Cancer Waiting Times

Agenda

- Clinical Review of Standards overview
- Faster Diagnosis Standard update
- Details of changes being considered
- Changes to dataset

Clinical Review of Standards overview

NHS England and NHS Improvement

Clinical Review of Standards

The Clinical Review of Standards' Interim Report published in March 2019 setting out:-

- Simplification of standards into 3 standards:
  - 28 day faster diagnosis standard
  - Combined 31 day decision to treat to treatment standard
  - Combined 62 day referral to treatment standard
- Removal of 2 week wait standard
- Update guidance to reflect modern clinical practice

Final changes due to go to consultation in early 2020, due to be implemented in 2020/21.

Process for considering clinical changes

- Engagement with key stakeholders including through Cancer Alliances over summer. Received over 40 organisational responses with suggested changes.

- These changes were reviewed by Clinically-led Advisory Group, which met in Autumn 2019 and agreed which changes would be taken forward.

- Alongside this the group considered thresholds for the standards.

Thresholds

Draft provider contract for 2020/21 states that for Faster Diagnosis Standard:

- Will initially be set at between 70 and 85%
- With phased increases in subsequent years as appropriate

Thresholds for merged 31 day and 62 day standards will be announced following Clinical Review of Standard engagement exercise, due to commence shortly.

