TE AHO O TE KAHU CANCER CONTROL AGENCY

Te Whatu Ora Health New Zealand

Faster Cancer Treatment Indicators:

Business Rules and Data Definitions

Delay Code Reporting Guidance

High Suspicion of Cancer Definitions

Tumour Specific Reporting Guidance

Use Cases

Document Version:	6.4
Date:	September 2023
Owner	Te Whatu Ora
Status	Final

Citation: Te Whatu Ora – Health New Zealand. 2023. Faster Cancer Treatment Indicators, Business Rules and Data Definitions. Wellington: Te Whatu Ora – Health New Zealand.

Published in September 2023 by Te Whatu Ora – Health New Zealand
PO Box 793, Wellington 6140, New Zealand

Te Whatu Ora
Health New Zealand

This document is available at https://www.tewhatuora.govt.nz/our-health-system/data-and-statistics/nz-health-statistics/data-references/data-dictionaries/

Contents

Introduction

The Faster Cancer Treatment (FCT) indicators were introduced in July 2012. FCT aims to help coordinate timely access to appointments and tests for people with a high suspicion of cancer leading to timely diagnoses, access to treatment and better outcomes for people with cancer. This is intended to reduce delays, identify where the cancer pathway is working well and where improvement could be made.

Te Aho o Te Kahu – Cancer Control Agency is an independent departmental agency hosted by Manatū Hauora but reports directly to the Minister of Health. Te Aho o Te Kahu provides strong central leadership, oversight of cancer control and unites efforts to deliver better outcomes in Aotearoa New Zealand. The establishment of Te Whatu Ora – Health New Zealand provides an opportunity to streamline historical Faster Cancer Treatment guidance documents by amalgamating them into a single document to support services reporting faster cancer treatment wait time indicators. This work also included clarification of the business rules to support nationally consistent reporting by services.

The faster cancer treatment indicators are:

The 62-day Indicator

The maximum length of time a patient should wait for their first treatment when referred with

- a high suspicion[1] of cancer[2] (without a confirmed pathological diagnosis of cancer at referral)
- where the triaging clinician believes the patient needs to be seen within two weeks to receive their first treatment[3] (or other management) for cancer.

The 62-day indicator is reported as 90% of patients receiving their cancer treatment (or other management) within 62 days from receipt of referral to first treatment.

The estimated cohort of patients on the 62-day pathway, that meet the criteria for measurement should be approximately 25% of all cancers registered on the New Zealand Cancer Registry.

To support the achievement of FCT indicators, reporting a delay code for patients that do not achieve the 62-day timeframe is mandatory. This is supported by the National Health Service England, experience where shorter cancer waits[4] showed that capturing and analysing delays (breach reasons) allows for identification of trends and highlighting systematic problems, which can be corrected or improved to positively impact patient experiences. Reporting delay codes also captures delays that are due to patient reasons and reasonable clinical considerations.

[1] High suspicion means the person presents with clinical features typical of cancer or has less typical signs and symptoms, but the triaging clinician suspects that there is a high probability of cancer.
[2] For the purposes of the FCT project, the term cancer is defined as the ICD-10-AM 8th Edition primary diagnosis codes set out in Appendix B.
[3] A patient's first treatment for cancer must be one that is publicly funded if it is to be included in FCT data reporting.
[4] *Delivering Cancer Waiting Times: A Good Practice Guide* NHS Interim Management and Support (2015). Available on https://www.england.nhs.uk/wp-content/uploads/2015/03/delivering-cancer-wait-times.pdf

The 31-day Indicator

The maximum length of time a patient should wait from the decision-to-treat[5] date to receiving their first treatment (or other management) for cancer.

The 31-day indicator includes all patients who receive their first cancer treatment, irrespective of how they were initially referred.

The 31-day indicator is reported as 85% of patients receiving their cancer treatment (or other management) within 31 days from the decision to treat.

All records submitted for the 62-day indicator, should, by definition, also contain data that enables the 31-day indicator to be calculated.

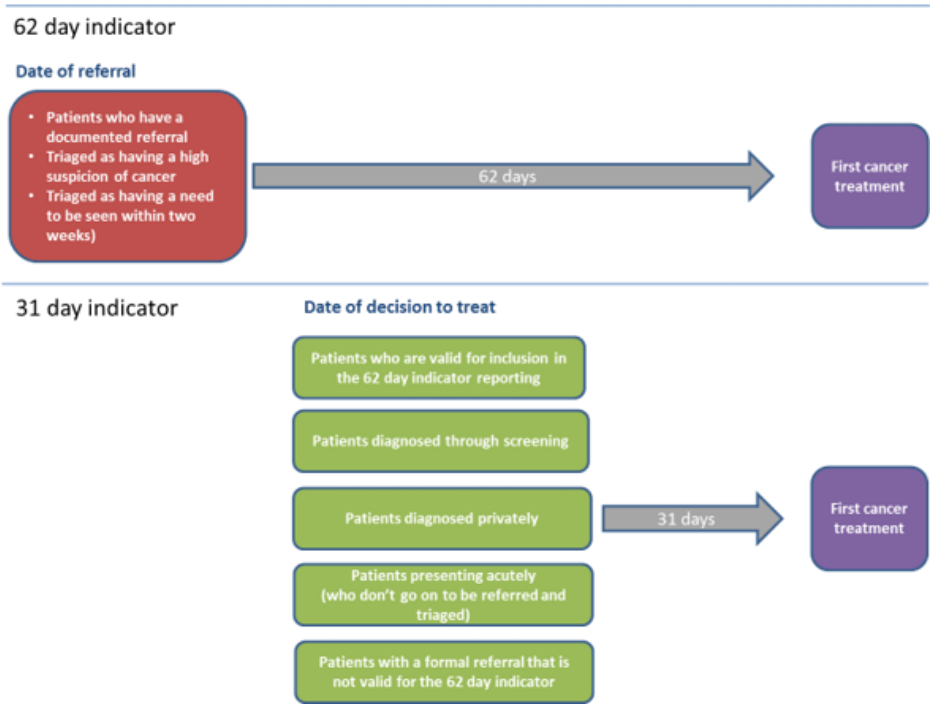

Figure 1: Cancer pathway entry points and associated FCT indicators. For more detailed inclusion and exclusion criteria refer to Section 1: Business Rules.

Purpose

The purpose of achieving the FCT indicators reflects that our systems are working to ensure timely access for patients with a high suspicion of cancer and/or requiring cancer treatment. It is also a strong indication of how well our facilities and services are functioning.

The purpose of this document is to provide FCT trackers/coordinators and others with information to support:

1. high suspicion of cancer criteria for referral
2. timely patient access to diagnosis and treatment
3. accurate data collection, reporting and monitoring of the FCT indicators

[5] Decision-to-treat: The date on which the treatment plan was agreed between the patient and the clinician responsible for first treatment.

4. decisions in assigning delay codes and analysing breaches
5. using the FCT indicators to inform service/system improvement.

The focus for improvement also includes developing optimal cancer care pathways for tumour streams and sustainable treatment service models of care.

Rationale

FCT indicator data can be used as:

- early identification of potential delays to patient care, enabling action to avoid a breach occurring
- a tracking system to remove the guesswork as to where patients are on the pathway
- finding solutions to problems and showing trends to understand bottlenecks and delay areas
- identifying learnings and areas where you are doing well
- comparing the pathway to the actual agreed pathway
- quality data leading to better decision-making
- allowing resources to be redirected
- providing background evidence when explaining faster cancer treatment outcomes to clinicians and other stakeholders
- enabling a strategic approach to service improvement
- a data source for audit and research.

Intended Audience

The main intended audiences for this document are:
Te Whatu Ora who are responsible for the commissioning and the delivery of health services for Aotearoa New Zealand.

- Anyone responsible for collecting, submitting, and reporting FCT indicator data such as:
  - district hospital and specialist services FCT trackers/coordinators who track patients to ensure timely access to appointments, diagnostic tests that detect cancer and cancer treatment
  - Data and Digital data management and business analysts verifying that all required data elements are present and specified correctly, and report FCT indicators
- clinicians and service management responsible for the safe delivery of quality and timely diagnostic and cancer treatment care to patients and whānau
- referrers to Te Whatu Ora hospital and specialist services – the document provides the criteria for referring people with a high suspicion of cancer
- software developers designing, implementing, and altering provider systems to ensure they export information in a format suitable for loading into the faster cancer treatment database.

Te Aho o Te Kahu leads a national work programme that supports the vision to achieve fewer cancers, better survival, and equity for all. Te Aho o Te Kahu monitors performance of FCT indicators which requires the analysis of data reported to Te Aho o Te Kahu via Te Whatu Ora. Te Aho o Te Kahu regional teams' partner with Te Whatu Ora regional district providers to support areas such as: data management, monitoring performance and regional service improvement.

Manatū Hauora has overall responsibility for the health system and monitors Te Whatu Ora performance.

Using This Document

Section 1 Business Rules:

This section contains the **Business Rules** which outline the requirements for reporting the FCT indicators. This section is key to identifying:

- inclusion and exclusion criteria for 62- or 31-day pathways
- data processing definitions for each of the requirement
- batch processing for Te Whatu Ora National Collections reporting.

Section 2 Delay Code Reporting Guidance:

All patients not meeting the 62- or 31-day indicators must be assigned a **Delay Code** and reasons for any delay in the pathway identified. This section defines the delay codes and gives guidance for their use. Prostate cancer surgery is managed as per the Standardised Adult Urology Waiting List Criteria noting the timeframes differ from the FCT wait times. This is addressed in section 2b.

Section 3 High Suspicion of Cancer Definitions:

Section three defines **high suspicion of cancer** criteria as they relate to each of the tumour streams, to assist clinicians in triaging referrals. High suspicion of cancer criteria for prostate cancer has been included using Community Health Pathways information. Refer section 3b.

Section 4 Tumour Specific Reporting Guidelines:

This section provides **Tumour Specific Reporting Guidelines** for FCT trackers/co-ordinators and others involved in the management of FCT. The tumour specific provides consistency and clarity by using FAQ's.

Section 5 Use Cases:

The **Use Cases** outlined in this section, provide FCT clinical case history examples. These case histories illustrate how the FCT business rules and data definitions should be applied. Those involved with data reporting will find the colour coding linking activities to data definitions useful.

Section 1: Business Rules

This section provides the updated Business Rules and Data Definitions for the FCT indicators and describes the business rules required.

Reporting against the FCT indicators will be based on three data points. These data points make up the start and stop points of the FCT indicators: date of referral, decision-to-treat and first cancer treatment.

Throughout this document clinical codes from ICD-10-AM 8th Edition are used. The newer 12th Edition of clinical codes released 1 July 2023, has not changed the codes reported by FCT. Therefore, the codes in this document are referenced to ICD-10-AM 8th Edition. The ICD-10-AM 8th Edition codes should not be confused with the ICD-10 World Health Organization classification.

Inclusions and exclusions for the 62-day indicator

Grouping	Patients are *included* in the 62-day indicator if they	Patients are *excluded* from the 62-day indicator if they
Eligibility	• Are eligible for treatment in New Zealand	• Are not eligible for treatment in New Zealand
Cancer pathways start point	• Have a pathway that begins inside the NZ health system • Have a cancer that was diagnosed publicly • Have entered the cancer pathway through an acute presentation, as long as there is a subsequent referral to an outpatient clinic • Have received treatment for metastatic cancer where the primary site is unknown	• Have a pathway that begins outside the New Zealand health system • Have a cancer that has been diagnosed through a screening programme • Have a cancer that was diagnosed privately • Have entered the cancer pathway through an acute presentation, which does not subsequently result in a referral to an outpatient clinic • Have a recurrent cancer (irrespective of the time frame of recurrence) • Have metastatic cancer, but the patient's primary cancer has already been included in FCT reporting[6]
Age of patient	• Are under the care of adult services **and** are 16 or older at the date of first cancer treatment	• Are not under the care of adult services **and/or** are not 16 or older at the date of first cancer treatment

[6] Metastatic cancers should not be recorded in FCT reporting unless the patient's primary cancer site is unknown. Such cancers should be recorded as C80 - Malignant neoplasm without specification of site.

Grouping	Patients are *included* in the 62-day indicator if they	Patients are *excluded* from the 62-day indicator if they
Treatment	• Have received a first treatment (or other management) for cancer that is publicly funded, in the reporting period	• Have not received a first treatment (or other management) for cancer that is publicly funded, in the reporting period • Have a first treatment for cancer that was undertaken privately
Triage	• Have been triaged as having a high suspicion of cancer **and** as having a need to be seen within two weeks	• Have been triaged as not having a high suspicion of cancer • Have a confirmed diagnosis of cancer at triage of referral • Have been triaged as not needing to be seen within two weeks
Primary diagnosis	• Have a primary diagnosis of cancer that is included in Appendix B of this document	• Have a primary diagnosis that is not included in Appendix B of this document

Inclusions and exclusions for the 31-day indicator

Grouping	Patients are *included* in the 31-day indicator if they	Patients are *excluded* from the 31-day indicator if they
Eligibility	• As per 62-day indicator	
Cancer pathways start point	• Have a treatment pathway that begins inside the New Zealand health system • Have a cancer that has been diagnosed through a screening programme • Have entered the cancer pathway through an acute presentation • Have a cancer that was treated following it being detected incidentally[7] • Have received treatment for metastatic cancer where the primary site is unknown	• Have a treatment pathway that begins outside the New Zealand health system • Have a recurrent cancer (irrespective of the time frame of recurrence) • Have metastatic cancer and the patient's primary cancer has already been included in FCT reporting
Age of patient	• Are under the care of adult services **and** are 16 or older at the date of first cancer treatment	• Are not under the care of adult services **and/or** are not 16 or

[7] An incidentally found cancer may be diagnosed and treated on the same day. If this is the case the patient should be reported for the 31-day indicator, with the decision-to-treat date being the date that the decision-to-treat *as cancer* was made (which may also be the date of surgery).

		older at the date of first cancer treatment
Treatment	• Have received a first treatment (or other management) for cancer that is publicly funded, in the reporting period	• Have not received a first treatment (or other management) for cancer that is publicly funded, in the reporting period • Have a first treatment for cancer that was undertaken privately
Primary diagnosis	• Have a primary diagnosis of cancer that is included in Appendix B of this document	• Have a primary diagnosis that is not included in Appendix B of this document

Exclusion of patients with a primary diagnosis of DCIS

ICD-10-AM 8th Edition code D05 *Carcinoma in situ of breast – intraductal* (DCIS) is excluded from the list of primary diagnoses that are valid for inclusion in the FCT reporting.
ICD-10-AM D-codes are excluded from FCT reporting as they are deemed low risk, non-invasive, non-malignant, low-grade, indolent, or asymptomatic.

