What data should be recorded on patients admitted as an emergency prior to surgery now that the system validation has been changed to only allow CANCER TREATMENT PERIOD START DATES that are on or before TREATMENT START DATE (CANCER)?

Some cancer patients are admitted as emergencies and remain as an inpatient until they receive treatment. As the date of admission is counted as the TREATMENT START DATE (CANCER), for surgical interventions the following scenarios should be considered when reporting this activity:

- If a CANCER TREATMENT PERIOD START DATE was determined prior to the emergency admission for the admitted period within which the surgical intervention took place that date should be recorded on the Cancer Waiting Times Database in all instances;
- If the surgical treatment being recorded is a first definitive treatment (CANCER TREATMENT EVENT TYPE 01 or 07) and a DECISION TO ADMIT DATE exists on the hospital PAS and the admission episode was for the condition that the TREATMENT START DATE (CANCER) relates to, then the DECISION TO ADMIT DATE should be recorded as the CANCER TREATMENT PERIOD START DATE and will be on or before the TREATMENT START DATE (CANCER).
• If the surgical treatment being recorded is a first definitive treatment (CANCER TREATMENT EVENT TYPE 01 or 07) and no DECISION TO ADMIT DATE exists on the hospital PAS due to the emergency nature of the admission with the patient having no prior communication with the provider for this condition i.e. no DECISION TO ADMIT DATE exists on PAS, and the admission episode was for the condition that the TREATMENT START DATE (CANCER) relates to, then the CANCER TREATMENT PERIOD START DATE should be the same date as the TREATMENT START DATE (CANCER);

• If the surgical treatment being recorded is a first definitive treatment (CANCER TREATMENT EVENT TYPE 01 or 07) and the original admission was not for the specific condition that the TREATMENT START DATE (CANCER) relates to, then the CANCER TREATMENT PERIOD START DATE should be recorded as the same date as the TREATMENT START DATE (CANCER). This will provide the same output as was generated from the Cancer waiting Times Database prior to the implementation of DSCN 20/2008 as all negative waiting times were previously rounded to zero in the reports; or

• If the surgical treatment being recorded in not the first definitive treatment (CANCER TREATMENT EVENT TYPE is not 01 or 07) and an Earlist Clinically Appropriate Date (ECAD) is being used to populate the field CANCER TREATMENT PERIOD START DATE, the CANCER TREATMENT PERIOD START DATE and the TREATMENT START DATE (CANCER) should be recorded as being the date of admission as it is assumed that the patient became fit for their next activity during the same hospital care spell.

3.9.8. If a patient’s DTT is in the private sector but treatment is in the NHS (by the same clinician they were seeing privately), how do we record this patient?

As the clinician seeing the patient in private practice is the same one that will be treating the patient in the NHS it would not appear a good use of NHS time to have an additional consultation to agree the treatment again. However, as DTT should be reached somewhere along the pathway of care the patient is following whilst in NHS commissioned care, the DTT in this scenario should be the point at which the NHS provider commissioned to provide the treatment is notified that the patient is being transferred back into the NHS and that the clinician has already agreed with the patient the course of action.

3.9.9. When does the 31 day period start for a treatment that can only be provided following an application for funding to the commissioner.

The clock would start at the DECISION TO TREAT DATE for the drug in question (recorded as the CANCER TREATMENT PERIOD START DATE). If an application then has to be made to the commissioner to approve funding of the treatment the 31 day clock has started and would not stop for the commissioner’s decision making process i.e. the commissioner would need to ensure their processes are streamlined to manage the pathway for patients effectively including hearing appeals etc.

3.9.10. Is it acceptable to instruct providers not to seek treatment decisions from patients (for non-routinely funded treatments) without first seeking prior approval from the commissioner?
No. This is not reasonable or in the best interest of the patient. It would appear to be a policy aimed at avoiding starting the 31 day clock at the appropriate time rather than ensuring speedy decisions are made related to patient treatment options.

If a clinician discusses a particular drug/treatment with a patient, informs them that they would need to apply for funding if they were to proceed and the patient agrees that they would like to try this treatment then the DTT has been reached i.e. there should be a DTT before an application to the commissioner. If there isn’t then any application being made to the commissioner is for a treatment a patient has not agreed.

The focus should be on streamlining the commissioner’s process for considering applications and appeals not seeking ways to delay the clock start and potentially provide an inferior and uncoordinated service to patients as a result.

3.9.11. Where does the 31 day standard for a first definitive treatment end?

The end point for this standard is the first definitive treatment. This is recorded as the TREATMENT START DATE (CANCER). This start date differs slightly for different treatments. For example, it would be:

- the date the patient is admitted for an operation, for surgery – CANCER TREATMENT MODALITY code 01;
- the date the first drug in an agreed course is given, for ‘anti-cancer drug regimen (cytotoxic chemotherapy)’ – CANCER TREATMENT MODALITY code 02
- the date the first fraction is given, for teletherapy (beam radiation excluding proton therapy) – CANCER TREATMENT MODALITY code 05.

3.9.12. Will end dates for treatments be collected?

No. There is no central requirement to collect end of treatment courses/episodes or discharge dates for cancer treatment within the CWT-Db.

3.9.13. What is the end date of the First Definitive Treatment if treatment is self-administered?

The TREATMENT START DATE (CANCER) should be recorded as the date of the outpatient appointment where the patient is given the prescription.

3.9.14. What is the end date of the First Definitive Treatment if the GP is requested by a hospital specialist to prescribe and manage treatment?

The TREATMENT START DATE (CANCER) is taken to be the date of the GP appointment where the patient is given the prescription. This should be recorded on the CWT-Db under the commissioner provider code. The commissioning organisation will need to be registered as a provider on the CWT-Db, to enable data to be uploaded by them. This needs to be arranged through the Helpdesk on 01392 251289. Plenty of notice needs to be given to arrange registration, and the registered user needs to ensure that their registration is maintained to enable data to be entered.
3.9.15. **What is the position regarding GPs/commissioners uploading data to CWT-Db for drug treatments?**

When a drug treatment is prescribed, the organisation that prescribed it records it. If the patient leaves the hospital with the prescription for the first batch of drugs and is to be supported for the remainder of course at the GP practice it is still the acute provider that should be reporting the treatment activity. If, however, the GP prescribes the treatment or the prescription is sent to the GP for action the commissioner should be recording the activity.

3.9.16. **Does primary care activity/treatment need to be uploaded by GPs/commissioners?**

It is not expected that GP practices will register to be able to use the CWT-Db (unless they are very large) - it is expected that commissioning organisations will register and upload data on behalf of their GPs when appropriate. A commissioner can input on to the CWT-Db if they are registered as a provider of cancer services. They need to get an Organisational Data Services (ODS) code then register to use the CWT-Db. In the first instance a commissioner should contact the Open Exeter helpdesk on 01392 251289 to contact the CWT-Db administrator to discuss this. Alternatively it is possible for NHS Providers to upload on behalf of Commissioners if a formal agreement for them to do so has been entered in to. This would be possible if the commissioner is in the provider code list at the acute Provider. In this case, the acute Provider could enter these data on that organisation's behalf, though it would not appear in the acute provider reports and the commissioner would need to ensure they validate these data somehow as they would be published by DH.

3.9.17. **If funding for a treatment is initially denied but then granted on appeal would it have to be given to a patient within the 31-day standard?**

Yes, it should be delivered within 31 days of the DECISION TO TREAT DATE.

3.9.18. **If a commissioner declines to fund a specific treatment (and there is no appeal) how do we mark the end of that 31 day period?**

You don’t need to end the 31 day period for the central upload as no treatment took place. If you wish to close the record locally you can – how you do it is for local determination.

3.9.19. **If a commissioner declines to fund a specific treatment (and there is no appeal) would a new decision to treat for an alternative treatment and hence a new 31 day period be started?**

Yes. The change to treatment would not be counted as part of the same 31 day period as that period did not end with a treatment. The 31 day clock would re-start once a new DECISION TO TREAT DATE for an alternative treatment is made (this would be recorded as the CANCER TREATMENT PERIOD START DATE). However, the clock for the 62 day period (if applicable) would continue until a treatment takes place (i.e. until there is a TREATMENT START DATE (CANCER)).

3.9.20. **Will you collect end dates for treatments?**

No. There is no central requirement to collect discharge dates following cancer treatment episodes.
3.9.21. How do you record when a patient dies before treatment?

You would not upload records for this patient as a treatment did not take place – local systems will, however, need to be able to flag a patient death and forward this information to cancer registries.

3.9.22. What happens if the optimal mode of treatment is not available within the 31 or 62 day timescale?

The clock cannot stop to take account of capacity issues.

3.9.23. There are various types of primary “treatment package” that patients may receive - what is classed as “first definitive treatment” (FDT) for these different options?

Examples of what should be classed as first definitive treatments for different treatment packages follow:

- **Single treatment modality** – FDT is the start of the treatment aimed at removing or eradicating the cancer completely or at reducing tumour bulk;

- **Combination of anti-cancer treatments** – For the purposes of the cancer waits dataset, combined treatments are: treatments of different modalities combined in a way that they must be scheduled to take place together. These should be regarded as single treatment package. Example of combined treatment include: chemoradiotherapy (where radiotherapy and chemotherapy are delivered within a strict schedule so that they interact to make both treatments more effective) or pre-operative or 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. For a combined treatment, FDT is the start date of the first of these modalities to be delivered. If two interventions are delivered on the same date the treatment that should be recorded is the modality that was chronologically first;

- **Interventions prior to anti-cancer** treatments (ie. enabling treatments) – the date of interventions prior to the delivery of the anti-cancer treatment(s) which do not themselves affect the cancer but form part of the planned “treatment package” and enable treatment to be carried out safely can be classed as FDT in two circumstances:
  - where surgery is the planned first treatment and the ‘enabling intervention’ is taking place as part of the same admitted care episode as the surgery;
  - where they are enabling interventions listed as FDTs in cancer waits guidance which was issued prior to the operational standards being calculated (version 5):
    - colostomy for bowel obstruction;
    - insertion of oesophageal stent;
    - Non Small Cell Lung Cancer (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. Also, if the stent is needed because of the patient’s wait for treatment it cannot be classed as FDT.

- **Referrals to a specialist palliative care (SPC) team** – for patients referred specifically to a SPC team and with no specific anti-cancer treatment planned, the date of the first assessment by a member of the SPC team is the date of FDT. This includes patients referred for possible anti-cancer treatment but found unsuitable and so receive SPC only;
• **Anti-cancer treatments prior to palliative care** – for patients who will receive both anti-cancer treatment and a SPC assessment, the date of the anti-cancer treatment is the FDT;

• **No anti-cancer treatments or referral to SPC team** – patients receiving symptomatic support/palliative interventions without anti-cancer treatments and/or being monitored only (Active Monitoring)". The FDT is the consultation date on which this plan of care (including any intervals between assessments) is agreed with the patient. This includes patients with early cancer (e.g. localised prostate cancer where serial monitoring of PSA is undertaken) and those with advanced cancers for which no immediate specific interventions are considered to be warranted but who may require general palliative care including symptom control given under the care of GPs and/or oncologists.

### 3.9.24.  In which circumstances do different treatments apply as First Definitive Treatments?

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 (e.g. pain relief), which should be recorded for these purposes. Some examples follow:

<table>
<thead>
<tr>
<th>CANCER TREATMENT MODALITY</th>
<th>Circumstances where this applies as FDT</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 Surgery</td>
<td>• Complete excision of a tumour;</td>
</tr>
<tr>
<td></td>
<td>• Partial excision/debulking of a tumour (but not a biopsy for diagnostic or staging purposes unless it effectively removed the tumour even if margins are not clear);</td>
</tr>
<tr>
<td></td>
<td>• Palliative surgical interventions where no active treatment is planned to follow (e.g. formation of a colostomy for a patient with an obstructing bowel cancer, insertion of an oesophageal stent or pleurodesis).</td>
</tr>
<tr>
<td>02 Anti-Cancer Drug Regimen (Cytotoxic Chemotherapy)</td>
<td>• Chemotherapy (including prior to planned surgery/radiotherapy);</td>
</tr>
<tr>
<td>03 Anti-Cancer Drug Regimen (Hormone Therapy)</td>
<td>• Biological therapy including treatments targeted against a specific molecular abnormality in the cancer cell (e.g. rituximab, trastuzumab, imatimib) and treatments which target the immune system (e.g. interferon, interleukin 2, BCG);</td>
</tr>
<tr>
<td>14 Anti-Cancer Drug Regimen (Other)</td>
<td>• Hormone treatments where:</td>
</tr>
<tr>
<td>15 Anti-Cancer Drug Regimen (Immunotherapy)</td>
<td>- Given as the sole treatment modality;</td>
</tr>
<tr>
<td></td>
<td>- Treatment plan specifies that a second treatment modality should only be given after a planned interval e.g. patients with locally advanced breast or prostate cancer may be given hormone therapy for a planned period to shrink the tumour before surgery or radiotherapy</td>
</tr>
<tr>
<td></td>
<td><em>It is not acceptable to use Hormone Therapy as a means to end a 62 day period if the initial choice of first definitive treatment is not available within the standard time due to capacity problems.</em></td>
</tr>
<tr>
<td>05 Teletherapy (Beam radiation excluding proton therapy)</td>
<td>• Given either to the primary site or to treat metastatic disease with an unknown primary.</td>
</tr>
<tr>
<td>06 Brachytherapy</td>
<td>• Given either to the primary site or to treat metastatic disease with an unknown primary.</td>
</tr>
<tr>
<td>07 Specialist Palliative</td>
<td>• Specialist Palliative Care (SPC) when no active treatment is planned</td>
</tr>
</tbody>
</table>
Care given via:
- Hospital SPC teams
- Community SPC teams
- Hospices – 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.

08 Active Monitoring (Excluding Non-Specialist Palliative Care)

• Active monitoring is not a substitute for patient ‘thinking time’. It 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/ may be required at a future date. 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. The patient would have to agree that they were choosing to be actively monitored for a period of time rather than receive alternative treatment. This treatment type may be used for any tumour site if appropriate and it would start on the date of the consultation where this plan of care was agreed with the patient.

*It is not acceptable to use this option as a means to end a 62 day period if the initial choice of first definitive treatment is not available within the standard time due to capacity problems, patient choice or fitness.*

09 Non-Specialist Palliative Care (Excluding Active Monitoring)

• For patients with advanced cancer who require general palliative care and no further active treatment is planned.

3.9.25. Is a list held nationally of the procedures that we should expect to be included in the treatments we track for a 31 day period?

There is no nationally held list. In effect anything falling within the scope of the data item CANCER TREATMENT MODALITY could be classed as a first definitive treatment and this includes the option ‘other’ so it can also include things that are not on that list.

3.9.26. How should treatments using new technologies be recorded?

If there is not a category appropriate for a new technology, it should be recorded under CANCER TREATMENT MODALITY as Code 23 (Other Treatment). If you are not sure about how a treatment undertaken using a new technology should be coded or if you are aware of new treatments coming on line that would need a new code in the future please contact cancer-waits@dh.gsi.gov.uk.

3.9.27. Would a treatment that takes place in a second provider be a shared activity with the referring provider?
No. A 31 day standard is not a shared activity. It is an activity of the treating Provider and it is this Provider that would be responsible for any breaches of the standard.

**Diagnostics**

**3.9.28. Can diagnostic procedures be counted as First Definitive Treatment?**

A diagnostic procedure `undertaken as therapeutic in intent (i.e. the intention is to remove the tumour) will count as FDT, irrespective of whether the margins were clear.

A purely diagnostic procedure (including biopsy) does not count as a FDT unless the tumour is effectively removed by the procedure. If the intention was diagnostic but the excised tissue was found to be malignant the procedure could count as FDT if the tumour had effectively been removed by the excision.

**3.9.29. Is Sentinel Node Biopsy classed as First Definitive Treatment?**

No. This is a staging procedure and does not count as FDT.

**Enabling Treatments**

**3.9.30. What enabling treatments can be classed as FDTs (and thus end the 62 day period)?**

The enabling treatments that can be classed as FDTs are:

- colostomy for bowel obstruction;
- insertion of oesophageal stent;
- non small cell lung cancer (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. Also, if the stent is needed because of the patient’s wait for treatment it cannot be classed as FDT.

Other enabling treatments can only mark the end of the 62 day 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.
3.9.31. Why are such a small number of enabling treatments classed as FDTs?

We recognise that there are a number of enabling treatments that are carried out prior to active treatment. The majority of these were not been able to be classed as first definitive treatments in the past because 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.

Under the old cancer waits rules (DSCN 22/2002) a small number of enabling treatments could be classed as FDTs. These are set out in the question above. Other enabling treatments (for example dental extraction prior to radiotherapy) would have been classed as medical suspensions and adjustments used.

When DH calculated the revised operational standards it took into account the level of medical suspensions previously uploaded onto the CWT-Db. The new operational standards therefore allow for the likely volume of breaches due to enabling treatments needed prior to FDT that were not allowed as FDTs previously.

The last list of enabling treatments set out in national guidance (v5) prior to DH producing the operational standards continue to be allowed as FDTs (see list above). In addition, enabling treatments can mark the end of the 62 day period where a patient is having these prior to surgery if the enabling treatment takes place within the same hospital provider spell as the surgery.

Any other enabling treatments are not classed as FDTs and the revised operational standards take this into account.

3.9.32. What do we do if we think an enabling treatment is being used differently to when the operational standard was set?

In exceptional circumstances DH might consider a particular enabling treatment again. Details would need to be sent to cancer-waits@dh.gsi.gov.uk setting out the procedure in question, what it is used for, how often and why its use has changed significantly since the publication of the current operational standards.

Surgery

3.9.33. Would “open and close” surgery count as a First Definitive Treatment?

A small number of patients will undergo open and close surgery which does not result in the removal of the tumour (for example surgery on the lung, which does not resect the lung). Although this does not remove the tumour this should still be counted as FDT as the procedure is intended to be “anti-cancer”, despite the outcome not being successful.

3.9.34. Is debulking of a tumour mass classed as first treatment?

Debulking is a substantive cancer intervention and could count as the first treatment.
3.9.35. Is stenting classed as surgery?

Yes. Stenting should be recorded as surgery but not all stenting can be classed as FDT (see sections on enabling treatments & palliative care). The cancer waiting times dataset will not tell us whether the surgery is curative, or palliative in intent, or what the actual intervention was. Providers and networks may want to record the intention of the surgery or the OPCS-4 code of the procedure on local systems, but that is beyond what is required nationally to monitor waiting times.

3.9.36. Does clearing a stent of tumour count as a treatment?

If this procedure could be classed as 'debulking' the tumour, then yes it would be classed as a treatment (most likely a subsequent treatment).

3.9.37. Does lymph node excision count as first treatment?

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

3.9.38. If a surgery is started and has to be abandoned because the patient becomes too ill to continue, could it still be counted as first treatment?

If the surgery had commenced but it had to stop then yes it would still be the FDT. However, if the patient is admitted for surgery and becomes ill prior to the surgery being carried out it is different. To be classed as the FDT the admission has to be for the episode of care that ended with the treatment that stopped the 31 day or 62 day period. If the patient did not get to the treatment because they were taken ill prior to having the agreed treatment then the clock would continue until the patient is able to be treated.

3.9.39. How are transplants handled for cancer waits?

When the agreed treatment for a cancer is a transplant the DECISION TO TREAT would be when the patient agrees the care plan that includes the transplant and the TREATMENT START DATE (CANCER) would be the date the patient is added to the transplant list. For the purposes of monitoring the 62-day standards a transplant should only be considered first treatment if no other active anti-cancer treatment is given in the interim. [Note: previous advice had been that the DECISION TO TREAT would be when a donor had been found and the patient agreed to proceed with the procedure and the TREATMENT START DATE (CANCER) was the admission date for surgery.]

Palliative care (incl. hospices)

3.9.40. What is Specialist Palliative Care?

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

3.9.41. What is Non-specialist Palliative Care (excluding Active Monitoring)?

This is palliative care (excluding Active Monitoring) that is not given under the management of a consultant specialising in palliative medicine.
3.9.42. **How do we record data where patients are treated in a hospice?**

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.

3.9.43. **Is specialist palliative care in hospices excluded from cancer waiting times if carried out by a non-NHS provider?**

The CWT-Db is not able to capture data from non-NHS Hospices as they do not have an N3 connection or an ODS site code and (most importantly) are not subject to DSCN 20/2008. It is estimated that approximately 20% of patients diagnosed do not receive first treatment within an NHS provider for various reasons which include: the local specialist palliative care service being non-NHS, the patient electing to follow private treatment options or the patient passing away before treatment can be administered. However, there are some instances where these services should be recorded:

- if the voluntary provider is sub-contracted to provide the service by an NHS organisation that has been commissioned to provide the care. In this case the commissioned organisation should report the activity, with the start date being the initial consultation (if available) or the referral to the voluntary service (if the consultation date is not available);
- if the service commissioned is a joint venture between the NHS provider and a voluntary provider the activity should be recorded by the NHS stakeholder with the start date being the initial consultation;
- If the activity is commissioned from the voluntary sector by the NHS and the contract includes the requirement for the voluntary provider to provide the regular NHS datasets, e.g. CDS, waits dataset etc. In these instances we would have expected the voluntary organisation to have made arrangements to pass these data back to the commissioning authority for processing with the start date being the initial consultation;
- if the consultant caring for the patient in the voluntary service is providing the service as outreach, the employing NHS organisation would record these statistics as per their normal practices.

Patients treated under these scenarios are going to be in the minority and most care in voluntary providers remain outside the scope of this data collection as it is not commissioned by the NHS.

3.9.44. **How are individual supportive care packages recorded?**

For the purposes of monitoring the 31-day subsequent treatment standards, supportive packages of care (ie. palliation of symptoms, symptomatic support etc) are to be considered as the whole. This means that whilst a patient may be receiving a range of care (e.g. transfusions, pain relief 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.

The recording of NHS supportive care provision will remain the responsibility of the organisation commissioned to provide that care, unless there is a local agreement in place for this activity to be recorded by another organisation.
3.9.45. How should we record the use of supportive care drugs on the CWT-Db?

Supportive care drugs alone are not considered a FDT unless a patient is receiving palliative care only (of which these drugs are part) and no active treatment is planned.

3.9.46. Can pain relief be counted as a FDT?

Such palliative care can only be classed as FDT (and therefore stop the clock) if no further treatment is planned.

3.9.47. Is palliative chemotherapy or palliative radiotherapy or palliative surgery classed as palliative care?

No. For cancer waiting times, palliative treatments (surgery, radiotherapy or anti-cancer drug regimens) should be recorded using the specific CANCER TREATMENT MODALITY code (eg. code 01 - surgery, code 05 - teletherapy etc) and not identified as palliative care generally.

Active Monitoring

3.9.48. What is Active Monitoring in terms of cancer waits?

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/ may be required at a future date. 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. A patient would have to agree that they are choosing to be actively monitored for a period of time rather than receive alternative 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 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.

3.9.49. If a decision is made to monitor the progress of a patient for a few months as cancer is suspected but still not confirmed can active monitoring be used?

No. For cancer waits, active monitoring is a legitimate treatment option for a confirmed cancer. In this scenario the patient has not received a confirmed diagnosis of cancer so active monitoring would not be a treatment option. This scenario is one of diagnostic uncertainty. The 62 period remains open and the patient will breach if cancer goes on to be confirmed. The operational standard for the 62 day standard has been revised to take into account that more patients will breach due to clinical reasons.
3.9.50. **How long can a patient have for thinking time before is is classed as ‘Active Monitoring’?**

There is no definitive answer for this. It depends on the individual scenario and why you would be considering using active monitoring. For example:

- if a patient has been offered invasive surgery and they want to take some time to think about this before confirming they wish to go ahead with the surgery this is thinking time not active monitoring;
- if a patient and clinician agree that the patient’s symptoms are not severe at the moment and so the patient does not want surgery at this stage and a review appointment is agreed for 3 months time then that could be active monitoring.

3.9.51. **A patient is on the 62 day period and is diagnosed with another condition which needs treating/resolving before cancer treatment can be given - can Active Monitoring be used for the cancer?**

In this scenario active monitoring is not appropriate. This would previously have been a medical suspension. We are now handling this differently. Instead of pausing the clock, the clock will continue and the patient will breach but the operational standard has allowed for a proportion of patient breaching as they are not clinically fit to be treated within the standard time.

3.9.52. **Active monitoring – could be abused i.e. used inappropriately to end 31 day/ 62 day periods – how will this be managed?**

Active monitoring is a legitimate recordable treatment. It is not acceptable to use this option as a means to end a 31 or 62 day period where there has been a complex diagnostic pathway or where the preferred choice of treatment is not available within the standard time due to capacity problems. We would expect unusual local or national trends in the use of active monitoring as a treatment to be investigated by SHAs.

**Combined Treatments**

3.9.53. **What do you class as combined treatments?**

For the purposes of the cancer waits dataset, combined treatments are: treatments of different modalities combined in a way that they must be scheduled to take place together. These should be regarded as single treatment package. Example of combined treatment include:

- chemoradiotherapy - where radiotherapy and chemotherapy are delivered within a strict schedule so that they interact to make both treatments more effective (e.g.: weekly 5FU during radiotherapy for rectal cancer, radiotherapy given synchronously with cycle 4 of CMF for breast cancer);

- pre-operative or 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. (e.g.: breast surgery followed by post-operative radiotherapy, chemotherapy for small cell lung cancer followed by consolidation radiotherapy).
3.9.54. Is there a definitive list of what can and can’t be classed as combined treatments?

No - combined treatments are classed as treatments of different modalities combined in a way that they must be scheduled to take place together.

3.9.55. Is Chemoradiotherapy covered by the 31 day subsequent chemotherapy or subsequent radiotherapy standard?

Chemoradiotherapy (code 04) is part of the 31 day radiotherapy standard.

Trials

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

If a patient has agreed to enter a national portfolio clinical trial (a National Institute for Health Research trial) then the trial protocol will determine which treatments are classed as first or subsequent treatments respectively and they will be assigned as such under cancer waits standards. For example:

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

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

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

The CANCER TREATMENT MODALITY for a placebo would be classed as Code 14 ‘anti cancer drug regimen (other)’ for cancer waits reporting purposes assuming it is known which patient had received the placebo instead of another type of anti-cancer drug regimen such as cytotoxic chemotherapy. If it is a blind trial and it is not possible to identify which patient received which type of drug then the ‘anti cancer drug regimen (other)’ category would be used for each drug arm.

3.9.57. Some trials require a prolonged work-up period before treatment can commence. Can any kind of adjustment be used?

No adjustment is possible in this scenario. If you have a significant number of patients entered into such a trial and the work-up genuinely takes a long time then email cancer-waits@dh.gsi.gov.uk for advice.

Treating Metastatic Disease

3.9.58. How should metastatic disease be recorded and reported on?

Treatment of metastatic disease is almost always classed as a subsequent treatment. The exception is treatment of metastatic disease with unknown primary where both first and subsequent treatments can be recorded.
3.9.59. If the primary cancer is identified after the metastatic disease of unknown origin was diagnosed and treated, how would treatment of the primary cancer be reported?

The treatment of the primary cancer would be classed as a subsequent treatment as the patient would no longer be on the 62 day period as they had had their first treatment for metastatic cancer of unknown origin.

3.9.60. If a new primary cancer is diagnosed with metastatic disease and the metastatic disease required treatment first, how should this be recorded?

Treatment of the metastatic disease would be a subsequent treatment and uploaded as such. It does not matter that sequentially it took place before treatment of the primary in terms of the CWT-Db i.e. you do not need to upload the treatment records sequentially. The 62 day clock would not stop at treatment of the metastatic disease as this is not treating the primary cancer. The 62 day standard is for new primaries only not recurrence/or metastatic disease. You would upload the treatment for the primary as normal once it had taken place and this would stop the 62 day clock.

3.9.61. Why can’t details of metastatic disease diagnosed at the time of the primary cancer be included on the primary cancer treatment record?

Treatment of metastatic disease is only classed as a subsequent treatment even if sequentially it is treated first. Metastatic disease details cannot be included on the record for the first treatment of a known primary because if metastatic details were included it would not be clear if the treatment being reported on the CWT-Db was for the first treatment of the primary or for the treatment of the metastases. DH is considering whether to revise the system to enable details of metastases to be recorded on the appropriate primary cancer record.

3.9.62. Why can’t treatment of metastases be classed as FDT?

Metastases with a known primary has been out of scope since cancer waits standards were defined in 2000 and remain out of scope for this reporting system. Metastases with a known primary is only monitored under the 31-day standard as a subsequent treatment. The treatment of the primary cancer is the one to which the 62-day standard applies, and is the one that should be coded as the first treatment. Previously there would have been a medical suspension for any delays in the first treatment due to the treatment of metastases, now the operational standard has been adjusted to reflect the unavoidable delay in cases such as these.

Patient Choice

3.9.63. How is First Definitive Treatment recorded for patients who are offered a range of treatments delivered in different hospitals?

The 31 day period would start when the patient decided which of the treatment options to proceed with (DTT) and the start of that treatment would mark the end of that 31 day period. No pauses can apply to thinking time the patient may take or to the time period waited because the patient might have to wait longer to receive one treatment modality among the options given than another, or because the patient might have to wait longer to receive treatment under different Providers offered. Active monitoring is not an acceptable substitute for thinking time about choices.
3.9.64. How should we manage patients who decline an initial treatment, but then later choose to have treatment?

Providing the patient is fully aware of what they have asked for and they know this is not just time to think, then they are making an informed choice to decline all treatment and this would be recorded as Code 98 (all treatment declined) in the CANCER TREATMENT MODALITY field. If the patient later agreed to treatment then this would be a separate 31 day subsequent treatment period.

3.9.65. How do we monitor a patient who agrees a treatment and then later changes their mind and wishes to receive a different treatment altogether?

The patient will have to agree a new decision to treat for a new treatment option and hence the 31 day clock is reset. The 62 day clock (if appropriate) would, however, continue.
3.10. 31 day standard for subsequent treatment

The period for this service standard is as follows:

A combination of treatments would then fit together as follows:
3.10.1. Where does the 31 day period for a subsequent treatment start?

The starting point for this 31 day period (recorded as the CANCER TREATMENT PERIOD START DATE) is either:

- The DECISION TO TREAT DATE (DTT) – i.e. the date that a patient agrees a treatment plan for first or subsequent treatments within a Cancer Care Plan; or,

- The EARLIEST CLINICALLY APPROPRIATE DATE (ECAD) – where there is no new DECISION TO TREAT DATE, but there has been a previously agreed and clinically appropriate period of delay before the next treatment can commence. In this case the subsequent activity may not be the start of the subsequent treatment itself, but could be the next activity that actively progresses a patient along the pathway for that treatment to take place.

**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.*

**Start of 31 day period**

**Decision to Treat**

3.10.2. What counts as a DTT i.e. is it the date the treatment is agreed with the patient or the date the consent form is signed?

The DTT is the date the patient agrees a treatment plan. The date the patient signs the consent form may, depending on administrative procedures locally, take place some days after the DTT. It is therefore advised that the face to face (or telephone) meeting where the treatment plan is agreed is classed as the DTT not the date the consent form is signed.

3.10.3. How will agreement of a treatment plan taken outside the clinic setting e.g. via a phone call be managed?

The 31-day subsequent treatment period starts on the date the care plan was discussed and agreed with the patient. The date could be based on a phone call rather than an appointment if appropriate. Either way the date would be recorded as the CANCER TREATMENT PERIOD START DATE and can be populated from the data items DECISION TO TREAT DATE or EARLIEST CLINICALLY APPROPRIATE DATE from the data dictionary.
3.10.4. Can a DTT date be changed?

Yes. If a patient decides they do not want the treatment originally agreed (which the DTT applies to) and therefore a different treatment is discussed and agreed then agreement for the treatment the patient goes on to have would be the new DTT i.e. for the 31 day standard the DTT could be reset but, as it is the patient’s first treatment, the clock would continue to tick for the 62 day standard.

For example, if a patient is offered surgery and is given a To Come In (TCI) date & then decides that they would rather have chemotherapy:

- the surgery did not take place so that 31 period does not need to be uploaded;
- a new DTT would be set for the chemotherapy and this is classed as the first treatment as the surgery did not take place;
- the DTT is the date that the patient agrees a treatment plan for chemotherapy;
- this would have implications for the 62 day period as the clock for this would continue to tick even though the patient changed their mind about surgery,

3.10.5. If a patient’s DTT is in the private sector but the treatment is in the NHS (by the same clinician they were seeing privately), how do we record this patient?

