Cheshire & Merseyside Cancer Alliance

Cancer Waiting Times Refresh

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Aims of the Session

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- Update on the National/Regional Position
- CWT Recap- Back to basics, Breach Allocation
- Recording of IPTs
- General tips on effective tracking and escalation
- Stepping patients down
- Recording of first treatments
- MDT Coordinator responsibilities

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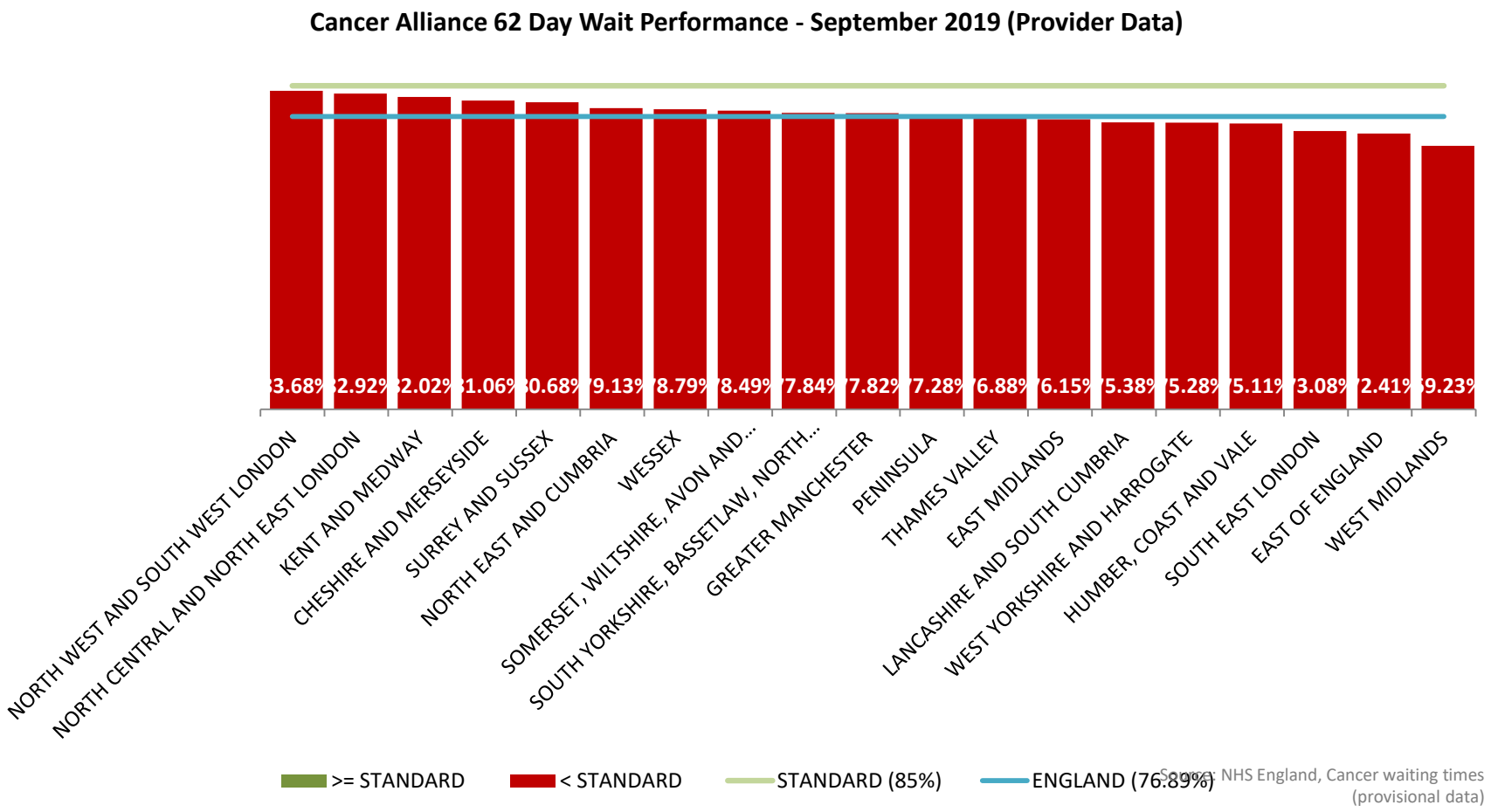
Update on the National/Regional Position

