Cancer Waiting Times

Data & Definitions – Frequently Asked Questions

This document provides questions and answers on data and definitions for Cancer Waiting Times. The references below provide context and further information on the question and answers discussed here. These can be found in the Guidance section of the Cancer Waiting Times webpage.

References:
Data and Definitions Manual
Query Log
Non-Standard Technology Review Process
Non-Standard Technology Review List

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Referral

Date of Receipt of Referral

Q
If a patient is referred from primary care but is then admitted as an emergency before the clinic date, what should the date of receipt of referral be?

A
The earliest and most appropriate date should be used. If the original referral meant that the patient was in the 62-day standard, then the original date and urgency and source of referral should be used. If the original referral was not in the 62-day standard then the date the patient presented to A&E should be used.
Q
Does onward referral to another specialty mean a new date of receipt of referral?

A
No – the date of receipt of referral is the date the initial referral is received in secondary care.

Urgency and Source of Referral

Q
What is the urgency and source of referral code for patients who are admitted to A&E and subsequently diagnosed with cancer?

A
If the patient presented with symptoms relating to the cancer diagnosed then urgency and source of referral should be coded 15 – direct referral to hospital’. If the symptoms were not relating to the cancer diagnosed code 17 - other should be used. Please see the ‘Urgency and Source of Referral section within the Data and Definitions Manual for further information.

Q
Can a referral be recorded as urgent with suspicion of cancer (USC) if a referral (electronic or otherwise) is not clearly identified as USC but is mentioned in the free text or body of the letter?

A
No, this should be coded as 16 – GP/GDP referral other. The data and definitions manual in section The Urgency and Source of Referral section within the Data and Definitions Manual states “that the urgency should be taken from the urgency/priority field in the top section of the letter, which must be clearly indicated, and not determined from the free text/body of the letter”.

Q
Can a referral be downgraded as a result of vetting?

A
The initial urgency of referral can only be downgraded if the primary and secondary care clinicians agree the referral did not meet the Scottish Referral Guidelines for suspected cancer. The result of this correspondence must be clearly documented.

Q
Can a non-urgent with suspicion of cancer referral be upgraded by a consultant to the 62-day standard?

A

No – if a patient is diagnosed with cancer, they will then be subject to the 31-day standard from decision to treat to treatment. However, it is considered good practice for secondary care clinicians to bring to the GP’s attention any cases which are considered to have been more appropriately referred via the Urgent with Suspected Cancer route, and for Boards to upgrade these patients on to an urgent cancer pathway, outwith the standard cohort.

**Cancer Type**

**Q**
What cancer/tumour types are included in the standards?

**A**
Cancer/tumour types should be included if the cancer is coded within the ICD-10 codes stated in the table under the Cancer Type section of the Data and Definitions Manual. Medical records departments and/or the responsible clinicians should be consulted for further guidance on the appropriate ICD-10 code.

**Decision to Treat**

**Q**
If a patient has two primary tumours, is the decision to treat date the same for each?

**A**
If two primary tumours have been diagnosed then these should be included in the relevant standards as two separate treatments. Record each pathway as it happens (there are likely to be separate decision to treat dates). Waiting times adjustments may be applicable if one tumour delays treatment of the other.

**Q**
If the date of decision to treat is not documented can an approximation be taken, e.g. MDT date, or earliest of a range of dates where the decision must have been made?

**A**
No, the decision to treat consultation must be clearly documented. If date decision to treat was not recorded this should be submitted as 09/09/0909 – not recorded and would be counted as a breach of the standard.

**Q**
Can the decision to treat take place outwith a clinical setting, e.g. over the phone?

**A**
Yes, the decision to treat date would be the date of discussion between the patient and the clinician where they decide and agree the treatment plan which can be outwith a clinical setting.
Q
What is the decision to treat for patients who die before treatment or refuse all treatment?

A
If a decision to treat has occurred, record that date. Otherwise, 10/10/1010 – inapplicable should be used.

First Treatment

Type of First Treatment

Q
If a patient has a biopsy carried out by their GP and subsequently diagnosed with melanoma, is this regarded as first treatment?

A
The table below shows when a biopsy should be regarded as first treatment.

<table>
<thead>
<tr>
<th>Biopsy Intent</th>
<th>Margin</th>
<th>First Treatment Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic</td>
<td>Clear</td>
<td>Date of Biopsy</td>
</tr>
<tr>
<td>Excision</td>
<td>Clear</td>
<td>Date of Biopsy</td>
</tr>
<tr>
<td>Diagnostic</td>
<td>Not clear</td>
<td>Date of subsequent treatment (irrespective of subsequent treatment finding)</td>
</tr>
<tr>
<td>Excision</td>
<td>Not clear</td>
<td>Date of Biopsy</td>
</tr>
</tbody>
</table>

If the biopsy is regarded as first treatment the date of decision to treat will be the same as date of first treatment.