As the clinician seeing the patient in private practice is the same one that will be treating the patient in the NHS it would not appear a good use of NHS time to have an additional consultation to agree the treatment again. However, as DTT should be reached somewhere along the pathway of care the patient is following whilst in NHS commissioned care, the DTT in this scenario should be the point at which the NHS provider commissioned to provide the treatment is notified that the patient is being transferred back into the NHS and that the clinician has already agreed with the patient the course of action.

3.10.6. When does the 31 day period start for a treatment that can only be provided following an application for funding to the commissioner?

The clock would start at the DECISION TO TREAT DATE or the EARLIEST CLINICALLY APPROPRIATE DATE for that treatment if it is subsequent (recorded as the CANCER TREATMENT PERIOD START DATE). If an application then has to be made to the commissioner to approve funding of the treatment the 31 day clock has started and would not stop for the commissioner’s decision making process i.e. the commissioner would need to ensure their processes are streamlined to manage the pathway for patients effectively including hearing appeals etc.
3.10.7. Is it acceptable to instruct providers not to seek treatment decisions (DTT) from patients (for non-routinely funded treatments) without first seeking prior approval from the commissioner?

No. This is not reasonable or in the best interest of the patient. It would appear to be a policy aimed at avoiding starting the 31 day clock at the appropriate time rather than ensuring speedy decisions are made related to patient treatment options.

If a clinician discusses a particular drug/treatment with a patient, informs them that they would need to apply for funding if they were to proceed and the patient agrees that they would like to try this treatment then the DTT has been reached i.e. there should be a DTT before an application to the commissioner. If there isn’t then any application being made to the commissioner is for a treatment a patient has not agreed.

The focus should be on streamlining the commissioner’s process for considering applications and appeals not seeking ways to delay the clock start and potentially provide an inferior and uncoordinated service to patients as a result.

3.10.8. If funding for a treatment is initially denied but then granted on appeal would it have to be given to a patient within the 31-day period?

Yes, it should be delivered within 31 days of the DECISION TO TREAT DATE or EARLIEST CLINICALLY APPROPRIATE DATE.

ECAD

3.10.9. What is the EARLIEST CLINICALLY APPROPRIATE DATE (ECAD)?

It is the earliest date that it is clinically appropriate for the next activity that actively progresses a patient along the pathway for that treatment to take place. The activity may not always be the start of the treatment itself but could be the next appointment which deals with the planning of that treatment. When determining an ECAD, only patient issues should be considered and not local capacity constraints. Within the CWT-Db, ECAD is an option for the population of the field CANCER TREATMENT PERIOD START DATE which marks the start of a 31 day subsequent treatment period. Examples would be:

- **Patient with rectal cancer is to have radiotherapy then surgery** – after the radiotherapy the patient is not expected to be clinically fit for surgery for 6 weeks so the ECAD would be set for 6 weeks after radiotherapy is complete;

- **Patient with breast cancer is to have surgery then radiotherapy** – the patient would not be fit for planning radiotherapy until they are able to lift their arm over their head – ECAD would be set for when the patient would be fit for radiotherapy planning to start.

3.10.10. Who should set the ECAD?

The member of the consultant team liaising with the patient about the treatment in question would set the ECAD. A mechanism would need to be in place to ensure the treating Provider is aware of this date if the member of the consultant team is employed by another NHS organisation.
3.10.11. When can an ECAD be set?

For patients waiting for subsequent treatments the ECAD can be set at a number of points:

- at the clinical review with the patient following the preceding treatment. If it is not possible to make a decision at the review a further review could be arranged;

- at the start of the preceding treatment if the patient will not be reviewed between treatments;

- at the Multi-Disciplinary Team (MDT) meeting if it is possible to identify the likely ECADs between treatments in an agreed package;

- following receipt of test results and prior to discussing with the patient if this is an appropriate date.

3.10.12. Can an ECAD be reviewed and changed once it has been set?

Yes, as long as the date has not passed. For example, if an ECAD was set for 21 February 2011 but at a clinical review on 26 January it was clear that the patient had not recovered from an operation the ECAD could be put back to 2 March 2011. However, if 21 February had passed and the patient was unwell/unfit it would not be possible to reset the ECAD. Under the previous system a medical suspension would have been possible but under the new system the operational standard for the 31 day standard has been lowered to take into account such circumstances.

3.10.13. What is classed as an ‘activity’ in the context of ECAD?

In the NHS Data Dictionary, ACTIVITY is defined as: “A provision of services to a PATIENT by one or more CARE PROFESSIONALS”. The ECAD relates to the next ACTIVITY that actively progresses a patient pathway, but not to any ACTIVITY that relates to determining a patient’s fitness to continue their care plan.
3.10.14. Does a patient have to be present when an ECAD date is set?

The patient does not have to be physically present on the ECAD date, as it can be set based on an earlier consultation.

*Example 1. ECAD determined at (and set as) date of outpatient attendance – i.e. patient present at ECAD date*

- At this point the patient agrees a care plan of surgery followed by teletherapy
- This is recorded as the admission date for the surgical episode
- This is the ECAD, it is the date the clinician assessed the patient as fit for their next ACTIVITY during an OUTPATIENT ATTENDANCE, in this example the next ACTIVITY is the care planning episode
- This the care planning episode, the ACTIVITY related to the ECAD in this example
- This START DATE of the teletherapy treatment course, and ends the subsequent 31-day pathway
Example 2, ECAD determined at patient outpatient attendance for a date in the future – i.e. patient not actually present at ECAD date:

- **CANCER TREATMENT PERIOD START DATE**
  - At this point the patient agrees a care plan of surgery followed by teletherapy

- **TREATMENT START DATE (CANCER)**
  - This is recorded as the admission date for the surgical episode

- **OUTPATIENT ATTENDANCE**
  - This the "follow-up" outpatient appointment at which the clinician responsible for the care of the patient determines they will be fit to undergo the radiotherapy (teletherapy) planning in one week, and it will therefore be clinically appropriate from that point.

  - One Week

- **TREATMENT START DATE (CANCER)**
  - This is the ECAD, it is the date the clinician determined the patient would be fit for the care planning, which is their next ACTIVITY in this example.

  - 31 Days

- **OUTPATIENT ATTENDANCE**
  - This the care planning episode, the ACTIVITY related to the ECAD in this example

- **TREATMENT START DATE (CANCER)**
  - This START DATE of the teletherapy treatment course, and ends the subsequent 31-day pathway

3.10.15. **What is the difference between ECAD under the new rules and a medical suspension used under the old rules (pre 01 January 2009) ?**

A medical suspension was the time taken out of a calculated time on a waiting list i.e. the clock had started and was then paused. ECAD means the patient is not clinically fit to be on a waiting list in the first place i.e. the clock has not started because they are not yet fit to undergo the next activity on their care pathway.
End of 31 day period

3.10.16. Where does the 31 day period for a subsequent treatment end?

The end point for this standard is the date of the subsequent treatment. This is recorded as the TREATMENT START DATE (CANCER). This start date may differ slightly for different treatments. For example, it would be:

- the date the patient is admitted for an operation, for surgery – CANCER TREATMENT MODALITY code 01;
- the date the first drug in an agreed course is given, for ‘anti-cancer drug regimen (cytotoxic chemotherapy)’ – CANCER TREATMENT MODALITY code 02;
- the date the first fraction is given, for teletherapy (beam radiation excluding proton therapy) – CANCER TREATMENT MODALITY code 05.

3.10.17. If a commissioner declines to fund a specific treatment (and there is no appeal) how do we mark the end of that 31 day period?

You don’t need to end the 31 day period for the central upload as no treatment took place and no treatment was declined by the patient. If you wish to close the record locally you can – how you do it is for local determination.

3.10.18. If a commissioner declines to fund a specific treatment (and there is no appeal) would a new DTT or ECAD for an alternative treatment and hence a new 31 day period start?

Yes. The change to treatment would not be counted as part of the same 31 day period as that period did not end with a treatment. The 31 day clock would re-start once a new DECISION TO TREAT DATE or EARLIEST CLINICALLY APPROPRIATE DATE for an alternative treatment is made( this would be recorded as the CANCER TREATMENT PERIOD START DATE.

3.10.19. Will you collect end dates for treatments?

No. There is no central requirement to collect discharge dates for cancer treatment episodes within this dataset.

3.10.20. How do you record when a patient dies before treatment?

You would not upload records for this patient as a treatment did not take place – local systems will, however, need to be able to flag a patient death and forward this information to cancer registries.

3.10.21. What if the optimal mode of subsequent treatment is not available within the 31 day timescale?

The clock cannot stop to take account of capacity issues.
3.10.22. Where the first treatment is showing as commenced but there are no treatment details, how are subsequent treatments recorded?

Subsequent treatments are individual 31 day periods. It is therefore possible to upload details for a 31 day subsequent treatment period even if the details for the first treatment period have not been entered onto the CWT-Db.

Subsequent treatments

3.10.23. Which patients can be on a 31 day subsequent treatment pathway?

All patients with ICD codes C00-97 (excl. basal cell carcinoma) or D05 (carcinoma in situ – breast) This includes children and patients with recurrent cancer.

3.10.24. What is classed as a subsequent treatment for the purposes of this standard?

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;

• symptomatic support by non-specialist palliative care teams where no active cancer treatment planned;

• active monitoring (where no active or palliative treatment is appropriate).

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

The 31 day subsequent treatment standards do not cover follow on treatments that are not directly related to shrinking or delaying growth/spread of the cancer (e.g. closure of stomas, reconstructive surgery following initial surgery, rehabilitative and psychological services etc). These follow-on treatments are clearly important to the overall package of care a patient receives and can make a huge difference to quality of life and patient experience. Timely delivery is therefore important but will not be monitored centrally.

3.10.25. Is a list held nationally of the procedures that can be counted as a subsequent treatment?

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.
3.10.26. **Is there a limit to the number of subsequent treatments that need to be recorded?**

There is no limit. All subsequent treatments for primary and recurrent cancer need to have a 31 day period recorded. However, it should be noted that supportive packages of care (i.e. palliation of symptoms, symptomatic support etc) are to be considered as the whole. This means that whilst a patient may be receiving a range of care (e.g. transfusions, pain relief 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.

3.10.27. **Do subsequent treatments in primary care need to be uploaded by GPs/commissioners?**

It is not expected that GP practices will register to be able to use the CWT-Db (unless they are very large) - it is expected that commissioners will register and upload data on behalf of their GPs when appropriate. A commissioner can input on to the CWT-Db if they are registered as a provider of cancer services. They need to get an Organisational Data Services (ODS) code [formally called a NACS code – National Administrative Code Service] to register to use the CWT-Db. In the first instance a commissioner should contact the Open Exeter helpdesk on 01392 251289 to contact the CWT-Db administrator to discuss this. Alternatively it is possible for NHS Providers to upload on behalf of commissioners if a formal agreement for them to do so has been entered into. This would be possible if the commissioner is in the provider code list at the acute Provider. In this case, the acute Provider could enter these data on that organisation's behalf, though it would not appear in the acute provider reports and the commissioner would need to ensure they validate these data somehow as they would be published by DH.

3.10.28. **Would a subsequent treatment that takes place in a second provider be a shared activity with the referring Provider?**

No. A 31 day standard is not a shared activity. It is an activity of the treating Provider and it is this Provider that would be responsible for any breaches of the standard.

3.10.29. **Do subsequent treatments have to be linked back to the initial referral (which could be years back, especially for a recurrence)?**

No. Each subsequent treatment will be a new 31 day period starting at DTT or ECAD. The cases could be linked by the NHS number locally if desired for audit or trend analysis but this is not an automatic link and is not required nationally.

3.10.30. **How long should patient records be kept open in order to take into account possible recurrences and therefore the need for subsequent treatments in the future?**

Indefinitely. Records are not closed. There can be multiple 31 day periods over a number of years each starting with a new DECISION TO TREAT DATE or an EARLIEST CLINICALLY APPROPRIATE DATE (recorded as the CANCER TREATMENT PERIOD START DATE). A process needs to be in place locally to ensure that patients needing a subsequent treatment
are identified and tracking re-starts. Different models may be needed to capture information on patients with different cancer types and/or requiring different modalities of treatment.

3.10.31. Do subsequent treatments (2\textsuperscript{nd}, 3\textsuperscript{rd}, 4\textsuperscript{th} etc) need to be uploaded sequentially?

The system does not automatically number subsequent treatments because, for example, Provider A might upload data to the CWT-Db after Provider B. Providers can capture the sequence locally if they wish (i.e. from the date each subsequent treatment started) but there is no need to capture it nationally.

\textit{Drug Treatment}

3.10.32. What is the position regarding GPs/commissioners uploading data to CWT-Db for subsequent drug treatments?

When a drug treatment is prescribed, the organisation that prescribed it records it. If the patient leaves the hospital with the prescription for the first batch of drugs and is to be supported for the remainder of course at the GP practice it is still the acute provider that should be reporting the treatment activity. If, however, the GP prescribes the treatment or the prescription is sent to the GP for action the commissioner should be recording the activity.

3.10.33. What is classed as chemotherapy for the 31 day subsequent standard?

For the purposes of this standard, chemotherapy is classed as drug treatments coded in the CANCER TREATMENT MODALITY field as:

- anti-cancer drug regimen (cytotoxic chemotherapy) – code 02
- anti-cancer drug regimen (hormone therapy) – code 03
- anti-cancer drug regimen (other) – code 14
- anti-cancer drug regimen (immunotherapy) – code 15

3.10.34. Is each chemotherapy cycle counted as a subsequent treatment?

No. A course of chemotherapy is counted as a subsequent treatment not each cycle within that course.

3.10.35. Would a change in drug type within chemotherapy be classed as a subsequent treatment?

If you are modifying a regimen during the course then the same 31 day standard could apply if it was decided to make a change to a drug mix but the treatment was carrying on uninterrupted. A change in drugs would be classed as a subsequent treatment if it was classed as a different course. However, we need to be pragmatic about this. 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 started.

3.10.36. Is palliative chemotherapy part of the 31 day subsequent chemotherapy standard or is it classed as ‘other’ treatment?

Palliative chemotherapy should be classed as chemotherapy rather than palliative care more generally. It is therefore included within the 31 day subsequent chemotherapy standard.
3.10.37.  Is Chemoradiotherapy covered by the 31 day subsequent chemotherapy or subsequent radiotherapy standard?

Chemoradiotherapy (CANCER TREATMENT MODALITY code 04) is part of the 31 day radiotherapy standard.

Radiotherapy

3.10.38.  What radiotherapy is covered by the 31 day subsequent treatment standard?

For the purposes of this standard, radiotherapy will be classed as treatments coded in the CANCER TREATMENT MODALITY field as:

- chemoradiotherapy – code 04
- teletherapy (beam radiation excluding proton therapy) – code 05
- brachytherapy – code 06
- proton therapy – code 13

3.10.39.  Is palliative radiotherapy under the 31 day subsequent radiotherapy standard or is it classed as ‘other’ treatment?

Palliative radiotherapy should be classed as radiotherapy rather than palliative care more generally. It is therefore included within the 31 day subsequent radiotherapy standard.

Surgery

3.10.40.  Which data item codes are covered by the 31 day subsequent treatment (surgery) standard?

Only code 01 (surgery) is covered by this standard. Everything else related to surgery (eg. cryotherapy) will be considered to be ‘other’ treatments.

3.10.41.  What are classed as subsequent treatments for surgery?

Curative or palliative surgery (Code 01) aimed at shrinking or delaying growth/spread of the tumour/ cancer can be classed as subsequent surgery. Surgery that is not directly related to shrinking or delaying growth/spread of the cancer (e.g. closure of stomas, reconstructive surgery following initial surgery) is not covered by this standard.

3.10.42.  Does a second excision/wide local excision count as a subsequent treatment even if no further tumour is found/margins are clear?

Yes – provided that the first excision was a form of treatment and not just a biopsy for diagnostic purposes only.

3.10.43.  If margins are clear but a surgeon decides to operate to extend the margins further is this classed as a subsequent treatment?

Yes
3.10.44. Is stenting classed as surgery?

Yes. Stenting should be recorded as a form of surgery if the scenario for its use is applicable for the 31 day standard.

3.10.45. Does clearing a stent of tumour count as a treatment?

If this procedure could be classed as 'debulking' the tumour, then yes it could be classed as a subsequent treatment.

3.10.46. If a surgery is started and has to be abandoned because the patient becomes too ill to continue, could it still be counted as a subsequent treatment?

If the surgery had commenced but it had to stop then yes it would still be the subsequent treatment. However, if the patient is admitted for surgery and becomes ill prior to the surgery being carried out it is different. To be classed as the subsequent treatment the admission has to be for the episode of care that ended with the treatment that stopped the 31 day or 62 day period. If the patient did not get to the treatment because they were taken ill prior to having the agreed treatment then the clock would continue until the patient is able to be treated.

3.10.47. How are transplants handled for cancer waits?

When the agreed treatment for a cancer is a transplant the DECISION TO TREAT would be when the patient agrees the care plan that includes the transplant and the TREATMENT START DATE (CANCER) would be the date the patient is added to the transplant list. [Note: previous advice had been that the DECISION TO TREAT would be when a donor had been found and the patient agreed to proceed with the procedure and the TREATMENT START DATE (CANCER) was the admission date for surgery.]

3.10.48. Is palliative surgery under the 31 day subsequent surgery standard or is it classed as 'other' treatments?

Palliative surgery should be classed as surgery rather than palliative care more generally. It is therefore recorded within the 31 day subsequent surgery standard.

3.10.49. What data should be recorded on patients admitted as an emergency prior to surgery now that the system validation has been changed to only allow CANCER TREATMENT PERIOD START DATES that are on or before TREATMENT START DATE (CANCER)?

Some cancer patients are admitted as emergencies and remain as an inpatient until they receive treatment. As the date of admission is counted as the TREATMENT START DATE (CANCER), for surgical interventions the following scenarios should be considered when reporting this activity:

- If a CANCER TREATMENT PERIOD START DATE was determined prior to the emergency admission for the admitted period within which the surgical intervention took place that date should be recorded on the Cancer Waiting Times Database in all instances;
- If the surgical treatment being recorded is a first definitive treatment (CANCER TREATMENT EVENT TYPE 01 or 07) and a DECISION TO ADMIT DATE exists on the hospital PAS and the admission episode was for the condition that the
TREATMENT START DATE (CANCER) relates to, then the DECISION TO ADMIT DATE should be recorded as the CANCER TREATMENT PERIOD START DATE and will be on or before the TREATMENT START DATE (CANCER);

- If the surgical treatment being recorded is a first definitive treatment (CANCER TREATMENT EVENT TYPE 01 or 07) and no DECISION TO ADMIT DATE exists on the hospital PAS due to the emergency nature of the admission with the patient having no prior communication with the provider for this condition i.e. no DECISION TO ADMIT DATE exists on PAS, and the admission episode was for the condition that the TREATMENT START DATE (CANCER) relates to, then the CANCER TREATMENT PERIOD START DATE should be the same date as the TREATMENT START DATE (CANCER);

- If the surgical treatment being recorded is a first definitive treatment (CANCER TREATMENT EVENT TYPE 01 or 07) and the original admission was not for the specific condition that the TREATMENT START DATE (CANCER) relates to, then the CANCER TREATMENT PERIOD START DATE should be recorded as the same date as the TREATMENT START DATE (CANCER). This will provide the same output as was generated from the Cancer waiting Times Database prior to the implementation of D SCN 20/2008 as all negative waiting times were previously rounded to zero in the reports; or

- If the surgical treatment being recorded in not the first definitive treatment (CANCER TREATMENT EVENT TYPE is not 01 or 07) and an Earliest Clinically Appropriate Date (ECAD) is being used to populate the field CANCER TREATMENT PERIOD START DATE, the CANCER TREATMENT PERIOD START DATE and the TREATMENT START DATE (CANCER) should be recorded as being the date of admission as it is assumed that the patient became fit for their next activity during the same hospital care spell.

**Other treatment**

3.10.50. What are classed as ‘other’ treatments in terms of a subsequent treatment 31 day period?

This includes palliative care, active monitoring and anything else that doesn't come under surgery, radiotherapy or drug treatments, for example, light therapy.

**Palliative care (incl. hospices)**

3.10.51. What is Specialist Palliative Care?

This is palliative care delivered under the management of a consultant in palliative medicine.
3.10.52. What is Non-specialist Palliative Care (excluding Active Monitoring)?

This is palliative care (excluding active monitoring) that is not given under the management of a consultant in palliative medicine.

3.10.53. Once a patient has been referred for palliative care, do any subsequent support treatments need to be collected for the purpose of CWT standards?

Possibly. For the purposes of monitoring the 31-day subsequent treatment standards, supportive packages of care are to be considered as the whole. This means that whilst a patient may be receiving a range of palliative treatments, if it is a single agreed package then the start of the package of care should be taken:

- as the 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 etc.

However, it is possible that additional palliative care/support might be agreed after/in addition to this package. That could count as a new 31 day period.

3.10.54. How are individual supportive care packages recorded?

For the purposes of monitoring the 31-day subsequent treatment standards, supportive packages of care (ie. palliation of symptoms, symptomatic support etc) are to be considered as the whole. This means that whilst a patient may be receiving a range of care (e.g. transfusions, pain relief 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.

The recording of NHS supportive care provision will remain the responsibility of the organisation commissioned to provide that care, unless there is a local agreement in place for this activity to be recorded by another organisation.

3.10.55. Is palliative chemotherapy, palliative radiotherapy or palliative surgery classed as palliative care for cancer waits standards?

Palliative treatments (surgery, radiotherapy or anti-cancer drug regimens) should be classed as the treatment in question ie. surgery etc rather than palliative care generally.

In terms of supportive packages of care (excluding 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.
3.10.56. How do we record data where patients are treated in a hospice?

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.

3.10.57. Is specialist palliative care in hospices excluded from cancer waiting times if carried out by a non-NHS provider?

The CWT-Db is not able to capture data from non-NHS Hospices as they do not have an N3 connection or an ODS site code and (most importantly) are not subject to DSCN 20/2008. It is estimated that approximately 20% of patients diagnosed do not receive first treatment within an NHS provider for various reasons which include: the local specialist palliative care service being non-NHS, the patient electing to follow private treatment options or the patient passing away before treatment can be administered. However, there are some instances where these services should be recorded:

- if the voluntary provider is sub-contracted to provide the service by an NHS organisation that has been commissioned to provide the care. In this case the commissioned organisation should report the activity, with the start date being the initial consultation (if available) or the referral to the voluntary service (if the consultation date is not available);

- if the service commissioned is a joint venture between the NHS provider and a voluntary provider the activity should be recorded by the NHS stakeholder with the start date being the initial consultation;

- if the activity is commissioned from the voluntary sector by the NHS and the contract includes the requirement for the voluntary provider to provide the regular NHS datasets, e.g. CDS, waits dataset etc. In these instances we would have expected the voluntary organisation to have made arrangements to pass these data back to the commissioning authority for processing with the start date being the initial consultation;

- if the consultant caring for the patient in the voluntary service is providing the service as outreach, the employing NHS organisation would record these statistics as parer their normal practices.

Patients treated under these scenarios are going to be in the minority and most care in voluntary providers remain outside the scope of the data collection as it is not commissioned by the NHS.
Active Monitoring

3.10.58. What is Active Monitoring in terms of cancer waits?

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/may be required at a future date. 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. A patient would have to agree that they are choosing to be actively monitored for a period of time rather than receive alternative 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 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.

3.10.59. Can Active Monitoring be a subsequent treatment?

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

3.10.60. How long can a patient have for thinking time before it is classed as ‘Active Monitoring’?

There is no definitive answer for this. It depends on the individual scenario and why you would be considering using active monitoring. For example:

- if a patient has been offered subsequent chemotherapy and they want to take some time to think about this before confirming they wish to go ahead this is thinking time not active monitoring;
- if a patient and clinician agree that the patient’s symptoms are not severe at the moment and so the patient does not want further surgery at this stage and a review appointment is agreed for 3 months time then that could be active monitoring.
Combined Treatments

3.10.61. What do you class as combined treatments?

For the purposes of the cancer waits dataset, combined treatments are: treatments of different modalities combined in a way that they must be scheduled to take place together. These should be regarded as single treatment package. Example of combined treatment include:

- Chemoradiotherapy - where radiotherapy and chemotherapy are delivered within a strict schedule so that they interact to make both treatments more effective (e.g.: weekly 5FU during radiotherapy for rectal cancer, radiotherapy given synchronously with cycle 4 of CMF for breast cancer);

- pre-operative or 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. (e.g.: breast surgery followed by post-operative radiotherapy, chemotherapy for small cell lung cancer followed by consolidation radiotherapy).

3.10.62. Is there a definitive list of what can and can’t be classed as combined treatments?

No - combined treatments are classed as treatments of different modalities combined in a way that they must be scheduled to take place together.

3.10.63. Is Chemoradiotherapy covered by the 31 day subsequent chemotherapy standard or the 31 day subsequent radiotherapy standard?

Chemoradiotherapy (code 04) is part of the 31 day radiotherapy standard.

Treating metastatic Disease

3.10.64. How should metastatic disease be recorded and reported on?

Treatment of metastatic disease is almost always classed as a subsequent treatment. The exception is treatment of metastatic disease of unknown primary where both first and subsequent treatments can be recorded.

3.10.65. If the primary cancer is identified after the metastatic disease of unknown origin was diagnosed and treated, how would treatment of the primary cancer be reported?

The treatment of the primary cancer would be classed as a subsequent treatment as the patient would no longer be on the 62 day period as they had had their first treatment for metastatic cancer of unknown origin.
3.10.66. If a new primary cancer is diagnosed with metastatic disease and the metastatic disease required treatment first, how should this be recorded?

Treatment of the metastatic disease would be a subsequent treatment and uploaded as such. 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.

**Trials**

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

If a patient has agreed to enter a national portfolio clinical trial (a National Institute for Health Research trial) then the trial protocol will determine which treatments are classed as first or subsequent treatments respectively and they will be assigned as such under cancer waits standards. For example:

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

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

The CANCER TREATMENT MODALITY for a placebo would be classed as code 14 - ‘anti cancer drug regimen (other)’ for cancer waits reporting purposes assuming it is known which patient had received the placebo vs any other type of anti-cancer drug regimen such as cytotoxic chemotherapy. If it is a blind trial and it is not possible to identify which patient received which type of drug then the ‘anti cancer drug regimen (other)’ category would be used for each drug arm.

3.10.68. Some trials require a prolonged work-up period before treatment can commence. Can any adjustment be used?

No adjustment is possible in this scenario. If you have a significant number of patients entered into such a trial and the work-up genuinely takes a long time then email cancer-waits@dh.gsi.gov.uk for advice.

**Private patients**

3.10.69. How do you manage patients who receive an initial treatment from a private provider, but then seek subsequent treatments through NHS providers?

You need to have processes in place to identify and track any patient having subsequent treatments commissioned by the NHS providers irrespective of whether earlier treatments were carried out by private providers. If a patient had a FDT in the private sector and then returned to the NHS for further treatment these further treatments would be classified as subsequent treatments (even if it is the first one they had on returning to the NHS).
Patient Choice

3.10.70. How should we manage patients who decline a subsequent treatment but then later choose to have such treatment?

Providing the patient is fully aware of what they have asked for and they know this is not just time to think, then they are making an informed choice to decline all subsequent treatment and this would be recorded as Code 98 (all treatment declined) in the cancer treatment modality field. If the patient later agreed to treatment then this would be a 31 day subsequent treatment.

3.10.71. How do we monitor a patient who agrees a subsequent treatment and then later changes their mind and wishes to receive a different subsequent treatment altogether?

The patient will have to agree a new decision to treat for a new treatment option and hence the 31 day clock is reset.
3.11. Managing recurrences under cancer waiting times service standards

3.11.1. Which cancer waits standards are patients with a recurrence covered by?

They are covered by the two week wait or the symptomatic breast two week wait if a recurrence is suspected, but if a recurrent cancer diagnosis is later confirmed, they would not proceed on to the 62 day period. They would, however, be covered by the 31 day standard for subsequent treatments. The dataset includes a data item CANCER OR SYMPTOMATIC BREAST REFERRAL STATUS. One option to complete this field is DIAGNOSIS OF A RECURRENT CANCER. Once this field is completed such patients would automatically be excluded from 62 day standard by the CWT-Db.

3.11.2. At which point does the 31 day standard for patients with recurrent disease start?

The starting point for this 31 day period will usually be the DECISION TO TREAT DATE (DTT) i.e. the date that a patient agrees a treatment plan for their recurrent cancer. However, if the plan includes more than one treatment, then there could be multiple 31 day periods for each component of the plan (surgery, radiotherapy etc). Each 31 day period would either start with a new DTT or the EARLIEST CLINICALLY APPROPRIATE DATE (ECAD). An ECAD is the earliest date after a clinically appropriate period of delay before the next ACTIVITY can commence e.g. if a patient is going to need recovery time between two treatments.

3.11.3. Can GPs refer suspected recurrences under a two week wait referral?

Yes. A GP can urgently refer a suspected recurrence. However, if the recurrence was confirmed the patient would not continue on the 62 day period. Instead they would be covered by the 31 day subsequent treatment standards.

3.11.4. Why aren’t patients with a recurrence covered by a 62 day standard?

Patients with a recurrence are covered by the 31 day standard not 62 day as it is assumed that they would have had a first treatment at some point in the past when their initial cancer was diagnosed. All treatments of a recurrence are therefore a form of subsequent treatment even though they may be the first in terms of the recurrence itself. That being the case, the only time treatment for a recurrence would be deemed a first treatment is if it was for metastases of unknown primary.

3.11.5. How is recurrent disease distinguished from development of a second primary at a later date?

This is a matter for clinical determination. A patient referred urgently with a suspected second primary would be on the 62 day period if cancer was confirmed. A patient referred urgently with a suspected recurrent cancer would not be on the 62 day period if the suspected recurrence is confirmed. They would, however, be covered the 31 day subsequent treatment standard.
3.11.6. How will the patient pathway identifier work for recurrences?

The identifier for the primary cancer would also be used for any recurrence of the same primary cancer in the future. This is because a recurrence is a progression of the same patient pathway and a patient pathway lasts for the entire progression of a single disease/condition i.e. from the ORIGINAL REFERRAL REQUEST RECEIVED DATE until a patient is cured or passes away. Even if a patient is discharged and then returns with a recurrence of the original condition, the identifier would be the same, as shown in the diagram below.

For patients diagnosed with a recurrence over the first few months/years that the new CWT-Db was running, it is possible that they will not have a patient pathway identifier as this identifier would not have been in use when their primary cancer was diagnosed. For these patients a patient pathway identifier would be allocated for the recurrence and then used for the entire progression of that recurrent cancer.

If a patient is diagnosed with a second primary cancer (i.e. not a recurrence of a cancer) this would have a new patient pathway identifier.

3.11.7. If a recurrence was diagnosed from a two week wait referral are we supposed to tag the treatment record for the recurrence to the two week wait referral?

No. A patient can be referred under the two week wait route with a suspected recurrence but if a recurrence is confirmed they will no longer be on the 62 day period. They will only be on the 31 day period. The Patient Pathway Identifier (PPI) would link appropriate periods together. Where a patient enters secondary care via a two week wait referral and is subsequently diagnosed with a recurrence they will only be reported against the two week wait and 31-day (subsequent) standards. In addition, if they are separate records uploaded (provided the data entered are correct), the matching algorithm within the CWT-Db will ensure that separate records are created for the different elements of activity.

3.11.8. If a recurrence is suspected, can it be upgraded onto a 62 day standard?

No. The 62 day upgrade standard is for suspected new primaries only not suspected recurrences. Patients with recurrent cancer will, however, be covered by the 31 day subsequent treatment standard if the recurrence is confirmed. If a consultant (or designated member of the team) wishes to upgrade a patient they suspect may have a recurrence, it would be good practice for the locality to ensure the patient is diagnosed and receives treatment as quickly as possible. This will not, however, be monitored centrally.
3.11.9. If a patient is first seen in 2001 with a primary and then a recurrence is diagnosed in 2009, would you have to go back retrospectively to get data from the old case?

No. Each subsequent treatment will be a new 31 day period. The cases could be linked by the NHS number locally if desired but this will not be an automatic link and will not be required nationally.