- Increased national scrutiny around the 62 day standard since July 2017
- The target hasn’t been met since April 2018 in this Alliance and longer than that nationally
- Worst ever national performance reported in January 2019

C&M Alliance Position



Source: NHS England, Cancer waiting times (provisional data)

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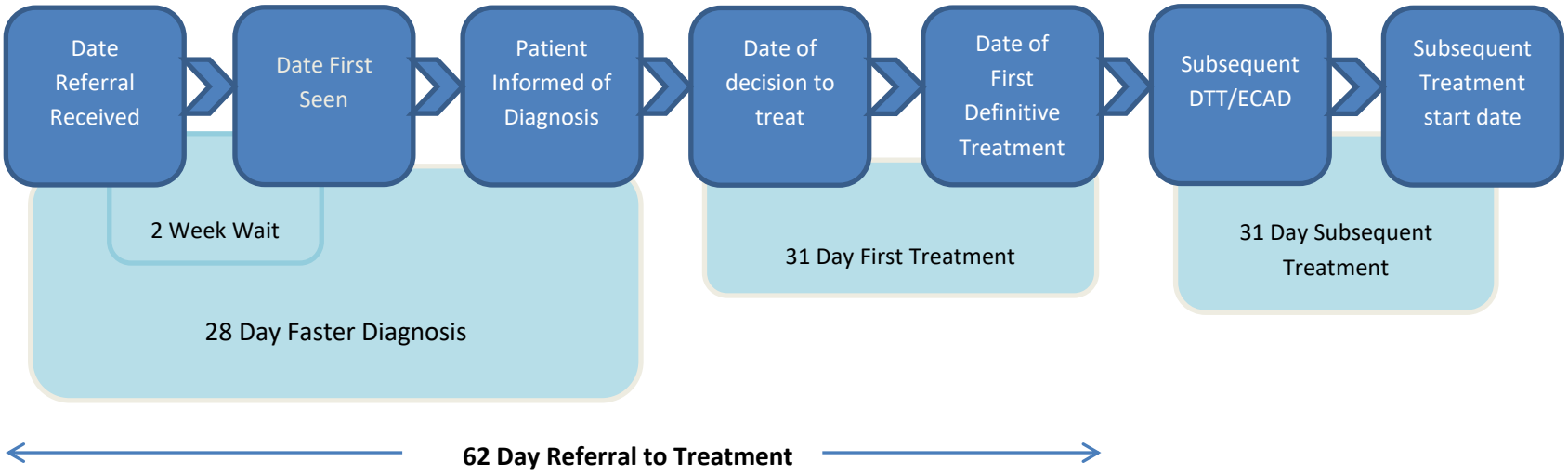
New CWT Database

- New Cancer Waiting Times Database launched 1st April 2019
- Some teething problems with reports and performance calculation which are slowly getting ironed out
- SCR hasn't caught up with the new methodology yet

CWT Basics


Date Referral Received
Date First Seen
Patient Informed of Diagnosis
Date of decision to treat
Date of First Definitive Treatment
Subsequent DTT/ECAD
Subsequent Treatment start date
2 Week Wait
28 Day Faster Diagnosis
31 Day First Treatment
31 Day Subsequent Treatment
62 Day Referral to Treatment

Making Adjustments

There are only scenarios where an adjustment can be made within a 62 day pathway:

- If a patient DNAs their first appointment the clock can be reset to when the appointment is rebooked
- If a patient declines an offer of an inpatient treatment

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Breach Allocation Guidance

Scenario	Referral Timeframe	Total Timeframe	Allocation
1	>38 days	≤ 62 days	100 % of success allocated to the treating provider
2	≤ 38 days	≤ 62 days	50 % of success allocated to the referring provider and 50% allocated to the treating provider
3	≤ 38 days	≥ 62 days	100 % of breach allocated to the treating provider
4	≥ 38 days	> 62 days, but treating trust treats within 24 days	100 % breach allocated to the referring provider
5	> 38 days	> 62 days and treating trust treats in >24 days	50 % of breach allocated to the referring provider and 50 % allocated to the treating provider