Exclusion of patients with a primary diagnosis of non-melanoma skin cancer

ICD-10-AM 8th Edition code C44 – *other malignant neoplasms of skin* are excluded from the FCT reporting for both the 62-day and 31-day indicators.

Clarification around indolent or asymptomatic haematological malignancies

- If a patient is triaged as having a high suspicion of cancer and has a need to be seen within two weeks (and then later receives a diagnosis of a haematological malignancy) they should be reported for both the 62-day and 31-day indicator.
- If a patient is triaged as not having a high suspicion of cancer and/or there is no need for the patient to be seen within two weeks (and then goes on to be diagnosed with a haematological malignancy) the patient should be recorded against the 31-day indicator – just as with every other ICD-10-AM C-coded cancer type.
- If at decision-to-treat the patient's cancer is deemed indolent or asymptomatic, then that patient's type of first treatment may be 'non-intervention management', with the record still valid for inclusion in the 31-day indicator data.

Patients with follicular lymphoma (C82) should be reported

- Patients diagnosed with follicular lymphoma should be included in the 31-day indicator reporting, and where appropriate, in the 62-day indicator reporting.
- Follicular lymphoma would rarely be valid for inclusion in the 62-day indicator, as it would be rare for a patient with this diagnosis to have a need to be seen in two weeks.
- A patient who receives treatment for this diagnosis, however, should be recorded against the 31-day indicator.
- This code is included in the list of ICD-10-AM 8th Edition codes in Appendix B.

Patients with 'Other specified types of T/NK-cell lymphoma (C86) should be reported

- ICD-10-AM 8th Edition includes a code for 'Other specified types of T/NK-cell lymphoma' under the code C86.
- Patients diagnosed under this code should be reported using the same rules that guide the reporting of all other haematological cancers.

Clarification for patients entering the cancer pathway through the Emergency Department and/or admitted acutely

- Any patient who enters their cancer pathway through an Emergency Department (ED) and/or is admitted acutely should not be recorded in the 62-day indicator.
- If a patient is discharged from ED and referred to an outpatient clinic, and the referral fits the criteria for inclusion, the patient may then be valid for inclusion in the 62-day indicator.
- If a patient is admitted following an ED attendance for a reason other than cancer but are subsequently referred to an outpatient clinic with a high suspicion of cancer, and the referral fits the criteria for inclusion, then the patient may be included in the 62-day indicator.
- All patients (including those entering the pathway through ED) who receive a first treatment for cancer, should be recorded in the 31-day indicator.

Clarification around reporting first treatment when chemotherapy and radiation therapy occur concurrently

- Chemotherapy and radiation therapy often occur on the same day. The FCT data definitions and business rules provide selection of a first treatment option of 'concurrent radiation therapy and chemotherapy'.
  Note: Concurrent radiation therapy and chemotherapy refers to where both radiation and chemotherapy are given simultaneously. This is different to when chemotherapy is given first followed by radiation therapy or vice versa.
- For concurrent treatment, the date of first treatment is the date on which either chemotherapy or radiation therapy is received (although this will usually occur on the same day).
- Date of decision-to-treat for patients undergoing concurrent therapy, should be the day that the patient has agreed to the concurrent therapy treatment option.

Clarification around patients enrolled in clinical trials

- The data definitions and business rules document allow selection of a first treatment option of 'clinical trial'.
- Irrespective of the modality of treatment, if a patient is enrolled in an ethically approved clinical trial, they should be recorded as such.
- Where first treatment is a clinical trial, the date of first treatment is the date the patient consents to be put forward for the clinical trial.

Clarification around incidentally found cancers

- Cancers found incidentally (for example during surgery) should be reported under the 31-day indicator only. Such cancers may be diagnosed and treated on the same day, resulting in a waiting time (from decision-to-treat to treatment) of zero days.
- Date of decision-to-treat should be the date that a decision-to-treat as cancer was made. For example, if cancer was found in a patient during an operation (where cancer was not initially suspected) and the cancer was removed (and treated) during the operation, the operation date would be used as the decision-to-treat date.

Clarification around recurrent and secondary/metastatic cancers

- Recurrent cancers and secondary/metastatic cancers should not be reported within the FCT indicators data.
- However, if a cancer has metastasised, but the primary site is unknown, this cancer should be reported under the ICD-10-AM 8th Edition code for malignant neoplasm without specification of site (C80).

Prospective patient monitoring and retrospective data reporting

Hospitals should ensure data collection and reporting systems collect information on patients as they track through the care pathway (ie, prospectively), thereby the patients pathway remains timely throughout.
FCT indicator data is reported to Te Whatu Ora retrospectively[8], after the first cancer treatment (or other management) has commenced.

Data collection responsibility

The district of domicile is responsible for collecting and collating information on the data items for their patients and submitting this information via submission of a text file to Te Whatu Ora National Collections, see *Data reporting process* below.

The district of **domicile** is responsible for collecting and reporting information on their domiciled population even if it is not the hospital of:

- receipt of referral or
- service.

Data reporting process

Data is reported via a pipe delimited text file and must be submitted to Te Whatu Ora National Collections via Secure File Transfer Protocol (SFTP).

All data must be submitted on or before the 20th of each month, following the month being reported.

Reportable data items for the FCT indicators

The mandatory **(M)** data items to be reported to Te Whatu Ora National Collections for the two FCT indicators are identified as follows:

Mandatory fields required for processing and calculation of the 62-day indicator

Record type	M
National Health Index (NHI) number (includes ethnicity)	M
First name	
Family name	
Date of birth	M
Sex	M
District of domicile	M
Date of diagnosis	

[8] Retrospective means that reporting the length of time it takes for each patient against the FCT indicators happens after the patient has started their first treatment.

Primary site ICD-10-AM 8th Edition	M
Date of receipt of referral	M
Hospital of receipt of referral	M
Date patient informed of diagnosis	
Date of first multidisciplinary meeting (MDM)	
Date of decision-to-treat	M
Date of first treatment	M
Type of first treatment	M
District of service for first treatment	M
Source of referral	
Clinician defined suspicion of cancer	M
2 Week flag	M
Delay code 62	M
Delay code 31	

Mandatory fields required for processing and calculation of the 31-day indicator

Record type	M
National Health Index (NHI) number (includes ethnicity)	M
First name	
Family name	
Date of birth	M
Sex	M
District of domicile	M
Date of diagnosis	
Primary site ICD-10-AM 8th Edition	M
Date of receipt of referral	
Hospital of receipt of referral	
Date patient informed of diagnosis	
Date of first multidisciplinary meeting (MDM)	
Date of decision-to-treat	M
Date of first treatment	M
Type of first treatment	M
District of service for first treatment	M
Source of referral	
Clinician defined suspicion of cancer	
2 Week flag	
Delay code 62	
Delay code 31	

Primary key

Each record has a unique primary key consisting of:

- NHI_Number
- Primary_site_ID.

The primary key is used to check for duplicates on insert or check for existence of a record for update or delete. During the load process, the FCT database checks that the data key is unique for the records with an A (add) record type.

Records will be rejected if they contain errors

All files submitted under version 2.0 will be loaded; however, records need to pass data quality checks and errors will be highlighted if:

- the NHI number is validated against the NHI repository and is not able to be matched
- the record does not have a date of first treatment, or the date of first treatment is prior to 01 January 2012 or is greater than the load date
- there is a missing primary site, or the primary site is out of range.

A patient who has previously been registered in the FCT database with a cancer may return later with a second primary tumour in the same site. This will create a duplicate record requiring validation.

Te Whatu Ora will run an error report after the 20th of each month. This will be sent to hospitals to verify these as either legitimate records or errors to be deleted.

Data definitions

Record type definition

<table>
<tr><td>Definition:</td><td>Each FCT event record in an input file must have a record type in order to be loaded correctly</td></tr>
<tr><td>Source standards:</td><td>N/A</td></tr>
<tr><td>Obligation:</td><td>Mandatory for any submitted record</td></tr>
<tr><td>Data domain:</td><td><table><tr><th>Value</th><th>Meaning</th></tr><tr><td>A</td><td>Add</td></tr><tr><td>U</td><td>Update</td></tr><tr><td>D</td><td>Delete</td></tr></table></td></tr>
<tr><td>Field Name:</td><td>Record_type</td></tr>
<tr><td>Format:</td><td>A(1)</td></tr>
<tr><td>Guide for use:</td><td>This field denotes whether a record is to be added to, updated within, or deleted from the FCT database.
Add: Creates a new event if no existing record with the same primary key[9] is found on the FCT database.
Update: Replaces any event with the same primary key.
Delete: Deletes the record from the FCT database based on the primary key.</td></tr>
</table>

[9] The Primary Key is made up of two fields: NHI and primary site

National Health Index (NHI) number definition

Definition:	The NHI is a unique 7-character identification number assigned to a healthcare user by the NHI database.
Source standards:	National Health Index Data Dictionary v5.3 (July 2009).
Obligation:	**Mandatory** for any submitted record
Field Name:	NHI_Number
Format:	AAANNNN
Guide for use:	The NHI number forms part of the primary key for the faster cancer treatment record. The NHI will also include ethnicity information.

First name definition

Definition:	The first given name of a healthcare user.
Source standards:	National Health Index Data Dictionary v5.3 (July 2009).
Obligation:	Non-mandatory
Data domain:	N/A
Field Name:	First_Name
Format:	A(50)

Family name definition

Definition:	The family name (surname) of a healthcare user.
Source standards:	National Health Index Data Dictionary v5.3 (July 2009).
Obligation:	Non-mandatory
Field Name:	Family_Name
Format:	A(50)

Date of birth definition

Definition:	The date on which the healthcare user was born.
Source standards:	HL7 v2.4 DT – date.
Obligation:	**Mandatory** for any submitted record
Data domain:	Valid date
Field Name:	Date_of_Birth
Format:	DDMMCCYY

Sex definition

Definition:	The person's biological sex
Source standards:	National Health Index Data Dictionary v5.3 (July 2009).
Obligation:	**Mandatory** for any submitted record
Data domain:	

Value	Meaning
F	Female
I	Indeterminate
M	Male
U	Unknown

Field Name:	Sex
Format:	A(1)

District of domicile definition

Definition:	The district of domicile is the code of the district responsible for the patient.
Source standards:	National Health Index Data Dictionary v5.3 (July 2009).
Obligation:	**Mandatory** for any submitted record
Data domain:	

Value	Meaning
011	Northland
021	Waitemata
022	Auckland
023	Counties Manukau
031	Waikato
042	Lakes
047	Bay of Plenty
051	Tairawhiti
061	Hawkes Bay
071	Taranaki
081	MidCentral
082	Whanganui
091	Capital and Coast
092	Hutt Valley
093	Wairarapa
101	Nelson Marlborough
111	West Coast
121	Canterbury
123	South Canterbury
160	Southern

Field Name:	DHB_of_domicile
Format:	NNN

Date of diagnosis definition

Definition:	The date on which the patient was definitively diagnosed with a particular condition or disease.
Source standards:	National Cancer Core Data Definitions Interim Standard HISO 10038.3 October (2011).
Obligation:	Non-mandatory
Data domain:	Valid date
Field Name:	Date_of_Diagnosis
Format:	DDMMCCYY
Guide for use:	The date of diagnosis is the date of the pathology report, if any, that first confirmed the diagnosis of cancer. This date may be found attached to a letter of referral or a patient's medical record from another institution or hospital. If this date is unavailable, or if no pathological test was done, then the date may be determined from one of the sources listed in the following sequence: 1. Date of the consultation at, or admission to, the hospital, clinic or institution when the cancer was first diagnosed. Note: do not use the admission date of the current admission if the patient had a prior diagnosis of this cancer. 2. Date of first diagnosis as stated by a recognised medical practitioner or dentist. Note: This date may be found attached to a letter of referral or a patient's medical record from an institution or hospital. 3. Date the patient states they were first diagnosed with cancer. Note: This may be the only date available in a few cases (for example, patient was first diagnosed in a foreign country). If a patient is admitted for another condition (for example a broken leg or pregnancy), and a cancer is diagnosed incidentally then the date of diagnosis is the date that the decision-to-treat *as cancer* was made.

Primary site International Classification of Diseases (ICD-10-AM 8th Edition) definition

Definition:	The Primary site ICD-10-AM 8th Edition is the code that describes the primary site of the cancer for which the patient is being seen.
Source standards:	ICD-10-AM 8th and subsequent editions
Obligation:	**Mandatory** for any submitted record
Data domain:	Valid ICD-10-AM 8th Edition codes recorded to the third digit (see Appendix B).
Field Name:	Primary_Site
Format:	ANN
Guide for use:	The 3-digit ICD-10-AM 8th Edition code forms part of the primary key for the faster cancer treatment record. See appendix B of this document for the list of the ICD-10-AM 8th Edition codes included in the FCT initiative.