3.11.10. How long should records be kept open to take into account possible recurrences in future years?

Indefinitely. A process needs to be in place locally to ensure that patients coming in with a recurrence are identified and tracking re-starts. Different models are likely to be needed for different cancers. This will be for local determination but options might include flagging of recurrences by clinical teams, MDTs, MDT co-ordinators or Clinical Nurse Specialists or use of forms available in all clinics (comparable to the RTT pathway forms).

3.11.11. Is there a stage at which it is assumed patients are 'cancer clear' eg. after 10 years?

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

3.11.12. Is there a time period after which time a recurrence would actually be classed as a new primary?

There is no time limit, a recurrence is a recurrence not a new primary if that is the clinical diagnosis.

3.11.13. Do all patients diagnosed with recurrence have to be discussed at an MDT meeting?

If the relevant Improving Outcomes Guidance (IOG) specifies that patients with a recurrence should be discussed at MDT then this should take place. Other than that, there is no national expectation that all patients with recurrence will go back through an MDT meeting. It is therefore for local determination if all patients with a recurrence, or a particular cohort, should be discussed.

3.11.14. What is the difference between recurrences (potentially cured but recurs in the future) and progression (not cured and will progress at some point) in terms of the cancer waiting times standards?

A recurrence is where a patient has previously been informed that they are free of the disease. A relapse or progression of a disease is where this has not happened.

Relapse and progression are terms more commonly associated with non-solid tumours (e.g. haematological malignancies) where it is more difficult to clearly identify if a neoplasm has been eradicated.

It is a clinical decision which category is most appropriate and, in terms of cancer waits, it is used for the CANCER TREATMENT EVENT TYPE data items.
3.11.15.  How do we identify the first treatment for recurrence as opposed to a subsequent treatment for a recurrence?

Treatments for a recurrence are always classed as subsequent treatments and therefore are only covered by the 31 day subsequent treatment standard – i.e. there would not be a first treatment for a recurrent cancer as it is assumed that some form of treatment would have been given when the cancer was initially diagnosed even if that was some time ago.

3.11.16.  If there is a recurrence of a previously treated metastatic site – do we record this?

Yes. This would be classed a subsequent treatment of metastatic disease.
4. Measurement of Cancer Waiting Times Standards

4.1. Adjustments

4.1.1. What adjustments are allowed?

Adjustments are allowed in two places:

1) If a patient DNAs their initial out-patient appointment – this would allow the clock to be re-set from the receipt of the referral (recorded as the CANCER REFERRAL TO TREATMENT PERIOD START DATE) to the date upon which the patient rebooks their appointment. This adjustment is relevant to the cancer two week wait and the 62-day standard.

2) If a patient declines an offer of admission for treatment in an in-patient (ordinary admission or day case) setting provided the offer of admission was “reasonable”. For cancer patients under the 31 or 62 day standard ‘reasonable’ is classed as any offered appointment between the start and end point of 31 or 62 day standards (i.e. any appointment within a CANCER TREATMENT PERIOD or CANCER REFERRAL TO TREATMENT PERIOD). The adjustment would be the time between the date of the declined appointment (the offered To Come In date) to the point when the patient could make themselves available for an alternative appointment.

4.1.2. Which patients are covered by these adjustments?

The adjustments apply to all patients with an ICD-10 code within the range C00-C97 or D05, who have a DATE FIRST SEEN or TREATMENT START DATE (CANCER) on or after 01 January 2009 irrespective of when the decision to refer was made or when the referral was received.

4.1.3. Why aren’t adjustments allowed for patient choice and medical suspensions?

The methodology shows the complete elapsed care time. Instead of a system of retrospective adjustments, which is time-consuming and difficult to justify to patients we have a more transparent system that gives a more accurate reflection of how long a patient has waited. It is recognised that for some patients, the standard times will be inconvenient or clinically inappropriate. This relates to the following three types of patients:

- those who choose not to accept earliest offered appointments along their pathway or choose to delay treatment i.e. patient choice;
- those who do not attend appointments along their pathway i.e. co-operation/engagement;
- those with clinically complex conditions and/or co-morbidities unsuitable to be seen/treated within the standard time i.e. clinical exceptions/medically unfit;

These three categories of patients are being dealt with by a combination of adjustments and and operational standards. Clock pauses are used to reflect some elements of patient choice (i.e. DNAing the first out-patient appointment or declining a reasonable appointment for admitted treatment). All other elements, including clinical exceptions, are taken into account by the operational standards ie) the operational standards have been set at a level to allow for a proportion of breaches due to patient choice and medical issues.
4.1.4. How can standards be met if adjustments cannot be used?

It is understood that it will not be possible to deliver the cancer waits standards for all patients. Operational standards have been set to reflect the fact that:

- some patients will not want to be seen/treated within the standard times (patient choice);
- for some patients it will not be clinically appropriate to see/treat them within the standard times (due to illness/co-morbidities/clinical complexities etc)

So, for example, a patient that exercises choice by cancelling and/or rearranging appointments might by so doing jeopardise themselves receiving treatment within 62 days and therefore fall into the tolerance as a patient that did not “want 62 day treatment”. As a result they would wait longer than 62 days and the operational standard allows for this. Likewise, the operational standard allows for a patient who is not clinically able to be seen within the standard timescales eg. a prostate patient that needs to wait between a TRUS biopsy and an MRI.

4.1.5. How does not having adjustments improve things for patients?

The system used is a more accurate reflection of how long patients wait and is therefore more transparent. It will highlight areas where sustainable improvements could be made to how services are organised and this will ensure efficient and effective services for future patients. The operational standards that the NHS has to achieve take into account that some patients will not be fit for treatment within the deadlines set by the standards and others will choose not to be seen within these deadlines.

4.1.6. What are the rules/principles that need to be followed when setting up local access/referral policies for cancer waits?

Local access and referral policies should be in line with cancer waits rules and, where there is scope for local interpretation, they should also be in the ‘spirit’ of the rules. For example:

- Patients should not be referred back to the GP because they are unable to accept an appointment within two weeks i.e. once a referral has been received by secondary care it should not be returned due to patient unavailability.
- Two week wait referrals can only be ‘downgraded’ by the GP - if a consultant thinks the two week wait referral is inappropriate this should be discussed with the GP and the GP asked to withdraw the two week wait referral status.
- Patients should not be referred back to the GP after first DNA of their first appointment.
- Patients can be referred back to their GP after multiple (two or more) DNAs if this is the agreed local policy.
- Patients should not be referred back to the GP after a single appointment cancellation.
- Patients should not be referred back to the GP after multiple (two or more) cancellations unless this has been agreed with the patient – by cancelling an appointment a patient has shown a willingness to engage/stay in contact with the NHS and it would not be appropriate to refer these patients back to their GP unless this was discussed and agreed with them as the most appropriate course of action.
4.1.7. **What would be examples of inappropriate local access/referral policies?**

It would be inappropriate to have a policy that refers a patient back to their GP because:

- they are not available for appointments on offer within a two week period eg. for social commitment or ill health or other reasons– it is expected that a certain proportion of patients will choose to wait longer and the operational standard takes this into account;

- they have not made contact after a first DNA within a given time period – one might reasonably expect a Provider to make some attempt to contact the patient or the GP;

- they are not immediately fit for diagnostics/treatments needed – this would previously have been a medical suspension. The operational standard for the 31 day and 62 day standards takes this into account.

It would also be inappropriate to have a policy that ‘downgrades’ patients urgently referred by their GP, for example:

- if a consultant thinks that a two week wait referral is inappropriate it should not be downgraded but the GP could be asked to withdraw it;

- if the patient cannot ‘guarantee’ attendance for tests or treatment within a certain timescale the patient should not be downgraded – the operational standard takes into account that a proportion of patients will choose to wait longer than the standard time. Additionally, there is a pause allowed if a patient declines a reasonable offer for admitted treatment

It would also be inappropriate to have a policy that:

- downgrades patients from the 62 day standard to the 31 day standard only or to a routine pathway because they are unavailable for non-admitted treatment for a period of time – the operational standard takes into account that a proportion of patients will choose to wait longer for treatment or will be unfit to start treatment at a given point in time;

- puts patients on pending lists for non-admitted treatment until they are available – the operational standard takes into account that a proportion of patients will choose to wait longer for treatment or are unfit for treatment.
4.1.8. Could having no of adjustments for patients that are medically unfit lead to a risk that patients will be treated before they are clinically ready?

If the patient is not clinically fit, it is clearly not in their best interest to be treated quickly and clinicians should not be put under pressure to do this. Patients should not be put under pressure to accept appointments before they are ready.

Clinical exceptions, previous medical suspensions and patient choice have been taken into account in the operational standards (ie. they have been set at a level that allows for a proportion of patients breaching due to choice and clinical reasons). We do recognise that the care pathways for patients with different tumour types can be very different and the operational standards are for performance as a whole i.e. all tumours taken together. It is not expected that all tumour groups would meet that level of performance – this is not realistic and would not be in the best interest of all patients.

For example, although the 62 day operational standard has been set at 85%, this does not mean that 85% of patients in all tumour areas would be seen and treated within this timescale. For some tumour areas, such as breast and skin cancer, it could be feasible to treat, for example, in excess of 95% of patients within 62 days whilst in some other areas due to complexities with diagnosis, treatment and patient co-morbidities it may be unlikely that a level of 85% could be achieved. We would not expect any patients to be rushed through to meet a 62 day standard if it is not appropriate for them.

DH has calculated operational standards that reflect a patient’s need to receive care as quickly as is appropriate for them. The NHS needs to ensure that it has efficient and effective clinical pathways in place to deliver the standard for those who are clinically fit and want to be seen within those standard times.

4.1.9. Why isn’t an adjustment allowed for patient thinking time?

Allowing a patient time to consider options is good clinical practice and patient thinking time will not jeopardise a provider’s performance against the standards because it has been taken into account in the operational standards that have been set (ie. the operational standards have been set at a level that allows for a proportion of patients breaching due to thinking time).

4.1.10. Is it appropriate to discharge patients back to their GP due to other conditions that need to be treated before their cancer pathway can continue.

No. Once the 62 or 31 day clock has started for a suspected cancer, we would not expect a patient to be referred back to their GP because of co-morbidities. Under the previous system of measurement the clock would have been paused (i.e. an adjustment made) on the grounds of a medical suspension. Now medical suspensions have been taken into account in the revised operational standards (ie. the operational standards have been set at a level that allows for a proportion of patients breaching due to medical suspensions).
4.1.11. If a patient wants to have fertility treatment prior to treatment can an adjustment be used for the resulting delay to treatment?

If fertility treatment is offered for a certain cohort of patients (and this would delay treatment) a pause is not possible as this would previously have been patient choice or medical suspension (depending on circumstances) – the operational standards take this into account (i.e. the operational standards have been set at a level that allows for a proportion of patients to breach).

4.1.12. Can we make an adjustment for radiographic investigations in menstruating females?

No. Under the previous system a medical suspension could be applied for the time the patient was unfit for the test. Under the new rule set introduced by DSCN 20/2008 this has been taken into account when the operational standards were set (i.e. the operational standards have been set at a level that allows for a proportion of patients to breach).

4.1.13. Can delays due to pregnancy result in any form of adjustment?

Delays incurred due to pregnancy would previously have been considered to be medical suspensions, and under the current rule set introduced by DSCN 20/2008 no adjustments for this can be made. Delays of this type have been addressed as part the operational standards set (i.e. the operational standards have been set at a level that allows for a proportion of patients to breach).

4.1.14. In terms of exceptional treatments where commissioner approval for funding is necessary, is there any adjustment possible while funding decisions are awaited?

It is not possible to stop the clock because a case has had to be put to the commissioner about funding a treatment. Commissioners will need to streamline their processes to ensure funding decisions are made in a timely manner if the cancer waits standards are to be met.

4.1.15. There can be pathway delays during Ramadan, for example, some patients won't attend any appointments during Ramadan or can't take preparations meaning that scopes and radiology may not be possible. Can any adjustments be made for these patients?

This is a matter of patient choice so no adjustment is possible except if the patient if declining a reasonable appointment for admitted treatment. The GP might want to take such circumstances into account when referring the patient as the secondary care organisation might be unaware of the religious requirements of the patient. If the GP is aware of this situation they would be in a position to make the patient aware of what the diagnostic pathway might involve to support an informed choice about their referral.

4.1.16. What is to stop someone entering an adjustment on the system that is no longer allowed (e.g. for a declined diagnostic appointment or a medical suspension)?

Some validations have been built in to the CWT-Db but the key is for the relevant people locally to understand the 2 adjustments that are allowed so they do not try to enter adjustments on the system for incorrect reasons.
4.1.17. How will you ensure there are no perverse incentives introduced e.g. offering admitted care to a patient when this is not necessary so that an adjustment can be used?

It will be for localities to consider local data and address any poor practice that becomes evident. If national trends indicate inappropriate changes in practice, this will be notified to SHAs to address.

**Pandemic Flu**

4.1.18. If patients have confirmed flu can we adjust for cancellations etc?

No adjustment is possible.

4.1.19. Will cancer waits standards be suspended in a flu pandemic?

Information on suspending or modifying operational or financial target requirements is set out in paragraph 3.2.18 of ‘Pandemic influenza: Guidance on preparing acute hospitals in England’. This guidance is available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080754

Currently, providers should continue to report waiting times as per published rules and keep their SHAs closely informed of any developments.

**Adverse Weather Conditions**

4.1.20. Are any adjustments allowed to counteract the impact of adverse weather conditions?

No. If an NHS Foundation Trust considers that its performance has been impacted by adverse weather conditions then it might want to consider liaising with Monitor.

At a national level, DH has no plans to suspend performance standards due to adverse weather conditions. Management is a decision for SHAs, but DH would only expect standards to be suspended in a sustained and serious emergency situation. This is unlikely to be considered for occasional periods of snow and ice.
### Pause for DNA of initial outpatient appointment

#### 4.1.21. How will the DNA pause for the initial out-patient appointment work?

If a patient does not turn up (i.e. gives no notice) for the outpatient appointment/diagnostic clinic that would have been recorded as DATE FIRST SEEN then the clock can be stopped from the date of the receipt of the referral (recorded as the CANCER REFERRAL TO TREATMENT PERIOD START DATE) to the date the patient rebooks their appointment as shown below:

![Diagram showing DNA pause process]

#### 4.1.22. Is there a national DNA policy for cancer waits?

For cancer the national position is:
- Suspected cancer patients should not be referred back to the GP after first DNA of their first appointment.
- Suspected cancer patients can be referred back to their GP after multiple (two or more) DNAs of any appointment if this is the agreed local policy.

#### 4.1.23. If a patient DNAs their initial out-patient appointment (OPA), how should the process of ‘re-booking’ be managed?

That is for local determination, however, it is suggested that the local provider seeks to proactively contact the patient (e.g. by phone) if they do not hear from them to try and arrange a new date.

#### 4.1.24. What is classed as the date the patient re-books?

It is the date the patients makes contact to re-book the appointment. It is not the date of the new appointment. The new appointment would be the DATE FIRST SEEN assuming the patient turned up/did not cancel etc.

#### 4.1.25. If a Provider does not hear from the patient so sends a letter with a new appointment date, is the date of the letter when the clock re-starts?

No. It would be the date that the patient made contact to confirm that the new appointment is acceptable and/or arrange an alternative date. The onus is on the patient to re-book (and hence restart the clock) after DNAing.
4.1.26. **Is the DNA adjustment allowed if a patient’s first appointment is a ‘straight to test’ diagnostic clinic?**

Yes. If the patient is going “straight to test” following an urgent referral for suspected cancer (from a GP or GDP) then appointment at the diagnostic clinic could count as DATE FIRST SEEN thus ending the two week period and a DNA of this appointment would enable the adjustment to be made.

4.1.27. **Is there any guidance on what can and can’t be classed as a diagnostic clinic?**

Comprehensive central guidance on what does and does not constitute a diagnostic clinic which could end the two week wait is not planned. Decisions should be made locally within the general principles that:

- we would assume it to be a clinic where tests will be carried out as part of a clinical pathway that seeks to rule a suspected cancer diagnosis in or out prior to an appointment with the consultant (eg. straight to test for colonoscopy following a two week wait referral for bowel symptoms);
- to be accepted as a diagnostic clinic/test the patient would see by a member of the consultant led team at the clinic in question; and that,
- the diagnostic test is appropriate for that pathway of care.

4.1.28. **RTT pathway rules allow an adjustment in the diagnostic phase – why don’t cancer waits?**

RTT pathway rules do not allow adjustments prior to diagnostic admissions unless a patient’s DATE FIRST SEEN is at a diagnostic clinic and they DNA this appointment – the same applies to cancer waits.

4.1.29. **Do the same DNA rules apply to symptomatic breast two week wait referrals (where cancer is not initially suspected)?**

Yes. The rules for the two week wait and the symptomatic breast two week wait are the same ie. you cannot send a patient back to their GP after one DNA.

4.1.30. **Does the adjustment for DNA of first out-patient appointment apply to patients on a 62 day screening period?**

Yes, this adjustment is allowed for DNAing the appointment that would be classed as DATE FIRST SEEN irrespective of whether the patient is on a 62 day screening period. Although patients coming through the screening route are not covered by the two week wait standards, the pause for DNA of first out-patient appointment would be included within the calculation of the 62 day period if applicable.

4.1.31. **Can an adjustment be made if a patient DNA’s the first out-patient appointment after a consultant upgrade onto a 62 day standard?**

The adjustment would apply if the upgrade took place before the DATE FIRST SEEN. For example if the consultant upgraded after reading the referral letter and the patient then DNA’d the appointment, the adjustment would apply as it would be included within the calculation of the 62 day period.
4.1.32. Why does a patient DNA nullify the RTT period but re-sets the clock for cancer patients?

The calculated waiting time would be the same using either method but given the serious nature of a potential cancer diagnosis, it was thought important to keep patients with suspected cancer on active tracking.

4.1.33. How many DNAs can a patient do before they can be referred back to the GP?

They can be sent back after multiple (two or more) DNAs subject to local protocol. Most localities have RTT pathway access policies that could be adapted for cancer. The key is to ensure that any decision is in the best interest of the patient. For example, would it be better for the GP to check whether the patient understands that he/she has a suspected cancer or does the GP have other intelligence about why the patient might be DNAing that the Provider needs to be aware of that make a referral back to the GP unnecessary.

4.1.34. What adjustment can be made if a patient has multiple DNAs of their first appointment?

When a patient DNAs their first out-patient appointment the clock is reset to when they make contact to rearrange their appointment. If they DNA a second time the clock can be reset again as they still have not had their first appointment. If a patient has multiple DNAs of the first appointment (two or more) then you can refer the patient back to their GP if that is in line with your agreed local protocol.

4.1.35. If a patient cancels their first out-patient appointment and then DNAs the rearranged date, can the clock be reset to the date the patient rebooks the appointment after the DNA?

Yes. A DNA of a first appointment will ‘trump’ any patient cancellations that may have preceded it so you can reset the clock.

4.1.36. If a patient DNAs their first OPA and the appointment is then rebooked and they cancel that appointment, rebook again and finally attend, what adjustment is allowed?

You can re-set the clock after the DNA to the date the patient rebooked but the clock continues after the cancellation.
4.1.37. **How much notice is needed before a cancellation can be counted as a DNA e.g. same day, one hour before appointment?**

A DNA is where a patient does not turn up, turns up late or turns up in a condition where you cannot carry out whatever was planned for them e.g. if they have not taken a preparation they needed to take prior to the appointment. A cancellation is when a patient gives any advance notice. In summary, a cancellation is a cancellation even if notice is very short.

4.1.38. **Is there any specific interpretation of ‘turns up late’ in the context of ‘DNAing’ a two week wait out-patient appointment?**

This would be if the patient arrives after the scheduled appointment time and it is not possible to fit them in (e.g. fully booked) or there is not enough time left to carry out the planned procedure/tests in the remainder of the session.

4.1.39. **If a patient arrives in clinic for their appointment but then leaves without being seen, would this be classed as a DNA or a cancellation?**

If a patient chooses to leave (i.e. is not sent away) then it could be classed as a DNA of their first appointment BUT you would need to be certain that the patient had not unreasonably passed their booked appointment time due to delays for which the NHS is responsible (i.e. if their booked appointment had passed and they could no longer/did not want to wait). It would not be appropriate to introduce an adjustment because the hospital failed to keep to its booked appointment slots.

4.1.40. **Can multiple DNAs count as refusal of tests?**

A DNA is not the same as a refusal to have a test. A refusal is when a patient has informed the NHS that they do not want to proceed with a test(s) or treatment(s) and can therefore be removed from the applicable cancer waits pathways in some cases.

A DNA is when a patient does not turn up for an appointment and does not give the NHS any notice. The NHS cannot assume that this DNA is the patient refusing to have the test(s) at all.

4.1.41. **What actions can be taken if a patient has multiple cancellations of their first appointment?**

By contacting the service to cancel/rebook the patient is showing an interest in staying in contact with the NHS and therefore in their treatment/tests. It would not therefore be appropriate to refer these patients back to their GP unless this was discussed and agreed with them as the most appropriate course of action. It would be deemed good practice for the Provider, when in contact with the patient about re-booking (after multiple cancellations) to try and establish if there is any problem. It is possible to refer the patient back to the GP, but this action should be taken with the knowledge and agreement of the patient.

4.1.42. **Can we make an adjustment if the patient reschedules multiple appointments?**

No.
Patient declines reasonable offer of admitted care

4.1.43. How will the adjustment for declining a reasonable offer of admitted care work?

A patient has to be offered a To Come In (TCI) date for admitted care (ordinary admission or day case) within the 31 or 62 day period. If the offer of admitted care is declined, the clock can be stopped from the date the declined appointment would have been to the point when the patient could make themselves available for an alternative appointment as shown below:

4.1.44. Why is the definition of ‘reasonable’ for an admitted treatment different to that used for RTT pathways?

Within the NHS Data Dictionary, ‘reasonable’ is classed as two appointments with at least 3 weeks notice. However, three weeks notice is not feasible for cancer patients who are on a much shorter pathway due to the potential seriousness of their condition [http://www.datadictionary.nhs.uk/](http://www.datadictionary.nhs.uk/).

4.1.45. Is there any requirement for a provider to offer two treatment dates for cancer patients?

There is no requirement to offer two dates for cancer waits just one offer within the start and end point of the 31 or 62 day period.

4.1.46. Is there a minimum amount of time that needs to elapse to allow an appointment to be ‘reasonable’ eg. is a TCI date on the same day reasonable?

A patient’s wishes, views and clinical needs should be taken into account but it will be for commissioners to determine whether, for example, a same day appointment can be considered reasonable.

4.1.47. Is an adjustment possible if a patient wishes to seek a second opinion before agreeing to a treatment?

No
4.1.48. **Is an adjustment allowed if a patient refuses a reasonable appointment for admitted diagnostics?**

No. For both RTT pathways and cancer waiting times, adjustments can only be applied if a patient declines a reasonable offer for admitted treatment.

4.1.49. **If a patient DNAs an agreed ‘To Come In’ date, can an adjustment be made?**

No, an adjustment is not possible for this eventuality. An adjustment is only possible if a patient DNA’s their first out-patient appointment (classed as DATE FIRST SEEN). DNAs elsewhere in the pathway have been taken into account in the operational standards. However, multiple (two or more) DNAs elsewhere in the pathway can result in a patient being referred back to their GP if this is in line with the locally agreed access policy.

4.1.50. **If a patient agrees a TCI but then cancels, can the clock be paused?**

No. If a patient has previously agreed to a reasonable offer which they subsequently cancel, the patient cancellation does not stop or pause the clock. However, as part of the rebooking process, the patient should be offered alternative dates for admission. If at the rebooking stage the patient declines a reasonable offer of admitted treatment (i.e. within the start and end point of the 31 or 62 day period – assuming the patient has not already breached) then an adjustment can be made. The clock is paused from the date of the earliest reasonable offer given as part of the rebooking process. The end of the pause will be the new date that the patient states they are available from.

4.1.51. **If a patient states at an appointment that they are unavailable for a set period of time (e.g. on holiday) before a reasonable date has been offered, is it legitimate to pause the clock if an appointment could have been offered during those times?**

Yes. Where a patient makes themselves unavailable for admission for a set period of time then this may mean that offering actual dates which meet the reasonableness criteria would be inappropriate (as the provider would be offering dates that they know the patient can’t attend). In these circumstances the clock can be paused from the date of the earliest reasonable offer that the provider would have been able to offer that patient. The clock would restart when the patient can made themselves available again.

4.1.52. **A patient is offered an appointment for admitted treatment which they decline as they have a holiday booked. They can’t be offered a surgical appointment as soon as they return as they are at a high risk of Deep Vein Thrombosis (DVT) following a transatlantic flight. When would they be considered as making themselves available again and the clock restarting?**

The clock restarts when the patient ‘makes themself available again’ ie. when they are back from their holiday. Any wait after that due to risk of DVT would have been a medical suspension under the old methodology so no adjustment is possible for this part of the pathway.

4.1.53. **Why can’t adjustments be made for non-admitted treatment?**

RTT pathways only allow adjustments for admitted care and cancer waits have adopted the same model.
4.1.54. What can and can’t be classed as admitted or non-admitted care?

- **Admitted** pathways are those that end in an admission to hospital (either in-patient or day case) for treatment.
- **Non-admitted** pathways are those that end in treatment that did not require admission to hospital (e.g. out-patient) or where no treatment is required.

4.1.55. Who decides the care setting to record – the commissioner or the provider?

The care setting of treatments should be recorded in line with what is delivered. This will be determined by what has been commissioned by the commissioner, the clinical need of the patient and what clinical guidelines say. The data uploaded should relate to the reported care in the Commissioning Dataset (CDS). If the patient is an out-patient, we would not expect them to be recorded as a day case admission just to enable an adjustment to the cancer waits pathway.

4.1.56. What is the position on adjustments if a patient wishes to wait for a specific treatment option?

If the patient has been offered a choice of treatments and they opt for one where there is insufficient capacity to provide the treatment within the standard deadline then it would not be possible to use an adjustment.

If you offer a choice of treatments and the patient asks about another treatment that, for example, they have heard about and, on reflection, it is deemed an appropriate treatment option then an adjustment would be possible as the patient declined a reasonable offer of treatment initially. The adjustment would be from the TCI date you would have offered and the clock restarts when the patient ‘makes themselves available’ for a further appointment.

Please note, it would be bad practice not to discuss a clinically appropriate option just to allow for an adjustment.

4.1.57. What is the position on adjustments if a patient wishes to wait for an admitted treatment under a specific consultant.

If you offered an appointment with either Consultant X or Consultant Y and the patient chose Consultant Y and you could not provide an appointment with Consultant Y within the standard time you could not include an adjustment – you offered a service and it is not the patient’s fault that you did not then have the capacity to provide it within the standard time if chosen.

If you made a reasonable offer for admitted treatment with Consultant X and the patient asked if it was possible to have treatment with Consultant Y and you cannot offer an appointment within the standard time you can use the adjustment because the patient declined a reasonable offer of admission. The pause would be from the TCI date you offered to when the patient ‘makes themselves available’ for a further appointment.

4.1.58. If a patient refused admitted treatment as they wanted to wait until a particular consultant is back from annual leave would an adjustment be possible?
Yes. Assuming you had not offered treatment with this consultant as an option, the patient is declining a reasonable offer of admitted treatment with another consultant. The clock would stop from the TCI date you would have offered and the patient would be classed as ‘making themselves available’ again (and therefore the clock re-start) once the consultant is back from leave.

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

If you offered the patient a choice of treatment at X or Y Provider and she chooses Y Provider an adjustment would not be possible.

If you offered admitted treatment in X Provider and the patient then asked to go to Y Provider to be closer to family then a reasonable offer of admitted treatment was rejected and an adjustment should be possible. The adjustment would be from the appointment date (TCI date) the patient declined (or you would have offered) to when they could make themselves available for treatment at Y Provider.

4.1.60. If a patient has been admitted for surgery but then changes their mind and does not proceed with the treatment can any adjustment apply?

If the patient decided that they did not want any treatment then you would end the period on the date that this was agreed and record the CANCER TREATMENT MODALITY as code 98 'All treatment declined'.

If they agree to a different form of treatment then you would use the DECISION TO TREAT date for the newly agreed treatment as the starting point for the relevant 31 day period. You cannot make any adjustments for the 62 day period for a patient considering treatment X then declining and agreeing to treatment Y instead. With surgery, the clock would normally stop when the patient has been admitted (ie. prior to the surgery itself if it was planned for the next day etc), however the admission date would not have stopped the 62 day clock in this example as the episode of care did not end with the treatment.

4.1.61. If we have offered a patient a TCI date but later are able to offer an earlier appointment which they refuse, is an adjustment possible ie. could the patient be classed as having refused a reasonable offer?

Part of being ‘reasonable’ is that the patient is consulted and listened to during the process of agreeing an appointment and it is not about ‘doing things’ to the patient. In this scenario the patient has been consulted and agreed a TCI. If an earlier TCI then comes up but the patient declines (for whatever reason) it does not seem reasonable to introduce an adjustment. The patient had agreed a TCI and was waiting for admission/treatment – it is not acceptable to then say they declined an alternative appointment offered after one they had agreed although it would be good to offer the patient the opportunity to have an earlier appointment if one becomes available.
4.1.62. Why is a DNA of an appointment for admitted treatment not the same as declining a reasonable offer?

A DNA is not the same as declining a reasonable offer because the patient did in fact accept the offer (ie. they did not decline it when given). In the end the patient did not turn up for the appointment they accepted and the operational standard takes these circumstances into account.

4.1.63. Are regular day attenders classed as admitted or non-admitted care?

There are two different types of regular day admission for cancer services, each of which may have a different admission status that should be considered when submitting data to form patient records for cancer waiting times. The different types of regular attender are:

- a Regular Day Admission - where a patient is admitted electively during the day, as part of a planned series of regular admissions for an on-going regime of broadly similar treatment and who is discharged the same day. If the intention is not fulfilled and one of these admissions should involve a stay of at least 24 hours, such an admission should be classified as an ordinary admission. This series of regular admissions ends when the patient no longer requires frequent admissions;
- a Regular Night Admission - where a patient is admitted electively for the night, as part of a planned series of regular admissions for an on-going regime of broadly similar treatment and who is discharged in the morning. If the intention is not fulfilled and one of these admissions should involve a stay of at least 24 hours, such an admission should be classified as an ordinary admission. This series of regular admissions ends when the patient no longer requires frequent admissions.

Both of these types of regular attendance include an admission, therefore they should be considered to be care in an admitted setting.

If the patient is being invited back for multiple outpatient attendances, but no admission is made then that episode of care should not be considered a Regular Day Admission and the episode of care should not be recorded as being within an admitted environment within the CWT-Db as it is merely outpatient activity.

4.1.64. In RTT pathways if a patient is not fit for treatment this ends their RTT period – why doesn't the same apply for cancer waits?

This is not correct. For RTT pathways, if a patient is not fit for treatment, the default should not be to automatically stop their clock and refer them back to the GP. It will depend on the circumstances as follows:

- if they become temporarily unfit during their wait but are likely be fit for treatment in future, the clock should continue to run and this should be considered within the operational standards under clinical complexity;
- if they become permanently unfit for treatment, then it is likely that a decision not to treat would be made, the clock would stop and the patient would be referred back to primary care;
- if a patient is admitted to hospital and then deemed temporarily unfit for treatment, their clock should continue unless a clinical decision is made that the patient is unsuitable for surgery and they are discharged back to primary care or a decision is made not to treat;
- if a patient isn't fit at the start of their pathway, then they should not be added to the waiting list in the first place.

Therefore the only scenario on RTT pathways where the patient could be referred back to their GP is if they become permanently unfit for treatment. In the case of cancer the patient is
still likely to require palliative care which can be classed as a FDT or a subsequent treatment.

4.1.65. **If a patient feels too unwell to undergo their treatment is any adjustment possible?**

No. this would have been a medical suspension under the old system. Medical suspensions have now been taken into account in the operational standards

4.1.66. **If a patient is given thinking time by the consultant it stops the RTT clock – why does the same not apply for cancer patients?**

For RTT pathways this depends on the individual scenario. If the agreed “thinking time” is short, then the RTT pathway clock should continue to tick e.g. where invasive surgery is offered as the proposed first definitive treatment, but the patient would like a few days to consider this before confirming they wish to go ahead with the surgery. If a longer period of thinking time is agreed, then active monitoring is considered appropriate e.g. where the patient and clinician agree that the patient’s symptoms are not severe at the moment so the patient does not want surgery at this stage. A review appointment is agreed for 3 months time and the patient is placed on active monitoring. The RTT pathway clock would stop at the point that the decision is made to commence active monitoring.