Faster Diagnosis Standard update

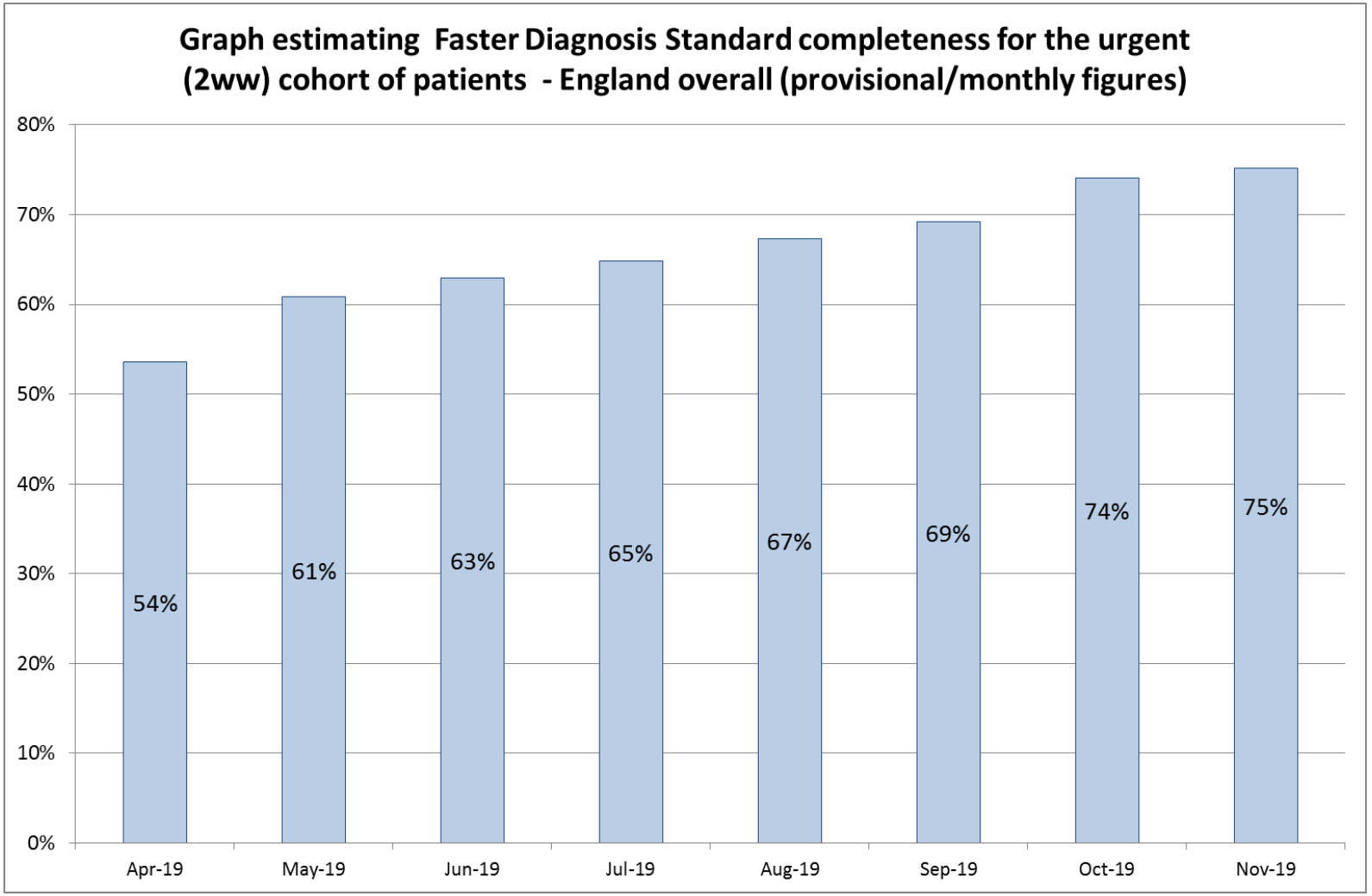
NHS England and NHS Improvement

Background – Faster Diagnosis Standard

- Initially recommended in the Cancer Taskforce in 2015
- Cancer Waiting Times dataset updated from April 2018 to allow collection of data
- Mandated for collection from April 2019
- Focus for 2019/20 has been on data completeness, rather than actual performance
- Due to be introduced as a performance standard from April 2020