Date of receipt of referral definition

Definition:	The date of receipt of referral is the date the referral is initially received into secondary care. If the referral is transferred to another hospital the date of referral remains the date that the referral was received by the first hospital.
Source standards:	National Cancer Core Data Definitions Interim Standard HISO 10038.3 October (2011). HL7 v2.4 DT – date.
Obligation:	**Mandatory** for the 62-day indicator. Non-mandatory for the 31-day indicator (as the patient may not have been referred with a high suspicion of cancer with a need to be seen within two weeks).
Data domain:	Valid date
Field Name:	Date_of_Receipt_of_Referral
Format:	DDMMCCYY
Guide for use:	As referrals are received in different formats the following provides a guide for consistency purposes *Electronic referrals* Best practice is for referrals to be submitted electronically. Where referrals are submitted electronically the date of receipt of referral is the date that initiates the handling/processing of the electronic referral. *Letter or faxed referrals* When referrals are made by letter or fax the date of receipt of referral is the date with which the referral is stamped as having first being received in secondary care. *Telephone or verbal referrals* When referrals are made by telephone or a face-to-face conversation there is a need for information to be recorded or documented so that the booking process can be initiated. The date of receipt of referral is the date recorded on that documentation of the conversation with secondary care. On occasion, there will be multiple referrals for an individual patient. Where a patient has been accepted into another care pathway a clinical decision will need to be made as to whether the newer referral overrides the current pathway or not. The clinical decision needs to be documented and will determine the date of receipt of referral. Electronic referrals must consider the Referrals, Status and Discharge Referrals (RSD) suite of standards. These provide guidance for electronic information exchange when all or part of patient care is transferred from one health care provider to another as based on HL7 V2.4.

District of receipt of referral definition

Definition:	The district of receipt of referral is the code of the hospital that received the initial referral.
Source standards:	National Health Index Data Dictionary v5.3 (July 2009).
Obligation:	**Mandatory** for the 62-day indicator. Non-mandatory for the 31-day indicator (as the patient may not have been referred with a high suspicion of cancer with a need to be seen within two weeks).
Data domain:	Valid 3-digit hospital code (refer to District of domicile definition).
Field Name:	DHB_of_Receipt_of_Referral
Format:	NNN
Guide for use:	On occasion, an individual patient will have multiple referrals. Where a patient has been referred from one hospital to another hospital use the code for the hospital that first received the referral that initiated the treatment for cancer.

Date patient informed of diagnosis

Definition:	The date the patient was informed of their diagnosis
Source standards:	HL7 v2.4 DT – date.
Obligation:	Non-mandatory for all records
Data domain:	Valid date
Field Name:	Date_Patient_Informed_of_Diagnosis
Format:	DDMMCCYY
Guide for use:	N/A

First multidisciplinary meeting (MDM) date definition

Definition:	Date on which the patient was first discussed at a MDM.
Source standards:	National Cancer Core Data Definitions Interim Standard HISO 10038.3 October (2011).
Obligation:	Non-mandatory for all records
Data domain:	Valid date
Field Name:	Date_of_First_MDM
Format:	DDMMCCYY
Guide for use:	N/A

Date of decision-to-treat definition

Definition:	The decision-to-treat is the date when the decision was made for the patient's treatment plan or other management plan, following discussion between the patient and the clinician responsible for treatment.
Source standards:	National Health Service Scotland New Cancer Waiting Times Targets Data and Definitions Manual (2010). National Patient Flow File Specification
Obligation:	**Mandatory** for all submitted records
Data domain:	Valid date
Field Name:	Date_of_Decision_to_Treat
Format:	DDMMCCYY
Guide for use:	Where there are two possible dates, the earliest date applies. When a patient has been discussed in MDM, it is in the best interests of the patient that the decision-to-treat discussion with the patient takes place as soon as possible after the MDM. Where decision-to-treat is not routinely collected, the date that a booking request for treatment is made can be used as a surrogate for decision-to-treat. An outpatient attendance outcome decision is required to be reported. The date that this is recorded is to be used in the first instance. Where there is no outpatient attendance outcome decision recorded then the following dates can be used as date of decision-to-treat (for the associated treatment type). • Surgery - date booking for surgery was requested. • Chemotherapy / Radiation therapy (or concurrent) - date chemotherapy or radiation therapy booking was requested. • Targeted therapy – date prescription was written. • Non–intervention management – date the decision of non-intervention management was recorded in the patient's record. • Best supportive care – date referral was written. • Patient declined treatment – date of outpatient visit. • Patient died – date of death.

Date of first treatment definition

Definition:	The date for first treatment is the date that the first treatment was provided for that patient for that cancer.
Source standards:	HL7 v2.4 DT – date.
Obligation:	**Mandatory** for all submitted records
Data domain:	Valid date
Field Name:	Date_of_First_Treatment

Format:	DDMMCCYY
Guide for use:	The date of first treatment is the date the first treatment was provided or attempted but not carried out or completed for clinical reasons. For example, 'open and shut surgery' would be coded under 01 surgery. Where a patient's diagnostic biopsy is included as first treatment, because the whole tumour has been removed and the margins are clear, the date of the biopsy is the date of first treatment. Where first treatment is targeted therapy – hormone therapy, the date of first treatment is the date the prescription is written for the treatment. Where the treatment is 'best supportive care' and there is a referral to a palliative or supportive care service outside the district, the date the referral was written can be used as date of first treatment. If a patient dies before treatment occurs, the date of death is used as the date of first treatment. Where first treatment is an ethically approved clinical trial, the date of first treatment is the date the patient consents to be put forward for the clinical trial. **Note** that the following treatments could have the same date as the date of decision-to-treat: • Non-intervention management • Best supportive care • Patient declined treatment • Targeted therapy.

Type of first treatment definition

Definition:	The type of first treatment is defined as the treatment or other management that attempts to begin the patient's first treatment, including palliative care or non-intervention management.
Source standards:	Based on the: National Cancer Core Data Definitions Interim Standard HISO 10038.3 October (2011). National Health Service Scotland New Cancer Waiting Times Targets Data and Definitions Manual (2010).
Obligation:	**Mandatory** for all submitted records

Data domain:

Value	Meaning
00	Other
01	Surgery: exclude diagnostic procedures such as punch, incisional, needle or core biopsy
02	Radiation therapy
03	Chemotherapy
04	Targeted therapy: refers to a medication / drug that targets a specific pathway in the growth and development of a tumour
05	Non-intervention management: an expectant or observational approach pending change in the patient's circumstances. It is a period of active management not unmanaged non-treatment
06	Palliative care (including best supportive care): covers the essential services provided to patients that are not surgical, chemotherapy or radiation therapy based. These are likely to be delivered by staff trained in delivering palliative and/or supportive care. The care maybe delivered in the patient's home or in a palliative care setting.
07	Patient declined treatment
08	Patient died before treatment
09	Concurrent radiation therapy and chemotherapy
10	Clinical trial: where a patient is being treated as part of a clinical trial, irrespective of modality of treatment
99	Not recorded

Field Name: Type_of_First_Treatment

Format: NN

Guide for use:

Patients should be included if first treatment is attempted but not carried out or completed for clinical reasons. For example, 'open and shut surgery' would be coded under 01 surgery.

A diagnostic biopsy should only be included as first treatment when the whole tumour has been removed and the margins are clear.

Where the treatment is a 'decision not to treat' the record should be allocated the most appropriate of either the 'best supportive care' or 'non-intervention management' codes.

Concurrent radiation therapy and chemotherapy refers to where both radiation and chemotherapy are given simultaneously. This is distinct to when both are given in sequence where a course of chemotherapy is followed by a course of radiation therapy (or vice versa).

District of service for first treatment definition

Definition:	The district of service for first treatment is the code of the hospital that provided the patient's first cancer treatment.
Source standards:	National Health Index Data Dictionary v5.3 (July 2009).
Obligation:	**Mandatory** for all submitted records
Data domain:	Valid 3-digit hospital code (refer to district of domicile definition).
Field Name:	DHB_of_First_Treatment
Format:	NNN
Guide for use:	This is the hospital that provided the first treatment recorded in the type of first treatment field. Where first treatment is a clinical trial, the hospital of first treatment is the hospital where the patient was enrolled in the clinical trial. Where first treatment is targeted therapy – hormone therapy, the hospital of first treatment is the hospital where the prescription is written for the treatment.

Source of referral definition

Definition:	The source of the referral is defined by the facility / health professional that made the referral.
Source standards:	National Health Service Scotland New Cancer Waiting Times Targets Data and Definitions Manual (2010).
Obligation:	Non-mandatory for all records
Data domain:	**Value** / **Meaning** 00 Other 01 Primary care clinician / practice 02 Primary dental clinician / practice 03 Accident and medical / after-hours 04 Emergency department 05 Other hospital department 06 Other hospital 07 Private specialist / hospital 08 National screening programme 09 Unknown
Field Name:	Source_of_Referral
Format:	NN

Suspicion of cancer (SCAN) definition

<table>
<tr><td>Definition:</td><td>Clinician defined suspicion of cancer</td></tr>
<tr><td>Source standards:</td><td>National Patient Flow documentation as of 28 February 2014</td></tr>
<tr><td>Obligation:</td><td>Mandatory for the 62-day indicator.
Non-mandatory for the 31-day indicator (as the patient may not have been referred with a high suspicion of cancer).</td></tr>
<tr><td>Data domain:</td><td><table><tr><th>Value</th><th>Meaning</th></tr><tr><td>10</td><td>The patient had a confirmed diagnosis of cancer at triage</td></tr><tr><td>20</td><td>There is not a high suspicion of cancer</td></tr><tr><td>30</td><td>There is a high suspicion of cancer</td></tr></table></td></tr>
<tr><td>Field Name:</td><td>SCAN</td></tr>
<tr><td>Format:</td><td>NN</td></tr>
<tr><td>Guide for use:</td><td>If set to ‘10’ this indicates that the patient already had a confirmed pathological diagnosis of cancer at the point of triage. If set to ‘20’ this indicates that the patient was triaged as not having a high suspicion of cancer. If set to ‘30’ this indicates that the patient was triaged as having a high suspicion of cancer. These decisions are at the discretion of the triaging clinician.
If not captured by the hospital, then set ‘30’ as default for all records where you wish the 62-day indicator to be calculated.</td></tr>
</table>

Two Week (2W) definition

<table>
<tr><td>Definition:</td><td>The triaging clinician has assessed that the patient needs to be seen within two weeks of the initial referral.</td></tr>
<tr><td>Source standards:</td><td></td></tr>
<tr><td>Obligation:</td><td>Mandatory for the 62-day indicator
Non-mandatory for the 31-day indicator (as the patient may not need to be seen within two weeks).</td></tr>
<tr><td>Data domain:</td><td><table><tr><th>Value</th><th>Meaning</th></tr><tr><td>0</td><td>No</td></tr><tr><td>1</td><td>Yes</td></tr></table></td></tr>
<tr><td>Field Name:</td><td>2W_flag</td></tr>
<tr><td>Format:</td><td>N</td></tr>
<tr><td>Guide for use:</td><td>If set to ‘1’ this indicates that the patient was triaged as needing to be seen within two weeks. This decision is at the discretion of the triaging clinician.
Otherwise, if not captured by the hospital, then set ‘1’ as default for all records where you wish the 62-day indicator to be calculated.</td></tr>
</table>

Delay code definition

<table>
<tr><td>Definition:</td><td>When the time taken for a patient to track through the patient pathway is outside the time identified for the indicator the main reason for the delay must be reported.

There is a separate delay code for each indicator, stored in two individual fields representing the two indicators, as required.</td></tr>
<tr><td>Source standards:</td><td>Unknown</td></tr>
<tr><td>Obligation:</td><td>Allocating delay codes are mandatory for 62-day indicators. Delay codes are non-mandatory for 31-day but it is highly recommended delay codes are completed for identifying service improvements and delay code analysis.</td></tr>
<tr><td>Data domain:</td><td><table><tr><th>Value</th><th>Meaning</th></tr><tr><td>1</td><td>Patient reason (chosen to delay)</td></tr><tr><td>2</td><td>Clinical consideration (co-morbidities)</td></tr><tr><td>3</td><td>Capacity constraint (resulting from lack of resources (theatre, equipment, facilities, or workforce) or process constraint including administrative errors)</td></tr></table></td></tr>
<tr><td>Field Names:</td><td>Delay_code_62
Delay_code_31</td></tr>
<tr><td>Format:</td><td>N</td></tr>
<tr><td>Guide for use:</td><td>This field should be used to indicate the reason why the timeframe was not met. The main reason for delay is the reason that contributed to the longest delay, or if there are two delays of equal length, use the first delay that occurred.

Districts are encouraged to report this information for all records that exceed the indicator timeframes, for both 62- and 31-day indicators.

If a record contains the fields to enable both the 62-day indicator and the 31-day indicator to be calculated, and both indicator timeframes have been exceeded, both the delay_code_62 and delay_code 31 fields should be completed for that record.</td></tr>
</table>

Indicator calculation

62-day indicator:

$$= \frac{Number\ of\ patients\ who\ met\ the\ 62\ days\ timeline(2W\_flag = 1, SCAN = 30, Ind\_1\_met = Y)}{Number\ of\ patients\ in\ 62\ days\ pathway\ cohort\ excluding\ unavoidable\ delayed\ cases}$$

$$[(2W\_flag = 1, SCAN = 30, Ind\_1\_met \neq Y,\ \ Delay\_code\_62 \neq 1, 2) +$$
$$(\ 2W\_flag = 1, SCAN = 30, Ind\_1\_met = Y\ )]$$

Measurement definitions	Numerator: Number of patients who receive their first cancer treatment (or other management) within 62 days of receipt of their referral. Denominator: Patients under the 62-day FCT pathway (excluding patients breaching with a delay code of clinical consideration or patient reason). Reason for Delay is a mandatory field, any missing or unknown delay codes will be included in the denominator.
Frequency that data is available	Quarterly Note: Te Whatu Ora Districts should establish their data collection and reporting systems to collect information on patients as they track through the care pathway (i.e., prospectively). This information is then reported retrospectively, including where necessary delay code reporting.
Level of disaggregation of data available	Geographic area
Data period	One quarter in arrears, 3 months rolling

31-day indicator:

$$= \frac{Number\ of\ patients\ who\ met\ the\ 31\ days\ timeline (Ind\_3\_met = Y)}{Number\ of\ patients\ in\ 31\ days\ pathway\ cohort\ (Ind\_3\_met = All)}$$

If quantitative, measurement definitions	Numerator: Number of patients who receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat. Denominator: Patients under the 31-day FCT pathway.
Frequency that data is available	Quarterly Note: Te Whatu Ora Districts should establish their data collection and reporting systems to collect information on patients as they track through the care pathway (i.e., prospectively). This information is then reported retrospectively, including where necessary delay code reporting, which is encouraged for service improvement and delay code analysis.
Level of disaggregation of data available	Geographic area
Data period	One quarter in arrears, 6 months rolling

Extract file requirements

Batch file name

The file naming convention used to supply batches to the FCT database must consist of the following elements:

- three-letter acronym allocated to each sending agency by Te Whatu Ora (see Appendix A for a list of the acronyms)
- sequential number to uniquely identify each batch
- file extension allocated by Te Whatu Ora National Collections ('fct' for FCT database upload files).