Active monitoring is a legitimate recordable treatment. It is not, however, acceptable to use this option as a means to end a 31 or 62 day period just to avoid a breach e.g. where the preferred choice of treatment is not available within the standard time due to capacity problems. We would expect unusual local or national trends in the use of active monitoring as a treatment to be investigated by SHAs.
4.2. **Performance Management**

4.2.1. For monitoring purposes, how many days are there in a week or month?

- Two weeks is 14 calendar days.
- A month is taken to be 31 calendar days.
- Two months is 62 calendar days.

4.2.2. How will providers be monitored, and by whom?

NHS Organisations will be performance managed against the current standards in the NHS Operating Framework 2011-12. Queries about what might be included in Monitor assessments should be sent to your usual contacts for Monitor.

4.2.3. Is it possible to re-upload information and have national reports re-run if an error is found locally?

It is the responsibility of the Provider to ensure that correct information is supplied for the purpose of performance management and performance assessment within the given timescale. Unfortunately, it is not possible to alter any provider, national, SHA, network or commissioner extracts/reports after the CWT-Db has generated them.

This is because these data have already been published within the NHS as part of an automated process on the day following the deadline, i.e. the CWT-Db will already have posted details of any reported activity to the commissioning organisation and SHA, your local SHA (if different) and your cancer network. In addition these patients will be recorded in multiple places within the aggregate commissioner and provider datasets that the CWT-Db generates for the Department of Health. A regeneration of reports would mean that the strict version control is lost as the new reports would not match the data held on the CWT-Db which relates to a snapshot of the database at a given date and time.

It should be noted, however, that quarterly reports are not produced as an aggregate of these three monthly reports, so it is possible to correct an error in a monthly upload prior to the quarterly reports being produced.

If there is an error in data published nationally it can be possible to include a caveat to the published statistics to explain that there has been an error with the data for a particular Provider. You would need to liaise with the DH Cancer Policy Team about this by emailing cancer-waits@dh.gsi.gov.uk.

4.2.4. Will the 31 day subsequent (surgery, drug, radiotherapy) standards be combined into a single standard?

The 31 day standards (FDT, subsequent drug, subsequent surgery, subsequent radiotherapy) are separately identified standards within the NHS Operating Framework 2011-12 and DH has issued separate operational standards.
4.2.5. **Will the 62 day standards (from urgent GP referral for suspected cancer, screening & upgrade) be combined into a single standard?**

The 62 day standards are separately identified standards within the NHS Operating Framework 2011-12 and DH has issued separate operational standards for the classic and screening standards. DH has no plans to merge these into a composite 62 day standard.

4.2.6. **Is the 62 day period for symptomatic breast patients measured separately (like screening and consultant upgrade patients) from the normal 62 day period and will it have its own operational standard?**

Symptomatic breast 62 day patients are a separate cohort to the 62 day classic standard patient cohort (i.e. those from urgent GP referral with suspected cancer). The 62 day period for symptomatic breast referrals went live from 1 January 2010 i.e. the same as the symptomatic breast two week wait standard. However, the 62 day symptomatic breast period is not being monitored centrally as it is not covered by the NHS Operating Framework 2011-12. We would, however, expect you to be keeping check on performance locally. DH have included reports to help with this in the report suite available on the CWT-Db.

4.2.7. **How is performance shared for 62 day standards?**

Performance figures appear under the accountable provider i.e. if the provider was commissioned to see the patient (DATE FIRST SEEN) and treat the patient (TREATMENT START DATE (CANCER)) the ‘whole’ patient is recorded against their organisation. If they were only responsible for one part of the pathway (i.e. just up to DATE FIRST SEEN or just TREATMENT START DATE (CANCER)) then they will be responsible for 0.5 of the patient i.e. performance is apportioned. The exception is for the 62 upgrade standard where the period is shared between the Provider where the CONSULTANT UPGRADE DATE was made and the provider that is commissioned to treat the patient.

Therefore for a 62 day standard a tertiary provider would only be responsible for 0.5 of a patient (assuming that the patient was first seen or the upgrade happened elsewhere).

4.2.8. **Will DH consider introducing a system of breach re-allocation?**

DH will continue to work with the NHS to consider how best to present data to support the NHS and to inform patients and the public. However, there are no current plans to introduce any form of national breach re-allocation system.

4.2.9. **How is performance shared for the 31 day standards?**

The treating provider is the accountable provider for the whole 31 day period i.e. activity is not shared.

4.2.10. **How are performance figures recorded for screening services?**

Performance figures would appear under the accountable provider i.e: the provider commissioned to provide the screening service is responsible for uploading the data up to DATE FIRST SEEN and the provider commissioned to provide any subsequent treatment is responsible for uploading this activity up to TREATMENT START DATE (CANCER). If the screening provider is commissioned both to see the patient (DATE FIRST SEEN) and treat the patient (TREATMENT START DATE (CANCER)) then the ‘whole’ patient is recorded against their organisation. If they were only responsible for one part of the pathway (i.e. just
DATE FIRST SEEN) then they will be responsible for 0.5 of the patient i.e. performance is apportioned.

4.2.11. Will Provider performance be rounded up or down to the nearest whole number?

The operational standards are in whole percentages, but the performance statistics are rounded to a single decimal point. For example, NHS organisations would be expected to reach 93.0% to be marked as achieving the two week wait. 92.8% would show as failing to achieve.

4.2.12. The number of cancers treated at some Providers is very small meaning one breach can have a huge impact on performance against the operational standards. How will this be taken into account?

When reviewing these data on a regular basis the Department of Health programme and performance teams do not usually apply a de minimis limit within their analytical outputs. This is because they choose to give the complete picture to the expert panel reviewing the data.

The caveats to this are that, depending on the audience, small cell count data may be suppressed. In addition, the performance teams that review these data are aware of the effects that small numbers will have on reported performance and consider this before deciding to enact any interventions.

4.2.13. Will a patient who declines all treatment [CANCER TREATMENT MODALITY: Code 98 (treatment declined)] appear in any of the published reports and consequently the Provider’s overall performance?

If a patient declines all treatments this is a valid "clock stop", but not a treatment. They are on the reports, but are separately identified. This means that the activity for the provider correctly identifies the number of pathways they manage, but reflects that a proportion do not result in an active or palliative treatment and therefore are not included in the numerator and denominator used to calculate the overall performance.

4.2.14. Providers achieving 100% compliance with the two week wait standard 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?

DH have suggested that SHA cancer waits leads pay particular attention to those providers performing very highly for the two week wait standard. We may be able to learn positive lessons from some that we can share. For others, SHAs may need to consider appropriateness of access and referral policies. The operational standard was set taking a whole range of data into account including at least a year's worth of data from the old DSCN22/2002-based system. DH will keep operational standards under review and SHA cancer waits leads have stressed to Providers the need for performance to reflect the TRUE position if we are to have appropriate operational standards. If you have local concerns about a Provider’s performance please liaise with your SHA cancer waits lead.

4.2.15. Are there any sanctions on Providers that don’t comply with the new cancer waits rules or don’t upload data?
DH could omit the Provider from the quarterly statistics with a note stating why their data was missing. Ultimately it is commissioners to performance manage implementation of cancer waits.

4.2.16. What action will be taken against Providers with access policies outside cancer waits rules?

If any Provider has an access policy that is not within the cancer waits rules it will be an issue for the commissioners to resolve.

Operational Standards

4.2.17. What are the operational standards?

<table>
<thead>
<tr>
<th>Commitment</th>
<th>Operational Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers [62 day classic]</td>
<td>85%</td>
</tr>
<tr>
<td>62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers [62 day screening]</td>
<td>90%</td>
</tr>
<tr>
<td>31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers [31 day FDT]</td>
<td>96%</td>
</tr>
<tr>
<td>31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments [31 day subsequent (drugs)]</td>
<td>98%</td>
</tr>
<tr>
<td>31-Day Wait For Second Or Subsequent Treatment: Surgery [31 day subsequent (surgery)]</td>
<td>94%</td>
</tr>
<tr>
<td>31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments [31 day subsequent (r/t)]</td>
<td>94%</td>
</tr>
<tr>
<td>All Cancer Two Week Wait [two week wait]</td>
<td>93%</td>
</tr>
<tr>
<td>Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected) [symptomatic breast two week wait]</td>
<td>93%</td>
</tr>
</tbody>
</table>

These operational standards were set out in the ‘Dear Colleague’ letter issued by Sir Bruce Keown, NHS Medical Director, on 30 July 2009 – see: http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_103436

4.2.18. Will DH set an operational standard for the 62 day upgrade standard?

DH will continue to consider how best to present these data to support the NHS and to inform patients and the public.

4.2.19. How were these operational standards set?

These operational standards were calculated using statistics collected in quarter three 2008/09 which gave accurate information detailing levels of patient choice or medical suspensions and current monitoring statistics (including performance levels and admission rates by tumour type and modality). Where insufficient numbers of patient records in relation to second or subsequent treatment existed, activity statistics from 2008/09 relating to first treatment activity have been used as a proxy. Advice on the levels of complex individual cases where the commitments should not be met for clinical reasons was also factored into the modelling. The appropriateness of these operational standards was considered by the Going Further On Cancer Waits Advisory Group, which included representatives from stakeholder organisations and the clinical community.
4.2.20. How will the operational standards be used?

The Department of Health will use these operational standards as part of the assessment of deliverables with the NHS Operating Framework 2011-12 and management of cancer waits within the NHS. DH recommend that these operational standards are used locally within the NHS to inform the development of services and the monitoring of Service Level Agreements.

4.2.21. What is the operational standard for the 31 Day rare (testicular, acute leukaemia & childrens) cancers standard?

There has never been an individual operational standard for the 31 Day Rare Cancers standard as the patient numbers involved are too small to reliably calculate one, or use it for performance management on a monthly/quarterly basis. However, these referral to treatment periods are a subset of the 62 day classic standard, therefore DH will add them to the numerator and denominator for that standard and apply the 85% operational standard.

4.2.22. Will there be an operational standard for the 31 Day period covering subsequent ‘other’ treatments (ie. those that are not covered by the surgery, drug or radiotherapy)?

The published operational standards relate directly to NHS Operating Framework 2011-12 monitoring. The 31 day subsequent ‘other’ treatments patient cohort is not currently part of this. The composition and level of operational standards will be kept under review as is normal practice, but there is no immediate plan to introduce operational standards for areas not specified in the NHS Operating Framework ie. 31 day subsequent treatment (other).

4.2.23. Will there be an operational standard for two week wait symptomatic breast patients on the 62 day pathway?

There are no plans to issue an operational standard as the 62-day symptomatic breast pathway is not covered by the NHS Operating Framework 2011-12.

4.2.24. Clinicians in some tumour areas will come under unacceptable pressure to treat patients more quickly than appropriate – how will you stop this?

We do recognise that the care pathways for patients with different tumour types can be very different and the operational standards are for performance as a whole i.e. all tumours taken together. It is not expected that all tumour groups would meet that level of performance – this is not realistic and would not be in the best interest of all patients.

For example, although the 62 day operational standard has been set at 85%, this does not mean that 85% of patients in all tumour areas would be seen and treated within this timescale. For some tumour areas, such as breast and skin cancer, it could be feasible to treat, for example, in excess of 95% of patients within 62 days whilst in some other areas due to complexities with diagnosis, treatment and patient co-morbidities it may be unlikely that a level of 85% could be achieved. We would not expect any patients to be rushed through to meet a 62 day standard if it is not appropriate for them.

DH has set meaningful operational standards to ensure that patients get care as quickly as is appropriate for them. The NHS needs to ensure that it has efficient and effective clinical pathways in place to deliver the standard for those who are clinically fit and want to be seen within those standard times.
4.2.25. How will you stop clinical pathways being adapted to meet the standard rather than the clinical needs of patients?

It is important to have effective clinical pathways to deliver cancer waiting times in a sustainable way – such as using single points of referral and one stop clinics etc. The changes being made to the way we measure cancer waits are not intended to result in inappropriate changes to clinical pathways. If a patient is not clinically fit to be treated or wants time to think about their options, it would not be appropriate for them to be put under pressure to be treated within 31/62 days. The new operational standards have been revised to take into account the adjustments that would previously have been allowed for both medical suspensions and for patient thinking time/patient choice. NHS IMAS can support those Providers that are struggling to deliver the cancer waits standards with their existing pathways.

4.2.26. Will you set different operational standards for different tumours?

This is unlikely as the commitments in the NHS Operating Framework 2011-12 are for all cancers taken together.

4.2.27. Will you set different operational standards for different Provider types?

The operational standards already take into account case mix. DH will continue to work with the NHS to ensure they remain appropriate.

4.2.28. Will you set different operational standards for admitted and non-admitted care for relevant standards?

There are no plans to do this as the NHS Operating Framework 2011-12 does not make this distinction.

4.2.29. Will you set separate operational standards for each of the three screening programmes (breast, bowel and cervical)?

There are no plans to do this as the NHS Operating Framework 2011-12 does not differentiate to this level - there is a single operational standard for the 62 day screening standard.
**Ready Reckoners**

4.2.30. Are there any data completeness measures that can be used locally?

DH considers the following data completeness mechanisms robust enough to share:

- all cancer two week wait - expect a submission of data each quarter that is at least 90% of the average quarter from the previous year;
- all cancer 31-day first definitive treatment - expect a submission of data each quarter that is at least 90% of the average quarter from the previous year;
- 62-day classic - expect a submission of data each quarter that is at least 90% of the average quarter from the previous year;
- 31-day subsequent radiotherapy - assume that there will be 190 new courses of radiotherapy per million population per month and that 82% of these will be subsequent treatments.

There are some assumptions in these models that local service patterns and reconfiguration may invalidate. However, these models should be robust enough to support local performance management. They would not however be robust enough for a complete audit, and we would always recommend an audit against local systems, e.g. PAS or Radiotherapy Verify & Record systems.

DH has recommended that locally agreed ready reckoners are used for the symptomatic breast two week wait standard.

4.2.31. Are there ready reckoners for the other standards (62 day screening, 31 day drugs, 31 day surgery)?

DH do not yet have a robust enough methodology to share for these standards.
4.3. **Breaches**

4.3.1. **Are there cases when the treatment time is expected to exceed the standard time?**

Yes. In a small number of cases there will be good clinical reasons for treatment time exceeding the standard time. For example:

- a patient where there is diagnostic uncertainty as to whether they have cancer or not who may require repeat diagnostic tests in order to reach a diagnosis;
- a patient who requires a particularly complex combination of scans and biopsies;
- a patient for whom there is genuine clinical uncertainty about the diagnosis; and
- where a clinician elects to observe a patient over a period of time before carrying out further investigations (clinical uncertainty).

Adjustments have never been allowed for these patients, the operational standard has always (and still does) taken into account these clinical exceptions.

In addition, there will be a proportion of patients that choose to wait longer than the standard time or are unfit for whatever reason to proceed with appointments/treatment within these timescales. The operational standards have also taken these patients into account.

4.3.2. **What information is required on breaches centrally?**

Reports on breaches are required on all patients that wait longer than the relevant service standard time (including where there were good clinical reasons or patient choice was a factor). The report should include how long the patient waited, the reason for the breach and action put in place to prevent further similar avoidable breaches.

Breach reports submitted via the CWT-Db should not contain either the name of the patient, other personal details or the clinician(s) responsible for their care.

4.3.3. **Are commissioners responsible for whole breaches?**

Yes, there are separate statistics to show commissioner performance.

4.3.4. **Can the screening service get half of a breach?**

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

4.3.5. **If you breach the 62 day standard do you, by default, breach the 31 day standard?**

No. You may have delivered treatment within 31 days of DECISION TO TREAT but taken longer than two weeks to first see a patient or taken a while to confirm a diagnosis.

4.3.6. **Is there any circumstance in which a 31 day standard breach (first definitive treatment or subsequent) would be shared?**
There are no circumstances where a 31-day breach will be shared between two providers.

4.3.7. How are breaches managed when Inter Provider Transfer (IPTs) are involved?

DH apportion a breach between the provider commissioned to carry out the appointment classed as DATE FIRST SEEN and the provider commissioned to carry out the treatment (TREATMENT START DATE (CANCER)). The provider treating the patient should always fully explain on the CWT-Db the reason for the breach.

4.3.8. Is there any recognition of breaches in pathways with more than two Providers involved?

The cancer waits dataset does not include information from multiple (more than 2) providers in a pathway so DH cannot apportion breaches across more than two Providers.

4.3.9. Is it possible to set a national cut-off point for referrals to a treating provider after which time the treating provider does not need to share a breach.

DH does not plan to set such a cut-off point. Providers/ networks could try locally to agree a cut-off as part of their Inter-Provider Transfer (IPT) policies to ensure that tertiary treating Provider are given sufficient time to treat patients without breaching the standard. However, this local cut-off date would not be monitored nationally and could not be used for breach reallocations.

4.3.10. Will DH consider introducing a breach reallocation process?

DH will continue to work with the NHS to consider how best to present data to support the NHS and to inform patients and the public.

4.3.11. Will a national inter-provider transfer form be introduced for cancer patients?

No. The RTT pathway inter-provider transfer form can be adapted locally.

4.3.12. Are independent sector providers eligible to hold or share breaches?

If an NHS Provider has sub-contracted to the private sector then the NHS Provider remain responsible for any breach. If a private sector provider has been directly commissioned to provide an NHS service then they can in theory share a breach. If, as part of their contract they are obliged to upload data on to the CWT-Db then the system will show them as sharing the breach. If, however, they submit the data to the commissioning organisation to upload then the commissioner will be shown on the system as sharing the breach.

4.3.13. The cancer waits measurement system reduces ability to performance manage as it is harder to identify genuine problem areas from ‘legitimate’ breaches (e.g. where previously medical suspensions and patient choice would have been used) – how can this be resolved?

There are categories to assign to breaches to help identify trends these will be extended (see Part 6).
4.3.14. If a patient is having a combined treatment the clock stops when the first part of the treatment starts. If the two parts are given by different Providers eg. chemotherapy first in Provider A and then radiotherapy in Provider B what happens with any breaches?

A 62 day 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 combination treatment if two providers split the treatments (ie one does the chemotherapy and one the radiotherapy), it would be the provider commissioned to deliver the first part of the combination treatment, in this example the chemotherapy, that would share any resulting 62 day breach and would have the whole of any 31 day breach.
5. Patient Tracking

5.1. Which patients do we need to be able to identify and track?

You will probably want to be able to identify and track patients cared for under the NHS in England at the following points:

- **patients urgently referred in by a GP (GMP or GDP) with suspected cancer** – you should already be doing this for the existing two week standard. These patients will need to be tracked for the 62 day period until a cancer is diagnosed and treated. If a non-malignant diagnosis is made the patient would be discharged or continue on RTT tracking if treatment was required.

- **patients referred with breast symptoms (where cancer is not suspected) from any relevant healthcare professional** – these are the patients on the expanded two week standard and will need to be tracked for the 62 day period until a cancer is diagnosed and treated. If a non-malignant diagnosis is made the patient would continue on RTT tracking if treatment was required.

- **patients referred for an outpatient appointment (and therefore being tracked under the RTT pathway) who are upgraded by a consultant (or designated member of their team) because of a suspicion of cancer at some point** – these patients will need to be tracked for the 62 day period until either a cancer diagnosis is confirmed and treated or a non-malignant diagnosis is made and the patient continues on RTT tracking if treatment was required.

- **patients being urgently referred (PRIORITY TYPE CODE 2) by one of the three cancer screening programmes with a suspected cancer:**
  - breast - after receipt of referral for further assessment following an abnormal mammogram;
  - bowel - after receipt of referral for a screening screening practitioner appointment to discuss suitability for colonoscopy following a positive Faecal Occult Blood test;
  - cervical - after receipt of referral for a colposcopy following a moderate or high risk cytology sample either direct from the laboratory [or via the GP/Choose and Book].

These patients will need to be tracked for the 62 day period until a cancer is diagnosed and treated. If a non-malignant diagnosis is made the patient would be discharged or would continue on RTT tracking if treatment was required.

- **patients diagnosed with cancer and with a decision to treat will need to be tracked until the start of the first definitive treatment** for the existing 31 day standard.

- **patients having subsequent treatments (i.e. treatments after the first definitive treatment) – these patients will need to be tracked for each anti cancer treatment they receive. Tracking would start from either a new DECISION TO TREAT DATE or the EARLIEST CLINICALLY APPROPRIATE DATE for the next treatment until the start of the treatment in question.**

- **patients diagnosed with a recurrent cancer** – these patients will need to be tracked under the 31 day subsequent treatment standard from the DECISION TO TREAT DATE or the EARLIEST CLINICALLY APPROPRIATE DATE for the next treatment until the start of these treatments.
5.2. **For RTT pathways, patients can come off their pathway for many reasons - do these reasons apply to cancer patients?**

The majority of reasons for a patient coming off a pathway will apply to RTT pathways and 62 day periods alike such as a patient dying or declining treatment. The main exception in cancer waits is if a patient DNAs their first outpatient appointment ie. for cancer waiting times you cannot refer the patient back to GP - due to the potentially serious nature of the suspected condition these patients are kept on tracking after their first DNA.
Two week/62 day standard specific tracking issues

5.3. At what point does a two week wait patient (urgent GP referral for suspected cancer or symptomatic breast referral) cease to be tracked as a potential 62 day standard patient?

A two week wait patient should cease to be tracked for the 62 day standard if a formal ‘non-malignant’ diagnosis is made (e.g. Chronic Obstructive Pulmonary Disease (COPD)) and communicated to the patient. Such a patient would, however, continue to be tracked for the RTT pathway. If such a patient is subsequently diagnosed with cancer, they will be tracked for the 31 day standard from the DECISION TO TREAT DATE (recorded as the CANCER TREATMENT PERIOD START DATE). This will exclude patients who are diagnosed with in-situ disease, as these patients are not included in the cancer waiting times standards (with the exception of those patients with in-situ breast disease, ICD10 D05).

5.4. What do you do if a diagnosis is unclear?

If a two week wait patient cannot be given a formal non-malignant diagnosis and is therefore followed up due to diagnostic uncertainty (for example, at three monthly intervals), the patient remains on 62 day tracking until either a cancer diagnosis is made and treatment given or a non malignant diagnosis is confirmed and the patient is discharged or continues on the RTT period.

A patient with diagnostic uncertainty is likely to have a longer than average diagnostic phase meaning that treatment will almost certainly be outside of 62 days and therefore reported as a breach. This was taken into account when the operational standards were set.

5.5. How do we record two week wait patients who are admitted as emergencies for the same condition before they are seen at their planned appointment?

Where a two week wait patient is admitted as an emergency for the same condition (i.e. related to the suspected cancer) before they are seen at their planned appointment they should no longer be recorded as a two week wait standard. The emergency admission is the referral into the system and effectively supersedes the original referral. However, such a patient could be upgraded onto the 62 day period if a consultant or authorised member of their team suspects cancer is the cause of the admission.

5.6. A patient is admitted as an emergency for another condition prior to their first seen appointment against a two week wait referral and cancer is ruled out during the emergency admission - how should this be recorded?

If a patient is an emergency admission prior to being seen for a two week wait appointment, and they are assessed as would have happened in the clinic they were waiting for and a benign diagnosis is given, then the date of the admission would be the clock stop for the two week wait. Subsequently the patient would (because of the benign diagnosis) be outside the scope of the 62-day standard, but the RTT period would still apply if they were not discharged.
5.7. A patient is admitted as an emergency for another condition prior to their first seen appointment against a two week wait referral and there are no investigations relevant to the two week wait referral during this admission - does this impact on the recording of the two week wait cancer wait?

If no investigation that could detect a cancer is carried out this admission is not equivalent to the DATE FIRST SEEN and the patient would stay on the waiting list for the relevant diagnostic clinic/ out-patient appointment to end the two week wait period.

5.8. How do we track a two week wait patient who refuses to have any diagnostic test and the clinician decides to continue to review?

Diagnostic tests will potentially diagnose the patient and by refusing altogether to have any test the patient has removed themselves from the 62 day standard. If cancer is subsequently diagnosed then the patient will need to be monitored under the 31 day standard.

5.9. Can patients take themselves off two week wait (and hence 62-day) periods?

Yes. If they refuse all offered appointments ie. said they did not want to be seen there would be no DATE FIRST SEEN to upload and therefore no two week wait period. However, if a patient declines a series of appointments that are offered, for example, because they are inconvenient this is not the same as refusing an appointment. To be a refusal the patient is effectively saying: ‘I do not want to be seen in the hospital at all for the symptoms I went to the GP about’.

If a patient refuses to have any type of diagnostic test that could potentially diagnose a cancer then they are removing themselves from a 62 day period but could be put back on 31 day tracking at a later date.

5.10. How do we record new cases of cancer where there is no pathology available?

Some patients with cancer never have microscopic verification of the tumour (i.e. histology or cytology). This is particularly the case for cancers such as pancreatic tumours and for elderly patients with lung cancer who are deemed unfit for bronchoscopy. In these cases diagnosis is made on non-microscopic information such as radiological investigations. For practical purposes if a patient has been told they have cancer and/or has received treatment for cancer then the relevant PRIMARY DIAGNOSIS code should be used and cases reported in the normal way.

5.11. If you are tracking a patient and they are diagnosed with 2 primary cancers on one referral date what would happen?

Each primary cancer could have a different patient pathway identifier (see Part 6). One would be generated at the point of referral and the other when the second primary is first suspected and the new (parallel) pathway starts. There would be one 62 day pathway linked to the initial urgent referral. For the second cancer there would be a 31 day pathway only (unless an upgrade takes place).
31/62 day standard specific tracking issues

5.12. Who will track patients receiving treatments in outreach services or those being treated by visiting consultants to District General Hospitals - how do you capture activity/treatments at other hospitals?

The organisation commissioned to deliver the care is responsible for tracking patients.

5.13. Do subsequent treatments have to be linked back to the original referral (which could be years back, especially for a recurrence)?

No. Each subsequent treatment will have a new 31 day period. The cases could be linked by the NHS number locally if desired for audit or trend analysis, but this is not an automatic link and is not required nationally.

5.14. Do patients have to be tracked indefinitely – at which point is this stopped e.g. eighth line treatment?

If or when a patient is discharged after the last planned course of treatment then tracking can stop. However, if they come in for a subsequent treatment, then they are covered by the 31 day subsequent treatment standard whether it is third or eighth treatment. A process therefore needs to be in place to ensure that these patients are identified and tracking re-starts when appropriate.

5.15. At what point do we cease tracking patients in case of a possible recurrence?

Records are not closed. There may multiple 31 day treatment episodes. A process therefore needs to be in place to ensure that patients coming in with a recurrence are identified and tracking re-starts from either a new DECISION TO TREAT DATE or an EARLIEST CLINICALLY APPROPRIATE DATE (recorded as the CANCER TREATMENT PERIOD START DATE) when appropriate.

5.16. Do we track treatments given in the independent sector?

If the independent sector is providing non-NHS treatment it will not be covered by the cancer waiting times standards and therefore the patient does not need to be tracked. If, however, the independent sector is providing NHS care under contract, the patient does need to be tracked.

5.17. How are treatments tracked when the commissioner is the Provider?

If treatment is given by a commissioner provider this should be recorded on the CWT-Db under the commissioner provider code. The commissioner will need to be registered as a provider on the CWT-Db to enable data to be uploaded by them. This needs to be arranged through the Open Exeter Helpdesk on 01392 251289. The registered user needs to ensure that their registration is maintained to enable data to be entered.

5.18. Do you track for a 62 day period and then if a benign diagnosis is made put the patient on RTT pathway tracking or do you run the two side by side until diagnosis is confirmed?

Run side by side. The start date for both is the same (except for upgrades).
5.19. **A patient goes to their GP as an NHS patient and the GP offers them a choice of provider and they choose a private hospital – who should be tracking and reporting these patients through their cancer pathway?**

If the patient is opting to pay for themselves (ie is becoming a private patient) then they are opting out of the two week wait and the 62 day standards. If however they subsequently return to NHS commissioned care for treatment then they would be covered by the 31 day treatment standard.

If the NHS has commissioned the private provider to see patients (ie. the patient is still an NHS patient) then the two week wait and the 62 day standards would still apply.

The organisation responsible for collecting and uploading these data depends on the commissioning arrangement eg. if the NHS Provider has subcontracted the activity to the private provider the activity and waiting time is to be recorded on the CWT-Db by the Provider that was originally commissioned to provide the work ie. the NHS Provider (Part 2 of this guidance includes different commissioning scenarios).

5.20. **How should a patient who is diagnosed incidentally for cancer be monitored?**

Some patients may be diagnosed for cancer during routine investigations or while being treated for another condition ie. incidental findings. These patients should be monitored under the 31 day DTT to treatment standard. Where the patient is treated immediately at point of diagnosis the decision to treat will be the same date as the date of the admission (e.g. when a patient is unexpectedly found to have a cancer during surgery for a suspected benign condition).
National Cancer Dataset: Waiting Times Subset

Introduction

The National Cancer Waiting Times Monitoring Dataset (NCWTMDS) contains 40 data items required for monitoring the cancer waiting time standards set out in the Coalition Government’s document ‘Improving Outcomes: A Strategy for Cancer’

The 40 data items in the NCWTMDS have been divided into a number of categories for the purposes of this guidance:

- Data items needed to identify a particular patient’s records:
  - NHS Number
  - Patient Pathway Identifier
  - Organisation Code (Patient Pathway Identifier Issuer)

- Data items needed to identify which organisations are responsible for certain activities:
  - Organisation Code (Patient Pathway Identifier Issuer) – same as above
  - Site Code (Of Provider Consultant Upgrade)
  - Site Code (Of Provider First Seen)
  - Site Code (Of Provider Decision To Treat (Cancer))
  - Site Code (Of Provider Treatment Start Date (Cancer))

- Data items which mark the start and end point of the different cancer standards:
  - Cancer Referral to Treatment Period Start Date
  - Consultant Upgrade Date
  - Date First Seen
  - Cancer Treatment Period Start Date
  - Treatment Start Date (Cancer)

- Data items related to adjustments to calculated waiting times:
  - Waiting Time Adjustment (First Seen)
  - Waiting Time Adjustment Reason (First Seen)
  - Waiting Time Adjustment (Treatment)
  - Waiting Time Adjustment Reason (Treatment)

- Data items related to breaches of standards:
  - Delay Reason Referral to First Seen (Cancer or Breast Symptoms)
  - Delay Reason Comment (First Seen)
  - Delay Reason (Decision to Treat)
  - Delay Reason Comment (Decision to Treat)
  - Delay Reason Referral to Treatment (Cancer)
  - Delay Reason Comment (Referral to Treatment)
  - Delay Reason (Consultant Upgrade)
  - Delay Reason Comment (Consultant Upgrade)

- Data items related to the suspected/diagnosed cancer:
  - Two Week Wait Cancer Or Symptomatic Breast Referral Type
  - Primary Diagnosis (ICD)
- Tumour Laterality
- Metastatic Site

• Data items related to the treatment used:
  - Cancer Treatment Modality
  - Cancer Care Setting (Treatment)
  - Clinical Trial Indicator
  - Radiotherapy Priority
  - Radiotherapy Intent

• Data items related to tracking and prioritisation of patients:
  - Source of Referral for Outpatients
  - Priority Type Code
  - Cancer or Symptomatic Breast Referral Patient Status
  - Cancer Treatment Event Type
  - Decision to Refer Date (Cancer or Breast Symptoms)

• Data items related to service improvement:
  - Multidisciplinary Team Discussion Indicator
  - Multidisciplinary Team Discussion Date (Cancer)

Each data item is explained in more detail within this section of the guidance.

In addition a table has been included at the end of this section of the guidance which summarises whether the collection of each data item is mandatory or optional for different service providers.
DATA ITEMS IDENTIFYING A PARTICULAR PATIENT’S RECORDS

- NHS NUMBER
- PATIENT PATHWAY IDENTIFIER
- ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)
6. NHS NUMBER

This is the 10 digit numeric number used to identify a patient uniquely within the NHS in England and Wales. It is a unique identifier for a patient and will not vary by any organisation of which a person is a patient.

6.1. Is this item mandatory?

Yes. It is mandatory to record the NHS number for each patient whose details are being included on the CWT-Db.

6.2. What is the policy for a patient with no NHS number eg. servicemen, prisoners and mobile populations such as non-UK citizens?

A patient with no NHS number should still be treated as clinically appropriate within the waits commitments but it will not be possible to upload related data on to the CWT-Db. DH expect there to be a certain proportion of such patients that they cannot collect data on.