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Breach Allocation Cont'd

The first step is to identify a single investigating provider to be 'accountable' for the investigation phase:

- If the period from referral received to last transfer to treatment is 38 days or less (the '38 day' investigative phase): The provider who has cumulatively spent the shortest amount of time with the patient is identified as the 'accountable' investigating provider
- If two or more providers saw the patient for the same amount of time, of those providers the one who saw the patient first is identified as the 'accountable' investigating provider
- If the period from referral received to the last transfer to treatment is over 38 days (the '38 day' investigative phase): The provider who has cumulatively spent the longest amount of time with the patient is identified as the 'accountable' investigating provider
- If two or more providers saw the patient for the same amount of time, of those providers the one who saw the patient last is identified as the 'accountable' investigating provider
- If a provider is involved in the investigative stage, and is also the treating provider (with another provider involved in between) the provider is considered separately in the calculations for responsibility for investigation and for treatment

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Breach Allocation Key Differences

- Cut off for referrals out to the treating Trust is now day 38
- Treating Trusts can ‘steal’ treatments within target if they receive late and treat within target.
- Treating Trusts have to treat within 24 days of receiving the referral if they are to have no part in a patient’s breach
- In multi trust pathways, all those IPTs (CARPS) in and out really count as middle Trusts may take within target treatments or may gain breaches.

IPT/CARPs

- IPTs should only be recorded when the patient's care is transferred
- It's often easier to think about who has the responsibility of communicating with the patient at that point e.g. PET scans
- Make sure that at the point of transfer all required information goes with the referral
- CARPs are essential so that the receiving team have all of the pathway information

Effective Tracking

- Know your timed patient pathways and what should have happened in what timescale
- Understand where all the information you need is within your own Trust systems
- Use all of these sources to check where the patient is up to and what is happening next
- Understand who your contacts are within your Trust

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Effective Tracking Con’td

- If you need something to happen e.g a date for a test, make sure the question is directed to someone and not left hanging in the tracking comments
- Use your PTL meetings
- Use your Trust escalation policy if events are not happening according to the timed pathway

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Taking Patients off the Pathway

- Clinical decision- if it's not clearly documented, ask your clinicians
- Think about what the patient would say if they were asked to describe their pathway- what were they told
- Use the Cancer Waiting Times Guidance- general and tumour specific
- Ask your Cancer Manager/Cancer Data Manager

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Ending the Pathway with a First Definitive Treatment

- The FDT is normally the first intervention which is intended to remove, debulk or shrink the tumour.
- Where no definitive anti-cancer treatment is planned almost all patients will be offered a palliative intervention (eg stenting) or palliative care (eg pain relief), which should be recorded for these purposes.

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Ending the Pathway with a First Definitive Treatment

- Always think about what the intention was i.e. was the intention to treat the tumour, even if this isn't the final outcome.
- Examples of FDTs are:
- Surgery
- Radiotherapy
- Chemotherapy
- Other drug treatments such as hormones
- Chemoradiation
- Palliative Care- specialist and non specialist
- Active Monitoring
- All treatment declined

Enabling Treatments

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The enabling treatments that can be classed as FDTs are:

- colostomy for bowel obstruction
- insertion of oesophageal stent
- non-small cell lung cancer stent
- ureteric stenting for advanced cervical cancer
- insertion of a pancreatic stent if planned to resolve jaundice before the patient has a resection or starts chemotherapy
- Gastrojejunostomy
- Monofer Infusion
- Cystodiathermy

Data- Your Responsibility

- It’s your responsibility to ensure that the data you enter is correct and complete
- If something looks odd or unusual, its probably not right so check it out
- Remember to run your check reports to identify missing data items
- Try to update records as you go rather than waiting for a deadline

Ask

- Most of all- ask if you're not sure- talk to your clinical team, colleagues and Cancer Team!
- Refer to the latest CWT guidance:

https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/cancerwaitingtimescwt