For example, a typical file name for Capital & Coast would be 'CCH00001.fct'.

Batch file format

The file is in ASCII format, where:

- only ASCII characters 32 through 127 (except for 34) are permitted
- records are delimited by carriage return and line feed (ASCII 13 and ASCII 10)
- fields are variable in length and delimited by the pipe "|" character.

Null fields

If a field is not mandatory and no data is being sent, a field delimiter must be present.

Dates, partial dates and date times

- Dates are DDMMCCYY unless otherwise specified
- Partial dates are not permitted
- Dates are sent as char
- Dates must be formatted with leading zeros.

Batch process overview

The FCT data collection is the responsibility of the provider (submitting Hospital).

The provider is to set up and maintain batch processes to supply the data to the Te Whatu Ora National Collections via secure FTP.

Te Whatu Ora National Collections will send an acknowledgement of the data processing via an e-mail.

Te Whatu Ora National Collections validates and loads data, and reports from the database.

Batch send process

Batch reporting will be carried out on a monthly basis.

All data must be submitted on or before the 20th of each month, following the month being reported.

Creating the FCT batch (input) file

The provider extracts data from their local FCT repository into a batch file (also known as the input file) to send to Te Whatu Ora National Collections. Each input file must contain a header record and an unlimited number of event details records.

- All fields should be pipe delimited.

- Commas, carriage returns, or other formatting must not appear in any field. (However, commas are allowed in text fields but not carriage returns or other formatting).
- Text fields should not be in quotes.
- No leading or trailing spaces are permitted unless otherwise stated.

Header record

Field	Type	Format	M	Notes
record type	Char 6	A(6)	M	'HEADER'
file name	Char 12	A(12)	M	Including .fct extension
number of records	Integer		M	The number of records, including the header, in the file eg, 23456
date sent	Date 8	DDMMCCYY	M	Must be a valid date and must be on or before the current date
file version	Char 5	ANN.N	M	Must be 'V02.0' if using the specifications set out in this document. All files must be V02.0 for patients who are treated on or after 1 July 2014, as V01.0 files will not be accepted after this time. Records for patients with a date of first treatment prior to 1 July 2014 can be sent using either of the V01.0 or V02.0 formats – both will be loaded into the FCT database.

FCT event record

Field	Type	Format	Notes
Record_Type	Integer	A(6)	'ADD', 'UPDATE' or 'DELETE' ('A', 'U' or 'D' also accepted)
NHI_Number	Text	AAANNNN	
First_Name	Integer	A(50)	Optional – District choice to include
Family_Name	Integer	A(50)	Optional – District choice to include
Date_of_Birth	Text	DDMMCCYY	
Sex	Integer	A(1)	
DHB_of_Domicile*	Integer	NNN	
Date_of_Diagnosis	Text	DDMMCCYY	
Primary_Site	Integer	ANN	
Date_of_Receipt_of_Referral	Text	DDMMCCYY	
DHB_of_Receipt_of_Referral*	Long Integer	NNN	
Date_Patient_Informed_of_Dx	Text	DDMMCCYY	
Date_of_First_MDM	Text	DDMMCCYY	
Date_of_Decision_to_Treat	Text	DDMMCCYY	
Date_of_First_Treatment	Text	DDMMCCYY	

Type_of_First_Treatment	Integer	NN	
DHB_of_First_Treatment*	Integer	NNN	
Source_of_Referral	Integer	NN	
SCAN	Integer	NN	Clinician defined suspicion of cancer
2W_flag	Integer	N	2-week flag
Delay_Code_62	Integer	N	
Delay_Code_31	Integer	N	

*The references to 'DHB' have not been updated to 'District' because the descriptions in the National Collections database tables have not yet been updated.

An example of the format of the file is shown below. In this example, Nelson Marlborough hospital (NMH) has submitted four records using the new format (version V02.0).

HEADER|NMH00007.fct|4|03082023|V02.0

A|NHI9999|XXX|YYYYY|15022001|M|022|21072023|C40|26072023|022|26072023|27072023|26072023|31072023|03|022|9|10|0||

A|ABC1234|JOHN|DOE|15022001|M|022|21072023|C40|26072023|022|26072023|27072023|26072023|31072023|03|022|9|10|0||

A|DEF5678|JANE|DOE|20111971|F|022|26062023|C50|30052023|022|03072023|27062023|03072023|26072023|01|022|9|30|1||

A|HIJ9101|BARBRA|STREISAND|18011964|F|022|14062023|C34|23052023|022|07072023||21072023|26072023|03|022|9|30|1|2|

Sending the batch to Te Whatu Ora

The batch file is sent to Te Whatu Ora National Collections via secure FTP.

Quarterly or monthly files are placed on Te Whatu Ora National Collections FTP server following the same mechanisms and software currently used when providing files for similar collection processes (eg, National Minimum Data Set (NMDS) or National Booking Reporting System (NBRS)). For FCT data, a separate directory structure called FCT has been created:

- \\[dhb]\FCT\

Te Whatu Ora National Collections batch pre-processing

Pre-processing

The input file is initially pre-processed. This checks that the:

- batch is in sequence
- the count of records in the header equals the actual number of records in the file (including the header record)
- number of fields per record complies with FCT database requirements.

Batch passes pre-processing

If the batch passes pre-processing the data is loaded into the FCT database and an email is generated to indicate how many records have been inserted, updated, and deleted.

Batch fails pre-processing

If the batch fails pre-processing, an e-mail is generated containing error messages indicating the cause of failure.

Load into the FCT database and validate (pre-processing passed)

When pre-processing is passed, the batch is loaded into the FCT database.

The records are processed as follows:

- each delete (D) record is applied, removing it from the database
- each new (A) record is added to the database
- each update (U) record is processed by first deleting the existing record with the same primary key, and then adding the new "update" record.

During the load process, if any record in a batch is found to contain an error, that record will not be loaded. Records with the following errors will not be loaded:

- if the NHI number is validated against the NHI repository and is not able to be matched, the record will not be loaded
- if the record is deemed to be a duplicate (based on the primary key of NHI and primary site) the record will not be loaded[10]
- if the record does not have a date of first treatment, or the date of first treatment is prior to 01 January 2012, or is greater than the load date the record will not be loaded
- if there is a missing primary site, or the primary site is out of range then the record will not be loaded.

Automated return files

From 1 March 2021: a warning was generated in a reconciliation file for all data submitted that does not meet the FCT database requirements.
From 1 July 2021: data would be rejected that does not meet the FCT database requirements, requiring Districts to correct and resubmit these data. Below is an example of email receipt. The deleted records are expected to be resubmitted.

Email acknowledgement for Faster Cancer Treatment file submission by [redacted] DHB

File [redacted]00109.fct passed pre-processing

RECORD COUNTS

Inserted records: 129
Updated records: 604
Deleted records: 0

Lines processed: 733

Date file [redacted]00109.fct loaded into FCT load database: 19/07/2021 1:05:25 pm

[10] In some instances, a 'legitimate duplicate' record will need to be reported. Such a record would have a primary site and NHI combination (ie a primary key) that already exists in the database. This would occur if a patient has been reported as having two primary cancers with the same site code, which is rare, but does occur. Such a record would be rejected using the current rules. If this is the case and a HOSPITAL has a legitimate duplicate record to submit, they should inform their Ministry FCT contact.

Data quality checks

Once each batch of data is successfully loaded into the FCT database, a series of routine data quality checks are performed, and the results are reported back to the submitting District. Examples include checking that:

- mandatory fields have been completed
- codes supplied for each field are within the expected code range
- dates are sensible and are in chronological order
- a range of tumour groups have been supplied
- a range of treatment types have been supplied
- a range of source of referral and delay codes have been supplied.

Section 2: Delay Code Reporting Guidance

Gaining visibility of breach numbers, locations and reasons is a critical component for districts to understand where they are in the process of delivering on the FCT indicators. Good breach tracking and analysis will allow districts to:

- develop local responses that reflect the complexities of their hospitals
- assess tumour streams and identify key priorities for improvement
- establish a baseline position and plan for improvements needed to achieve targets.

Delays to treatment can be categorised as either 'avoidable breaches' or 'unavoidable breaches. Having clear visibility of the difference, and the volumes and locations of each type, is an invaluable tool in the improvement cycle.

- Unavoidable = legitimate patient choice, an unusually complex diagnostic pathway, or the delay was a clinical exception and in the best clinical interest of the patient.
- Avoidable = breaches resulting from administrative or capacity issues.

To support achievement of FCT indicators, the reporting of a delay code for records that do not achieve the 62-day timeframe is mandatory. The delay code reported should relate to the reason that contributed to the longest delay, or if there are two delays of equal length, the first delay that occurred.

There are three delay code reporting values[11]:

Value	Meaning
1	Patient reason (eg, patient has chosen to delay)
2	Clinical consideration (eg, co-morbidities, further testing, unconfirmed diagnosis)
3	Capacity constraint (eg, lack of resources such as theatre, equipment, facilities or workforce or process constraint including administrative errors)

Good practice points include:

- having an escalation plan to highlight potential breaches (Appendix C: Example of Escalation Procedure)
- all breaches (62- and 31-day) should be reviewed in detail to identify learnings, understand bottlenecks, and identify capacity issues.
- comparison of the actual pathway with time at each milestone against locally agreed milestones is often helpful (Appendix D: Examples of Breach Analysis)
- sub-categorising delays by each stage of the pathway are helpful to determine specific issues, some examples of sub-categories could include:

[11] It is understood that some Districts and/or Regional Cancer Networks are capturing more detailed delay code information than specified in the *Faster Cancer Treatment Indicators: Business Rules and Data Definitions*. This is supported, so long as Districts/RCNs ensure that for reporting to the national FCT collection this information is aggregated into the three values specified in the *Faster Cancer Treatment Indicators: Business Rules and Data Definitions*.

- DNA
- non-routine staging or further investigation
- capacity constraint: administrative process
- capacity constraint: FSA
- capacity constraint: diagnostics
- capacity constraint: staffing – unplanned, annual or sick leave
- capacity constraint: preadmission and anaesthetic assessment
- capacity constraint: oncology
- capacity constraint: theatre management
- capacity constraint: clinic cancellation

(Note these sub-categories are mapped to the appropriate delay codes: 1, 2 or 3)

- findings should be presented back to clinical and management teams/departments
- actions should be identified and immediately put into place to prevent further similar and/or avoidable breaches.

Delay code guidance

Value	Meaning	General principles	Valid example	Not valid example
1	**Patient reason (eg, patient choses to delay)**	• Must be able to demonstrate the patient generated the delay by choosing to wait longer. • Patients should be supported to understand their care pathway and treatment options and to make informed decisions. • Patients should be offered reasonable choice and given sufficient notice of their appointments and treatments. If patients are unable to attend at very short notice or are given little choice this should not be considered a patient reason/choice delay.	• A patient who is going on holiday and is unavailable for a period greater than 1 calendar week[12]. • A patient who is not available to attend any offered appointments and the impact of the delay is greater than 1 calendar week (from the earliest date offered). • A patient who changes their mind about their treatment *(*note, this should generate a review of the information and support provided to the patient to make a decision on their care and treatment)*. • A patient who does not attend (DNA) their appointment or treatment *(*note, DNAs should be reviewed to understand any contributing factors and how patients can be supported to attend)*. • Patient seeks a second opinion. • Patient chooses to delay due to the specialist being unavailable (eg, on leave) and has declined to be treated by another specialist who is available.	• A patient who is unavailable to attend on an appointment or treatment date offered (so long as they are able to accept an alternative date that does not delay their care by more than 1 calendar week). • A patient who wants to take a few days to consider their options and discuss with family/whanau (so long as this does not delay their care by more than 1 calendar week). • Patient's agreed treatment option is not offered at their District-of-domicile (so long as the treatment is part of a standard treatment pathway. Improving coordination and provision of care across Districts should be a key focus of FCT).
2	**Clinical consideration (eg, co-morbidities,**	• Where a co-morbidity or complication needs to be	• Where diagnosis is complex or requires investigations additional to the standard pathway of care.	• Where a clinical assessment was not completed within agreed timeframes.

[12] The period of 1 calendar week is given as a guide for when these types of delay can be coded as 'patient reason' (a patient-generated delay) rather than 'capacity constraint' (a delay due to the system not supporting patient choice and access).