Local protocols should be developed and staff should be aware how to attempt to source an NHS Number for these persons. In the case of armed forces patients, they are no longer registered with a GP, although their demographics details remain on national IT systems. This also applies to their dependents and other entitled civilians. Some NHS hospitals treat a significant number of armed forces personnel and service dependents in embedded MoD Hospital Units. In these cases, any military security information, including the patient's rank and service number, must be held securely. In the case of service dependents only, the NHS continues to be responsible for the movement of their primary care record between and within the NHS and Defence Medical Services. This process is managed by the Personal Demographics Service (PDS) National Back Office.

6.3. How do we handle patients treated in England whose care was commissioned by a Welsh Local Health Board (LHB)?

All patients treated by Providers within the English NHS should be reported. Those whose care is commissioned by a Welsh LHB can be removed from the statistics derived from the CWT-Db (if required) using patient registration details.

6.4. What does the ‘English NHS’ mean in relation to cancer waits?

For cancer waits, a Provider within the English NHS refers to Health Care Provider Organisations within England that are treating patients with cancer (including those referred from outside England) who have NHS NUMBERs which exist on the Patient Demographic Service database, and which can be used within the National Cancer Waiting Times Monitoring Data Set for transmission purposes. A Commissioner within the English NHS refers to any English primary care organisation commissioning services.

6.5. What is the position of patients that are not residing in England (eg. Brits in Spain)?

Anyone treated in England with an acceptable NHS number can have their record uploaded onto the CWT-Db. However, they may not be included in all outputs (eg. reports) derived from the CWT-Db if their care was not commissioned by an English commissioner. These patients are identified as being commissioned by an ‘unknown’ PCT in the CWT-Db outputs.
7. PATIENT PATHWAY IDENTIFIER (PPI)

This is an identifier that is unique to a patient for a particular condition. It consists of a 20 digit alphanumeric figure which, together with the organisation code of the issuer, uniquely identifies a patient pathway for the length of a particular condition eg. breast cancer. For example

Patient Pathway Identifier plus Organisation Code = Unique Identifier for patient pathway for a given condition

Patient Pathway Identifier

20 digit alphanumeric number

Organisation Code

a1b1c1d1e1f1g1h1i1j1

ZZZ

7.1. The PPI is mandatory for all two week wait records but only 'mandatory when applicable' for all others – why is that?

All cancer waiting times records need a PPI so it is mandatory. The term ‘mandatory if applicable’ (M*) means that a PPI has to be there when the record is complete at the end of a reporting period. It is used to ensure a PPI is given where the patient doesn't already have one (as a contingency). For example, patients coming through two week wait referrals from January 2009 should have been given a PPI, they will then have this PPI for first and subsequent treatment periods for that condition so it would not need to be created again. However someone diagnosed with a recurrence in February 2011 after say 5 years clear would not already have had a PPI so it would need to be created for this 31 day subsequent treatment period and would then be used for any other subsequent treatments for that condition. The basic assumption for the conditional mandation is that if the PPI already exists on Open Exeter in an outpatient record you will not need to re-enter it in a first treatment record. However the recommendation would be to always include it in any upload to ensure correct record matching thus reducing the burden of validation.

7.2. Who allocates a patient pathway identifier (PPI) & how?

The PATIENT PATHWAY IDENTIFIER is allocated by the organisation receiving the referral request which would result in the patient being seen for the first time for a particular condition/suspected condition. It is for the organisation in question to determine how to generate the 20 digit alphanumeric number.
7.3. Is it OK to generate the PPI from cancer systems?

The PPI used for referral to treatment (RTT) pathways should be the one used for cancer reporting. If these are different, the Inter Provider Transfer (IPT) Commissioning Dataset (CDS) mandate for RTT (which also covers cancer patients) cannot be applied, which means the PPI cannot flow between provider organisations.

7.4. What will the impact be if the RTT and cancer PPI do not match?

The RTT PPI must be the one used for cancer reporting. If the RTT and cancer PPIs are different the IPT CDS mandate for RTT (which also covers cancer patients) cannot be applied, which means the PPI cannot flow between provider organisations. This would place an unacceptable risk upon RTT and cancer reporting because of the chance that the PPI would not apply to the entire progression of a disease across multiple organisations. Resetting a PPI, and therefore by default an RTT clock at transfer, can significantly impact reported performance for RTT pathways.

7.5. How can screening hosts generate PPIs?

The PATIENT PATHWAY IDENTIFIER needs to be generated by the organisation receiving the referral request which would initiate a new RTT /62 day pathway. In terms of screening that would be the provider receiving the referral request for:

- breast - further assessment;
- bowel - appointment with specialist screening practitioner (SSP) to discuss suitability for colonoscopy;
- cervical - colposcopy appointment.

It is for the organisation in question to determine how to generate the PPI but it is something they are mandated to do. Please also note that the Provider commissioned to provide the screening service MUST provide a PPI that is the same as that provided for the RTT pathway for this patient.

7.6. How is a PPI generated if the patient comes via Choose and Book?

Where the referral request comes via Choose and Book, the UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) is used as the 20 digit number (the patient pathway identifier). The organisation code for NHS Connecting for Health (which is X09) is then used to ensure the identifier is unique to a particular patient. However, the UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) generated by Choose and Book is only a 12 digit number (n12), and not alpha-numeric. Therefore packing characters are required to enable this data item to be used as a proxy for the PATIENT PATHWAY IDENTIFIER.

Some Patient Administration Systems (PAS) and other local systems have been enhanced to include a local solution to this problem, however the NHS Data Dictionary and Model Service Team are currently consulting with systems suppliers (and the producers of XML schema) to standardise a solution. It is this proposed solution that should be used within the CWT-Db.

Where the UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) is used to produce a PATIENT PATHWAY IDENTIFIER for use within the CWT-Db and the local systems that feed into it, the following packing characters must be used:

<table>
<thead>
<tr>
<th>X</th>
<th>0</th>
<th>9</th>
<th>U</th>
<th>B</th>
<th>R</th>
<th>N</th>
<th>=</th>
</tr>
</thead>
</table>
These digits must be entered into the an20 PATIENT PATHWAY IDENTIFIER field in front of the n12 UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) derived from the Choose and Book system. For example:

<table>
<thead>
<tr>
<th>Packing Digits</th>
<th>UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)</th>
</tr>
</thead>
<tbody>
<tr>
<td>X 0 9 U B R N</td>
<td>1 2 3 4 5 6 7 8 9 1 2 3</td>
</tr>
</tbody>
</table>

This new an20 number should then be used in the normal manner:

So, for example, the patient pathway identifier would be constructed as follows:

7.7. The SITE CODE field for the PPI will allow up to five digits, however the Choose and Book code (X09) is only 3 digits – will the CWT-Db accept organisation codes of less than 5 digits?

The SITE CODE (PATIENT PATHWAY IDENTIFIER) will only be accepted by CWT-Db if it is a five digit code unless the organisation is Connecting for Health (CfH) and the booking was made via the central Choose and Book system. In these instances the 3-digit code will be accepted by CWT-Db because CfH does not specify site codes for national services.

7.8. Can the 20 digit PPI be generated automatically?

That will depend on your local system.

7.9. What is the best way of creating a PPI?

That is for local decision but the PPI used must be consistent with that used for RTT pathways ie. it must be consistent across all provider systems.

7.10. Our Provider produces a PPI that is less than 20 characters long? Is that acceptable?
No. The PPI is mandated to be 20 characters long, so you will need to use ‘filler characters’ if your organisation generates a shorter PPI. It is advised that all providers on a patient pathway use the same format for packing digits/filler characters.

7.11. Some staff have commented that their organisation generates a PPI that is less than 20 digits and that the CWT-Db does not reject these – is that true?

The PPI must be a 20 digit alphanumeric number – the one used for monitoring and tracking patients on the RTT pathway. If the PPI is included within the CWT-Db record and is NOT 20 digits in length the record will fail validation and therefore it will BE REJECTED on upload.

All organisations that are submitting the CDS (Commissioning Dataset) v6.0 (or subsequent revisions) to the Secondary User Service (SUS) and including the PPI are returning 20 digits. If they were returning less than 20 digits the CDS would be rejected at upload, which would impact on many areas including Payment by Results (PbR). If PAS systems only appear to use an identifier of say 12 digits it is possible that it actually has a field length of 20 digits and exports leading zeros (padding fields) to pass external validation checks. Local staff may not realise this if only the completed digits are displayed on organisations’ IT systems.

If the PPI is accepted for the SUS upload it should be accepted for the CWT-Db upload.

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

7.12. Why is the PPI set at 20 digits?

20 digits is the NHS Data Dictionary standard. The NHS Data Dictionary and Model Service is consulting on standardising use of the 12 digit UBRN for use within the PPI field. The cancer waits guidance uses this centrally developed solution.

7.13. Does it matter what format is used for a PPI?

There are no restrictions, as long as the number is an20 (alphanumeric and 20 digits). We would however recommend that there are no spaces within the 20 characters as this has been shown to cause problems on some NHS systems. We would also recommend that it does not include NHS number details as it is an unencrypted field and this could breach patient confidentiality.

7.14. How can you ensure locally defined PPIs are unique nationally?

The PPI should be alphanumeric and 20 characters in length, as defined in DSCN 18/2006. If the booking is generated through Choose and Book then the UNIQUE BOOKING REFERENCE NUMBER (UBRN) will be nationally unique. For non Choose and Book pathways, the Provider receiving the referral needs to generate a number unique to the Provider. In the rare event of another Provider or CAB generating a number the same as one assigned by a local system, the organisation code added to the PPI (recorded as ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) differentiates the locally generated PPI from the CAB or the other Provider generated PPI. These two parts (PPI and organisation code) stay with the patient through the pathway so if the patient gets a
tertiary referral to another Provider their PPI still contains the organisation code of the initial Provider and therefore remains unique.

7.15. **Do the first 5 characters of the PPI have to be the organisation code?**

No. The first 5 characters of the PPI do not have to be the organisation code as this is recorded in a separate field (ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)). You can create a PPI how you want, however, the PPI must be the same as that used for the RTT pathway. If your PAS does not generate a PPI and you are creating your own PPI it is important that this is also the RTT PPI. If it is not and the RTT team is creating the PPI you need to use that one.

7.16. **Can our organisation code be part of the PPI given that it also needs to be appended to the PPI?**

Yes. The organisation code could form part of the 20 digits (as it does when a UBRN is incorporated). However the code would also need to be included in the field ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) – this is what makes the PPI unique (as, in theory, two organisations could output the same 20 character reference number).

7.17. **How does the PPI relate to PAS systems?**

If PAS is compliant with CDS (Commissioning Data Set) v6.0 (or subsequent revisions) then your PAS should be set up to store the patient pathway identifier.

7.18. **Does the PPI have to be used by all providers treating the patient for the cancer eg. if a bowel cancer patient is referred to Provider A as a two week wait referral and diagnosed but then referred to Provider B for treatment does the treating provider have to use the same PPI which includes the code of the referring provider rather than their own organisation code?**

Yes - the same code should be used. The treating provider should not create a new PPI code. The PPI plus the organisation code of the PPI issuer uniquely identify the patient for the duration of their condition. The pathway for an individual condition can include multiple instances of timed periods (eg. multiple 31 day periods for subsequent cancer treatments) over a patient’s lifetime and the same identifier should always be used for episodes of care on the same pathway.
7.19. **Can a patient have more than one PPI?**

Yes, but not for the same condition. If a patient has breast cancer they will have a PPI which will run for the length of that condition i.e. if the patient is in remission and then relapses any further treatments are linked to the initial PPI for this condition. If they have any other conditions (including a second primary cancer) then each separate condition would have a different PPI. For example:

![Diagram of PPIs for different conditions]

7.20. **Originally, if a patient was referred for two suspected cancers on the same day only one could be covered by the 62 day standard – is that still the case?**

No. Each of the suspected cancers would have a different patient pathway identifier and hence both can now be distinguished and reported against a 62 day standard.

7.21. **How long does the PPI last?**

The PPI for a particular patient for a particular condition will last for the lifetime of the patient. The pathway for an individual condition can include multiple instances of timed periods (e.g. multiple 31 day periods for subsequent cancer treatments) over a patient’s lifetime.

7.22. **What benefit does the PPI bring that the NHS NUMBER does not?**

The NHS NUMBER is not specific to a condition. The PPI provides a means to match timed periods for a particular condition together and will be particularly useful in reducing the number of orphan records (i.e. where a two week wait period and a 31 day period have not been linked to create a 62 day period).
7.23. How do we create a PPI for patients that come through Accident & Emergency?

It is assumed that a patient coming though A&E and diagnosed with cancer or a suspicion of cancer would be referred on to an elective pathway from A&E (eg. following stabilisation) or admitted for assessment then referred internally within the provider to the relevant MDT. They should therefore receive a PPI at the point of the referral to the cancer service. The same principle applies on RTT pathways for other acute services, for example, patients admitted with heart problems.

On the rare occasion where first treatment does take place following an emergency admission (eg. at the time of emergency bowel surgery) a PPI would not be available related to this episode (ie. where the patient is first treated) and therefore cannot be entered. As such the CWT-Db system validation will allow you to enter a record without a PPI - see Schema on CfH website.

7.24. If a patient is admitted as an emergency prior to their planned appointment what do we do about the PPI?

The PPI would have been issued at the receipt of the initial referral on to the elective pathway.

7.25. If a patient is admitted to hospital, has cancer diagnosed whilst on the ward, is seen by the palliative care team and then dies on the ward there is no real pathway so a PAS may not generate a PPI – what do we do in this scenario?

The fact a patient was already on a ward for a condition other than cancer, and was referred to another consultant-led service (palliative care) for a consultation regarding a cancer suspicion, should initiate a new RTT and cancer waits pathway, because there had to be a service request to a new service. In addition to this there is no restriction on RTT or cancer waits pathways starting and ending on the same day.

7.26. If a patient has been diagnosed and treated for a cancer and reported under a relevant PPI and then is referred in again with a suspected second primary to another site this patient will have a new PPI. If the new referral is subsequently diagnosed as a recurrence rather than a new primary cancer (eg. colorectal patients who develop lung mets) what should we do?

You should try to link back to the original PPI if you find that a suspected second primary cancer is in fact a recurrence linked to the initial primary cancer ie. retrospectively change the record to ensure it links to the original PPI. However, we need to be pragmatic. If it would take a disproportionate amount of work/time to retrospectively change the PPI on local systems then it is acceptable to keep the new PPI albeit not strictly speaking correct.
7.27. If a patient is referred urgently for suspected cancer by their GP and no cancer is diagnosed, then is re-referred in six months time for suspected cancer at the same site (eg. a breast patient initially diagnosed with cysts) should the same PPI be used or would a new one be appropriate?

If the patient was initially referred with a suspected breast cancer - they would have a unique identifier for that referral even if the referral ended with a non-cancer diagnosis (ie. cysts). If they were then re-referred at a later date, and the referral was linked to the initial referral, ie. cancer was once again suspected then this would come under the same PPI unless:

- the second referral was unrelated to the initial symptoms and/or diagnosis (this would then have a new identifier); or
- the patient had been formally given a benign diagnosis following the earlier pathway (this would also have a new identifier).

7.28. If you have a patient diagnosed with two cancers, eg. one in the left breast and one in the right would they require two different PPIs?

If these are two separate primaries then yes they have separate PPIs.

7.29. How do we manage synchronous cancers?

There should be one PPI for each new primary. If a person needs a treatment that would treat both primaries at the same time there are two options:

- record the 31 day period against both PPIs;
- pick one of the PPIs to record it against (it will just look like a person did not have so many 31 day periods for one of the primaries).

If the patient has a bi-lateral primary, it would be considered a single primary and would have a single PPI. The bilateral nature of the primary would be recorded using the field TUMOUR LATERALITY.

7.30. Will records uploaded without a PPI be rejected by the CWT-Db?

Records uploaded without a PPI will not be rejected. However, the PPI is a mandatory field within the CWT dataset if applicable to the episode of care. All mandatory fields are expected to be completed where applicable on the database by the end of the 25th working day after the end of a month or quarter.

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

Although the PPI is a mandatory field the CWT-Db does not have checks and measures in place to ensure that this is included in every record at the point of upload. These validations have not been included in the system so that part-records can be uploaded. However, it is possible that in the future, actions such as audit of data completeness would be considered if there are concerns nationally that the mandate is not being followed.
7.31. If a patient has been referred from an outside Provider (therefore the date of referral and date first seen is at the first Provider) how do we ensure that the PPI is transferred robustly?

There is an Inter-Provider Transfer dataset (see DSCN44/2007 & DSCN07/2008) that has been mandated to support RTT measurement – this should ensure all the information required is transferred across in a timely fashion.

7.32. If PPI is mandatory within the cancer waiting times dataset does that mean that it is also mandatory for Cancer Registration purposes?

Anything that is mandatory in the Cancer Dataset: Waiting Times Subset is collectable by cancer registries – they have the ability to download data from the CWT-Db. Whether or not you choose to include the data item in a separate system which has been designed specifically for cancer registration purposes is a matter for local determination.

Submission of the full Cancer Registration Dataset can be via the submission of multiple data extracts which make up the full dataset e.g. from Cancer Waiting Times and Radiotherapy Datasets. You might want to discuss the specific process for data submission with your local Cancer Registry.

In the longer term you might want to consider developing an integrated approach to electronic data collection of cancer data in order to fulfil all the informatics requirements in ‘Improving Outcomes: A Strategy for Cancer’ within a single system.
8. ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)

This is the code of the organisation issuing the patient pathway identifier (i.e., the organisation that receives the referral request resulting in the patient being seen for the first time for a particular condition/suspected condition).

It is the use of this organisation code, along with the 20 digit PPI, that creates a unique reference number for a patient pathway and any timed periods it contains.

Where Choose and Book has been used, the organisation code for NHS Connecting for Health should be used. This is Code X09.

8.1. Is this data item mandatory?

Yes (where the PPI is present). Any patient whose case is being uploaded on to the CWT-Db should have both the patient pathway identifier and the organisation code of the issuer. Used with the organisation code of the issuer the patient pathway identifier becomes unique to the patient.

8.2. Where do we find our Organisation Code?

Your organisation code can be found in the Organisation Data Service (ODS) tables on nww. The link is as follows: www.connectingforhealth.nhs.uk/systemsandservices/data/ods/data-files

It may be possible to populate this field automatically with your local NHS IT systems.
DATA ITEMS IDENTIFYING ORGANISATIONS RESPONSIBLE FOR ACTIVITIES

• ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)

• SITE CODE (OF PROVIDER CONSULTANT UPGRADE)

• SITE CODE (OF PROVIDER FIRST SEEN)

• SITE CODE (OF PROVIDER DECISION TO TREAT (CANCER))

• SITE CODE (OF PROVIDER TREATMENT START DATE (CANCER))
ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)

See section 3

9. SITE CODE (OF PROVIDER CONSULTANT UPGRADE)

This is the Site Code of the organisation acting as commissioned health care provider when a decision is made to upgrade the patient from the RTT pathway to the 62 day standard ie. it is the Site Code of the organisation where a 62 day period for the consultant upgrade standard starts.

The decision to upgrade must be made by a consultant or an authorised member of the consultant’s team.

9.1. Is this data item mandatory?

This item is mandatory within the CWT-Db for records that include CONSULTANT UPGRADE DATE.

9.2. Where do we find our Site Code?

Your Site Code can be found in the Organisation Data Service (ODS) tables on nww. The link is as follows: www.connectingforhealth.nhs.uk/systemsandservices/data/ods/data-files

It may be possible to populate this field automatically with your local NHS IT systems.

9.3. If a patient is upgraded but cancer is not diagnosed do we have to report on this patient?

No. There is no national requirement to collect this information but local collection would aid local awareness and education about the magnitude and appropriateness of upgrades.
10. **SITE CODE (PROVIDER FIRST SEEN)**

This is the Site Code of the organisation acting as a commissioned health care provider where the patient is first seen (where the DATE FIRST SEEN would be recorded) ie. where the end point of the two week wait period takes place.

10.1. **Is this data item mandatory?**

This item is mandatory within the CWT-Db for records that include a DATE FIRST SEEN.

10.2. **Where do we find our Site Code?**

Your Site Code can be found in the Organisation Data Service (ODS) tables on nww. The link is as follows: [www.connectingforhealth.nhs.uk/systemsandservices/data/ods/data-files](http://www.connectingforhealth.nhs.uk/systemsandservices/data/ods/data-files)

It may be possible to populate this field automatically with your local NHS IT systems.

10.3. **If bowel screening is commissioned from Provider X but Provider X provides outreach services with Specialist Screening Practitioner (SSP) appointments at different hospital sites, which organisation’s code should be used?**

Where a commissioned provider gives an outreach service and they have registered an office/ward/facility on one of another providers sites as being theirs within the ODS they should use that code. For example, the main site code at Provider A could be ABC11, but if rooms for SSP appointments given at Provider B by Provider A and are registered by Provider A as, for example, ABC22 you should use that code ie. ABC for Provider A and 22 for the site.
11. **SITE CODE (PROVIDER DECISION TO TREAT (CANCER))**

This is the Site Code of the organisation acting as commissioned health care provider where the decision to treat the patient (the starting point for the 31 day period for first treatments and for some subsequent treatments) was made – the CANCER TREATMENT PERIOD START DATE.

11.1. **Is this data item mandatory?**

This item is mandatory within the CWT-Db dataset for records that include a CANCER TREATMENT PERIOD START DATE (a Decision to Treat (DTT) or an Earliest Clinically Appropriate Date (ECAD)).

11.2. **Where do we find our Site Code?**

Your Site Code can be found in the Organisation Data Service (ODS) tables on nww. The link is as follows: [www.connectingforhealth.nhs.uk/systemsandservices/data/ods/data-files](http://www.connectingforhealth.nhs.uk/systemsandservices/data/ods/data-files)

It may be possible to populate this field automatically with your local NHS IT systems.

11.3. **Why was the name of this data item changed?**

The original name is now relevant to organisations uploading data relevant to the RTT pathway. The name was therefore changed to make clear that this was the starting point of a cancer waits standard specifically.

12. **Site Code (Provider Treatment Start Date (Cancer))**

This is the Site Code of the organisation acting as commissioned health care provider where a patient receives a treatment which ends a 62 and/or 31 day period(s) (ie. the organisation where the TREATMENT START DATE (CANCER) takes place).

12.1. **Is this data item mandatory?**

This item is mandatory within the CWT-Db dataset for records that include a TREATMENT START DATE (CANCER).

12.2. **Where do we find our Site Code?**

Your Site Code can be found in the Organisation Data Service (ODS) tables on nww. The link is as follows: [www.connectingforhealth.nhs.uk/systemsandservices/data/ods/data-files](http://www.connectingforhealth.nhs.uk/systemsandservices/data/ods/data-files)

It may be possible to populate this field automatically with your local NHS IT systems.
DATA ITEMS RELATING TO START/ END POINTS OF DIFFERENT CANCER STANDARDS

• CANCER REFERRAL TO TREATMENT PERIOD START DATE

• CONSULTANT UPGRADE DATE

• DATE FIRST SEEN

• CANCER TREATMENT PERIOD START DATE

• TREATMENT START DATE (CANCER)
13. **Cancer Referral to Treatment Period Start Date**

This is the starting point for the two week and 62 day standards. It will be one of the following:

- **receipt of referral direct from GP (GMP OR GDP)** (ORIGINAL REFERRAL REQUEST RECEIVED DATE) – for two week wait referrals for suspected cancer and two week wait referrals for patients with breast symptoms (cancer not suspected);
- **receipt of referral direct from any health professional** (ORIGINAL REFERRAL REQUEST RECEIVED DATE) – for two week wait referrals for patients with breast symptoms (cancer not suspected);
- **receipt of referral via Choose & Book**,(UBRN CONVERSION - the Unique Booking Reference Number conversion date for an appointment) – for two week wait referrals for suspected cancer and two week wait referrals for patients with breast symptoms (cancer not suspected);
- **receipt of referral for further assessment following a suspicious mammogram** (recorded as ORIGINAL REFERRAL REQUEST RECEIVED DATE) – this is for patients coming in via urgent referral from the breast screening programme with suspected cancer;
- **receipt of referral for an appointment with a specialist screening practitioner (SSP) to discuss suitability for colonoscopy** (recorded as ORIGINAL REFERRAL REQUEST RECEIVED DATE) – this is for patients coming in via urgent referral from the bowel screening programme with suspected cancer;
- **receipt of referral for a colposcopy appointment** (recorded as ORIGINAL REFERRAL REQUEST RECEIVED DATE or UBRN CONVERSION) – this is for patients coming in via urgent referral from the cervical screening programme with moderate or worse cytology.

13.1. **Is this data item mandatory?**

Yes - but this is conditional on the type of waiting time period being recorded within the patient pathway – see the table at the end of part 6.

13.2. **Why not start the 62 day period for a consultant upgrade with receipt of the upgrade given that the other 62 day periods start at the receipt of a referral?**

There is no formal process by which the receipt of an upgrade could be measured ie. it is not like the receipt of a referral for an appointment which would be generated by a service request. The decision has therefore been taken that the date of the decision to upgrade (CONSULTANT UPGRADE DATE) should start the process as local systems could be introduced to capture this date.

13.3. **Why not start the 62 period for a consultant upgrade with receipt of the original referral which the consultant went on to upgrade?**

At the point the original referral is received (recorded as the REFERRAL TO TREATMENT PERIOD START DATE for the RTT pathways) cancer is not suspected and it might be a few weeks before a consultant (or authorised member of a consultant team) decides to upgrade the patient onto a faster pathway. It is not appropriate to calculate a timed 62 day period from this point (ie. retrospectively starting the clock from the original referral) as the patient was not on a faster pathway at that point.
14. **Consultant Upgrade Date**

This is the date that the consultant responsible for the care of the patient (or an authorised member of the consultant team - as defined by local policy) decided that the patient should be upgraded from an RTT period to a 62 day period as cancer is suspected.

14.1. **Is this data item mandatory?**

This item is mandatory if a patient has been subject to a consultant upgrade.

14.2. **What referrals can and can’t be upgraded?**

Referrals that can be upgraded are:

- any routine referrals (ie. PRIORITY TYPE CODE 1);
- urgent referrals that are not from the cancer screening programmes (ie PRIORITY TYPE CODE 2).

Referrals that cannot be upgraded are:

- two week wait referrals for suspected cancer (PRIORITY TYPE CODE 3);
- two week wait referrals for breast symptoms (cancer not suspected) (PRIORITY TYPE CODE 3);
- urgent screening referrals (PRIORITY TYPE CODE 2) – these referrals can be identified by data item SOURCE OF REFERRAL FOR OUT-PATIENTS Code 17 which is for a referral from a National Screening Programme.

These are exceptions because the patient would automatically be covered by the 62 day standard if cancer was diagnosed. [See section on data items related to tracking & prioritisation of patients for more on PRIORITY TYPE CODEs]

14.3. **Is there a time after which an upgrade is not allowed?**

Yes. An upgrade must be on or before:

- a Decision to Treat a patient has been agreed (ie before the DECISION TO TREAT DATE recorded as the CANCER TREATMENT PERIOD START DATE).
- the multidisciplinary team meeting where the care plan that was subsequently agreed with the patient was discussed ie. the MULTIDISCIPLINARY TEAM DISCUSSION DATE (CANCER) (if the patient is discussed at an MDT).

14.4. **Why doesn’t the 62 day period start with receipt of the upgrade given that the other 62 day periods start at the receipt of a referral?**

There is no formal process by which the receipt of an upgrade could be measured ie. it is not like the receipt of a referral for an appointment which would be generated by a service request. The decision has therefore been taken that the date of the decision to upgrade should start the process as it should be possible to introduce local systems to enable this date to be captured. It will be recorded as the CONSULTANT UPGRADE DATE and marks the start of the 62 day period for upgraded patients.

14.5. **Why not start this 62 day period from the receipt of the original referral which the consultant then went on to upgrade?**

At the point the original referral is received (recorded as the REFERRAL TO TREATMENT PERIOD START DATE for RTT pathways) cancer is not suspected and it might be a few weeks before a consultant (or authorised member of a consultant team) decides to upgrade
the patient onto a faster pathway. It is not appropriate to calculate a timed 62 day period from this point (i.e. retrospectively starting the clock from the original referral) as the patient was not on a faster pathway at that point.

14.6. Do we have to record the original referral date (prior to the upgrade) anywhere and if so why?

Yes. It should be recorded in the CANCER REFERRAL TO TREATMENT PERIOD START DATE field. The CWT-Db needs this item as it is a primary key that the system uses to create records. In addition, it should be useful for local quality assurance (QA) of upgrades.

This date will either be the REFERRAL TO TREATMENT PERIOD START DATE relating to the RTT pathway the patient is on or the ORIGINAL REFERRAL REQUEST RECEIVED DATE, which is the date the original referral was received in secondary care.

This data item is recorded for three reasons:

- to enable local audit of the time taken between receipt of the initial referral, and a decision to upgrade because cancer is suspected;
- to enable patients upgraded onto a 62-day pathway to be recorded on the CWT-Db as the CANCER REFERRAL TO TREATMENT PERIOD START DATE forms part of the primary key, and is used for record management;
- to enable the collection of data relating to consultant upgrade pathways on local systems which use ORIGINAL REFERRAL REQUEST RECEIVED DATE as part of their primary key or record identifier.

14.7. Who collects the upgrade dates?

These dates should be uploaded retrospectively by the Provider delivering the treatment. It is for local policies to determine processes to facilitate this.

14.8. If a patient is upgraded but cancer is not diagnosed do you have to report on this patient?

No. There is no national requirement to collect this information but local collection would aid local awareness and education about the magnitude and appropriateness of upgrades.
15. **DATE FIRST SEEN**

*This is the date when the patient is seen for the first time by a consultant (or member of their team) or in a clinic following the referral receipt.*

15.1. **Is this data item mandatory?**

Yes. This data item is mandatory for:

- patients referred urgently by their GP or GDP for suspected cancer and for referrals from any source for breast symptoms where cancer is not suspected as it marks the end of the two week wait period for both sets of patients;
- patients coming onto the 62 day period from other routes ie. upgrades (if cancer is subsequently diagnosed) and screening (irrespective of whether cancer is subsequently diagnosed) - although these patients are not covered by the two week wait standard, it is possible that an adjustment could be applicable to the 62 day period if a patient Did Not Attend (DNAed) their first out-patient appointment – it is therefore necessary to complete this field.

15.2. **What can be classed as a first seen date?**

It will be one of the following (whichever is the earliest service relating to the referral request):

- **first out-patient appointment** - this is the attendance date with a consultant or member of the consultant team;
- **first diagnostic procedure** (if this precedes the first out-patient appointment) eg CT scan prior to appointment with chest physician ie. straight to test;
- **first appointment following referral (or recall) from (or by) a screening provider** ie:
  - breast: appointment for further assessment following screening mammogram;
  - bowel: appointment with a specialist screening practitioner to discuss suitability for colonoscopy;
  - cervical: appointment for colposcopy.
- **first seen as an emergency** – this is the start date of the Hospital Provider Spell or the Arrival Date of the Accident And Emergency Attendance. If a patient is admitted as an emergency for the same condition they have been referred under the two week wait standard for but have yet to have their first seen date, this admission would count as the DATE FIRST SEEN. The patient would, however, no longer be counted as part of the two week wait cohort. This patient could however be upgraded onto the 62 day period if a consultant (or authorised member of the team) suspected cancer.

15.3. **If the DATE FIRST SEEN relates to activity carried out by an NHS Cancer Screening Service who is responsible for returning the data?**

An NHS Cancer Screening service would usually be hosted within another NHS body. It is the responsibility of the host organisation that has been commissioned to provide the service to return the data.

15.4. **Who returns data when a private provider is used?**

If an NHS Commissioner directly commissions services from a private provider, the upload of data will depend on the contractual arrangements between the Commissioner and Provider.
16. CANCER TREATMENT PERIOD START DATE

This is the date that marks the start of the 31 day period for both first and subsequent treatments. It will be either:

- the DECISION TO TREAT DATE (DTT) - the date that a patient agrees a treatment plan for either first or subsequent treatments. An individual patient may have multiple DTTs; or
- the EARLIEST CLINICALLY APPROPRIATE DATE (ECAD) – this is where there is no new DTT date but there has been a previously agreed and clinically appropriate period of delay before the next treatment can commence. In this case the subsequent activity which the patient needs to be ready for may not be the final treatment itself but could be the next appointment which deals with the planning of that subsequent treatment.