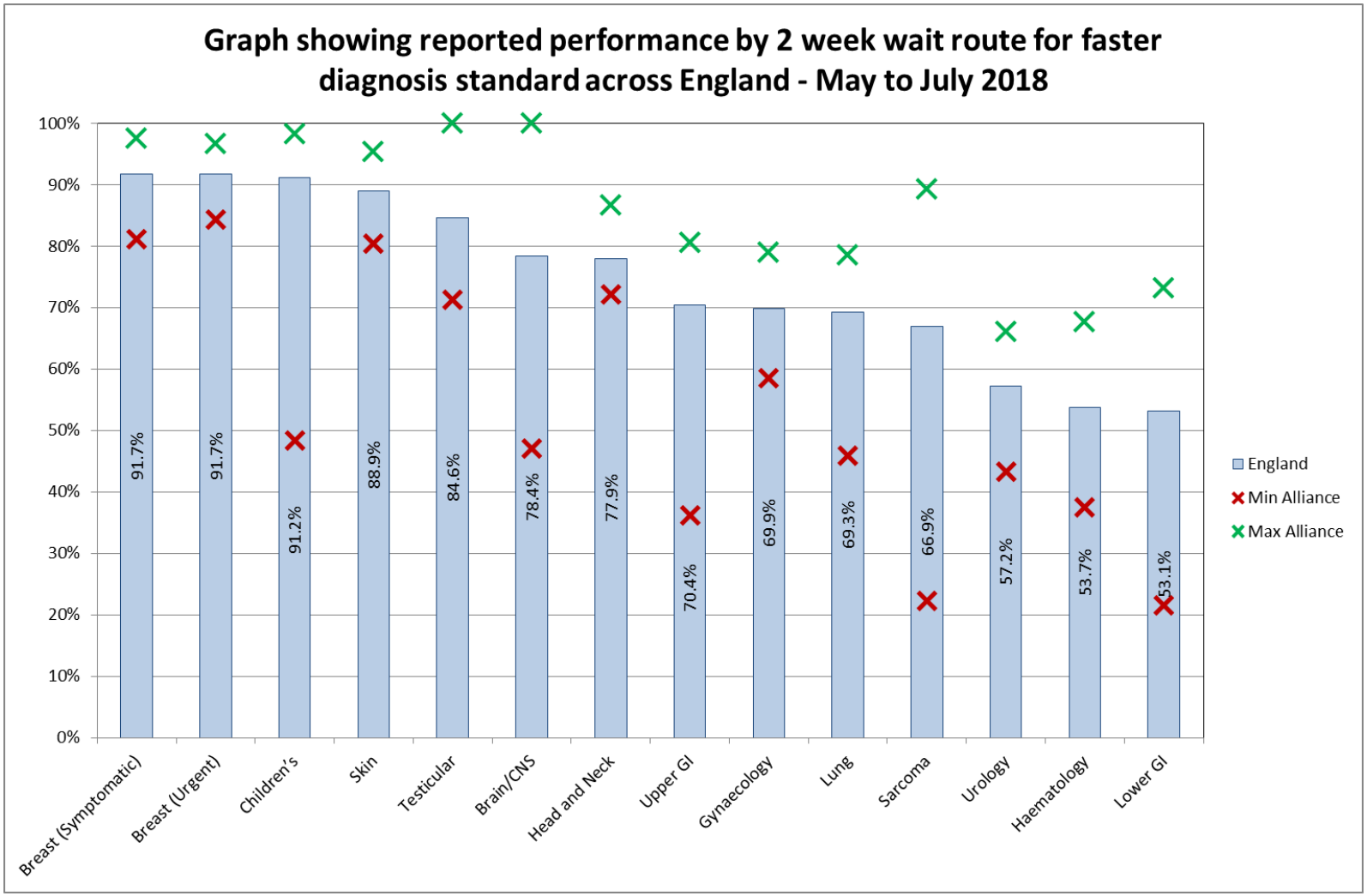
Data completeness

Provisional Data:

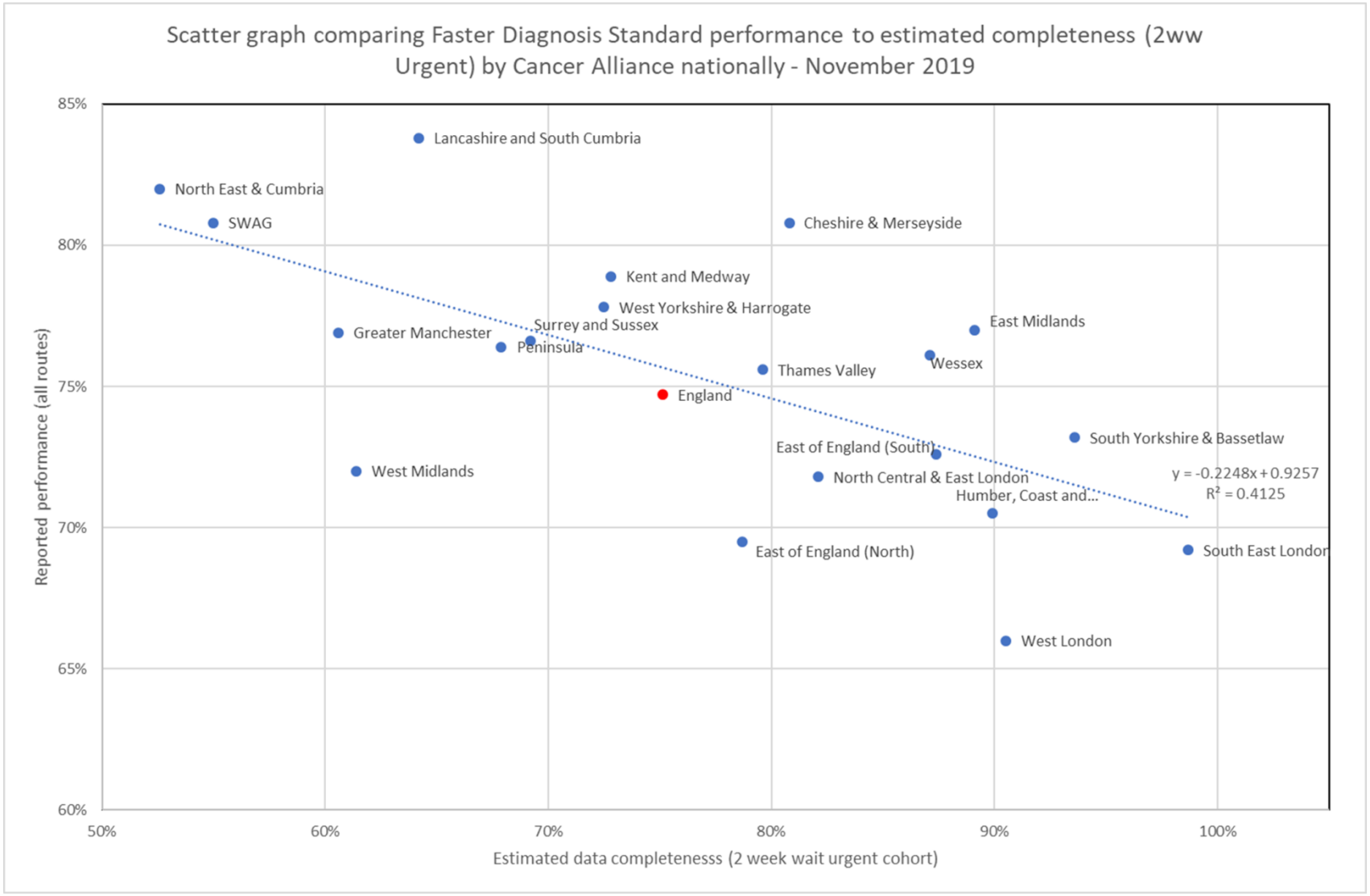


Variation in performance by suspected cancer type

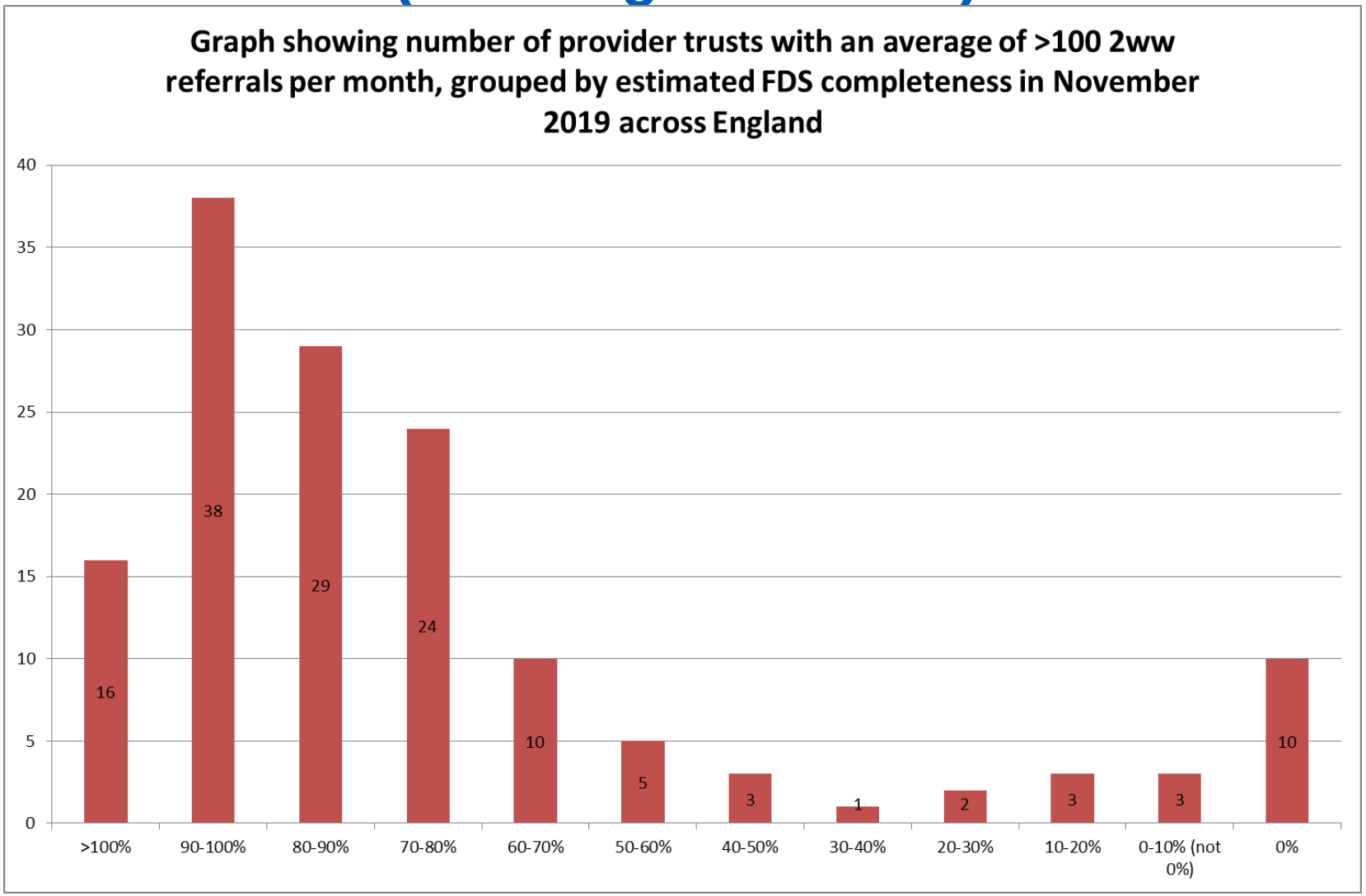
Provisional Data:



Baseline completeness and performance by Cancer Alliance – November 2019



Provider estimated completeness – FDS November 2019 (2ww urgent cohort)



Example approach (West London)

Local priorities

1. Cancer systems updated to support collection of FDS data
2. Processes established to collect real time data
3. Screening programmes to establish data collected and tracking processes
4. Local MDT awareness of standard
5. Changes to letter templates and reduced turn-around times
6. Rollout of virtual telephone results clinics
7. Polling times for 2 week wait clinics reduced to 7 days
8. Roll out of priority tumour type pathways:- Prostate, Colorectal, Lung & OG

Example approach (West London) – Tumour level aspirations

NHS England

- Agreed approach in West London to RAG rate Faster Diagnosis Standard performance based on tumour level aspirations (to be reviewed regularly)

- Principles
  - Green – Lowest of top 3 providers in Alliance in Q2 2019/20
  - Amber - Not meeting aspiration but within <50% excess breaches
  - Ceiling set at 95%, and floor at 65%.

- Currently set at a level where performance overall would reach just over 80%

Suspected cancer type	Aspiration
Breast	95%
Childrens	93%
Brain/CNS	91%
Testicular	90%
Skin	89%
Head and Neck	83%
Lung	81%
Gynaecology	77%
Urology	74%
Upper GI	66%
Sarcoma	65%
Haematology	65%
Lower GI	65%

Next steps – key areas of focus

- Focus on data completeness, ensuring all patients have their FDS clock stop or exclusion reason recorded
- Work to ensure consistent recording of communication date
- Implementation of national best practice pathways
- Focus on tumour level variation in performance
- Consider realistic local ‘aspirations’ at tumour level

Changes under consideration

Changes under consideration – standards

1. Merged 62-day referral to first treatment standard

To include:

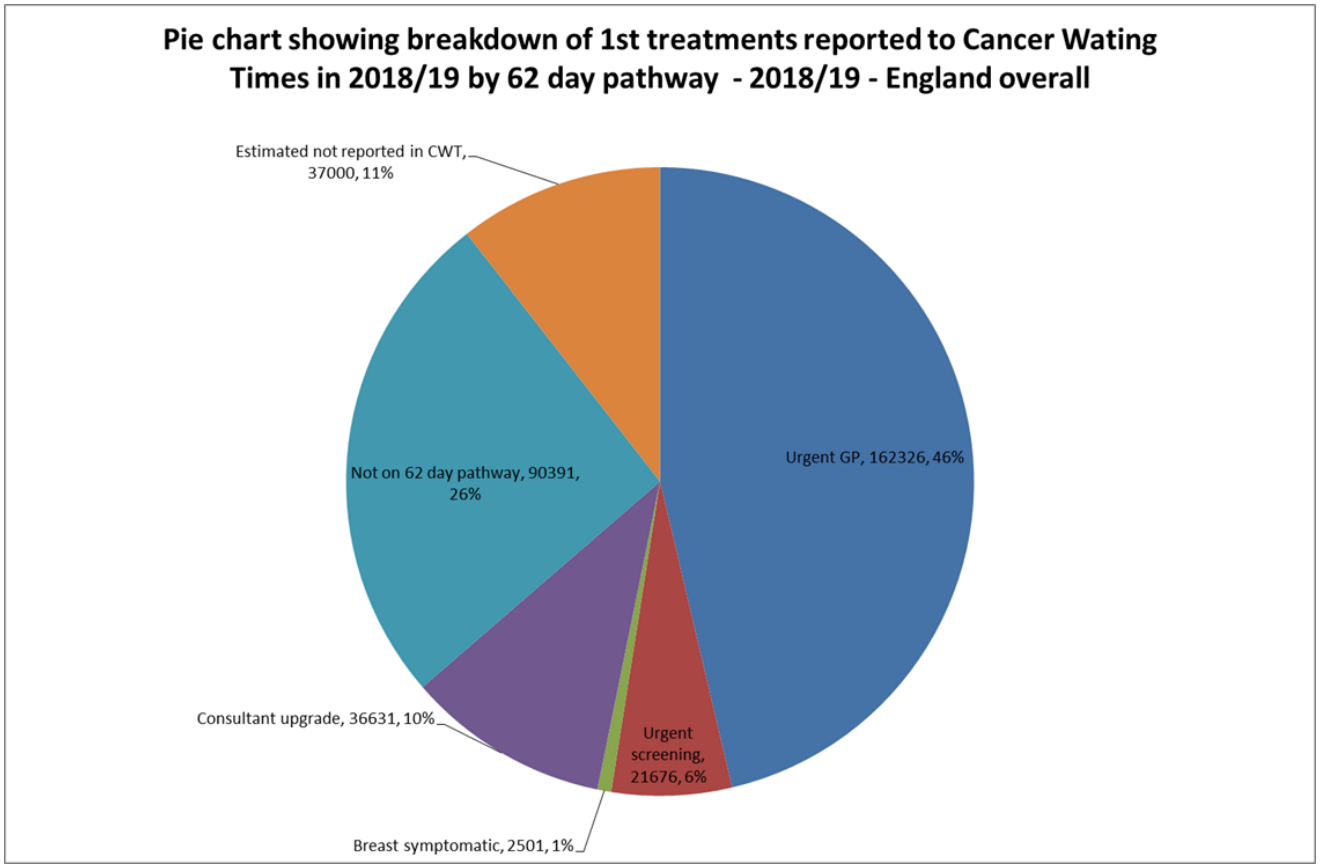
- Urgent suspect cancer referral
- Urgent screening referral
- Breast symptomatic referrals
- Consultant upgrade

2. Mandating consultant upgrade

- Default consultant upgrade (unless already on a 62-day pathway, including previous consultant upgrade):
  - Referral to Cancer Multi Disciplinary Team (MDT) meeting with suspicion of or confirmed cancer
  - Exploring other points to bring in upgrade to ensure as many newly diagnosed cancer patients are included as possible.

Changes under consideration – standards

Context of 62 day standard



Newly diagnosed Cancer patients

- 62 day (GP) – 46%
- 62 (Screening) – 6%
- Breast symptomatic – 1%
- Consultant upgrade – 10%
- 31 day only – 26%
- Not reported in CWT – 11%

Changes under consideration – standards

3. Merged 31-day decision to treatment/ECAD treatment standard

Merged standard to include:

- All first treatments for cancer
- All subsequent treatments, excluding active monitoring and palliative care (treatment modalities 07, 08 and 09)

4. Replace 31 day rare cancer referral to treatment standard

- Recognition that other specific cancer may require faster than 62-days for referral to treatment, and that most patients receive care in well under 62-days.
- Avoid a situation where we try to specify every scenario in which a patient should be seen more quickly.
- Replaced with guidance which states that patients should be treated based on clinical need which could include needing to treat in short time-frames.

Changes under consideration – standards

5. Withdrawal of two week wait standards

- Proposed to withdraw two week wait standard and shift focus to Faster Diagnosis Standard
- Shift of focus to communication date of diagnosis with patient, rather than 1st seen date.
- Two week wait standard is a legal right in the NHS constitution so needs to undergo parliamentary process to implement
- Earliest implementation is October 2020.

Changes under consideration – referrals

6. Allow triage from abnormal direct access diagnostic to count as a urgent referral for all tumour types

- Version 10 of guidance introduced this for:
  - Lung timed pathway (direct triage from chest x-ray or CT chest)
  - Oesophago-gastric timed pathway (direct triage from endoscopy)

- Guidance to be updated to allow for all tumour types.

- Subject to local agreement between trusts and commissioners.