Value	Meaning	General principles	Valid example	Not valid example
	further testing, unconfirmed diagnosis)	addressed before the patient can receive their cancer treatment. • Should not be used where there are delays to assessments, tests or procedures that are part of the standard plan of care as these should be factored into the treatment pathway and timeframe.	• There are cancer-related complications, eg, formation of a defunctioning stoma prior to chemo or radiation therapy. • There are intercurrent problems or pre-existing co-morbidities that need to be managed prior to treatment, eg, patient requiring steroids to manage chest symptoms prior to starting chemotherapy or patient requiring antibiotics to treat urinary tract infection prior to having the prostate biopsied. • The patient fails anaesthetic assessment. • There is a delay post-biopsy to allow healing and/or infection to subside (e.g., between TRUS (Trans Rectal UltraSound) biopsy and MRI (Magnetic Resonance Imaging); after a LLETZ (Large Loop Excision of the Transformation Zone) or formal cone biopsy). • Where a patient receives fertility treatment/preservation prior to treatment.	• Where the patient underwent tests or treatment at a District other than their District-of-domicile (so long as it was part of a standard treatment pathway. Improving coordination and provision of care across Districts should be a key focus of FCT). • Volume study prior to implantation of low-dose radiation therapy seeds for brachytherapy.
3	**Capacity constraint (lack of resources such as theatre, equipment, facilities or workforce or process constraints)**	• Situations where the capacity of the system, hospital, service or process have limited the ability to achieve the FCT indicators. • Had more capacity or improved processes been available it could reasonably be expected that the patient would not have breached.	• Lack of resources – theatre, equipment, facilities, or workforce. • Process constraint, including administrative errors. • Communication and process issues in the transfer of patient care between hospitals.	

Section 2b: Delay Code Reporting Guidance for Prostate Cancer

To schedule surgery for low/intermediate risk prostate patients, urology services use the Standardised Adult urology waiting list criteria as below.

Standardised Adult Urology Waiting List Criteria:

URGENT <1 MONTH (100 points)	SEMI-URGENT <2 MONTHS (90 points)	ROUTINE <100 days (80 points)
Prostate Cancer: Radical Retropubic Prostatectomy (RRP) (high risk: ISUP grading >3) **Bladder Cancer: Transurethral Resection Bladder Tumour (TURBT) new lesions, Cystectomy Transitional Cell Carcinoma (TCC)** **Renal Cancer: Nephrectomy (high risk and TCC renal tract)** **Diagnostic ureteroscopy for TCC:** **Testis Cancer: Orchidectomy** **Penile Cancer: Biopsy and partial penectomy** **Surgeon request: patient with urgent condition**	**Prostate Cancer: Orchidectomy, RRP (low / intermediate risk)** **Bladder Cancer: TURBT recurrence (papillary)** **Renal Cancer: nephrectomy/partial nephrectomy (low risk lesions)**	

FCT reporting of indicators requires the first treatment to be completed within 31 days of the decision-to-treat. This contradicts the 2-month wait list criteria (shown above) for low / intermediate risk prostate cancer, triggering a breach.

For reporting purposes, delay code 2 “clinical considerations” should be used if the clinical risk has been determined as low / intermediate by the clinician.

Section 3: High Suspicion of Cancer Definitions

The following definitions have been developed by clinical experts from tumour standard working groups to support achievement of the FCT indicators by clarifying what constitutes a 'high suspicion of cancer' for tumour streams.

The following points are applicable across all definitions.

A resource for triaging (or prioritising) clinicians

The definitions have been developed for use, in the first instance, by triaging (or prioritising) clinicians within secondary and tertiary care who are responsible for determining or confirming the 'high suspicion of cancer' flag. Districts are encouraged to consider how the definitions can be used to support improved detection and referral of patients with a high suspicion of cancer from primary care.

Apply to the 'high suspicion of cancer' component of the health target

To be included within the FCT indicator cohort a patient must have both a high suspicion of cancer *and* a need to be seen within two weeks. The definitions only apply to the 'high suspicion of cancer' component of the FCT indicator and are not intended to define the urgency of the referral. The triaging clinician will need to make a separate assessment of whether a patient meets the criteria of needing to be seen within two weeks.

Guidance to help inform clinical judgement

The definitions are intended as guidance to help inform clinical judgement. If other features/symptoms/signs exist that raise concerns, the triaging clinician can still choose to triage as 'high suspicion of cancer'.

Risk factors have been included for some tumour types

Some tumour streams have included risk factors to support their high suspicion of cancer definitions, with consideration to specific factors that may influence the triaging process. It should also be noted that Māori may present with cancer at an earlier age than non-Māori across all tumour types.

Referrals with a positive fine needle aspiration and/or biopsy

Patients referred though an outpatient pathway with a positive fine needle aspiration (FNA) and/or biopsy for cancer at the time the referral is received within secondary/tertiary care should be triaged as having a high suspicion of cancer (rather than a confirmed cancer) and included within the FCT indicator cohort. This is because these patients will require further investigations and assessment before a confirmed diagnosis and decision on treatment is made. It also supports direct access to diagnostics from primary care.

Breast Cancer[13]	
If the patient presents ***with one or more*** of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	**YES or NO**
Diagnosed cancer on fine needle aspiration or core biopsy (or results suspicious of malignancy)	
Imaging suspicious of malignancy	
Discrete, hard breast lump with fixation (with or without skin tethering)	
Discrete breast lump that presents in women ***with one or more of the following***: • age 40 years or older, and persists after her next period or presents after menopause • aged younger than 40 years and the lump is increasing in size or where there are other reasons for concern (see risk factors below), such as strong family history • with previous breast cancer or ovarian cancer.	
Suspected inflammatory breast cancer or symptoms of breast inflammation that have not responded to a course of antibiotic	
Spontaneous unilateral bloody nipple discharge	
Women aged over 40 years with recent onset unilateral nipple retraction or distortion	
Women aged over 40 years with unilateral eczematous skin or nipple change that does not respond to topical treatment	
Men aged 50 years and older with a unilateral, firm sub-areolar mass, which is not typical gynaecomastia or is eccentric to the nipple	

[13] **Risk Factors:**

- A first degree relative diagnosed with breast cancer before aged 50 years
- Two or more first degree relatives on the same side of the family diagnosed with breast cancer at any age
- Two second degree relatives on the same side of the family, diagnosed with breast cancer, at least one before age 50
- First or second degree relative diagnosed with bilateral breast cancer
- First or second degree relative with male breast cancer
- Known to carry a breast cancer susceptibility gene mutation (eg, BRCA1 or BRCA2)
- Radiation Therapy delivered to the chest or mediastinum.

Bowel Cancer[14]

If the patient presents ***with one or more*** of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.

Red flags	YES or NO
Known or suspected bowel cancer (on imaging, or palpable or visible on rectal examination)	
Unexplained rectal bleeding (benign anal causes treated or excluded) **WITH** iron deficiency anaemia (haemoglobin and ferritin below the local reference range)	
Altered bowel habit (looser and/or more frequent) > 6 weeks duration **PLUS** unexplained rectal bleeding (benign anal causes treated or excluded) **AND** aged ≥ 50 years	

[14] Please note that these criteria are for high suspicion of cancer that would warrant direct access colonoscopy within two weeks - it is not an exhaustive list of the possible manifestations of bowel cancer that may warrant colonic investigation. Please interpret this guideline in conjunction with *Referral Criteria for Direct Access Outpatient Colonoscopy* (Ministry of Health, December 2012) and *Guidance on Surveillance for People at Increased Risk of Colorectal Cancer* (New Zealand Guidelines Group, 2011).

Gynaecological Cancer

If the patient presents ***with one or more*** of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.

Red flags	YES or NO
Biopsy-proven or cytology positive gynaecological malignant or premalignant disease[15] or Gestational Trophoblastic Disease	
A visible abnormality suspicious of a vulval, vaginal or cervical cancer (such as an exophytic, ulcerating or irregular pigmented lesion)[16]	
Significant symptoms (including abnormal vaginal bleeding, discharge, or pelvic pain) AND Abnormal clinical findings suspicious of gynaecological malignancy (including lymphadenopathy, vaginal nodularity, or pelvic induration)[17]	
Post-menopausal bleeding**. (***N.B. High suspicion of cancer may be excluded if physical examination, smear and vaginal ultrasound are normal*[18]*)*	
A rapidly growing pelvic mass or genital lump[19]	
Women with a palpable or incidentally found pelvic mass (including any large complex ovarian mass >8 cm) UNLESS investigations (ultrasound and tumour markers) suggest benign disease[20]	
Women with a documented genetic risk who have a suspicious pelvic abnormality or symptoms[21]	

[15] Please see National Cervical Screening Programme recommendations for colposcopy referral.

[16] Women with an undiagnosed visible genital abnormality which is not highly suspicious of malignancy should be referred for gynaecological or dermatology review or undergo a biopsy.

[17] Women with gynaecological abnormalities or symptoms may also have gynaecological malignancy and the development of triage pathways is encouraged. Specific consideration includes premenopausal women with abnormal uterine bleeding. Those with persistent or deteriorating symptoms should be reviewed by a gynaecologist. A raised CA125 supports the need for further investigation in woman with persistent pelvic or abdominal symptoms.

[18] Early access to vaginal ultrasound will reduce demand on secondary services. Women without post-menopausal bleeding but with a thickened endometrium should undergo gynae review but are not defined as high risk.

[19] Discernible growths within a 3-month period is normally of concern. Undiagnosed external genital lumps with any discernible growth should normally be reviewed by a gynaecologist and/or biopsied.

[20] The development of referral pathways is recommended to ensure rapid assessment of patients with a pelvic mass, early access to pelvic ultrasound is seen as crucial to this process.

N.B. Suspicion of ovarian malignancy is indicated by metastatic disease, ascites or radiologist's impression, a raised CA125 in a post-menopausal woman or germ cell markers in a woman under 25. The risk of malignancy index (RMI) is utilised to triage patients for subspecialty care.

[21] Usually women with strong family history or known hereditary nonpolyposis colorectal cancer (HNPCC) or BRCA mutations.

Head and Neck Cancer – Oral/Throat/Lip Lesion[22]	
If the patient presents ***with one or more*** of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	**YES or NO**
A visible or palpable Oral, Throat, or Lip Lesion ***and one or more*** of the following:	
• unexplained ulcer/lesion/lump persisting for > 3 weeks	
• leukoplakia – must be either nodular, swollen, or bleeding (flat leukoplakia requires standard referral)	
• erythroplakia	
• unexplained tooth mobility/ non-healing socket	
• persistent numbness chin, lip, palate or tongue	

[22] **Risk factors:**

- Smoking history
- Excess alcohol intake
- Immunosuppression
- Betel nut
- Previous history of mouth cancer.

Head and Neck Cancer – Neck/Salivary Lump	
If the patient presents ***with one or more*** of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	**YES or NO**
An unexplained neck/salivary mass ***and one or more*** of the following:	
• mass > 1cm and persisting > 3weeks	
• mass is increasing in size	
• previous head and neck cancer including skin cancer	
• facial palsy	
• any new unexplained upper respiratory tract symptoms such as hoarseness, dysphagia, throat or ear pain, blocked nose or ear	

Head and Neck Cancer – Upper Aerodigestive Tract[23]	
If the patient presents ***with one or more*** of the following red flags **(new unexplained symptoms > 3 weeks)**, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	**YES or NO**
New throat pain or referred otalgia	
New hoarseness with a history of smoking	
New progressive dysphagia to solids or liquids (excluding isolated globus sensation)	
Stridor/upper airway noise	
New nasal obstruction associated with another red flag	
New epistaxis associated with another red flag	

[23] **Risk factors:**

- Smoking history
- Excess alcohol intake
- Past history of head and neck cancer
- Immunosuppression.

Lung Cancer	
If the patient presents ***with one or more*** of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	**YES or NO**
Chest x-ray or other imaging suggestive/suspicious of lung cancer (including new pleural effusion, pleural mass, and slowly resolving consolidation)	
Persistent or unexplained haemoptysis in high risk[24] individuals over 40 years of age	
New pathological diagnosis of lung cancer	

Notes for referrer.

A. An urgent chest X-ray is required for lung cancer in people aged 40 and over if they have:

- any persistent or unexplained haemoptysis
- unexplained/persistent (more than 3 weeks)
  - cough
  - shortness of breath
  - chest/shoulder pain
  - weight loss greater than 10%
  - Abnormal chest signs
  - Unresolved chest infection
  - Hoarseness.
- Finger clubbing
- Features suggestive of metastasis from a lung cancer (e.g. in brain, bone, liver or skin) as part of appropriate work up
- Cervical and/or persistent supraclavicular lymphadenopathy.

Any person who has been referred for an urgent chest x-ray for the above indications and has been found with consolidation should have a repeat chest x-ray 6 weeks later to confirm resolution.

B. **Chest x-ray normal.** If any symptoms or signs detailed above persist for longer than 6 weeks despite a normal chest x- ray, consider referral to respiratory services.

C. **Mesothelioma**. Suspected mesothelioma should also be triaged as above. It is essential that a careful career history is taken to identify any possible occupations at high risk of asbestos exposure.

All symptoms related to SVC obstruction, spinal cord compressions, airway obstruction, and massive haemoptysis, are medical emergencies and should be referred appropriately.

[24] **High risk factors**

When making a decision to refer, assess and document risk factors for lung cancer. These include:

- smokers or ex-smokers
- history of exposure to asbestos,
- pre-existing lung disease particularly COPD or interstitial lung disease
- history of cancer
- family history of lung cancer.

It should be noted the incidence of non-smoking related cancer is increasing particularly in women and East Asians

Lymphoma

If the patient presents ***with one or more*** of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'

Red flags	YES or NO
Lymphadenopathy persistent for 4 weeks or lymph nodes rapidly increasing in size (otherwise unexplained)	
Lymph nodes > 2cm, widespread nature, firm, non-tender	
Unexplained drenching night sweats or fevers or weight loss of greater than 10% of body weight	
Radiology suspicious for lymphoma	

Malignant Melanoma of Skin

Red flags

EITHER:	
Skin lesion AND three or more of the following features:	
A. Asymmetry of shape, structure or colour	Y/N
B. Border irregularity	Y/N
C. Colour variation / multiple colours	Y/N
D. Different from other lesions ('ugly duckling')	Y/N
E. Evolving, changing	Y/N
Risk factors	
Personal history of melanoma	Y/N
Family history of 2+ first degree relatives <40 yrs diagnosed with melanoma	Y/N
OR:	
☐ Dermoscopy of skin lesion is suspicious for melanoma	Y/N
IN ADDITION:	
All referrals must include the following supporting results:	
Required: Size of lesion	(Space to write size)
Required: Body location	(Attachment or description) (Space to write location)
Required: Digital macroscopic image of lesion	(Attachment)

Myeloma – Plasma Cell Neoplasms	
If the patient presents with the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	**YES or NO**
M-protein in serum and/or urine ***and one or more*** of the following	
• otherwise unexplained hypercalcaemia (> 2.75 mmol/L)	
• otherwise unexplained renal impairment – creatinine clearance <40 ml/min	
• otherwise unexplained anaemia – Hb <100g/L	
• bony lytic lesions on radiologic imaging	
• serum monoclonal protein (IgG or IgA >30g/L or involved:uninvolved serum free light chain ratio >10025	

[25] The serum free light chain ration is currently defined (nationally) as a Tier 2 test, which means the test cannot be requested in primary care without cost to the patient.