16.1. Is this data item mandatory?

This item is mandatory for any patient receiving first or subsequent treatment for primary cancer or recurrences.

16.2. What is a Decision To Treat (DTT)?

The DTT is the date the patient agrees a treatment plan. The date the patient signs the consent form may, depending on administrative procedures locally, take place some days after the DTT. It is therefore advised that the face to face (or telephone) meeting where the treatment plan is agreed is classed as the DTT not the date the consent form is signed.
16.3. **What is an Earliest Clinically Appropriate Date (ECAD)?**

It would either be:

- a pre-determined date, set by the clinician responsible for the care of the patient, upon which they determine a patient will be fit to undergo the next activity on the care pathway; or
- a date agreed with the patient during an assessment appointment with a member of a clinical team, upon which a patient is expected to be fit to undergo the next activity on the care pathway.

Examples would be:

- **Patient with rectal cancer is to have radiotherapy then surgery** - after the radiotherapy the patient is not expected to be clinically fit for surgery for 6 weeks so the ECAD would be set for 6 weeks after radiotherapy ends;
- **Patient with breast cancer is to have surgery then radiotherapy** – the patient would not be fit for planning radiotherapy until they are able to lift their arm over their head – ECAD would be set for when the patient would be fit for radiotherapy planning to start.

16.4. **What is classed as an ‘activity’ in the context of ECAD?**

The ECAD will relate to the next ACTIVITY that actively progresses a patient pathway, but not to any ACTIVITY that relates to determining a patient’s fitness to continue their care plan.

In the NHS Data Dictionary ACTIVITY is defined as: “A provision of services to a PATIENT by one or more CARE PROFESSIONALS”. However, this needs to be considered in relation to the intent of the ACTIVITY, as this broad definition may include the out-patient or tele-medicine contact at which the ECAD is set.

The patient does not have to be physically present on the ECAD date, as it can be set based on an earlier consultation.

*Example 1, ECAD determined at (and set as) date of out-patient attendance - ie. patient present at ECAD date*
At this point the patient agrees a care plan of surgery followed by teletherapy.

This is recorded as the admission date for the surgical episode.

31 Days

OUTPATIENT ATTENDANCE

This the care planning episode, the ACTIVITY related to the ECAD in this example.

TREATMENT START DATE (CANCER)

This START DATE of the teletherapy treatment course, and ends the subsequent 31-day pathway.

Example 2, ECAD determined at patient out-patient attendance for a date in the future - ie. patient not actually present at ECAD date:

At this point the patient agrees a care plan of surgery followed by teletherapy.

This is recorded as the admission date for the surgical episode.

This the "follow-up" outpatient appointment at which the clinician responsible for the care of the patient determines they will be fit to undergo the radiotherapy (teletherapy) planning in one week, and it will therefore be clinically appropriate from that point.

This is the ECAD, it is the date the clinician determined the patient would be fit for the care planning, which is their next ACTIVITY in this example.

This the care planning episode, the ACTIVITY related to the ECAD in this example.

TREATMENT START DATE (CANCER)

This START DATE of the teletherapy treatment course, and ends the subsequent 31-day pathway.

16.5. How will ECAD work for radiotherapy?
In 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.

16.6. When can an ECAD be set?

The ECAD can be set at a number of points including:

- at the clinical review with the patient following the preceding treatment - if it is not possible to make a decision at the review a further review could be arranged;
- at the start of the preceding treatment if the patient will not be reviewed between treatments;
- at the MDT meeting if it is possible to identify the likely ECADs between treatments in an agreed package;
- following receipt of test results and prior to seeing the patient if this is quickest.

16.7. Can an ECAD date be changed once it is set?

Yes, as long as the date has not passed. ECAD decisions can be kept under review. For example, if an ECAD is set for 21 February 2011 but at a clinical review on 26 January it is clear that the patient has not recovered from an operation the ECAD could be put back to 2 March 2011. However, if 21 February has passed and the patient is unwell it would not be possible to reset the ECAD. Under the previous system a medical suspension would have been possible but under the new system the operational standard for the 31 day period has been revised to take into account such circumstances.
17. **TREATMENT START DATE (CANCER)**

This is the start date of the first or subsequent cancer treatments and marks the end of the 62 day period and the end of the 31 day period for first or subsequent treatments.

17.1. **Is this data item mandatory?**

This item is mandatory within the CWT-Db for any patients receiving first or subsequent treatment for primary cancer or recurrences.

17.2. **What is classed as the starting point for different treatments?**

For the three main cancer treatments (surgery, chemotherapy and radiotherapy) the starting points are as follows:

- for surgery - the date the patient is admitted for surgery i.e. START DATE (HOSPITAL PROVIDER SPELL) of the related admission from the CDS (Commissioning Data Set);
- for cytotoxic chemotherapy - the date the first drug in an agreed course is given;
- for radiotherapy - the date the first fraction is given.

17.3. **What is the date of the First Definitive Treatment (FDT) where treatment is self-administered eg. tablets?**

The TREATMENT START DATE (CANCER) should be recorded as the date of the outpatient appointment where the patient is given the prescription.

17.4. **What happens if a patient refuses any type of treatment?**

If a patient declines all treatment then the TREATMENT START DATE (CANCER) should be recorded as the date on which the patient made this decision. The CANCER TREATMENT MODALITY would then be recorded as Code 98 - All treatment declined.

17.5. **The TREATMENT START DATE (CANCER) marks the end of the 62 day period but what if cancer was not diagnosed – how does the 62 day period then end?**

If cancer has been discounted then the 62 day period would have ended at the DATE FIRST SEEN.
DATA ITEMS RELATED TO ADJUSTMENTS

- WAITING TIME ADJUSTMENT (FIRST SEEN)
- WAITING TIME ADJUSTMENT REASON (FIRST SEEN)
- WAITING TIME ADJUSTMENT (TREATMENT)
- WAITING TIME ADJUSTMENT REASON (TREATMENT)
18. **WAITING TIME ADJUSTMENT (FIRST SEEN)**

This records the number of days that should be removed from the calculated waiting time for the two week wait period and potentially the 62 day period (if cancer is confirmed) - ie. between receipt of the referral or decision of consultant upgrade (recorded as CANCER REFERRAL TO TREATMENT PERIOD START DATE or CONSULTANT UPGRADE DATE)) and the DATE FIRST SEEN.

18.1. **Is this data item mandatory?**

This item is mandatory if applicable i.e. if a patient has DNA’ed (Did Not Attend) their first outpatient appointment (the appointment that would have been classed as DATE FIRST SEEN).

18.2. **What adjustments are allowed at this point in the patient pathway?**

The only permissible adjustment is when a patient does not attend (DNAs) the appointment that would have been classed as DATE FIRST SEEN.

18.3. **When does the clock stop and re-start following DNA of what would have been the DATE FIRST SEEN?**

The period of time that should be removed from a calculated waiting time is the period between the receipt of referral (the ORIGINAL REFERRAL REQUEST RECEIVED DATE or UBRN CONVERSION) and the date the patient rebooks their appointment. As shown in the diagram below:

18.4. **Which cancer waiting times standards does this adjustment apply to?**

This adjustment can be used for the following standards:

- two week wait (i.e. patients who were referred urgently for suspected cancer by a GP or GDP) and the corresponding 62 day standard if cancer is diagnosed;
- symptomatic breast two week wait (i.e. patients referred from any health professional with breast symptoms where cancer is not suspected) and the corresponding 62 day standard if cancer is diagnosed;
- 62 day screening (i.e. patients who enter a 62-day period from a cancer screening service);
- 62 day upgrade (i.e. patients who are upgraded onto the 62-day period but only if the CONSULTANT UPGRADE DATE took place before the FIRST SEEN DATE).

*See Part 4 for more Q&A on this adjustment.*
19. **WAITING TIME ADJUSTMENT REASON (FIRST SEEN)**

This data item is where you record the reason for using an adjustment prior to the first seen date.

19.1. **Is this data item mandatory?**

This item is mandatory within the CWT-Db dataset for records where the WAITING TIME ADJUSTMENT (FIRST SEEN) field is complete.

19.2. **What reasons can be used?**

There are two options to populate this field:

9 - No adjustment to waiting time
3 - DNA

19.3. **If there is only one option (ie DNA) available why do we need this data item - it will be obvious that any adjustment recorded in the WAITING TIME ADJUSTMENT (FIRST SEEN) field is due to a DNA?**

This is to ensure that any adjustment value entered is validated by local staff ie. they have to confirm that it was for a DNA. Keeping this data item would also allow any rule changes to be easily accommodated (eg. different reasons for adjustments) if they were to be added in the future – this is not expected at the present time.

19.4. **Why do we need to select an option that no adjustment was used, if no figure has been entered in the WAITING TIME ADJUSTMENT (FIRST SEEN) it is obvious no adjustment has been made?**

If you enter a 0 in the WAITING TIME ADJUSTMENT (FIRST SEEN) field then you need to enter Code 9 in this field. However, you can choose to leave both fields blank if you prefer. The option to include a 0 and then Code 9 has been included because some local systems find it easier to output zeros than blanks. This was an attempt to be helpful to local system developers.
20. WAITING TIME ADJUSTMENT (TREATMENT)

This data item is used to record the number of days that should be removed from the calculated waiting time between the CANCER TREATMENT PERIOD START DATE and the TREATMENT START DATE (CANCER) ie. the number of days that a clock can be paused for a 31 or 62 day period if a reasonable offer of treatment in admitted care has been declined.

20.1. Is this data item mandatory?
This item is mandatory within the CWT-Db dataset for records if a patient has declined a reasonable offer of admitted treatment.

20.2. What type of adjustments can be included in this data item?
There is only one. A patient has to be offered a reasonable To Come In (TCI) date for admitted treatment (ordinary admission or day case) within the 31 or 62 day period. If the reasonable offer is declined the clock can be stopped from the date of the declined appointment (TCI date) to the point when the patient could make themselves available for admission again as shown below:

20.3. What is classed as a ‘reasonable’ offer?
It is any offer for an appointment between the start and end point of the 31 or 62 day period – this would effectively mean offering the patient the next available date of admission or an offer of admission consistent with their clinical need - the full definition of a reasonable offer can be found at the following web address: http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/r/reasonable_offer_de.asp?shownav=1.

20.4. Why can’t an adjustment also be made for non-admitted care ie. the majority of radiotherapy and chemotherapy treatments are non-admitted care?
RTT pathways only allow adjustments for admitted care and cancer waits have adopted the same model.

20.5. What can and can’t be classed as admitted or non-admitted care?
• Admitted pathways are those that end in an admission to hospital (either inpatient or day case) for treatment;
• Non-admitted pathways are those that end in treatment that did not require admission to hospital or where no treatment is required (ie. outpatient or other).

20.6. What will stop a Provider entering an adjustment for non-admitted care?
There are validation rules in the CWT-Db to ensure adjustments are not used for non-admitted care. This type of adjustment would only be accepted by the central system where the CANCER CARE SETTING (TREATMENT) is recorded as either National Code 01 (Ordinary admission) or National Code 02 (Day case admission).
See Part 4 for more Q&A on this adjustment.
21. WAITING TIME ADJUSTMENT REASON (TREATMENT)

This data item is where you record the reason for using an adjustment prior to admitted care.

21.1. Is this data item mandatory?

This item is mandatory within the CWT-Db dataset for records where the WAITING TIME ADJUSTMENT (TREATMENT) field is complete.

21.2. What reasons can be used?

There are two options to populate this field:

9 - No adjustment to waiting time
8 - Patient Pause

21.3. If there is only one option available (ie. patient pause) why do we need this data item ie. it will be obvious that any adjustment recorded in the WAITING TIME ADJUSTMENT (TREATMENT) field is due to a patient declining a reasonable TCI date?

This is to ensure that any adjustment value entered is validated by local staff ie. they have to confirm that it was for a patient pause (ie. declining a reasonable offer of admitted treatment). Keeping this data item would also allow any rule changes to be easily accommodated (eg. different reasons for adjustments) if they were to be added in the future – this is not expected at the present time.

21.4. Why do we need to select an option that no adjustment was used, if no figure has been entered in the WAITING TIME ADJUSTMENT (TREATMENT) field it is obvious no adjustment has been made?

If you enter a 0 in the WAITING TIME ADJUSTMENT (TREATMENT) field then you need to enter Code 9 in this field. However, you can choose to leave both fields blank if you prefer. The option to include a 0 and then Code 9 has been included because some local systems find it easier to output zeros than blanks. This was an attempt to be helpful to local system developers.

21.5. What will stop a Provider entering an adjustment for non-admitted care?

There are validation rules in the CWT-Db to ensure adjustments are not used for non-admitted care in accordance with the business rules set out in the NHS Data Dictionary. This type of adjustment would only be accepted by the central system where the CANCER CARE SETTING (TREATMENT) data item is recorded as either Code 01 (Ordinary admission) or Code 02 (Day case admission).
DATA ITEMS RELATED TO BREACHES OF STANDARDS

• DELAY REASON REFERRAL TO FIRST SEEN (CANCER OR BREAST SYMPTOMS) – TWO WEEK WAIT

• DELAY REASON COMMENT (FIRST SEEN) – TWO WEEK WAIT

• DELAY REASON (DECISION TO TREAT) – 31 DAY

• DELAY REASON COMMENT (DECISION TO TREAT) - 31 DAY

• DELAY REASON REFERRAL TO TREATMENT (CANCER) – 62 DAY

• DELAY REASON COMMENT (REFERRAL TO TREATMENT) – 62 DAY

• DELAY REASON (CONSULTANT UPGRADE) – 62 DAY UPGRADE

• DELAY REASON COMMENT (CONSULTANT UPGRADE) – 62 DAY UPGRADE
22. DELAY REASON REFERRAL TO FIRST SEEN (CANCER OR BREAST SYMPTOMS)

This data item enables you to identify from a list of options an overarching reason why (after any adjustments have been removed) a delay/breach occurred to the two week period i.e. why the health care provider was unable to provide an appointment date within the service standard of two weeks. This reason will also be applicable if the patient went on to breach the related 62 day standard.

22.1. Is this data item mandatory?

Yes but it is conditional. The CWT-Db will require this data item if the waiting times standard is not met. It will not be possible to save a record that has an aggregate waiting time of more than 14 days if this field is not populated.

22.2. Why rename this data item?

The data item was renamed to include those patients referred with breast symptoms where cancer is not initially suspected.

22.3. What is classed as a breach?

A breach is when the period from receipt of referral to date first seen (less any adjustments) is more than 14 days.

Using the data item names this is when CANCER REFERRAL TO TREATMENT PERIOD START DATE to DATE FIRST SEEN (less WAITING TIME ADJUSTMENT (FIRST SEEN)) is more than 14 days.

22.4. What options are available for breach reasons?

The options available along with their codes are:
01 Clinic cancellation
02 Out-patient capacity inadequate (i.e. no cancelled clinic, but not enough slots for this patient
03 Administrative delay (e.g. failed to be rebooked after Did Not Attend, lost referral)
05 Patient declines (the patient declines any appointment within two weeks prior to any appointment being offered)
06 Patient choice (the patient declines all appointments offered within two weeks)
07 Patient cancellation (the patient cancels their booked appointment)
08 Patient care not commissioned by the English NHS (waiting time standard does not apply)
98 Other reason

22.5. What option do we pick if there are multiple reasons for a breach?

You should pick the option that accounted for the largest proportion of the breach.

22.6. Why do we need to identify categories for delays?

This will help you identify local trends in reasons why patients wait longer than the specified two week period. This should help you to identify how to improve waiting times and patient experience.
22.7. Why is ‘Code 04 - referral not received within 24hrs’ included as a potential breach reason as the period starts from date of receipt of referral?

We do not expect this code to be used for patients that came into the system from 1 January 2009. DH will consider removing this data item code.

22.8. Why aren’t medical suspensions included as an option?

They are not relevant to the first out-patient appointment – the patient has yet to be seen so cannot be suspended on medical grounds.

22.9. What do we do if patient choice is the reason for a delay?

Use code 98 ‘other reason’ and use the related comment field [DELAY REASON COMMENT(FIRST SEEN)] to describe the problem in more detail. DH will be taking steps to add additional coding options for patient choice in the future.

22.10. If ‘other reason’ is used frequently, how will we be able to identify if there are problems that need to be addressed?

Further details must be recorded for the precise cause of the delay, within the DELAY REASON COMMENT (FIRST SEEN) field. This will enable trends to be identified locally and supports central recording.
23. **DELAY REASON COMMENT (FIRST SEEN)**

*This is the free text comment field to describe in more detail why the maximum two week wait period (and potentially the 62 day period also) has been breached. It should not include the name of the patient, any other personal details or clinician(s) involved in the case.*

23.1. **Is this data item mandatory?**

It is mandatory when applicable ie. it must be recorded if a standard was breached (after any adjustments have been made).

23.2. **Are comments only needed if ‘other reason’ has been selected in the ‘Delay Reason Referral to First Seen (Cancer or Breast Symptoms)’ field?**

No. Comments are needed whatever option was selected to categorise the type of breach.

23.3. **Why do we need to add more detailed comments if we have already selected a category which describes the breach reason?**

The aim of these additional comments should be to provide enough information to help identify issues/problems that need to be resolved locally.

23.4. **If ‘other reason’ has been selected in the ‘Delay Reason Referral to First Seen (Cancer or Breast Symptoms)’ field what additional information is required?**

An explanation of why the breach occurred should be included. The aim should be to provide enough information to help identify issues/problems that need to be resolved and will support national reporting.

23.5. **A dash or random number in this field fools the CWT-Db validation and lets me upload without giving a reason – is that acceptable?**

This field will be audited and the outcome communicated back to cancer networks and SHAs for local action/education if such practices are identified.
24. **DELAY REASON (DECISION TO TREATMENT)**

This data item enables you to identify from a list of options an overarching reason why (after any adjustments have been removed) a delay/breach occurred to the 31 day periods ie. why the health care provider was unable to provide the treatment in question within the service standard of 31 days.

24.1. **Is this data item mandatory?**

Yes but it is conditional. The CWT-Db will require this data item if the waiting times standard is not met. It will not be possible to save a record that has an aggregate waiting time of more than 31 days if this field is not populated.

24.2. **What is classed as a breach?**

A breach is when the period from DTT or ECAD to the start of the treatment in question (less any adjustments) is more than 31 days.

Using the data item names, a breach is when the period from DTT or ECAD (recorded as CANCER TREATMENT PERIOD START DATE) to the start of the treatment in question (recorded as TREATMENT START DATE (CANCER)) (less WAITING TIME ADJUSTMENT (TREATMENT)) is more than 31 days.

24.3. **What options are available for breach reasons?**

The options available, along with their codes are:

### Delays relating to diagnostic and pre-treatment events

- **01** Clinic cancellation
- **02** Out-patient capacity inadequate (i.e. no cancelled clinic, but not enough slots for this PATIENT)
- **03** Administrative delay (e.g. failed to be rebooked after Did Not Attend, lost referral)
- **07** Complex diagnostic pathway (many, or complex, diagnostic tests required)
- **11** Diagnosis delayed due for medical reasons (patient unfit for diagnostic episode, excluding planned recovery period following an invasive diagnostic test)
- **13** Delay due to recovery after an invasive test (patient diagnosis or treatment delayed due to planned recovery period following an invasive diagnostic test)
- **17** Patient choice delay relating to first outpatient appointment
- **18** Health Care Provider initiated delay to diagnostic test or treatment planning
- **19** Patient initiated (choice) delay to diagnostic test or treatment planning, advance notice given
- **20** Patient Did Not Attend an appointment for a diagnostic test or treatment planning event (no advance notice)
- **98** Other reason

### Delays relating to treatment in an admitted care setting

- **04** Elective cancellation (for non-medical reason)
- **05** Elective capacity inadequate (patient unable to be scheduled for treatment within standard time)
- **10** Treatment delayed due to co-morbidity (patient unfit for treatment episode, excluding recovery period following diagnostic test)
- **21** Patient failed to present for elective treatment (choice)
22  Patient care not commissioned by the English NHS (waiting time standard does not apply)
98  Other reason

Delays relating to treatment in a non-admitted care setting

<table>
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<tr>
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<tr>
<td>14</td>
<td>Patient Did Not Attend treatment appointment.</td>
</tr>
<tr>
<td>16</td>
<td>Patient Choice (patient declined or cancelled an offered appointment date for treatment)</td>
</tr>
<tr>
<td>22</td>
<td>Patient care not commissioned by the English NHS (waiting time standard does not apply)</td>
</tr>
<tr>
<td>98</td>
<td>Other reason</td>
</tr>
</tbody>
</table>

24.4. What option do we pick if there are multiple reasons for a breach?

You should pick the option that accounted for the largest proportion of the breach.

24.5. Why do we need to identify categories for delays?

This will help you identify local trends in reasons why patients wait longer than the specified 31-days. This should help you to identify how to improve waiting times and patient experience.

24.6. What do we do if patient choice is the reason for a delay?

Use ‘code 98 - other reason’ and the related comment field [DELAY REASON COMMENT (DECISION TO TREATMENT)] to describe the problem in more detail. DH will be taking steps to add additional coding options for patient choice in the future.

24.7. What do we do if medical suspension was the reason for delay?

Medical suspensions will need to be included under ‘Code 98 - Other Reason’ and the equivalent comment field [DELAY REASON COMMENT (DECISION TO TREATMENT)] used to describe the problem in more detail. DH will be taking steps to add additional coding options for medical suspensions in the future.

24.8. If ‘other reason’ is used frequently, how will we be able to identify if there are problems that need to be addressed?

Further details must be recorded for the precise cause of the delay, within DELAY REASON COMMENT (DECISION TO TREATMENT) field. This will enable trends to be identified locally.
25. DELAY REASON COMMENT (DECISION TO TREATMENT)

This is the free text comment field to describe why the maximum 31 day period has been breached. It should not include the name of the patient, any other personal details or clinician(s) involved in the case.

25.1. Is this data item mandatory?

It is mandatory when applicable ie. it must be recorded if any 31-day period is breached (after any adjustments have been removed).

25.2. Are comments only needed if ‘other reason’ has been selected in the ‘Delay Reason (Decision to Treatment)’ field?

No. Comments are needed whatever option was selected to categorise the type of breach.

25.3. Why do we need to add more detailed comments if we have already selected a category which describes the breach reason?

The aim of these additional comments should be to provide enough information to help identify issues/problems that need to be resolved locally.

25.4. If ‘other reason’ has been selected in the ‘Delay Reason (Decision to Treatment)’ field what additional information is required?

An explanation of why the breach occurred should be included. The aim should be to provide enough information to help identify issues/problems that need to be resolved and will support national reporting.

25.5. A dash or random number in this field fools the CWT-Db validation and lets me upload without giving a reason – is that acceptable?

This field will be audited and the outcome communicated back to cancer networks and SHAs for local action/education if such practices are identified.
26. **DELAY REASON REFERRAL TO TREATMENT (CANCER)**

This data item enables you to identify from a list of options an overarching reason why (after any adjustments have been removed) a delay/breach occurred to the 62 day period ie. why the health care provider was unable to provide treatment within the service standard of 62 days.

26.1. **Is this data item mandatory?**

Yes but it is conditional. The CWT-Db will require this data item if the waiting times standard is not met. It will not be possible to save a record that has an aggregate waiting time of more than 62 days if this field is not populated.

26.2. **Why rename this data item?**

The data item was renamed to make it cancer specific ie. to identify that the breach occurred at 62 days not RTT pathways.

26.3. **What is classed as a breach?**

A breach is when the period from receipt of referral to the start of treatment (less any adjustments for DNA of first out-patient appointment and/or declines of reasonable appointments for admitted treatment) is more than 62 days. Using the data item names this is when CANCER REFERRAL TO TREATMENT PERIOD START DATE to TREATMENT START DATE (CANCER) (less WAITING TIME ADJUSTMENT (FIRST SEEN) and WAITING TIME ADJUSTMENT (TREATMENT)) is more than 62 days.

26.4. **What options are available for breach reasons?**

A category must be selected which describes the reason why the maximum 62 day wait from receipt of referral to the start of the treatment in question could not be met. The choice of National Codes are:

**Delays relating to diagnostic and pre-treatment events**

01  Clinic cancellation  
02  Out-patient capacity inadequate (i.e. no cancelled clinic, but not enough slots for this PATIENT)  
03  Administrative delay (e.g. failed to be rebooked after Did Not Attend, lost referral)  
07  Complex diagnostic pathway (many, or complex, diagnostic tests required)  
11  Diagnosis delayed due to medical reasons (patient unfit for diagnostic episode, excluding planned recovery period following an invasive diagnostic test)  
13  Delay due to recovery after an invasive test (patient diagnosis or treatment delayed due to planned recovery period following an invasive diagnostic test)  
17  Patient choice delay relating to first outpatient appointment  
18  Health Care Provider initiated delay to diagnostic test or treatment planning  
19  Patient initiated (choice) delay to diagnostic test or treatment planning, advance notice given  
20  Patient Did Not Attend an appointment for a diagnostic test or treatment planning event (no advance notice)  
98  Other reason

**Delays relating to treatment in an admitted care setting**
04 Elective cancellation (for non-medical reason)
05 Elective capacity inadequate (patient unable to be scheduled for treatment within standard time)
10 Treatment delayed due to co-morbidity (patient unfit for treatment episode, excluding recovery period following diagnostic test)
21 Patient failed to present for elective treatment (choice)
22 Patient care not commissioned by the English NHS (waiting time standard does not apply)
98 Other reason

Delays relating to treatment in a non-admitted care setting

01 Clinic cancellation
02 Out-patient capacity inadequate (i.e. no cancelled clinic, but not enough slots for this PATIENT)
10 Treatment delayed due to co-morbidity (patient unfit for treatment episode, excluding recovery period following diagnostic test)
14 Patient Did Not Attend treatment appointment.
16 Patient Choice (patient declined or cancelled an offered appointment date for treatment)
22 Patient care not commissioned by the English NHS (waiting time standard does not apply)
98 Other reason

26.5. What option do we pick if there are multiple reasons for a breach?

You should pick the option that accounted for the largest proportion of the breach.

26.6. Why do we need to identify categories for delays?

This will help you identify local trends in reasons why patients wait longer than the specified 62-days. This should help you to identify how to improve waiting times and patient experience.

26.7. What do we do if patient choice is the reason for a delay?

Use ‘code 98 - other reason’ and the equivalent comment field to describe the problem in more detail. DH will be taking steps to add additional coding options for patient choice in the future.

26.8. How are medical suspensions recorded?

Medical suspensions will need to be included under ‘Code 98 - Other Reason’ and the equivalent comment field [DELAY REASON COMMENT (REFERRAL TO TREATMENT)] used to describe the problem in more detail. DH will be taking steps to add additional coding options for medical suspensions in the future.

26.9. If ‘other reason’ is used frequently, how will we be able to identify if there are problems that need to be addressed?
Further details must be recorded for the precise cause of the delay, within DELAY REASON COMMENT (REFERRAL TO TREATMENT) field. This will enable trends to be identified locally.

26.10. Are all 62 day standard breaches recorded using this field?

No. It is for any breach of a 62 day period starting from:

- receipt of urgent GP/GDP referral for suspected cancer;
- receipt of urgent referral from any healthcare professional for breast symptoms (cancer not suspected);
- receipt of urgent referral from screening programmes (breast, bowel or cervical).

It is not to be used for breaches of the 62 day period following a consultant upgrade. These breaches are recorded under different data items (see DELAY REASON (CONSULTANT UPGRADE) and DELAY REASON COMMENT (CONSULTANT UPGRADE)) because the starting point of the upgrade period is different ie. date of decision to upgrade rather than receipt of referral.
27. **DELAY REASON COMMENT (REFERRAL TO TREATMENT)**

This is the free text comment field to describe why the maximum 62 day period has been breached. **It should not include the name of the patient, any other personal details or clinician(s) involved in the case.**

27.1. Is this data item mandatory?

It is mandatory when applicable ie. it must be recorded if any 62-day period is breached (after any adjustments have been removed) if the standard started from:

- receipt of urgent GP/GDP referral for suspected cancer;
- receipt of urgent referral from any healthcare professional for breast symptoms (cancer not suspected); or
- receipt of urgent referral from screening programmes (breast, bowel or cervical).

It is not to be used for breaches of the 62 day period following a consultant upgrade. These breaches are recorded under different data items (see DELAY REASON (CONSULTANT UPGRADE) and DELAY REASON COMMENT (CONSULTANT UPGRADE)) because the starting point of the upgrade period is different ie. date of decision to upgrade rather than receipt of referral.

27.2. Are comments only needed if ‘other reason’ has been selected in the ‘Delay Reason Referral to Treatment (Cancer)’ field?

No. Comments are needed whatever option was selected to categorise the type of breach.

27.3. Why do we need to add more detailed comments if we have already selected a category which describes the breach reason?

The aim of these additional comments should be to provide enough information to help identify issues/problems that need to be resolved locally.

27.4. If ‘other reason’ has been selected in the ‘Delay Reason Referral to Treatment (Cancer)’ field what additional information is required?

An explanation of why the breach occurred should be included. The aim should be to provide enough information to help identify issues/problems that need to be resolved and will support national reporting.

27.5. A dash or random number in this field fools the CWT-Db validation and lets me upload without giving a reason – is that acceptable?

This field will be audited and the outcome communicated back to cancer networks and SHAs for local action/education if such practices are identified.
28. **Delay Reason (Consultant Upgrade)**

*This data item enables you to identify from a list of options an overarching reason why (after any adjustments have been removed) a delay/breach occurred to the 62 day consultant upgrade period i.e. why the health care provider was unable to provide treatment within the service standard of 62 days following a decision to upgrade.*

28.1. **Is this data item mandatory?**

Yes but it is conditional. The CWT-Db will require this data item if the waiting times standard is not met. It will not be possible to save a record that has an aggregate waiting time of more than 62 days following a decision to upgrade if this field is not populated.

28.2. **What is classed as a breach?**

A breach is when the period from the consultant’s decision to upgrade to the start of the treatment (less any adjustments) was more than 62 days.

In terms of data items it is if the time between the CONSULTANT UPGRADE DATE and the TREATMENT START DATE (CANCER), less any adjustments recorded for a DNA of a first out-patient appointment (recorded as WAITING TIME ADJUSTMENT (FIRST SEEN)) and/or decline(s) of reasonable appointments for admitted treatment (recorded as WAITING TIME ADJUSTMENT (TREATMENT)) is more than 62 days.

28.3. **What options are available for breach reasons?**

A category must be selected which describes the reason why the maximum 62 day wait from consultant’s decision to upgrade to the start of the treatment in question could not be met. The choice of National Codes are:

**Delays relating to diagnostic and pre-treatment events**

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</tr>
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<td>02</td>
<td>Out-patient capacity inadequate (i.e. no cancelled clinic, but not enough slots for this PATIENT)</td>
</tr>
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<td>03</td>
<td>Administrative delay (e.g. failed to be rebooked after Did Not Attend, lost referral)</td>
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<td>98</td>
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</table>

**Delays relating to treatment in an admitted care setting**

<table>
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<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>04</td>
<td>Elective cancellation (for non-medical reason)</td>
</tr>
<tr>
<td>05</td>
<td>Elective capacity inadequate (patient unable to be scheduled for treatment within standard time)</td>
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</tbody>
</table>
10 Treatment delayed due to co-morbidity (patient unfit for treatment episode, excluding recovery period following diagnostic test)
21 Patient failed to present for elective treatment (choice)
22 Patient care not commissioned by the English NHS (waiting time standard does not apply)
98 Other reason

**Delays relating to treatment in a non-admitted care setting**

01 Clinic cancellation
02 Out-patient capacity inadequate (i.e. no cancelled clinic, but not enough slots for this PATIENT)
10 Treatment delayed due to co-morbidity (patient unfit for treatment episode, excluding recovery period following diagnostic test)
14 Patient Did Not Attend treatment appointment.
16 Patient Choice (patient declined or cancelled an offered appointment date for treatment)
22 Patient care not commissioned by the English NHS (waiting time standard does not apply)
98 Other reason

28.4. **What option do we pick if there are multiple reasons for a breach?**

You should pick the option that accounted for the largest proportion of the breach.

28.5. **Why do we need to identify categories for delays?**

This will help you identify local trends in reasons why patients wait longer than the specified 62-days. This should help you to identify how to improve waiting times and patient experience.

28.6. **What do we do if patient choice is the reason for a delay?**

Use code 98 ‘other reason’ and the equivalent comment field to describe the problem in more detail. DH will be taking steps to add additional coding options for patient choice in the future.