- New data item being introduced to support monitoring - Cancer Diagnostic Referral Route:

  01 - Abnormal diagnostics result following a NICE guidance NG12 referral to a direct access diagnostics service

  02 - Other (not listed)

Changes under consideration – referrals

7. Changes to referral management

a) Urgent suspected cancer referrals to be allowed from any referral source, not just GP, GDP and Optometrist, subject to local agreement.

As a minimum, referrals would still be accepted from GP, GDP and Optometrist.

b) Clarification around referral management, and stating what are national requirements (restating guidance) including:-

- Referrals can only be rejected or downgraded if agreement by referrer.
- Patient clock starts from when initial referral received irrespective if patient choice to delay appointment or additional information is needed.
- Patient should not be discharged because they are unavailable within a specified period of time.

Changes under consideration – referrals

8. Updated reporting methodology for Faster Diagnosis Standard and application of Decision to Treat

Currently, reporting is as follows:-

- Where decision to treat (Cancer Treatment Period Start Date) is recorded, the data item is used as the FDS clock stop if:
  - it is before the Cancer FDS pathway end date; or
  - the Cancer FDS pathway end date is missing.
- Month of activity is dependant on the data item used for FDS clock stop
- Organisation allocated performance dependant on data item used.

Proposed to change in April 2020, to:

- Reporting to be fully driven by **Cancer FDS pathway end date**
- Decision to Treat (DTT) / Cancer Treatment Period Start Date is only used for calculation where it is before a recorded Cancer FDS pathway end date.
- Organisation allocated to the FDS pathway end date organisation irrespective of whether DTT is used.

Changes under consideration – referrals

9. Introduce Rapid Diagnosis Centre non-site specific referral as urgent suspected cancer route.

National requirement to have non-site specific Rapid Diagnosis Centre (RDC) service established across whole population over next 5 years

New dataset allows recording of these referrals:
- New suspected cancer type:- 17 - Suspected cancer - non-specific symptoms
- New data item:- Rapid Diagnosis Centre Pathway Compliant Indicator (Y - Yes as defined in the RDC specification, N – No)

Intention is there will be phased implementation using priority type field to distinguish between referrals counted as urgent suspected cancer and those not

Changes under consideration – treatments

10. Permitting treatment of metastatic disease site to count as first definitive treatment

- Treatment of a metastatic disease site, for a known primary will count as a first definitive treatment
- Subsequent treatment of the primary site would then count as a subsequent treatment

11. Additional treatment adjustment – egg harvesting

- New treatment adjustment for period waiting for egg harvesting
- Will apply from the point patient is seen by the egg harvesting service to when it is possible to harvest eggs (due to the patient's cycle)
- Cannot be taken for the period waiting to be seen by egg harvesting service.

Changes under consideration – treatments

12. Patient choice adjustment to now apply to both admitted and non-admitted pathways

- Validation rules relaxed to allow a patient choice adjustment to apply in both admitted and non-admitted treatments
- Current rules for admitted care will still apply but for all treatments

13. Additional treatment adjustment – Clinically urgent treatment of another condition

- Can be applied where it is necessary to treat another condition prior to treatment of a specific cancer.
- Applied from the point at which it is confirmed that a patient needs treatment for the other medical condition, to the point at which after receiving treatment for this condition the patient is deemed clinically fit to commence their cancer treatment.
- Cannot be applied for:-
  - Period waiting for assessment or diagnostics
  - A period of time for a patient to make life-style changes (e.g. weight loss)

Changes under consideration – treatments

14. Updates to permitted enabling treatments

- Clinical led group agreed on following criteria to assess enabling treatments

1. Clinically necessary prior to definitive cancer treatment
2. Is not required as a result of a delay for definitive cancer treatment
3. Definitive cancer treatment, cannot start immediately after enabling treatment (>1 week)

- Group recommended following revised list of permitted enabling

  - colostomy for bowel obstruction
  - stenting where this is necessary prior to definitive treatment unless this is necessary due to the length of wait for definitive treatment
  - Gastrojejunostomy
  - Portal vein embolization prior to surgery for liver cancer (primary or secondary) to allow liver growth prior to surgery
  - Dental extractions to enable radiotherapy **(NEW)**
  - PEG line insertions **(NEW)**
  - Vaccinations prior to removal of spleen **(NEW)**
  - Trans-positioning of ovaries (for preserving fertility/reducing side effects) **(NEW)**

Changes under consideration – treatments

14. Updates to permitted enabling treatments (cont.)

- Following recommended to be removed:
  - Iron infusions
  - Cystodiathermy

- Recommendation that anti-cancer therapies guidance should be updated:-
  - to allow treatment start state to count from point at which first drug as part of regimen is delivered, even if SACT. E.g. B12 vitamin as part of lung cancer chemotherapy regimen.