Sarcoma – Soft tissue lumps (adults 15 years and older)	
If the patient presents with the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	**YES or NO**
An unexplained soft tissue mass ***and one or more*** of the following	
• mass size > 5cm in size	
• increasing in size	
• deep to fascia	
• painful	
• radiology suspicious for malignancy	
• a recurrence after previous excision	

Sarcoma – Soft Tissue Lumps (children up to 15 years)[26]	
If the patient presents with ***one or more*** of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	**YES or NO**
An unexplained soft tissue mass ***and one or more*** of the following	
• mass size >2cm in size	
• increasing in size	
• deep to fascia	
• painful	
• radiology suspicious for malignancy	
• unexplained presence of ***one or more*** of the following: - proptosis - persistent unilateral nasal obstruction - aural polyps and/or aural discharge - urinary retention - blood-stained vaginal discharge - scrotal swelling	

[26] Children under the age of 16 years are not included within the FCT indicators. Sarcoma have included high suspicion of cancer definitions for children as an educational tool to raise awareness of the signs/symptoms of sarcoma in children.

Sarcoma – Bone Cancer (adults and children)[27]	
If the patient presents with the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	**YES or NO**
An unexplained bony mass ***and one or more*** of the following	
• palpable mass fixed to bone	
• increasing in size	
• radiology suspicious for malignancy	
• a recurrence after previous excision	
• suspected spontaneous fracture	
• unexplained presence of ***one or more*** of the following: - increasing or persistent bone pain (especially at rest) - night pain - limp (for a child)	

[27] Children under the age of 16 years are not included within the Faster Cancer Treatment health target. Sarcoma have included high suspicion of cancer definitions for children as an educational tool to raise awareness of the signs/symptoms of sarcoma in children.

Thyroid Cancer	
If the patient presents with **thyroid swelling *and one or more*** of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	**YES or NO**
Thyroid swelling ***and one or more*** of the following:	
• unexplained voice change or stridor	
• thyroid nodule in a child	
• cervical lymphadenopathy	
• painless thyroid mass rapidly enlarging, i.e. over a period of 2-3 months	
• family history of multiple endocrine neoplasm	
• cytology result indicating a high risk of cancer, ie Bethesda 5-6[28]	

[28] Although Bethesda 4 does not necessarily constitute a high suspicion of cancer, review by an endocrinologist or surgeon is required (risk of malignancy being up to 30%).

Upper GI Cancer – Stomach Cancer[29]	
If the patient presents ***with one or more*** of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	**YES or NO**
Unexplained weight loss ***with one or more*** of the following: • upper abdominal pain in patient aged > 40yrs • dyspepsia • nausea and vomiting • haematemesis /malaena • new onset heartburn	
Upper abdominal mass consistent with stomach cancer	
Dysphagia (new onset or progressive)	
Māori or Pacific of any age with a family history of stomach cancer ***and one or more*** of the following: • upper abdominal pain • dyspepsia • reflux symptoms	

[29] **Risk factors for stomach cancer, which when present increases the suspicion**

- Excess alcohol intake
- Smoking
- High animal fat diet
- Socio-economic deprivation
- Previous gastric surgery
- Helicobacter pylori infection
- Type A blood
- Immune deficiency
- Family history of first-degree relatives with stomach cancer
- Genetic syndromes (hereditary diffuse gastric cancer (CDH1), hereditary non-polyposis colorectal cancer (HNPCC), familial adenomatous polyposis (FAP, BRCA1 and 2, Li-Fraumeni syndrome, Peutz-Jeher syndrome).

Investigations that would be consistent with an increased risk of stomach cancer:

- Iron-deficient anaemia/low ferritin
- Platelet count
- H.pylori infection
- Endoscopy findings of chronic gastritis.

Upper GI Cancer – Oesophageal Cancer[30]	
If the patient presents ***with one or more*** of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	**YES or NO**
Dysphagia (new onset and/or progressive)	
Unexplained weight loss in patients > 55 years ***with one or more*** of the following: • upper abdominal pain • new onset heartburn • dyspepsia • nausea/vomiting • upper abdominal pain	
Haematemesis/malaena	
Māori or Pacific of any age with family history of oesophageal cancer ***with one or more*** of the following: • upper abdominal pain • new onset heartburn • dysphagia (new onset or progressive) • dyspepsia	

[30] **Risk factors for oesophageal cancer which when present increases the suspicion**

- Age over 55 years
- Smoking
- Male
- High animal fat diet
- Longstanding Gastro-Oesophageal Reflux Disease (GORD)
- Barrett's metaplasia of the oesophagus
- Previous gastric surgery
- Socio-economic deprivation
- Obesity/BMI >35
- Excess alcohol intake.

Investigations that would be consistent with an increased risk of oesophageal cancer

- Endoscopy findings of long segment Barrett's (>3cm)
- Iron-deficient anaemia/low ferritin
- Elevated platelet count.

Upper GI Cancer – Pancreatic Cancer[31]	
If the patient presents ***with one or more*** of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	**YES or NO**
Painless obstructive jaundice	
Unexplained weight loss ***with one or more*** of the following: • new-onset diabetes • new onset mid-back discomfort • steatorrhoea • nausea/vomiting	

[31] **Risk factors for pancreatic cancer (which when present increases the suspicion):**

- Smoking
- Obesity/BMI >35
- Chronic pancreatitis, especially with mass
- Family history of first-degree relatives with pancreatic cancer;
- Genetic syndromes (hereditary breast and ovarian cancer syndrome, familial melanoma, familial pancreatitis, hereditary non-polyposis colorectal cancer, Peutz-Jeghers syndrome, Von Hippel-Lindau syndrome).

Investigations that would be consistent with an increased risk of pancreatic cancer

- Cholestatic liver dysfunction
- New onset diabetes
- HbA1c>41 (pre-diabetes)
- Elevated CEA and/or Ca19-9.

Upper GI Cancer – Biliary/Gallbladder Cancer[32]	
If the patient presents ***with one or more*** of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	**YES or NO**
Painless obstructive jaundice	
Abdominal mass consistent with a gallbladder tumour	

[32] **Risk factors for biliary/gallbladder cancer (which when present increases the suspicion):**

- Polyps (>1 cm)
- Gallstones (>20 years)
- Porcelain gallbladder
- Primary sclerosing cholangitis.

Investigations that would be consistent with an increased risk of biliary/gallbladder cancer

- Cholestatic liver dysfunction
- Ultrasound ± CT showing asymmetric wall thickening or mass in gallbladder or bile duct
- Elevated CEA and/or Ca 19-9.

Upper GI Cancer – Liver Cancer[33]	
If the patient presents with the following red flag, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	**YES or NO**
Upper abdominal mass consistent with enlarged liver ***and one or more*** of the following:	
• unexplained weight loss	
• jaundice	
• risk factor(s)	

[33] **Risk factors for liver cancer (which when present increases the suspicion):**

- Previous history of bowel cancer
- Chronic viral hepatitis (B or C)
- Cirrhosis
- Heavy alcohol consumption
- Family history of primary liver cancer
- Haemachromatosis
- Inherited metabolic disease.

Investigations that would be consistent with an increased risk of biliary/gallbladder cancer:

- US/CT/MR showing mass(es) in liver
- Elevated AFP and/or CEA and/or Ca 19-9
- Liver dysfunction including increased INR and decreased albumin.

Section 3b: Prostate Cancer

Prostate Cancer	
Seek "**acute radiation oncology advice"** if patient presents with all of the following:	
	YES or NO
• a PSA greater than 10 micrograms/L	
• severe back pain	
• acute neurology symptoms, consistent with spinal compression or cauda equina syndrome.	
Request "**non-acute urology assessment"** indicating high suspicion of cancer, if patient presents with a PSA greater then 10 micrograms/L and any of the following:	
• renal failure	
• bone pain (new onset, progressive and severe)	
• macroscopic haematuria	
• abnormal DRE	
ADDITIONAL INFORMATION	
If PSA greater than 10 micrograms/L, request **non-acute urology assessment** for **prostate biopsy** within 4 weeks	
If DRE is suspicious of malignancy, or elevated PSA on 2 or more tests is less than 10 micrograms/L, request **non-acute urology assessment,** indicating high suspicion of cancer for **prostate biopsy.**	
In all requests include the following information for triage of HSCAN prostate • Presence of outflow tract symptoms as these patients may also require a flow rate and residual. • DRE findings. • All PSA results. • eGFR • MSU	

References:

- BPAC. PSA screening in asymptomatic men - The debate continues. Best Tests. 2010. [Abstract]
- Prostate Cancer Working Group and Ministry of Health. Prostate Cancer Management and Referral Guidance. Wellington: Ministry of Health; 2015. [Abstract]
- The Royal College of Pathologists of Australia. Choosing Wisely: tests, treatments & procedures health professionals should question. Choosing Wisely New Zealand; 2. Do not perform PSA testing for prostate cancer screening in men with no symptoms and whose life expectancy is less than 7 years. 2018. [cited 2018 Feb 23].
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Section 4: Tumour Specific Reporting Guidelines

4.1.0 General Cancers

Patients included/excluded from FCT

4.1.1 Are all basal cell carcinomas (BCCs) and squamous cell carcinomas (SCCs) excluded from FCT reporting?

No, the only BCCs and SCCs excluded from FCT are those coded as ICD-10-AM 8th Edition code C44 (skin). All other BCCs and SCCs are to be reported.

4.1.2 How should patients with no definitive (pathological) diagnosis be managed?

For some patients a pathological diagnosis may not be available or appropriate (eg, frail or elderly patients). In these cases, a diagnosis may be based on clinical and/or radiological findings. The key is what the patient is told, what is documented in their clinical notes, and the intent of the treatment provided. If the patient is told and it is documented that they are considered to have cancer, and there is a treatment/management plan for cancer, they should be reported in FCT.

4.1.3 How should cases where cancer is not initially suspected but is diagnosed after treatment be reported? eg, thyroid cancers diagnosed following surgery for benign thyroid disease.

These should be reported as incidental cancers in the 31-day FCT indicator. As there was no intention to treat for cancer at the time, the date of decision-to-treat for these cases can be reported as the same as the first treatment date (ie, the number of days for the 31-day FCT indicator will be 0). Refer Section 5, page 104 Final cancer diagnosis differs from working diagnosis use case (31-day indicator). The purpose of reporting these cases is to support the capture of cancers within FCT.

4.1.4 Why aren't cancers classified as D codes in ICD-10-AM 8th Edition included within FCT reporting?

Appendix B of this document provides a list of the International Classification of Disease ICD-10-AM 8th Edition codes included in FCT monitoring and reporting.

It notes that cancers classified as D code within ICD-10-AM 8th Edition are excluded from FCT because they generally relate to cancers that are "low-risk, or non-invasive, or non-malignant, or low-grade, asymptomatic or indolent". A common example is carcinoma in situ (CIS) (D00-D09). Progression of CIS is variable, and in some cases may become invasive cancer. While the CIS would not be reported for FCT, if progression to invasive cancer (a C code diagnosis) occurs, the patient would then be monitored and reported in FCT.

First Treatments

4.1.5 When do excisions count as a first treatment?

The key factor here is the intent of the procedure.

As a general rule, if there is no existing diagnosis then it is likely that the procedure will be diagnostic in intent and therefore should not be recorded as a first treatment. However, if the tumour is completely removed by the excision, the procedure can be recorded as first treatment, even if the intent was diagnostic, as no further treatment is required.

If there is a diagnosis (pathological or clinical) and the intent of the procedure is therapeutic (ie, to remove the tumour) then this can be recorded as first treatment, irrespective of whether the procedure was successful in completely removing the tumour.

4.1.6 When does an activity count as part of the first treatment rather than preparatory to?

The intent of FCT reporting is to follow patient activity through to definitive treatment, not treatments that are for symptom management.

In general, if a procedure or action is preparatory to treatment or to mitigate the effects of the treatment once it starts, then it does not count as first treatment or close the 62 or 31-day FCT pathway.

If a procedure or action is integral to the treatment itself (ie, to facilitate the effectiveness of the treatment) then it can be classed as the start of first treatment.

Specific examples of when a procedure or action counts as part of first treatment can be found in the tumour specific sections of this document.

4.1.7 Does treatment of metastases count as a first treatment?

Yes. If a patient is diagnosed with metastatic cancer, any definitive first treatment they receive, whether directed at the primary or the metastases, can count as their first treatment and the patient can come off the 62 or 31-day FCT pathway.

4.1.8 When is palliative care reported as the first treatment?

In cases where no curative treatment is planned, any actions carried out with palliative intent can be considered a first treatment and the FCT pathway is complete for FCT indicators.

If treatment with curative intent is planned for a patient, intermediate actions to relieve symptoms do not count as a first treatment or close the FCT pathway.

For the purposes of FCT monitoring and reporting, supportive/palliative packages of care are to be considered as the whole. This means that whilst a patient may receive a range of treatments (e.g., stent and pain relief etc), if it is part of a single agreed package then the start of the package of care should be taken as:

- date of the delivery of the first episode within the agreed package of care; or
- date of referral to a specialist palliative care service; or
- the consultation at which the patient receives a prescription.