28.7. **What do we do if medical suspensions are the reasons for delay?**

Medical suspensions will need to be included under Code 98 Other Reason; DH will be taking steps to add additional coding options for medical suspensions in the future.

28.8. **If ‘other reason’ is used frequently, how will we be able to identify if there are problems that need to be addressed?**

Further details must be recorded for the precise cause of the delay, within DELAY REASON COMMENT (CONSULTANT UPGRADE) field. This will enable trends to be identified locally.
29. **DELAY REASON COMMENT (CONSULTANT UPGRADE)**

This is the free text comment field to describe why the maximum 62 day consultant upgrade period has been breached. **It should not include the name of the patient, any other personal details or clinician(s) involved in the case.**

29.1. **Is this data item mandatory?**

It is mandatory when applicable ie. it must be recorded if the 62-day period is breached (after any adjustments have been removed) following a consultant's decision to upgrade. It is not to be used for 62 day standards from other routes (urgent GMP/GDP referral for suspected cancer; symptomatic breast referrals, urgent screening referrals). These breaches are recorded under different data items because the starting point of the upgrade standard is different ie. date of decision to upgrade rather than receipt of the original referral on the patient pathway.

29.2. **Are comments only needed if ‘other reason’ has been selected in the ‘Delay Reason Referral to Treatment (Cancer)’ field?**

No. Comments are needed whatever option was selected to categorise the type of breach.

29.3. **Why do we need to add more detailed comments if we have already selected a category which describes the breach reason?**

The aim of these additional should be to provide enough information to help identify issues/problems that need to be resolved locally.

29.4. **If ‘other reason’ has been selected in the ‘Delay Reason (Consultant Upgrade)’ field what additional information is required?**

An explanation of why the breach occurred should be included. The aim should be to provide enough information to help identify issues/problems that need to be resolved and will support national reporting.

29.5. **A dash or random number in this field fools the CWT-Db validation and lets me upload without giving a reason – is that acceptable?**

This field will be audited and the outcome communicated back to cancer networks and SHAs for local action/education if such practices are identified.
DATA ITEMS RELATED TO THE SUSPECTED/DIAGNOSED CANCER

- TWO WEEK WAIT CANCER OR SYMPTOMATIC BREAST REFERRAL TYPE
- PRIMARY DIAGNOSIS (ICD)
- TUMOUR LATERALITY
- METASTATIC SITE
30. **TWO WEEK WAIT CANCER OR SYMPTOMATIC BREAST REFERRAL TYPE**

This data item is used to record the site where cancer is suspected by the GP or GDP referring the patient as a two week wait. It is also used to identify patients being referred on the basis of exhibited (non-cancer) breast symptoms from any healthcare professional.

30.1. **Is this data item mandatory?**

Yes, for urgent GP/GDP referrals for suspected cancer and symptomatic breast referrals from any health professionals ie. two week wait referrals (PRIORITY TYPE CODE 3) and for urgent referrals from cancer screening services (PRIORITY TYPE CODE 2).

30.2. **What options are available under this item?**

The codes are as follows:

01  Suspected breast cancer
02  Suspected children's cancer
03  Suspected lung cancer
04  Suspected haematological malignancies excluding acute leukaemia
05  Suspected acute leukaemia
06  Suspected upper gastrointestinal cancers
07  Suspected lower gastrointestinal cancers
08  Suspected skin cancers
09  Suspected gynaecological cancers
10  Suspected brain or central nervous system tumours
11  Suspected urological cancers (excluding testicular)
12  Suspected testicular cancer
13  Suspected head and neck cancers
14  Suspected sarcomas
15  Other suspected cancer
16  Exhibited (non-cancer) breast symptoms - cancer not initially suspected

30.3. **When should Code 01 and Code 16 be used ie. how do we distinguish between suspected and non suspected breast cancer?**

Code 01 is used for GP referrals for suspected breast cancer. Code 16 is only to be used for referrals of patients with breast symptoms where cancer is not suspected. Any relevant health professional can make a referral under code 16.

30.4. **Why do we need to distinguish between suspected breast cancer (code 01) and exhibited (non-cancer) symptoms (code 16) if both sets of patient will be seen within two weeks?**

This distinction is necessary to support the monitoring of the NHS Operating Framework 2011-12. The differentiation might also help to monitor appropriateness of referrals and therefore identify any education needed about signs and symptoms of breast cancer amongst relevant healthcare professionals.
30.5. **Do these codes apply to referrals from any source?**

No, with one exception. Codes 01-15 should only be used for two week referrals from GPs or GDPs for suspected cancer. Code 16, however, is not restricted to two week wait referrals from a GP or GDP, these can be from any source.

30.6. **How is a child defined i.e. when should code 02 be used?**

For monitoring of the cancer two week wait standard, a child is defined as under the age of 16 years at the receipt of the referral (recorded as the CANCER REFERRAL TO TREATMENT PERIOD START DATE).
31. PRIMARY DIAGNOSIS (ICD)

This data item is used to record a four figure ICD-10 diagnosis of the primary tumour ie. the code which identifies the type of cancer. The full list of ICD-10 codes that can be used is available on the Connecting for Health website.

The following address should take you to the “Clinical Coding for CRS Standards” page:

http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/clincoding/?searchterm=clinical%20coding%20for%20crs%20standards

31.1. Is this data item mandatory?

Yes, it is mandatory for any patient diagnosed and treated for cancer.

31.2. What are ICD-10 codes?

ICD-10 is an abbreviation for the International Statistical Classification of Disease and Related Health Problems (10th revision). It is used in the NHS acute sector to record diseases and health-related problems (the diagnosis or reason for a patient episode of healthcare).

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

Any ICD-10 code within the list published at:  
http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/clincoding will be accepted by the CWT-Db system.

31.4. The ICD-10 field now needs 5 digits (inclusive of a decimal point) but not all codes are 5 digits eg. C61 for Prostate and C20 for Rectum – will these still be accepted?

The 5 digit code requirement in the CWT-Db is the maximum field length. We are aware that some ICD-10 codes do not breakdown to this level of detail and have therefore been retained at a three digit level (i.e. Cnn). These will not be rejected. These codes are specified at:  
http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/clincoding

31.5. Why do we have to record ICD-10 codes to four characters – under the old rules we only used three characters?

Some of the haematology cancer waiting time codes were already 4 characters, so the database and the CSV export format could already accommodate the extra digit. As we increasingly move towards cancer waits data being a key data source for cancer registration the extra digit is of value to the users of Cancer Registry data as it provides an indication of the location of the cancer within the organ concerned. It is also in line with PAS and the Commissioning Datasets extracts which can code to 4 characters. Although the overall list looks daunting, for any one MDT, there will only be a limited number of ICD-10 codes which are applicable.
31.6. Now that we are recording the ICD-10 code to the 4th digit, if a patient is diagnosed with 2 different foci of breast cancer - one in the upper inner quadrant (C50.2) and one in the lower outer quadrant (C50.5) of the same breast, would we just record one of these or both bearing in mind that the treatment would most likely be a mastectomy so Decision to Treat and Treatment Dates would be the same for both?

If there were two urgent suspected cancer referrals (ie two different PPIs) leading to the diagnosis of two primary cancers then you could have separate records one for each of the primaries and they would both end on the same day i.e. with the same operation. However, it is more likely that this was a single referral that has resulted in cancer being found in two sites. It is not possible to record two ICD10 codes. For this rare occurrence, you will need to either pick one of these sites and record it or code it as breast cancer with site unspecified. It is suggested that you seek advice from your local Cancer Registry for their preferred option.

31.7. How do we code secondary or metastatic disease?

For any recurrent or metastatic disease the ICD-10 code of the primary site (rather than the metastatic site) needs to be recorded as the PRIMARY DIAGNOSIS.

31.8. What ICD-10 code do you use when treating an unknown primary?

If you are treating metastatic disease of an unknown primary you would use codes C78.0-C79.8 as relevant to the metastatic site you are treating.

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

31.9. If a patient has an unknown primary and is recorded as ICD-10 code C80 but at some point afterwards the primary site is identified, should we change the ICD10 code?

No, you do not need to change the ICD10 code. The correct ICD10 code can be used for any 31 day subsequent treatments that follow but you would not need to retrospectively change the ICD10 code for a record that had been completed (ie First Definitive Treatment given for metastases of unknown primary) as the ICD10 code was unknown at the time. You may wish, however, to update records submitted to cancer registries.

31.10. ‘Carcinoids of the appendix are coded as D37 but carcinoids of other sites are coded to a C code in ICD10 – are all carcinoids reported for cancer waits?

No. Only C codes are included in the scope of the cancer waiting times dataset with the exception of breast cancer in situ which has a D code (D05)

31.11. Does C17 comes under Upper or Lower Gastrointestinal Cancers. CfH shows it as Lower GI but the Information Centre, lists C17 within the Upper GI appendix. Could you please advise which is correct.

For cancer waits we use the clinical codes listed at: http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/clincoding
This shows C17 as lower gastrointestinal (LGI) cancer.
32. **TUMOUR LATERALITY**

This identifies the position of a tumour within a patient.

32.1. **Is this data item mandatory?**

Yes, it is mandatory for records where an ICD-10 code is present.

32.2. **What options are available?**

The code options are:

- L  Left
- R  Right
- M  Midline
- B  Bilateral
- 8  Not applicable
- 9  Not known

32.3. **Why is it important to record the position of the tumour for cancer waits?**

A patient could potentially have two cancers (eg. one in the left breast and then a couple of years later one in the right breast). As we increasingly move towards cancer waits data being a key data source for cancer registration the extra information provided by indicating where a tumour is located within a paired organ e.g. breast, lung is of enormous value to the Cancer Registries as it enables them to match records from other data sources more accurately.
33. **METASTATIC SITE**

This data item is used where the primary cancer has spread elsewhere in the body - it identifies the site of the metastatic disease. ie to where a primary cancer has spread.

33.1. **Is this data item mandatory?**

Yes, if applicable ie. if the patient has metastatic disease and the treatment being recorded is for that metastatic disease.

33.2. **What are the options to choose from?**

02 Brain  
03 Liver  
04 Lung  
06 Multiple metastatic sites  
08 Skin  
09 Distant lymph nodes  
10 Bone  
11 Bone marrow  
12 Other metastatic site  
07 Unknown metastatic site

33.3. **Why do we need to code metastatic disease?**

This allows the site of the metastatic disease to be recorded for subsequent treatments alongside the original primary site for example breast cancer with bone metastases. This will provide information both locally and nationally as to how patients with metastases are treated.

33.4. **Why is it important to record the metastatic site for cancer waits?**

For the first time cancer waits gives us the opportunity to capture information for all patients with metastatic disease. This is extremely important for beginning to assess clinical outcomes and patterns of care.

33.5. **How should metastases be recorded?**

You should record the site of the primary diagnosis (if known) in the PRIMARY DIAGNOSIS field using the ICD-10 code and record in the METASTATIC SITE field the actual site of the metastases (ie. you do not use the ICD-10 code for the metastases itself). For example, where a patient is diagnosed with a primary lower GI cancer with lung metastases the ICD-10 code used should be that of the lower GI cancer with the metastatic site given as lung for any subsequent treatments.

You only fill in the metastatic site for a first treatment for treatment of an unknown primary.

33.6. **Do we document the metastatic site at the point of diagnosis or at the given point on the pathway?**

The metastatic site is linked to the treatment event in question eg a 31 day subsequent treatment period. It is therefore related to the point on the pathway not the point at diagnosis unless the patient is being treated for metastases of unknown origin.
Why can’t the details of the metastatic site be included within the treatment record of the primary cancer?

We are aware that the first treatment record will not include the metastatic details. If metastatic details were included on the record for a known primary it would not be clear if the treatment being reported on the CWT-Db was for the first treatment of the primary or for treatment of the metastases. Therefore, for first treatment of a primary you don’t include the metastatic site. However you could upload a 31 day subsequent treatment record related to the metastatic site if a treatment was delivered.

33.7. **A patient could be diagnosed with a primary and metastatic cancer at the same time – how should this be recorded?**

Treatment of metastatic disease has to be classed as a subsequent treatment if the primary is known. The 31 day subsequent treatment of the metastatic disease is a separate record. It can be uploaded before the 31 day first treatment record for the primary has been uploaded as treatments do not need to be uploaded sequentially. If the patient needs the treatment for the metastatic disease BEFORE the treatment of the primary cancer you can upload a 31 day subsequent treatment record even though it took place ahead of the first treatment but if the patient is on a 62 day pathway for the primary cancer that subsequent treatment would NOT stop the 62 day clock.

33.8. **A patient is diagnosed with primary and metastatic disease - is the patient on a 62 day pathway for primary and a separate 31 day pathway for metastases?**

Yes. Treatment of the primary is on the 62 day standard (if it was, for example, a two week referral) and treatment of the metastatic disease would be a 31 day subsequent treatment.

33.9. **A patient is diagnosed with primary and metastatic disease - the patient is treated first for the primary then for the metastases – how do you upload this?**

Upload the 62 day for the primary without the detail about the metastatic disease plus a 31 day record for a subsequent treatment of the metastatic disease.

33.10. **A patient is diagnosed with a primary and metastatic disease and the metastases is treated first - why won’t the CWT-Db allow this to be classed as the first treatment?**

Metastases with a known primary has been out of scope since cancer waits standards were defined in 2000 and remain out of scope for this reporting. Metastases with a known primary is only monitored under the 31-day standard as a subsequent treatment. The treatment of the primary cancer is the one to which the 62-day standard applies, and is the one that should be coded as the first treatment. Previously there would have been a medical suspension for any delays in the first treatment due to the treatment of metastases, now the operational standard has been adjusted to reflect the unavoidable delay in cases such as these.

33.11. **A patient is diagnosed with a primary and metastatic disease at the same time - the metastases requires emergency treatment FIRST prior to any treatment for the primary. How would we record this?**

Treatment of the metastases would be a subsequent treatment and uploaded as such. It does not matter that sequentially it took place before treatment of the primary cancer in terms of the CWT-Db i.e. you do not need to upload the treatment records sequentially. The 62 day clock would not stop at treatment of the metastases as this is not treating the primary
- the 62 day standard is for treatment of new primaries only not recurrence/metastases. You would upload the treatment for the primary as normal once it had taken place and this would stop the 62 day clock.

33.12. **What happens if a primary cancer is diagnosed and confirmed AFTER a metastases has been treated?**

If the primary cancer had not been diagnosed before a treatment was given you would have been treating metastases of an unknown primary which CAN be classed as first definitive treatment. If the primary cancer is diagnosed at a later date the ICD-10 code can be included for any subsequent treatments.
DATA ITEMS RELATED TO THE TREATMENT USED

- CANCER TREATMENT MODALITY
- CANCER CARE SETTING (TREATMENT)
- CLINICAL TRIAL INDICATOR
- RADIOTHERAPY PRIORITY
- RADIOTHERAPY INTENT
34. **CANCER TREATMENT MODALITY**

*This data item identifies the type of treatment or care that a patient receives within the episode that ends a 31 or 62 day period.*

34.1. **Is this data item mandatory?**

Yes, it is mandatory for all records which have a TREATMENT START DATE (CANCER) present.

34.2. **What options are available?**

The National Codes to choose from are:

- 01 Surgery
- 02 Anti-cancer drug regimen (Cytotoxic Chemotherapy)
- 03 Anti-cancer drug regimen (Hormone Therapy)
- 04 Chemoradiotherapy
- 05 Teletherapy (Beam Radiation excluding Proton Therapy)
- 06 Brachytherapy
- 07 Specialist Palliative Care
- 08 Active Monitoring (excluding non-specialist Palliative Care)
- 09 Non-specialist Palliative Care (excluding Active Monitoring)
- 10 Radio Frequency Ablation (RFA)
- 11 High Intensity Focussed Ultrasound (HIFU)
- 12 Cryotherapy
- 13 Proton Therapy
- 14 Anti-cancer drug regimen (other)
- 15 Anti-cancer drug regimen (Immunotherapy)
- 16 Light Therapy (including Photodynamic Therapy and Psoralen and Ultra Violet A (PUVA) Therapy)
- 17 Hyperbaric Oxygen Therapy
- 19 Radioisotope Therapy (including Radioiodine)
- 20 Laser Treatment (including Argon Beam therapy)
- 21 Biological Therapies (excluding Immunotherapy)
- 22 Radiosurgery
- 23 Other Treatment
- 98 All treatment declined

34.3. **Are modality codes only used for first treatments?**

No. The modality codes need to be used for both first and subsequent treatments.

34.4. **Can ‘other’ be used as a treatment option for First Definitive Treatments and for subsequent treatments?**

Yes. It can be used for both first and subsequent treatments where appropriate.

34.5. **Which anti-cancer drug regimens come under the 31 day subsequent chemotherapy standard?**
As stated in SQU05 of the Technical Guidance for the 2011/12 Operating Framework, all four of the anti-cancer drug regimen categories are included in the 31 day subsequent treatment standard ie:
02 cytotoxic chemotherapy
03 hormone therapy
14 other
15 immunotherapy.

34.6. Which treatments are covered by the 31 day subsequent radiotherapy?

As stated in SQU05 of the Technical Guidance for the 2011/12 Operating Framework, the following treatment modalities are covered by this standard:
04 Chemoradiotherapy
05 Teletherapy (Beam Radiation excluding Proton Therapy)
06 Brachytherapy
13 Proton Therapy.

34.7. Which treatments are covered by the 31 day subsequent surgery standard?

As stated in SQU05 of the Technical Guidance for the 2011/12 Operating Framework, only those surgical treatments that you would code as ‘01 Surgery’ are covered by this standard. Treatments such as cryosurgery would be coded as 18 ‘other treatments’.

34.8. What is classed as Specialist Palliative Care (Code 07)?

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

34.9. What is classed as Active Monitoring (excluding non-specialist Palliative Care) – Code 08?

Active Monitoring will commence when a decision is made (and agreed with the patient) that it is clinically appropriate to start a period of monitoring, possibly whilst the patient receives symptomatic support, but without any specific or significant clinical intervention at this stage. It is not to be used for thinking time.

During Active Monitoring the patient will remain under the care of a Consultant although the GMP/GDP will be updated with the progress of their patient.

If a decision to treat is made during Active Monitoring, this will end the Active Monitoring.

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 slow growing 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.

34.10. What is classed as Non-specialist Palliative Care (excluding Active Monitoring) – Code 09?

This is palliative care (excluding active monitoring) that is not given under the management of a consultant specialising in Palliative Medicine.

34.11. Is Code 16 for light therapy only to be used for dermatological treatment?
Code 16 – light therapy is not skin cancer specific.

34.12. If a patient decides not to proceed with any treatment, how should this be recorded?

If a patient decided not to proceed with any treatment, Code 98 ‘all treatment declined’ should be used. This would end a 31 or 62 day period.

34.13. If a combination treatment is radiotherapy combined with surgery do we use the code for teletherapy as that is the initial treatment or surgery as that is the main radical treatment in the combination?

For the purposes of cancer waits, combined treatments are treatments of different modalities combined in a way that they must be scheduled to take place together. A combination treatment should be coded according to the treatment that is given first sequentially unless it is chemoradiotherapy, which has its own code (code 04).

34.14. How should treatments that are not listed be recorded (including new technologies)?

If there is not a category appropriate for a technology it should be recorded under ‘Other Treatment – Code 18’. If you are not sure about how a treatment should be coded or if you are aware of new treatments coming on line (especially those likely to become standard practice in the future) please contact cancer-waits@dh.gsi.gov.uk as it may be possible to include additional codes in future versions of the dataset/CWT-db.

34.15. How should biological therapies be coded?

This should be coded as ‘14 - anti-cancer drug regimen - other’.

34.16. How should thyroxine be coded?

This should be coded as ‘03 - anti-cancer drug (hormone)’

34.17. How should Bone Marrow Transplantation be coded?

These should be coded as ‘01 – surgery’.
35. **CANCER CARE SETTING (TREATMENT)**

This data item is used to record the type of care setting where the cancer treatment took place that marks the end of the 31 and/or 62 day period (i.e. the TREATMENT START DATE (CANCER)).

35.1. **Is this data item mandatory?**

Yes, it is mandatory for records which contain a TREATMENT START DATE (CANCER).

35.2. **What options are there?**

The National Codes to choose from are:

- **01** Cancer treatment delivered as part of a Hospital Provider Spell (where PATIENT CLASSIFICATION is National code 1 – Ordinary admission)
- **02** Cancer treatment delivered as part of a Hospital Provider Spell (where PATIENT CLASSIFICATION is National Code 2 - Day case admission)
- **03** Cancer treatment delivered in an Out-patient setting
- **04** Cancer treatment delivered in another care setting
- **99** Setting Unknown

35.3. **Why do we need to identify the care setting for waiting times?**

An adjustment is allowed if a patient declines a reasonable offer of admitted treatment – this is known as the WAITING TIME ADJUSTMENT REASON (TREATMENT). It is therefore necessary to know the type of care setting for a treatment to verify whether any adjustments used are valid. In addition, knowing the care setting for treatment could support local capacity planning.

35.4. **What can and can’t be classed as admitted or non-admitted care?**

- **Admitted** pathways are those that end in an admission to hospital (either in-patient or day case) for treatment.
- **Non-admitted** pathways are those that end in treatment that did not require admission to hospital or where no treatment is required (e.g. out-patients).

35.5. **Will DH monitor whether treatments take place in an admitted or non-admitted setting?**

The CANCER CARE SETTING (TREATMENT) data item identifies hospital spells and treatments in out-patient and other care settings. DH will break national standards down by setting and will publish this breakdown as part of its National Statistics.

35.6. **Who decides the care setting to record – the commissioner or the provider?**

The care setting of treatments should be recorded in line with what is delivered. This will be determined by what has been commissioned, the clinical need of the patient and what clinical guidelines say. The data uploaded should relate to the reported care in the Commissioning Dataset (CDS). If the patient is an out-patient, we would not expect them to be recorded as a day case admission just to enable an adjustment.
35.7. Is the CANCER CARE SETTING (TREATMENT) data item linked to the mode of treatment ie. should all chemotherapy be classed as out-patient etc?

No. The care setting is not linked to the treatment modality and no efforts to link coding in this manner is being made nationally. It is perfectly appropriate to receive chemotherapy or radiotherapy in both the admitted or non-admitted environment. Therefore the CANCER CARE SETTING (TREATMENT) should be coded to reflect the care setting where the individual episode of care was delivered and what was commissioned for the patient.

35.8. What care setting should be used for combined treatments such as chemoradiotherapy when one part might be non-admitted and the other admitted?

You should use the care setting for the treatment that is given first in the sequence.

35.9. Are regular day attenders classed as admitted or non-admitted care?

There are two different types of regular day admission for cancer services, each of which may have a different admission status that should be considered when submitting data to form patient records for cancer waiting times. The different types of regular attender are:

- a Regular Day Admission - where a patient is admitted electively during the day, as part of a planned series of regular admissions for an on-going regime of broadly similar treatment and who is discharged the same day. If the intention is not fulfilled and one of these admissions should involve a stay of at least 24 hours, such an admission should be classified as an ordinary admission. This series of regular admissions ends when the patient no longer requires frequent admissions;

- a Regular Night Admission - where a patient is admitted electively for the night, as part of a planned series of regular admissions for an on-going regime of broadly similar treatment and who is discharged in the morning. If the intention is not fulfilled and one of these admissions should involve a stay of at least 24 hours, such an admission should be classified as an ordinary admission. This series of regular admissions ends when the patient no longer requires frequent admissions.

Both of these types of regular attendance include an admission, therefore they should be considered to be care in an admitted setting.

If the patient is being invited back for multiple outpatient attendances, but no admission is made then that episode of care should not be considered a Regular Day Admission and the episode of care should not be recorded as being within an admitted environment within the CWT-Db as it is merely outpatient activity.
36. CLINICAL TRIAL INDICATOR

This data item is used to record whether the treatment package recorded under CANCER TREATMENT MODALITY was part of a clinical trial of a new treatment (eg. drug or procedure).

36.1. Is this data item mandatory?

Yes, it is mandatory for records which contain a TREATMENT START DATE (CANCER).

36.2. How do we record this?

The National Codes to choose from are:

01 PATIENT is taking part in a CLINICAL TRIAL
02 PATIENT is not taking part in a CLINICAL TRIAL
99 Unknown

36.3. Why is this data item relevant to cancer waits?

Feedback from implementing cancer waits in the early stages indicated that delays could take place in the treatment of patients taking part in clinical trials. This data item provides localities with additional information to support the investigation of any breaches.

36.4. What do we do if the patient is part of a trial that is not directly related to the treatment they are receiving eg. a cohort study?

If the clinical trial relates to a part of the pathway other than a treatment episode then code “02” should be used ie. the patient is not taking part in a clinical trial.
37. **RADIOTHERAPY PRIORITY**

This data item is used to record the priority for a Radiotherapy Treatment Course identified by the requesting clinician, and is also included in the Radiotherapy Dataset (RTDS).

37.1. **Is this data item mandatory?**

It is only mandatory where radiotherapy is the treatment used i.e. where the TREATMENT MODALITY CODE is National Code 05 – Teletherapy (Beam radiation excluding Proton Therapy).

37.2. **How do we record this?**

The National Codes to choose from are:

- E - Emergency (treatment required within 24 hours)
- R - Routine
- D - Elective delay (treatment delayed for clinical reasons)

37.3. **What should be classed as: RT Priority - "D" - elective delay (treatment delayed for clinical reasons)**

This may be a patient who is too ill to start their radiotherapy due to, for example, concurrent cardiac problems which need to be treated first.

37.4. **Why record the priority – will we be monitored against the higher standards set by the Royal College of Radiologists (RCR)?**

The national standard that you will be monitored against is 31 days. However, local providers and commissioners will want to provide the best service possible for an individual patient and these categories will facilitate that by enabling localities to see the volume of patients assigned to the different categories, the impact that has on capacity needed and whether they are able to deliver the level of service to their patients recommended by the RCR.

37.5. **Why do we need to record this data item in the cancer waits dataset if it is already being collected for the radiotherapy dataset?**

This data item, in conjunction with the data item RADIOTHERAPY INTENT has been included to enable the RCR to continue to undertake their radiotherapy waiting times audit, based on RCR Guidance, which has different parameters from those used for cancer waits.

37.6. **The majority of people who collect this information are not medically trained, how will they know the RADIOTHERAPY PRIORITY?**

Local processes will need to ensure that this information is provided and captured in order to meet the requirements of the NHS Data Dictionary.
38. RADIOTHERAPY INTENT

This data item is used to record the intent of the radiotherapy treatment i.e. to see if it is being used to actively treat the cancer or to palliate symptoms or for some other reason.

38.1. Is this data item mandatory?

It is only mandatory where radiotherapy is the treatment used ie where the TREATMENT MODALITY CODE is National Code 05 – Teletherapy (Beam radiation excluding Proton Therapy).

38.2. How do we record this?

The Codes for this data item are:

01 Palliative (i.e. for symptom control)
02 Anti-cancer (i.e. treatment which aims to be curative - including adjuvant)
03 Other

These codes are based on Royal College of Radiologists (RCR) recommendations.

38.3. Why is it important to know the intent of the treatment?

This will support local planning i.e. identifying future capacity requirements. For example, actively treating a cancer will generally require more fractions over a longer period of time than treatment to palliate symptoms. Identifying the proportion of patients in each category will support localities in identifying their radiotherapy requirements for the future.

38.4. Why do we need to record this data item if it is not collected for the radiotherapy dataset?

This data item, in conjunction with the data item RADIOTHERAPY PRIORITY has been included to enable the RCR to continue to undertake their radiotherapy waiting times audit, based on RCR Guidance, which has different parameters from those used for cancer waits.

38.5. The majority of people who collect the information are not medically trained, how will they know the RADIOTHERAPY INTENT?

Local processes will need to ensure that this information is provided and captured in order to meet this requirement.

38.6. Can the radiotherapy intent field be used to record the intent of other treatments?

No. This would not be in line with the NHS Data Dictionary definition.
DATA ITEMS RELATED TO TRACKING & PRIORITISATION OF PATIENTS

- SOURCE OF REFERRAL FOR OUTPATIENTS
- PRIORITY TYPE CODE
- CANCER OR SYMPTOMATIC BREAST REFERRAL PATIENT STATUS
- CANCER TREATMENT EVENT TYPE
- DECISION TO REFER DATE (CANCER OR BREAST SYMPTOMS)
39. **SOURCE OF REFERRAL FOR OUT-PATIENTS**

This data item identifies the source of referral for the consultant-led out-patient episode which would generally be the DATE FIRST SEEN for the patient unless they went to a diagnostic clinic first. It can be initiated by a range of health professionals although an urgent two week wait referral has to be initiated by a GP (GMP or GDP).

39.1. **Is this data item mandatory?**

Yes but this is conditional on the type of waiting time period being recorded – see the table at the end of part 6.

39.2. **Does this have to be completed for every referral for an out-patient appointment a patient receives for a particular cancer?**

No. Within the CWT-Db upload, this data item is only required for the first referral by the NHS to a provider that initiates a CANCER REFERRAL TO TREATMENT PERIOD and results in a DATE FIRST SEEN.

39.3. **What are the potential sources of referral?**

The potential sources of referral initiated by the consultant responsible for the consultant out-patient episode are:

- **Initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode**
  
  01 following an emergency admission
  02 following a Domiciliary Consultation
  10 following an Accident and Emergency Attendance (including Minor Injuries Units and Walk In Centres)
  11 other - initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode

- **Not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode**
  
  03 referral from a GENERAL MEDICAL PRACTITIONER
  92 referral from a GENERAL DENTAL PRACTITIONER
  12 referral from a General Practitioner with a Special Interest (GPwSI) or Dentist with a Special Interest (DwSI)
  04 referral from an Accident and Emergency Department (including Minor Injuries Units and Walk In Centres)
  05 referral from a CONSULTANT, other than in an Accident and Emergency Department
  06 self-referral
  07 referral from a Prosthetist
  13 referral from a Specialist NURSE (Secondary Care)
  14 referral from an Allied Health Professional
  15 referral from an OPTOMETRIST
  16 referral from an Orthoptist
  17 referral from a National Screening Programme
  93 referral from a Community Dental Service
  97 other - not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode
39.4. **How do we code referrals made by specialist nurses in primary care?**

Such referrals are made under the authority of the General Medical Practitioner leading their team and should therefore be classified as referrals from the GP (ie. **Code 03**). Referrals from Specialist Nurses in Secondary Care should be classified as code 13.

39.5. **How do we code referrals from GPs with a Special Interest?**

Where a patient is referred by a GP acting in the capacity of GP with Special Interest, code 12 should be used. Where a patient is referred by that GP acting in their capacity as an ordinary GP, code 03 or code 92 (if a GDP) should be used as appropriate. Note: A GP acting in their capacity as a GP with a Special Interest cannot make an urgent two week wait referral.

39.6. **What sources of referral are permitted for an urgent referral for suspected cancer?**

Codes 03 (General Medical Practitioner) and Code 92 (General Dental Practitioner) are allowed for urgent two week wait referrals for suspected cancers (**PRIORITY TYPE CODE 3**).

39.7. **How should source of referral for subsequent treatments be recorded?**

The data item **SOURCE OF REFERRAL FOR OUTPATIENTS** is **not** applicable to subsequent treatments.
40. **PRIORITY TYPE CODE**

*This data item identifies the priority of a referral.*

40.1. **Is this data item mandatory?**

Yes but this is conditional on the type of waiting period being recorded – see the table in section 46.

40.2. **What priority type codes are available?**

There are three priority type codes relevant to cancer waiting times:

- **3** this is for two week wait referrals for suspected cancer and two week wait referrals for patients with breast symptoms (cancer not suspected);
- **2** this is for urgent referrals – this would include urgent screening referrals coming on to the 62 day pathway
- **1** this is for routine referrals.

40.3. **Which of these priority type codes can be upgraded on to the 62 day pathway?**

- Priority 3 (two week wait referrals) - this will cover urgent GP referrals for suspected cancer and referrals for breast symptoms (cancer not suspected) - both sets of patients automatically go on to 62 day pathway if cancer is diagnosed so patients referred under this priority type code do not need to be upgraded.
- Priority 2 (urgent referrals) - for cancer standards this would be used for patients coming on to 62 day pathway from screening programmes. An upgrade is not needed for these patients. Patients with this referral code not from cancer screening services could be upgraded on to the 62 day pathway if a clinician suspects cancer and a local protocol to upgrade is in place.
- Priority 1 (routine referrals) - for cancer standards any patient routinely referred could be upgraded to be covered by the 62 day standard if a clinician suspects cancer and a local protocol to upgrade is in place.