  (Now proposed that this will be another additional enabling treatment, as per discussions with NCRAS as a result of our engagement at COSD roadshows)

Changes under consideration – treatments

15. TURBT (trans urethral resection of bladder tumour) to only count as first definitive treatment if tumour effectively removed

- Significant feedback from individual bladder cancer clinicians & cancer charities that this should be changed.
- Urology GIRFT report recommended change with supporting analysis showing median wait to full bladder removal at 144 days (supporting academic paper showing survival in this cohort of patients would be adversely affected by this length of delay).
- Thought to account for approximately 1 in 5 newly diagnosed bladder cancer patients.
- Brings guidance in line with other tumour specific guidance. E.g. Polyp removal only counts if effectively removes tumour.

Changes under consideration – treatments

16. Prostate cancer – approach to patient with low or low-intermediate risk disease

- Proposal to apply ‘active monitoring’ for patients with low or low-intermediate prostate cancer at point of communication of diagnosis even if patient is taking some time to consider their treatment options

- Risk classified as follows (based on maximum of stage/PSA/Gleason):

Risk	Stage	PSA	Gleason
Low	T1-T2a	<10 ng/ml	≤6
Low-Intermediate	T2b	10-20ng/ml	7 (3+4)
Intermediate-High			7 (4+3)
High	≥T2c	>20ng/ml	8-10

- Key is that patients where this is applied are continued to be tracked

Changes to Cancer Waiting Times dataset

NHS England and NHS Improvement

Dataset changes (items)

New data items

Data item	Options
CANCER DIAGNOSTIC REFERRAL ROUTE	01 - Abnormal diagnostics result following a NICE guidance NG12 referral to a direct access diagnostics service 02 - Other (not listed)
RAPID DIAGNOSTIC CENTRE PATHWAY COMPLIANCE INDICATOR	Y - Yes as defined in the RDC specification N - No
PROSTATE CANCER CLINICAL RISK CATEGORY	01 - Low risk 02 - Low-intermediate risk 03 - High-intermediate risk 04 - High risk

Retired data items

- MULTIDISCIPLINARY TEAM CANCER CARE PLAN DISCUSSED INDICATOR
- MULTIDISCIPLINARY TEAM DISCUSSION DATE (CANCER)
- RADIOTHERAPY PRIORITY

Dataset changes (dropdowns)

NHS England

Changes to dropdown/options

Data item	Change to options
TWO WEEK WAIT CANCER OR SYMPTOMATIC BREAST REFERRAL TYPE	Additions:- 17 - Suspected cancer - non-specific symptoms 18 - Other suspected cancer (not listed) Removal 15 - Other suspected cancer (not listed)
CANCER OR SYMPTOMATIC BREAST REFERRAL PATIENT STATUS	Additions:- Multiple statuses to better identify types of recurrence
CANCER FASTER DIAGNOSIS PATHWAY END REASON	Addition:- 04 - Interval scanning
CANCER FASTER DIAGNOSIS PATHWAY EXCLUSION REASON	Removal:- 07 – Patient opted not to continue faster diagnosis standard pathway

Dataset changes (dropdowns)

NHS England

Changes to dropdown/options

Data item	Change to options
CANCER TREATMENT EVENT TYPE	Additions:- 11 Treatment for transformation of Primary Cancer (second or subsequent) 12 First treatment for metastatic disease following a known Primary Cancer
CANCER TREATMENT MODALITY	Additions:- 23 - Surgery (excluding enabling treatment) 24 - Surgery (enabling treatment) Removal:- 01 – Surgery
WAITING TIME ADJUSTMENT REASON (TREATMENT)	Additions 6 - Egg harvesting 7 - Clinically urgent treatment of another condition

Questions?

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