Q
What if a first treatment is not listed in the appendices of the Data and Definitions Manual?

A
The treatments types found here are not an exhaustive list; the query log should be viewed (found in the recording guidance page of the cancer waiting times website) to see if any similar queries have been raised. If not, then the cancer waiting times team should be contacted.

Q
Where treatment is palliative, how should this be recorded?

A
Depending on what the treatment is, treatments can be recorded as the treatment type, e.g. palliative chemotherapy should be recorded as 03 – Chemotherapy. Or, recorded under 07-Supportive Care e.g. blood transfusion (if this is the intended first treatment).
**Date of First Treatment**

Q Can date of first treatment be before date of decision to treat?

A No – the decision to treat date must be on or before first treatment date.

**Waiting Times Adjustment**

Q If a patient chooses to wait for a named consultant to carry out first treatment, can a waiting times adjustment be applied?

A A waiting times adjustment can be applied based on patient choice (code 05 – other patient induced suspension). The adjustment should be made from the date of first treatment with the named consultant back to the earlier date the patient could have been treated.

Q Is a waiting times adjustment applicable when a pathology specimen is required to be sent for further review?

A A waiting times adjustment is applicable where confirmatory or further histopathological analysis is necessary. This would be recorded as 06 – medical suspension.

Q When should ‘temporary co-morbidity’ and ‘medical suspension’ codes be used when recording waiting times adjustments?

A In some cases the waiting times adjustments reasons – ‘co-morbidity’ and ‘medical suspension’ could be argued to be interchangeable, but as general outline guidance the following broad rule could be applied:

Code 04 – temporary co-morbidity should be used when the patient has or develops an illness or condition which makes the patient unfit to attend for a diagnostic investigation or treatment e.g. viral infection, neutropaenia, exacerbation of a chronic condition like chest disease or hypertension.

Code 06 – medical suspension should be used when an additional and necessary pre-treatment step is required or when a step in the pathway has to be delayed because an unacceptable risk would be incurred if that step were to take place within a fixed time period.
Q
A letter goes out to the patient asking them to contact the NHS Board to arrange an appointment. Can a waiting times adjustment be made for the period of time it takes the patient to make contact?

A
No adjustment can be made in this scenario. Waiting times adjustments should only be made if the reason for delay corresponds with the reasons specified in the waiting times adjustment section of the Data and Definitions Manual.

Q
If there is a pre-treatment step in a patient’s pathway which causes a delay e.g. request for a non-formulary/off-protocol drug can an adjustment be applied?

A
A waiting times adjustment (recorded as 06 – medical suspension) can be made in these instances.

Q
If a patient was offered an open resection and declined and wanted to wait for a laparoscopic resection, can a waiting times adjustment be made?

A
This is not covered by a waiting times adjustment, unless the decision was a clinician decision for medical reasons. If the patient breaches target, and this is deemed the main reason, code 19 - range of treatment options offered but patient's choice not available within target should be used.

Reason for Delay

Q
What if a patient is offered a choice of treatment options and chooses a treatment that is not available within the standards time?

A
The waiting times standards are only one measure of quality – patients should still be offered the best possible treatment. In this case, the patient would breach the standard.

Q
Why do we exclude clinically complex patients?

A
Cancer is a particular area of clinical practice where pathways are not always clear. With no single 'test' that can be applied to determine whether a patient has or does not have cancer or to accurately stage the disease, because many of the tests carried out are ambiguous and open to interpretation, and
because it is often an area where clinical judgement is tested to the maximum and requires opinion from a variety of disciplines, it has been acknowledged that the guidance for waiting times definitions should allow some degree of flexibility. For further information please see the Reason for Delay section within the Data and Definitions Manual.

Q
What if initial investigations were inconclusive or implied the patient did not have cancer?

A
After determining if waiting time adjustments (which should be looked at in first instance) can or cannot be applied, the patient’s pathway may be considered clinically complex. Clinically complex cases have ‘genuine clinical uncertainty’.

Q
Should a delay in a patient’s pathway as a result of a new technology that is not yet part of a routine pathway be counted as clinically complex?

A
The introduction of a new investigation or treatment technology is likely to result in a waiting times adjustment due to an additional step in the pathway (see the Waiting Times Adjustments section and scenarios within the Data and Definitions Manual). For further information please see Non-Standard Technologies in the guidance section of the Cancer Waiting Times webpage.