Note that **palliative care** is defined as *"covers the essential services provided to patients that are not surgical, chemotherapy or radiation therapy based"*. Therefore, a referral to a palliative care service (in the hospital or community) would be reported as the first treatment and would close the 62 or 31-day FCT pathway. However, if the first treatment given is chemotherapy or radiation therapy, regardless of whether it is given with non-curative (ie, palliative) intent, the type of first treatment should be reported as the respective modality (ie, radiation therapy or chemotherapy).

4.1.9 If the treatment plan changes, does this impact on the decision-to-treat?

The decision-to-treat is the date when the decision was made for the patient's treatment following discussion between the patient and "the clinician responsible for treatment". Therefore, if the treatment plan changes prior to the treatment commencing, the decision-to-treat should change to when the patient agrees to a new treatment plan with the responsible clinician.

For example, a patient agrees to surgery, but their anaesthetic pre-assessment raises concerns and as a result a new treatment plan for chemotherapy is agreed. For the 31-day FCT indicator the decision-to-treat and first treatment dates reported should relate to the chemotherapy not the surgery. The 62-day FCT indicator, however, would continue until the chemotherapy commenced.

4.1.10 If treatment is commenced but not completed, does it still count as a first treatment and end the FCT pathway?

Yes. For example, open and close surgery where the intention of the surgery was to remove the tumour, but it was not found to be possible would still be reported as the first treatment and end the FCT pathway.

Miscellaneous

4.1.11 How should patients who present acutely to the emergency department and are then diagnosed with cancer be reported?

If cancer is diagnosed as part of an emergency department presentation and/or a resultant inpatient admission it should be reported in the 31-day FCT indicator.

If a patient presents to an emergency department but cancer is not diagnosed as part of the emergency department presentation and/or a resultant inpatient admission, and the patient is subsequently referred to an outpatient clinic, if the referral is triaged as high suspicion of cancer and 2-week wait then it can be reported in the 62-day FCT indicator.

4.1.12 A patient who is being tracked on a 62 or 31-day FCT pathway but has not yet received their first treatment presents to ED with complications from their cancer (eg, bowel obstruction). Is treatment received within this episode of care recorded in FCT?

If the treatment provided during the episode of care associated with the emergency department presentation is considered a first cancer treatment (eg, bowel resection) then this should be recorded in FCT, and the patient can come off the 62 or 31-day pathway.

4.1.13 A patient is triaged as high suspicion of cancer, and 2-week wait but is found to have a different type of cancer from that initially suspected. Should this be reported as one pathway?

Yes. The patient was referred with a suspicion of cancer and the investigations are part of the same pathway of care. The patient should be reported in the 62-day FCT indicator from the initial date they were triaged as high suspicion of cancer, and 2-week wait.

4.1.14 What happens in a situation of a patient receiving a CT scan for one thing but as a result a mass is shown in another organ – would this be classed as an incidental finding or a high suspicion?

As the patient has already entered the secondary care pathway then this should be considered an incidental finding and reported in the 31-day FCT indicator.

4.1.15 What if the CT scan was requested by a GP?

In this case, as the patient has not already entered the secondary care pathway then this could be triaged as high suspicion of cancer, and 2-week wait and reported in the 62-day FCT indicator.

4.1.16 When are private patients included/excluded from FCT?

All patients who have a first cancer treatment undertaken in private are excluded from FCT reporting.

If a patient has their cancer diagnosed in private but receives a first treatment that is publicly funded, then they should be reported in the 31-day FCT indicator, but not the 62-day indicator.

4.1.17 Can a patient be up or down-graded into or out of the 62-day FCT indicator cohort once they are within secondary care?

No. A patient who is initially triaged as high suspicion of cancer and 2-week wait can only be removed from the 62-day FCT indicator if they are subsequently found not to have cancer or it is a recurrent cancer. All others remain on the 62-day FCT indicator until they receive their first cancer treatment (or other management).

Similarly, a patient who was *not* initially triaged as high suspicion of cancer and 2-week wait should not be ‘upgraded’ onto the 62-day pathway following further assessment or investigations.

The triaging of the initial referral received within secondary care is key in terms of whether a patient is included within the 62-day FCT cohort.

4.2.0 Cancers of the Brain and Central Nervous System (CNS)

Patients included / excluded from FCT

4.2.1 What Brain and CNS cancers are included / excluded from FCT?

In Scope:

- WHO Grade 3 & 4 tumours (generally considered malignant)
- ICD-10-AM 8th Edition codes: C47, C69-C72.

Out of Scope:

- WHO Grade 1 & 2 tumours (generally considered benign)
- Von Hippel-Landau syndrome (a benign condition).

4.2.2 A tumour was WHO Grade 2 on de-bulking and radiation therapy was given. The patient then had a WHO Grade 3 tumour in the same area. Is this classed as recurrence or a new primary?

The Grade 3 tumour should be reported as a new primary as the Grade 2 tumour was outside the scope of FCT.

First Treatments

4.2.3 What cannot be classified as a first definitive treatment for Brain & CNS cancers (ie, cannot close the 31 or 62-day pathway)?

- Palliative or symptomatic care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment).
- Surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure).
- Dexamethasone (when used as a symptomatic treatment, unless described as palliative care with no other anti-cancer treatment being planned).

4.3.0 Breast Cancer

Patients included / excluded from FCT

4.3.1 What breast cancers are included / excluded from FCT?

In Scope:

- ICD-10-AM 8th Edition code: C50
- Paget's disease of nipple/breast (clinical coders and cancer registries code this condition as ICD-10-AM 8th Edition code C50).

Out of Scope:

- Atypical Ductal Hyperplasia (ADH)
- ICD-10-AM 8th Edition code: D05 (ie, breast cancer in situ).

4.3.2 Are in-situ breast cancers included within FCT?

No. Both ductal carcinoma in situ (DCIS) and lobular carcinoma in situ (LCIS) are excluded from FCT reporting (ICD-10-AM 8th Edition code D05).

4.3.3 How should patients coming through BreastScreen Aotearoa be reported?

Patients who have their cancer diagnosed through a screening programme (eg, BreastScreen Aotearoa) are included in the 31-day FCT indicator from date of decision to treat through to first cancer treatment (or other management). They are an exclusion for the 62-day FCT indicator.

First Treatments

4.3.4 What cannot be classed as first treatment for breast cancers (ie, cannot close the 31 or 62-day pathway)?

- Surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure).
- Sentinel Lymph Node Biopsy – this is a diagnostic staging procedure to determine whether the cancer has spread to the lymph nodes.
- Palliative or symptomatic care for any patient who is fit for active treatment (unless they decline active treatment option and wish to have only palliative treatment).

Miscellaneous

4.3.5 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 one or both of these be recorded?

It depends. If diagnosed as two separate primary cancers then these should be reported separately in FCT (ie, two records would be reported).

4.3.6 A patient previously treated for cancer in the left breast has attended a follow up appointment and there is suspicion of cancer in the right breast. If cancer is confirmed, how is this managed?

It depends.

- If the patient is being followed up in secondary care and a new primary cancer is diagnosed, then this would be an incidental finding and would be reported in the 31-day FCT indicator.
- If the patient is having, follow up in secondary care and a recurrent cancer is diagnosed then this would not be reported in FCT.
- If the patient is having follow up in primary care and a GP suspect either a recurrence or a new primary, the referral can be triaged as high suspicion of cancer and 2-week wait. If a new primary is diagnosed, the patient would be reported in the 62-day FCT indicator. If a recurrence is confirmed, the patient would not be reported for FCT.

4.3.7 A patient was referred with a breast lump and triaged as high suspicion of cancer, and 2-week wait. A triple assessment did not diagnose cancer. Due to the nature of the lump the clinician decided to review the patient after 6 weeks and at that review decided to excise the lump. Histology confirmed cancer. How is this reported for FCT?

The key is what the patient was told and what was documented in their notes.
If the patient was told and it was documented that they were not considered to have cancer, they can be removed from the 62-day FCT pathway. When cancer was later

confirmed (eg, following excision) then the patient would be reported in the 31-day FCT indicator (ie, this is treated as an incidental cancer – *refer General section 4.1.3)*

If the patient was told that they had a high suspicion of cancer, the patient remains in the 62-day FCT indicator until a first treatment (or other management) occurs. The decision to review the patient after 6 weeks does not count as active surveillance as they have not yet been diagnosed with cancer (and therefore have no decision to treat for the cancer).

4.3.8 A patient previously had lobular carcinoma in left breast, now has a new diagnosis of ductal carcinoma in right breast (or same breast). How is this managed?

Whether a cancer is new, recurrent or a metastatic is a clinical decision based on pathology and other information available in each case. If a new cancer, this should be reported in FCT. If a recurrence or metastases, it is not reported.

4.4.0 Gynaecological Cancers

Patients included / excluded from FCT

4.4.1 What cancers are included / excluded from FCT?

In Scope:

- ICD-10-AM 8th Edition codes: C51-C58

Out of Scope:

- CIN3

4.4.2 Do we report BCCs for Gynaecological cancers?

Yes. The only BCCs excluded from FCT are those coded as C44 (skin). All other BCCs are to be reported. *Refer General section, paragraph 1.1*

4.4.3 Is Borderline Ovarian Histology in the remit of FCT?

It depends if the patient has a confirmed diagnosis (ICD-10-AM 8th Edition) with a C code or not. C codes are reported in FCT; D codes are not. Borderline ovarian histology is generally coded as either C56 or D39.1 – the former would be within the remit of FCT while the latter would not.

4.4.4 How are patients coming through the National Cervical Screening Programme reported?

Patients who have their cancer diagnosed through a screening programme (eg, the National Cervical Screening programme) are included in the 31-day FCT indicator from date of decision to treat through to first treatment (or other management). They are an exclusion for the 62-day FCT indicator.

First Treatments

4.4.5 What <u>cannot</u> be classed as first treatments for gynaecological cancers (ie, cannot close the 31 and 62-day pathway)?

- Cone or loop or LLETZ biopsy/hysteroscopy/colposcopy/vulvoscopy if diagnostic in intent (unless the tumour is effectively removed by the procedure). If therapeutic in intent (ie, if the intention of the procedure was to remove the tumour) then these would count as first treatment irrespective of whether the margins were clear. *Refer General section 4.1.5.*
- Removal of polyps for diagnostic purposes (unless the tumour is effectively removed by the procedure).
- Removal of para-aortic nodes before a patient starts radiation therapy or chemotherapy (this is not classed as a therapeutic procedure unless clinically involved nodes are having to be de-bulked prior to radiation therapy).
- Ileal conduit urinary diversion surgery to treat a bladder problem prior to active treatment (eg, chemoradiation).
- Removal/draining of ascites prior to chemotherapy (unless no other active treatment is planned).
- Palliative or symptomatic care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment).

4.4.6 Is open and close surgery (usually for ovarian cancer) classed as first treatment?

Where the initial intention of the surgery had been to remove the tumour, but it is not found to be possible at the time of surgery then this open and close surgery would still be classed as first treatment. *Refer General section, 4.1.10.*

4.4.7 Is removal of pelvic lymph nodes considered a first treatment for cervical cancer?

Removal of pelvic lymph nodes as part of a two-part operation to treat cervical cancer can be classed as first treatment.

Miscellaneous

4.4.8 After a LLETZ cone or formal cone biopsy the time taken for infection to subside and the cervix to heal is approximately six weeks and it is therefore inappropriate to undertake radical surgery before this time – how can this be managed for FCT?

The patient would remain on the 62-day FCT indicator until the first treatment, surgery, takes place. The target achievement levels take into account that some patients will not be clinically fit enough to receive treatment within the timeframes. If this was the significant delay that contributed to the patient breaching the 62-day indicator, the delay could be coded as a clinical consideration breach.

4.4.9 Are any adjustments possible if a patient's diagnostic tests or treatments have to be delayed due to the menstrual cycle, pregnancy or a recent termination of pregnancy?

No, adjustments are not permitted in FCT reporting. The FCT indicators take into account that some patients will not be clinically fit to receive treatment within the timeframes. If this was the significant delay that contributed to the patient breaching the 62-day indicator, the delay could be coded as a clinical consideration breach.

4.5.0 Haematological Cancers

Patients included / excluded from FCT

4.5.1 What haematological cancers are included / excluded from FCT?

In Scope:

- ICD-10-AM 8th Edition codes: C81-C86, C88, and C90-C96 including:
  - chronic lymphocytic leukaemia
  - chronic myelomonocytic leukaemia (CMML) - for the purposes of cancer this is classed as a form of leukaemia rather than a form of myelodysplastic syndrome although it is noted that many are not clinically urgent
  - B-cell chronic lymphocytic leukaemia (CLL)
  - Small Lymphocytic Lymphoma (SLL)
  - all cases of acute leukaemia.

Out of Scope:

- Myeloid dysplastic syndrome (D464 or D46).

First Treatments

4.5.2 What <u>cannot</u> be classed as first treatment for haematological cancers (ie, closing the 31 and 62-day pathway)?

- Removal of Lymph Nodes – this will be a biopsy to establish a diagnosis of Lymphoma and there is likely to be additional disease throughout the body that will need active treatment.
- Blood transfusions (unless a patient has no other active treatment planned, in this case the transfusions would be classed as palliative treatment).
- Palliative or symptomatic care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment).

4.5.3 Are antibiotics a valid first treatment for low grade gastric lymphomas?

Antibiotics would count as the start of treatment if the intent was to treat the lymphoma.

4.5.4 A patient with a haematological cancer is given steroids to manage chest symptoms for a few months prior to chemotherapy starting. Can the steroids be classed as a first treatment?

No. As the steroids are to manage chest symptoms to get the patient into better shape for the chemotherapy, this is an ‘enabling’ treatment and does not count as the first treatment.