In terms of the upgrade therefore, patients with a PRIORITY TYPE CODE of either 1 (routine) or 2 (urgent - but not from screening programmes) could be upgraded onto the 62 day pathway if a clinician suspects cancer and a local protocol to upgrade is in place.

Without the upgrade the patient would be on the RTT pathway.

40.4. **Can you provide an example of how upgrades for PRIORITY TYPE CODE 1 and 2 referrals work in practice?**

Examples to illustrate upgrades follow:

- a patient is a routine referral (PRIORITY TYPE CODE 1) with a serious cough, on seeing the patient the consultant (or authorised team member) suspects lung cancer so upgrades the patient on to a 62 day pathway;
- a patient is urgently referred (PRIORITY TYPE CODE 2) with suspected tuberculous, on seeing the patient the consultant (or authorised team member) suspects lung cancer so upgrades the patient on to a 62 day pathway;
- a patient has low risk abnormalities on cervical screening (cancer is not suspected) and a routine referral is made (PRIORITY TYPE CODE 1) on seeing the patient the consultant (or authorised team member) suspects cervical cancer and upgrades the patient on to a 62 day pathway.
40.5. If urgent referrals (not from screening programmes) or routine referrals are upgraded, should their PRIORITY TYPE CODE be changed to PRIORITY TYPE CODE 3 (ie. equivalent to two week wait)?

No. The PRIORITY TYPE CODE is that which relates to the initial referral. The upgrade flags the fact that the patient is now on a faster pathway.

40.6. What PRIORITY TYPE CODE would patients under the 31 day first treatment standard have been referred under?

Patients under the 31 day first treatment standard could potentially have been referred as PRIORITY TYPE CODE 1, 2 or 3.

40.7. What is the PRIORITY TYPE CODE for subsequent treatments?

The data item PRIORITY TYPE CODE is not applicable to subsequent treatments (see table at the end of Part 6).
41. CANCER OR SYMPTOMATIC BREAST REFERRAL PATIENT STATUS

This data item enables local tracking of the status of patients referred with a suspected cancer (via GP/GDP or screening service), or referred from any health professional with breast symptoms where cancer was not suspected; or upgraded onto the 62 day period.

41.1. Is this data item mandatory?

Yes, it is mandatory for all records.

41.2. What options can be used?

The codes that can be used are:

14 Suspected primary cancer
09 Under investigation following symptomatic referral, cancer not suspected (breast referrals only) - this code can only be used for two week wait symptomatic breast referrals ie. those with a TWO WEEK WAIT CANCER OR SYMPTOMATIC BREAST REFERRAL TYPE of Code 16 - Exhibited (non-cancer) breast symptoms - cancer not initially suspected
03 No new cancer diagnosis identified by the Healthcare Provider
10 Diagnosis of new cancer confirmed - first treatment not yet planned
11 Diagnosis of new cancer confirmed - English NHS first treatment planned
07 Diagnosis of cancer confirmed - no English NHS treatment planned
08 First treatment commenced (English NHS only)
12 Diagnosis of new cancer confirmed - subsequent treatment not yet planned
13 Diagnosis of new cancer confirmed - subsequent English NHS treatment planned
21 Subsequent treatment commenced (English NHS only)
15 Suspected recurrent cancer
16 Diagnosis of recurrent cancer confirmed - first treatment not yet planned
17 Diagnosis of recurrent cancer confirmed - English NHS first treatment planned
18 Diagnosis of recurrent cancer confirmed - no English NHS treatment planned
19 Diagnosis of recurrent cancer confirmed - subsequent treatment not yet planned
20 Diagnosis of recurrent cancer confirmed - subsequent English NHS treatment planned

41.3. Do these codes need to be updated throughout the patient journey?

It is mandatory to complete this field at the point of DATE FIRST SEEN and also at the TREATMENT START DATE (CANCER) and it is likely that the code will need to change at the second of these points, for example, changing from Code 14 (suspected primary cancer) to Code 08 (first treatment commenced). You might, however, wish to update the codes more frequently locally to aid local tracking and record management – this might be particularly useful where Inter-Provider Transfers take place or to identify when records can be closed eg. when cancer is ruled out (Code 03). It was important that all these codes were included to support local tracking.

41.4. Can we upload data for this item more frequently than monthly ie. so that our local systems and the national system remain synchronised?

Yes
41.5. If a patient is not diagnosed with cancer how will the record on the national system be closed?

If no data is uploaded after DATE FIRST SEEN the assumption is made that the patient did not have cancer that was treated by the English NHS as a cancer treatment period is not recorded.

41.6. There will be lots of open records on the national system ie. where the non-cancer diagnosis is not confirmed – could there be automatic closure of records after say 6 months of not being opened/edited?

No. Automatically defaulting status fields on dormant records is not considered good information practice.

41.7. Can CANCER OR SYMPTOMATIC BREAST REFERRAL PATIENT STATUS Code 08 ‘First treatment commenced (English NHS only)’ be used for first treatment of a recurrent cancer?

No. Recurrent cancers are only covered by the 31 day subsequent treatment standard. Code 08 is not relevant to recurrent cancer. A patient may be having the first treatment for the recurrence but it would still be classed as a subsequent treatment as there would have previously been treatments for the primary. Code 21 should be used to mark the start of treatment of a recurrence.

41.8. Is it intended that code 08 will indicate First Treatment commenced on BOTH new cancer diagnosed and recurrent cancer diagnosed.

No. Code 08 is for first treatment for a primary cancer. Code 21 (subsequent treatment commenced) should be used for treatment of a recurrence on the basis that such a patient is likely to have had previous treatment (even if it was some years ago) when the primary cancer was initially diagnosed.

41.9. Is it intended that code 21 will indicate Subsequent Treatment commenced for BOTH new and recurrent cancers?

Yes.

41.10. There is no code for 'no recurrent cancer diagnosis identified' following a suspected recurrent cancer referral – what code should be used?

You should use Code '03 - No new cancer diagnosis identified'. The term 'new' cancer is used but does not specify whether that is a new primary or recurrent cancer. It was specifically worded so that is could be used where both suspected new primary or suspected recurrence is ruled out.
41.11. All treatments for recurrences are counted as a subsequent treatment but codes 16 and 17 allow you to record first treatments for these recurrences – why is that?

For local planning purposes you might wish to record that the first treatment for the recurrence is being planned. However, for the national standard, treatment of a recurrence when given is always assumed to be a subsequent treatment on the basis that the patient would have had some form of treatment for their initial cancer even if that was some years ago.

41.12. How do we code treatment of a recurrence?

Use code 21 (subsequent treatment commenced). It is assumed that any treatment of a recurrence is a subsequent treatment as the first treatment would have been to the primary even if that was some years ago.

41.13. How do we code treatment of a metastases?

Use code 21 (subsequent treatment commenced). It is assumed that any treatment of a metastases is a subsequent treatment as the first treatment would have been to the primary even if that was some years ago. However, if it is treatment of metastases of unknown origin you can use code 21 or code 08 First treatment commenced (English NHS only)

41.14. How should relapses and progressions be recorded?

Treatments for relapses and progressions of disease should be classified as forms of subsequent treatment as they are not the first definitive treatments on a patient pathway.

41.15. There does not appear to be a status for metastatic cancer with known primary, is this correct?

Metastatic disease after a known primary is considered to be a form of recurrence within the dataset and should be coded using Codes 15-21 as appropriate.

41.16. An urgent screening referral goes on to be diagnosed with a recurrence rather than a new primary. How should this be coded?

Use codes 15-21 as appropriate.

41.17. If a patient dies before diagnosis or planned treatment how should this be recorded?

You would not upload records for a patient that dies prior to treatment as the treatment did not take place. The exception is if the patient had declined all treatments offered prior to death in which case you would record the date they decided to decline all treatments as the clock stop. Local systems will, however, need to be able to flag a patient death and forward this information to cancer registries.

41.18. This item seems similar to CANCER TREATMENT EVENT TYPE – what is the difference/why do we need both?

- This item CANCER OR SYMPTOMATIC BREAST REFERRAL PATIENT STATUS is for local tracking and record management.
- The item CANCER TREATMENT EVENT TYPE is about reporting the final event that
will mark the end of a 62 day and/or 31 day period.

41.19. If a Patient Status code has been incorrectly uploaded can it be corrected?

You can correct this code on the system - it will not impact on the reports CWT-Db produces.
42. **CANCER TREATMENT EVENT TYPE**

This identifies the phase treatment has reached during a cancer patient pathway for primary, recurrent or metastatic cancer.

42.1. **Is this data item mandatory?**

Yes, it is mandatory for records which contain a TREATMENT START DATE (CANCER).

42.2. **What options are available?**

The Codes that can be used are:

- 01 First Definitive Treatment for a new primary cancer
- 02 Second or subsequent treatment for a new primary cancer
- 03 Treatment for a local recurrence of a primary cancer
- 04 Treatment for a regional recurrence of cancer
- 05 Treatment for a distant recurrence of cancer (metastatic disease)
- 06 Treatment for multiple recurrence of cancer (local and/or regional and/or distant)
- 07 First treatment for metastatic disease following an unknown primary
- 08 Second or subsequent treatment for metastatic disease following an unknown primary
- 09 Treatment for relapse of primary cancer (second or subsequent)
- 10 Treatment for progression of primary cancer (second or subsequent)

These codes are used to distinguish between first and subsequent treatments and also identify whether the cancer is primary or a type of recurrence.

42.3. **Which of these codes are for first treatments that can end a 62 day period?**

Only codes “01” and “07” will be considered to be first treatment events, and therefore suitable for reporting as the end points to the 62 day period (from urgent GP referral, referral with breast symptoms where cancer is not suspected, urgent referral from screening programmes or consultant upgrades) and against the original 31 day standard for first treatment.

42.4. **Can Event Types 03, 04, 05 or 06 be used for a first treatment?**

No. It is assumed that a patient with a recurrence has, at some time in the past, received treatment for the initial cancer (even if this predated the cancer waits standards). As such, these codes would always be used to indicate a subsequent treatment.

42.5. **What is code 06 (Treatment for multiple recurrence of cancer (local and/or regional and/or distant)) used for?**

This is for a patient who is treated for a cancer which has spread in more than one way.

42.6. **What is the difference between local, regional and distant disease (Code 06)?**

- Local would be a recurrence very close to the site of the original primary cancer;
- Regional would be, for example in the case of a breast patient, spread to the axilla, supraclavicular or inter-mammary nodes;
- Distant would be metastatic spread to somewhere like the liver, brain or lungs.
42.7. **What is code 07 (first treatment for metastatic disease following an unknown primary) used for?**

This is for a patient who presents with metastatic disease, for whom the clinical team do not know where the site of the primary is (or was) and the patient has their first treatment for the metastatic disease. The site of the primary may become apparent after treatment or not at all whilst the patient is alive.

42.8. **What is code 08 (Second or subsequent treatment for metastatic disease following an unknown primary) used for?**

This is for a patient who presents has a second or subsequent treatment for metastatic disease, for whom the clinical team do not know where the site of the primary is (or was). The site of the primary may become apparent after the second or subsequent treatment or not at all whilst the patient is alive.

42.9. **What are code 09 (Treatment for relapse of primary cancer (second or subsequent)) and code 10 (Treatment for progression of primary cancer (second or subsequent)) used for?**

As haematological cancers do not spread/recur in the same way as solid tumours, haematologists consulted about cancer waited advised including this description within the coding structure. It is for clinical teams locally to decide which is the most appropriate category to use for their haematological patients.

42.10. **What is the difference between relapse and progression?**

It is for clinical teams locally to decide which is the most appropriate category to use for their haematological patients.

42.11. **Why do we need to collect this data item?**

This data item is used to ensure that subsequent treatments are not incorrectly mapped to first treatments and reported against the 62-day standards ie. it is part of the system validation to ensure that a 62 day period ends with the correct treatment episode.

42.12. **This item seems similar to Cancer or Symptomatic Breast Referral Patient Status – what is the difference/why do we need both?**

- This item (CANCER TREATMENT EVENT TYPE) is about reporting the final event that will mark the end of a 62 day and/or 31 day period;
- The CANCER OR SYMPTOMATIC BREAST REFERRAL PATIENT STATUS item is for local tracking and record management.

42.13. **If a patient dies before planned treatment how should this be recorded?**

You would not upload records for a patient that dies prior to treatment as the treatment did not take place - local systems will, however, need to be able to flag a patient death and forward this information to the relevant person/organisations eg. Cancer Registries.
42.14. If you enter the CANCER TREATMENT EVENT TYPE as code 01 First Definitive Treatment for a new primary cancer, the CWT-Db will not allow you to enter a metastatic site. Is that correct?

Yes. If you treat a primary where there is metastases you don't upload the detail of the metastases on the first treatment record. If metastases details were included on the record for a known primary it would not be clear if the treatment being reported on the CWT-Db was for the first treatment of the primary or for treatment of the metastases. Therefore, for first treatment of a primary you don't include the metastatic site. However you could upload a 31 day subsequent treatment record related to the metastatic site if a treatment was delivered. DH is considering whether to revise the system to enable details of metastases to be recorded on the appropriate primary cancer record.

42.15. The CANCER TREATMENT EVENT TYPE doesn’t allow you to identify if a subsequent treatment is 2\(^{nd}\), 3\(^{rd}\), 4\(^{th}\) etc within a period – is this sequence necessary?

The system can't automatically number subsequent treatments because Provider A might upload data to the CWT-Db after Provider B. In these cases the subsequent treatments could be sequentially numbered incorrectly. Providers can capture the sequence locally (i.e. from the date each subsequent treatment started) but there is no need to capture it nationally.
43. **DECISION TO REFER DATE (CANCER OR BREAST SYMPTOMS)**

This is the date on which:

- a GP or GDP decides to refer a patient urgently to secondary care with suspected cancer;
- any health professional decides to make a referral to secondary care for breast symptoms where cancer is not suspected;
- a screening service decides to urgently refer a patient with suspected cancer;
- a consultant decides to upgrade.

43.1. **Is this data item mandatory?**

No. It is optional. Feedback suggested that some localities might wish to use this data item as a lever locally to ensure referrals (particularly from GPs) are made promptly.

43.2. **Why have you renamed this data item?**

It has been renamed to reflect the fact that referrals will no longer just be for suspected cancer patients but will also cover patients with breast symptoms where cancer is not suspected.

43.3. **How do we get this date?**

This date may be, for example:

- the date on the letter, proforma or email from the general medical practitioner, general dental practitioner or other health professional;
- the appointment date of the first out-patient appointment, if the referral was a self-referral;
- the date on the letter for patients recalled for further assessment following a routine screening programme appointment.

The date may not be available to the health care provider if the initial service request to secondary care was made via the Choose and Book system and no supporting information was received.
DATA ITEMS RELATED TO SERVICE IMPROVEMENT

• MULTIDISCIPLINARY TEAM DISCUSSION INDICATOR

• MULTIDISCIPLINARY TEAM DISCUSSION DATE (CANCER)
44. **Multidisciplinary Team Discussion Indicator**

*This records whether the Cancer Care Plan (that was subsequently agreed with the patient) was discussed at a Multidisciplinary Team (MDT) Meeting.*

44.1. **Is this data item mandatory?**

This item is mandatory if applicable ie. if the waiting time period being recorded has included a discussion at the MDT where the Cancer Care Plan subsequently agreed with the patient was discussed.

44.2. **How is this item recorded?**

There are two options to choose from:

A  The PATIENT was discussed at a MULTIDISCIPLINARY TEAM meeting  
B  The PATIENT was not discussed at a MULTIDISCIPLINARY TEAM meeting

44.3. **Why is this data item important for cancer waits?**

‘Improving Outcomes: A Strategy for Cancer’ notes that MDT working has led to improved decision-making, more co-ordinated care patient care and improvement in overall quality of care. It is important that speed of diagnosis and treatment do not take place at the expense of good clinical practice such as MDT discussions. This item therefore acts as a check to ensure that timely care is not at the expense of good practice.

44.4. **A patient’s case may be discussed at multiple MDT meetings – which one does this data item relate to?**

It is the MDT where the care plan that is agreed with the patient is discussed.

44.5. **What happens if a care plan is drawn up before/after an MDT meeting but is not actually discussed at an MDT - for these patients it will look like they were not discussed at an MDT meeting in the upload, is this correct?**

This data item is designed to capture the date of the MDT meeting where the care plan that was agreed was discussed. This may be one of many MDT meetings where an individual case is discussed. By omitting these data from the upload you are not saying the patient was not discussed, only that the agreed care plan was not discussed at an MDT meeting.
45. **MULTIDISCIPLINARY TEAM DISCUSSION DATE (CANCER)**

*This data item records the date on which the patient was discussed at an MULTIDISCIPLINARY TEAM meeting and a treatment planning decision was made.*

45.1. **Is this data item mandatory?**

This item is mandatory if applicable ie. if MULTIDISCIPLINARY TEAM DISCUSSION INDICATOR is completed this item must also be completed.

45.2. **Why is this data item important for cancer waits?**

‘Improving Outcomes: A Strategy for Cancer’ notes that MDT working has led to improved decision-making, more co-ordinated care patient care and improvement in overall quality of care. It is important that speed of diagnosis and treatment do not take place at the expense of good clinical practice such as MDT discussions. This item therefore acts as a check to ensure that timely care is not at the expense of good practice.
46. Data items in Waiting Times Subset: Mandatory or Optional

The following table lists the 40 data items in the waiting times subset of the national cancer dataset and sets out whether their collection is mandatory or optional for different service providers. The data items are presented in the same order as the Comma Separated Values (.csv) file which can be exported from Provider-based systems and uploaded to the Cancer Waiting Times system. This system is hosted nationally on NHSnet.

The seven columns in the table show which data items are required for a range of health care scenarios, these are:

- **Scenario 1** The Health Care Provider where PATIENT first seen following a REFERRAL REQUEST with PRIORITY TYPE CODE of 'Two Week Wait', or the referral is from a Cancer Screening Service;
- **Scenario 2** The Health Care Provider where the PATIENT receives First Definitive Treatment for cancer following a REFERRAL REQUEST with PRIORITY TYPE CODE ‘Two Week Wait’, or the referral is from a Cancer Screening Service;
- **Scenario 3** The Health Care Provider where the PATIENT receives second or subsequent treatment for cancer following a REFERRAL REQUEST with PRIORITY TYPE CODE ‘Two Week Wait’, or the referral is from a Cancer Screening Service;
- **Scenario 4** The Health Care Provider where the PATIENT receives First Definitive Treatment for cancer following a consultant upgrade onto a 62 day PATIENT PATHWAY;
- **Scenario 5** The Health Care Provider where the PATIENT receives second or subsequent treatment for cancer following a consultant upgrade onto a 62 day PATIENT PATHWAY;
- **Scenario 6** The Health Care Provider where the PATIENT receives First Definitive Treatment for cancer following a REFERRAL REQUEST from another SOURCE OF REFERRAL FOR OUT-PATIENTS or a different PRIORITY TYPE CODE; and
- **Scenario 7** The Health Care Provider where the PATIENT receives second or subsequent treatment for cancer following a REFERRAL REQUEST from another SOURCE OF REFERRAL FOR OUT-PATIENTS or a different PRIORITY TYPE CODE.

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</table>

Key:
- **M** = Mandatory - the Standard Contract Schedule 5 requires NHS provider organisations to submit this information on a monthly basis. The Department of Health require the data to be submitted 25 working days after the end of each month or quarter.
- **M** = Mandatory if applicable - the Standard Contract Schedule 5 requires NHS provider organisations to submit this information on a monthly basis, where collection of the item was applicable to them. The Department of Health require the data to be submitted 25 working days after the end of each month or quarter.
- **O** = Optional
- **O** = Optional if applicable – These optional fields should only be populated if they relate to the PATIENT PATHWAY identified in scenarios 1 to 7 and the conditions required for their use are met
- **N/A** = Not Applicable

46.1. In the table why are the screening patients being grouped in with the two week wait patients (second column) when screening patients are on the 62 day pathway not the 14 day pathway?

The screening patients referred to in this column would be those urgently referred (PRIORITY TYPE 2). The screening patients are not monitored under the two week wait
standard but the relevant data items need to be collected in case there are any relevant adjustments in the first half of the pathway that would be relevant for the 62 day screening standard.
Cancer Waiting Times Database (CWT-Db)

46.2. What support is available for the database?

There is a user manual for the database available at http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation

You can also contact the Open Exeter helpdesk on 01392 251 289.

46.3. Will providers be able to update data on patients for which there is an existing record on the database?

Yes. The database allows records to be automatically updated through the CSV upload or through manual entry on screen provided the provider is in possession of the patient’s NHS NUMBER. See Cancer Waiting Times User Manual for details.

46.4. What are the upload dates & times?

These are available on the cfh website at: http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation

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

This is dependent on:

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

46.6. Can we still access the old CWT-Db?

Yes. The system has been archived so that old data can be downloaded. It can be accessed by clicking the legacy icon on the CWT-Db menu bar. However, it is no longer possible to upload on to this old system or to add, append or amend records.

46.7. Can we do manual uploads to the CWT-Db?

Yes, but this may not be feasible/appropriate for large number of records. It is not a recommended option for the long term as the CWT-Db is not a patient management tool it is a retrospective data collection system.

46.8. Where is the csv input specification?

It is on the Connecting for Health Website http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation
46.9. It would be better to have a national system for all MDTs to input data into rather than lots of different local systems being used which then upload onto CWT-Db – is a national system possible?

No. DH is not able to endorse a single system. Client end software is the role and remit of the Local Service Provider (LSP).

46.10. Are the deadlines for data uploads going to be tightened?

The timescale for submitting national data will remain 25 days until further notice. The long term aim is to reduce the time interval for uploading to the CWT-Db to within 15 operational days but there are no plans to action this yet. Any change of this type will need to be agreed with the Information Standards Board.

46.11. If the reports produced by CWT-Db do not look correct – who can investigate?

If you have concerns with how tables are reporting data you should first re-check the data and if you still have concerns you should report them to the Open Exeter helpdesk on 01392-251289.

DH does not have access to the level of data necessary to investigate such concerns.

46.12. Are tertiary providers able to upload data for the treatment part of the pathway if the referring provider has yet to upload the first part of the pathway?

Yes. The treatment data can be uploaded to the CWT-Db before the out-patient data. The system was set up like this because it was recognised that the tertiary centre might have a more automated process than the unit. The only reason a Provider might wait to upload is if they are using the CWT-Db as an alert system for referrals - the CWTDb has not been set up for this purpose and it is not recommended.
46.13. Will individual GP practices be required to register with Open Exeter in order to obtain a provider code to upload data on to CWT-Db?

We don’t expect all individual GP practices to register (unless they are very large). We are expecting Primary Care Trusts (PCT Clusters) to register and to upload on behalf of their GP practices where appropriate.

A commissioner can input on to the CWT-Db if they are registered as a provider of cancer services. They need to get an Organisational Data Services (ODS) code [formally called a NACS code – National Administrative Code Service] to register to use the CWT-Db. In the first instance a commissioner should contact the Open Exeter helpdesk on 01392 251289 to contact the CWT-Db administrator to discuss this. Alternatively, it is possible for NHS Providers to upload on behalf of commissioners if a formal agreement for them to do so has been entered in to. This would be possible if the commissioner is in the provider code list at the acute Provider ie. then the acute Provider could enter these data on that organisation's behalf. However, it would not appear in the acute provider reports and the commissioner would need to ensure they validate these data somehow as they would be published by DH.

46.14. Will SHAs be able to access preview reports?

The preview reports cannot be accessed by the SHAs as they are only there to support data quality and validation purposes. SHAs will not have access to reports until the dataset for the period is closed and published by the system in line with the preannounced timetable.

46.15. Can the CWT-Db be developed to include an auto-close for two week wait records if there is no further activity on the patient record for a period of time eg. 6 months?

No. Automatically defaulting status fields on dormant records is not considered good information practice.

46.16. Why can’t we analyse 31 day standard data by Tumour Type and Treatment Group together?

The reports available break down performance by tumour or modality. To break down by both would mean very small cell-counts, which would degrade the value of the report and potentially infringe patient confidentiality.

It is because of this some organisations have access to anonymised data for local analysis in a secure manner. The reports are a simplistic high-level overview. We anticipated that networks, commissioners and SHAs will want to drill down into the dataset to look at the performance of individual services. Due to the small numbers in some cases and inconsistent service configurations nationally it was decided that this type of work is best done by local analysis using the anonymised download function.

46.17. On all the 31 day treatment reports, consultant upgrades are missing from the breakdown of referral types – why?

Consultant upgrade is not a source of out patient referral for this dataset this is why it is not identified separately on the 31-day reports.
46.18. How can we suggest changes to the CWT-Db?

If you have suggestions for how the CWT-Db could be enhanced and improved these should be logged with the Open Exeter helpdesk on 01392 251289. This will then go to the developers and DH for consideration. DH will consider all recommendations for change requests once they have delivered the core functionality they have committed to.

46.19. Can Welsh providers access the CWT-Db to check patient records for referrals from or to English providers?

A Welsh LHB could be given access like any other commissioner and see information on patients they are responsible for but this would be dependent on the security policies covering access to Open Exeter.

DH has previously shared performance data on Welsh patients treated in the NHS with analysts attached to the Welsh Assembly but in terms of patient level data the appropriate mechanisms for access would be either via the provider, with the LHB requesting data on their patients directly, or via Open Exeter (if their policy allows access for Welsh organisations).

46.20. How is the primary key for a record in the CWT-Db defined?

The CWT-Db assigns a random record ID internally, it does not derive a primary key from the dataset. Instead matching records is based on an algorithm, the current version of which is published in the csv schema. (see http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/csvuploadschema.pdf)
47. Cancer Site Specific Information

This section is produced as a separate document alongside this guidance. It is available on a secure Connecting for Health website at:

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

The groups of tumours covered are:

- Brain and central nervous system (CNS)
- Breast
- Children’s cancers
- Gynaecological
- Haematological
- Head and neck
- Lower gastrointestinal – GI (colon, rectal, anal)
- Lung
- Sarcoma
- Skin
- Upper gastrointestinal – GI (oesophageal, stomach, pancreatic, liver)
- Urological (bladder, prostate, renal, penile, testicular, upper tract transitional cell)

For clinical information relating to patient pathways, see the Map of Medicine (www.mapofmedicine.com).
48. **Contacts and Further Information**

48.1. **Who do we contact if we have cancer waits queries?**

If you have queries about:

- this guidance: send them to cancer-waits@dh.gsi.gov.uk (this is DH managed mailbox)
- the cancer waits dataset: send them to cancer-waits@dh.gsi.gov.uk (this is DH managed mailbox)
- the CWT-Db: contact the helpdesk on 01392 251 289.
- obtaining intensive support for your Provider: contact Peter Kennedy, Head of Intensive Support, NHS IMAS, Peter.Kennedy@southwest.nhs.uk, Tel: 020 7633 7302

48.2. **Where do we find guidance and documents related to cancer waits?**

The main guidance on cancer waiting times including this guidance and the guide to using the CWT-DB can be found on the CfH website at:

http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation#support

Other useful guidance can be found as follows:

Ensuring Better Treatment: Going Further on Cancer Waits – An Improvement guide for Supporting Sustainable Delivery’ can be found at: www.improvement.nhs.uk/cancer


‘Top tips for delivering the two week wait standard for breast symptoms (where cancer is not initially suspected)’ can be found at: www.ncin.org.uk/Breast2ww

The Cancer High Impact Changes can be found at: www.improvement.nhs.uk/cancer

Further service improvement information can be found at: http://www.improvement.nhs.uk/cancer/CancerHome/UsefulResources/Publications/tabid/331/Default.aspx
49. **Glossary of Terms**

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<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
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<td>BCC</td>
<td>Basal Cell Carcinoma</td>
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<tr>
<td>CAB</td>
<td>Choose and Book</td>
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<tr>
<td>CAS</td>
<td>Clinical Assessment Services</td>
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<tr>
<td>CDS</td>
<td>Commissioning Dataset</td>
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<td>CfH</td>
<td>Connecting for Health</td>
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<tr>
<td>CSV</td>
<td>Comma Separated Values</td>
</tr>
<tr>
<td>CWT</td>
<td>Cancer Waiting Times</td>
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<tr>
<td>CWT-Db</td>
<td>Cancer Waiting Times Database</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DNA</td>
<td>Did Not Attend</td>
</tr>
<tr>
<td>DSCN</td>
<td>Dataset Change Notice</td>
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<tr>
<td>DTT</td>
<td>Decision to Treat</td>
</tr>
<tr>
<td>DVT</td>
<td>Deep Vein Thrombosis</td>
</tr>
<tr>
<td>ECAD</td>
<td>Earliest Clinically Appropriate Date</td>
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<tr>
<td>FAQ</td>
<td>Frequently Asked Questions</td>
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<tr>
<td>FBC</td>
<td>Full Blood Count</td>
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<tr>
<td>FDT</td>
<td>First Definitive Treatment</td>
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<tr>
<td>FOB</td>
<td>Faecal Occult Blood</td>
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<tr>
<td>FOBT</td>
<td>Faecal Occult Blood Test</td>
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<tr>
<td>GDP</td>
<td>General Dental Practitioner</td>
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<tr>
<td>GFOCW</td>
<td>Going Further on Cancer Waits</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>GPwSI</td>
<td>General Practitioner with Special Interest</td>
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<tr>
<td>GDP</td>
<td>General Dental Practitioner</td>
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<tr>
<td>GMP</td>
<td>General Medical Practitioner</td>
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<tr>
<td>HSC</td>
<td>Health Service Circular</td>
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<tr>
<td>ICD</td>
<td>International Statistical Classification of Disease and Related-Health Problems</td>
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<tr>
<td>IOG</td>
<td>Improving Outcomes Guidance</td>
</tr>
<tr>
<td>IPT</td>
<td>Inter-Provider Transfer (formerly ITT – Inter-Trust Transfer)</td>
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<tr>
<td>ISB</td>
<td>Information Standards Board</td>
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<tr>
<td>ISB</td>
<td>Information Standards Board (Health and Social Care)</td>
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<tr>
<td>IT</td>
<td>Information Technology</td>
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<tr>
<td>IPT</td>
<td>Inter-Provider Transfer</td>
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<tr>
<td>LHB</td>
<td>Local Health Board</td>
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<tr>
<td>MDT</td>
<td>Multidisciplinary Team</td>
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<tr>
<td>NCIN</td>
<td>National Cancer Intelligence Network</td>
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<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>NHSFTs</td>
<td>National Health Service Foundation Trusts</td>
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<td>NSCLC</td>
<td>Non Small Cell Lung Cancer</td>
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<td>Nww</td>
<td>NHS wide web</td>
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<td>ODS</td>
<td>Organisation Data Services</td>
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<td>OPA</td>
<td>Out-patient appointment</td>
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<td>PAS</td>
<td>Patient Administration System</td>
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<td>PbR</td>
<td>Payment by Results</td>
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<td>PCT</td>
<td>Primary Care Trust</td>
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<td>PDS</td>
<td>Personal Demographics Service</td>
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<tr>
<td>PPI</td>
<td>Patient Pathway Identifier</td>
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<tr>
<td>PTL</td>
<td>Priority Target List/Patient Tracking List</td>
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<tr>
<td>QA</td>
<td>Quality Assurance</td>
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<tr>
<td>Q&amp;A</td>
<td>Questions and Answers</td>
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<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>RCR</td>
<td>Royal College of Radiologists</td>
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<td>ROCR</td>
<td>Review of Central Returns</td>
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<td>RTDS</td>
<td>Radiotherapy Dataset</td>
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<td>RTT</td>
<td>Referral to Treatment</td>
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<td>R/T</td>
<td>Radiotherapy</td>
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<td>SCC</td>
<td>Squamous Cell Carcinoma</td>
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<tr>
<td>SCG</td>
<td>Specialist Commissioning Group</td>
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<tr>
<td>SHA</td>
<td>Strategic Health Authority</td>
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<tr>
<td>SPC</td>
<td>Specialist Palliative Care</td>
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<tr>
<td>SSP</td>
<td>Specialist Screening Practitioner</td>
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<tr>
<td>SUS</td>
<td>Secondary Uses Service</td>
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<tr>
<td>TCI</td>
<td>To Come In</td>
</tr>
<tr>
<td>UBRN</td>
<td>Unique Booking Reference Number</td>
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