4.5.5 How are bone marrow transplants (BMT) managed for FCT?

The date of decision-to-treat would be when the patient agrees to the care plan that includes the BMT and the date of first treatment would be the date the patient is added to the BMT list. For the purposes of FCT, BMT should only be considered the first treatment if no other active anti-cancer treatment is given in the interim.

4.5.6 If a patient is going to be admitted to harvest stem cells for future use does that count as a treatment?

Re-infusion is the treatment rather than the harvest, although it is possible that they could take place within the same admission/episode of care.

4.5.7 Can total body radiation prior to BMT be classed as first treatment?

If a patient requires some other procedure prior to BMT (eg, total body radiation) assuming this takes place as part of the same package of care then this would count as the first treatment.

4.5.8 If a patient requires cycles of chemotherapy prior to a BMT, would this be recorded as part of the BMT treatment package and end when the chemotherapy started?

Yes, chemotherapy delivered as part of a package of care prior to BMT would count as first treatment.

Miscellaneous

4.5.9 If a patient is diagnosed with one haematological condition that transforms to a different type, how is this managed?

If the initial haematological condition was reported under FCT and transforms, then it would be classed as a relapse or recurrence and not reported. For example:

- follicular lymphoma transforming into a diffuse large B cell lymphoma, or acute myeloid leukaemia (AML) transforming to CML, or CLL transforming to Hodgkin's – these would be classed as a recurrence as the initial conditions in each case should have already been reporting in FCT.

If the initial condition was not within the remit of FCT and then transforms, the new condition would be classed as a new primary and reported in FCT. For example:

- Myeloid dysplastic syndrome (MDS) transforming into AML – the AML would be classed as a new primary as MDS is not within the scope of FCT (as it is a D code in ICD-10-AM 8th Edition).

4.5.10 A patient diagnosed with lymphoma agreed to be put on active monitoring. A year later, he is referred back by his GP due to swelling in lymph nodes in his groin. After investigation the patient is offered further treatment. How is this managed for FCT?

FCT only covers to first treatment, which in this case was the initial active monitoring. Therefore, this next episode of care is not reported for FCT.

4.5.11 A patient was referred to the sarcoma team and went on to have surgery. After surgery the patient was diagnosed with a haematological cancer. Would the surgery be counted as the first treatment?

It depends on the scenario.

- If a patient had a lump which was a suspected sarcoma and surgery with an intent to treat was carried out which found that it was a lymphoma, then this would still be the first treatment and the patient would come off the 31 or 62-day FCT pathway. All haematological cancer treatments after that would not be reported for FCT.

- If a patient had a lump which was a suspected sarcoma and surgery with an intent to treat was carried out which found that it was a metastasis, then the surgery would be a first treatment of a metastases of unknown origin. All haematological cancer treatments after that would not be reported for FCT.
- If a patient had a lump which was a suspected sarcoma and surgery with an intent to treat was carried out which found it to be something benign then this would not be reported for FCT (as there was no cancer diagnosis). But, if a haematological cancer was discovered incidentally as part of this, it would be reported in the 31-day FCT indicator. The initial surgery would not count as the first treatment as it treated a non-cancerous condition.

4.6.0 Head and Neck Cancers (including Thyroid Cancer)

Patients included / excluded from FCT

4.6.1 What cancers are included / excluded from FCT?

In Scope:

- ICD-10-AM 8th Edition codes: C00-C14, C30-C32, C73.

Out of Scope:

- Barrett's oesophagus
- C77 *Secondary and unspecified malignant neoplasm of lymph nodes.*

First Treatments

4.6.2 What <u>cannot</u> be classed as first treatment for head, neck or thyroid cancers (ie, cannot close the 31- or 62-day pathway)

Head & neck

- Surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure).
- Dental clearance, eg, prior to radiation therapy.
- Insertion of a PEG (percutaneous endoscopic gastrostomy).
- Palliative or symptomatic care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment).

Thyroid

- Surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure).
- Palliative or symptomatic care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment).

4.6.3 Can tonsillectomy be considered first treatment when a patient goes on to have chemoradiation therapy?

If the tonsillectomy excised or de-bulked the tumour with therapeutic intent, then it would count as first treatment even if the margins were not clear. *Refer General section, 4.1.5.*

Miscellaneous

Head and Neck

4.6.4 A head & neck patient is to have a single dose of chemotherapy as an in-patient and then chemoradiation therapy after twelve weeks. Do we treat the single dose as first treatment?

It would appear that chemotherapy is the first treatment and chemoradiation therapy is subsequent treatment on the basis that if the patient is to wait 12 weeks for the chemoradiation therapy then the initial chemotherapy could not be classed as part of the chemoradiation therapy.

This advice is based on the assumption that the chemotherapy being given first is a genuine treatment option and not being given as a means to stop the 31 or 62-day FCT pathway because of delays in accessing chemoradiation therapy.

4.6.5 A patient was referred for a suspected head & neck cancer which was subsequently confirmed. An oesophageal cancer was also found incidentally. The first treatment for the head & neck cancer also treats the oesophageal cancer – how should this be reported?

The same treatment can be used to close both the 62-day pathway for the head and neck cancer and the 31-day pathway for the incidental oesophageal cancer.

4.6.6 A patient was referred with suspected head & neck cancer and required a biopsy. The patient is already having chemotherapy for lung cancer. How should this be reported?

Assuming the head & neck cancer is a new primary cancer and not a metastasis, if the patient is not fit enough to commence diagnostics and/or treatment for the head and neck cancer then the FCT record for this cancer remains open. The FCT indicators take into account that some patients will not be clinically fit to receive treatment within the timeframes.

Thyroid

4.6.7 What treatment modality should radioactive iodine be recorded as?

Radioiodine is a radioisotope therapy and should be classified as Code 00 'other treatments' in the ‘Type of first treatment’ field.

4.6.8 A patient is required to prepare for treatment by having injections of recombinant human thyroid-stimulating hormone in addition to withdrawal of hormone treatment in order to obtain higher potential uptake at treatment. Would these injections be the start of treatment?

If these 'preparations' are to mitigate the effects of the treatment once it starts, then they are not counted as part of the treatment. However, if they are integral to the treatment itself (i.e., to facilitate the effectiveness of the treatment) then they could be classed as the start of the treatment. If this is in effect a combined treatment (i.e., treatments of different modalities combined in a way that they must be scheduled to take place together) then the injections would be the start of the treatment. *Refer General section 4.1.6.*

4.7.0 Lower-Gastrointestinal (LGI) Cancers (including Colon, Rectal, Anal)

Patients included / excluded from FCT

4.7.1 What LGI cancers are included / excluded from FCT?

In Scope:

- ICD-10-AM 8th Edition codes: C18-C21, C26.

Out of Scope:

- Tis (carcinoma in situ) found in polyps excised at colonoscopy – Tis includes cancer cells confined within the glandular basement membrane (intraepithelial) or lamina propria (intramucosal) with no extension through muscularis mucosae into submucosa
- Carcinoids of the appendix (coded as ICD-10-AM 8th Edition D37.3).

First Treatments

4.7.2 What cannot be classed as first treatment for LGI cancers (ie, closing the 31 or 62-day pathway)?

- Surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure).
- Palliative or symptomatic care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment).

4.7.3 Can stenting be classed as a first treatment?

In general, stenting can be classed as a first treatment only when used as a palliative y

4.7.4 Can a de-functioning stoma be counted as a first treatment for patients with LGI cancers?

Patients with an LGI cancer often require neo-adjuvant chemotherapy and radiation therapy (to shrink the tumour) prior to surgical resection. A de-functioning stoma (ileostomy or colostomy) may be necessary before this therapy as the cancer may be partially obstructing already or may swell with treatment and cause an emergency, life threatening bowel obstruction. In these cases, a de-functioning stoma can be classed as a first treatment and close the 62 or 31-day FCT pathway.

A de-functioning stoma can also be classed as a first treatment if:

- it's the only procedure/treatment being given and would be palliative
- it's an emergency procedure following an ED admittance with actual bowel obstruction.

Miscellaneous

4.7.5 Some LGI patients at risk of bowel cancer may be on a regular recall in accordance with agreed national clinical guidance. The recall can include a CT scan and/or endoscopy. These tests might be booked well in advance. What would be the date of decision to treat if cancer was diagnosed and treated during the endoscopy?

If cancer was found at a recall appointment and treated at the same time then the patient would be recorded under the 31-day FCT indicator with the date of decision of treat and the treatment date recorded as the date of the recall procedure (i.e., the same date). *Refer General section 4.1.3.*

4.7.6 A patient is referred to the LGI team with suspicion of rectal cancer – this is confirmed along with a bladder cancer. The bladder cancer was treated first. How should this be managed for FCT?

If the two cancers are both primaries, then both should be recorded under FCT. A treatment can only close the 62 or 31-day FCT pathway if it treats the specific cancer.

If the bladder lesion is a metastasis of the rectal cancer, then this would be reported as one cancer (the primary rectal cancer) and the treatment for the bladder metastasis would be counted as the first treatment and close the FCT pathway. *Refer General section 4.1.7.*

4.8.0 Lung Cancer

Patients included / excluded from FCT

4.8.1 What lung cancers are included in FCT?

ICD-10-AM 8th Edition codes: C33-C34, C38-C39, C45.

First Treatments

4.8.2 What <u>cannot</u> be classed as first treatments (ie, cannot end the 31 or 62-day pathway)?

Lung cancer

- Drainage of a pleural effusion for symptom control if further anti-cancer treatment is planned.
- Pleurodesis for symptom control if further anti-cancer treatment is planned.
- Mediastinoscopy (unless the excised tissue was found to be malignant, and the tumour had effectively been removed by the excision irrespective of whether the margins were clear – this is unlikely).
- Stenting of the airway or superior vena cava (SVC) if further anti-cancer treatment is planned.
- Laser treatment of major airways obstruction if further anti-cancer treatment is planned.
- VATS (Video Assisted Thoracic Surgery) biopsy for diagnostic purposes (unless procedure could be considered as de-bulking the tumour).
- Palliative or symptomatic care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment).

Mesothelioma

- Drainage of a pleural effusion for symptom control if further anti-cancer treatment is planned.
- Pleurodesis for symptom control if further anti-cancer treatment is planned.
- Interventional analgesia (eg, nerve block or cordotomy) for symptom control if further anti- cancer treatment is planned.

- Palliative or symptomatic care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment).

4.8.3 If brain metastases need to be treated first, how is this managed for FCT?

Treatment of brain metastases can be reported as the first treatment for the primary lung cancer. *Refer General section 4.1.7.*

4.8.4 Some lung cancer patients need to take oral vitamin supplements or have vitamin B12 injections prior to commencing chemotherapy. Does this count as the start of first treatment?

It would depend on the purpose. If they are to get the patient into better shape for the treatment then no, this would be an enabling treatment. However, if the supplement is integral to the treatment (ie, reacts with chemotherapy to make treatment more effective) it could be classed as the start of treatment. *Refer General section 4.1.6.*

Miscellaneous

4.8.5 How are pleural effusions covered by FCT?

Managing pleural effusions can only be classed as first treatment if no further anti-cancer treatment is planned.

4.8.6 What cancer treatment modality should be used to code a pleural effusion?

There is no perfect answer for coding pleural effusions. It is best to code them as palliative care (Code 06) as per advice of your local clinical team. Some pleurodesis procedures are carried out by surgeons under general anaesthetic (probably no more than 5% of the total) so some could legitimately be coded as surgical procedures.

4.8.7 How should management of ascites be covered for FCT?

Managing ascites can only be classed as first (palliative) treatment if no further anti-cancer treatment is planned.

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

Palliative symptom control should only be classed as first treatment if no active cancer treatment is planned.

Any activities to manage symptoms while treatment options are being considered do not count as a first treatment and the FCT record should remain open.

If it is decided not to proceed with active treatment but a supportive/palliative package of care instead, the start of ‘treatment’ can be taken as: date of the delivery of the first episode of care (which could be symptom control); the referral to a specialist palliative care service; the consultation at which the patient receives a prescription for palliative symptom control. *Refer General section 4.1.8.*

4.9.0 Sarcoma

Patients included / excluded from FCT

4.9.1 What cancers are included / excluded from FCT?

In Scope:

- ICD-10-AM 8th Edition codes: C40-C41,C46, C48-C49.
- Kaposi sarcoma (malignant tumour arising from blood vessels in the skin) – rare in the western world except for patients with Aids.
- Fibrosarcoma.

Out of Scope

- Fibromatosis.

First Treatments

4.9.2 What <u>cannot</u> be classed as first treatment for sarcomas (ie, closing the 31 and 62-day pathway)?

Surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure).
Palliative or symptomatic care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment).

4.10.0 Skin Cancer

Patients included / excluded from FCT

4.10.1 What cancers are included /excluded from FCT?

In Scope:

- ICD-10-AM 8th Edition codes: C43 including Malignant Melanomas.
- Cutaneous lymphomas (C84 – included in haematological sub-group).

Out of Scope:

- ICD-10-AM 8th Edition code: C44
  - Squamous Cell Carcinoma (SCC)
  - Basal Cell Carcinoma (BCC)
  - Merkel Cell Carcinoma
  - Multicentric Basal Cell Carcinoma
  - Basal Cell Carcinoma, Morphoea
  - Basal Cell Carcinoma, Fibroepithelial
  - Basosquamous Carcinoma
  - Metatypical Carcinoma
  - Pilomatrix Carcinoma.
- Lentigo Malignas (considered Carcinoma In-Situ)
- Bowen's Disease (considered Carcinoma In-Situ)
- Intraepidermal Carcinomas (considered Carcinoma In-Situ)
- Keratoacanthoma (benign condition not malignant).

4.10.2 Is malignant melanoma in-situ within the remit of FCT?

No. Carcinoma in situ is excluded from FCT. *Refer General section 4.1.4.*

4.10.3 Is Superficial Spreading Malignant Melanoma within the remit of FCT?

It depends. If it is specified as being 'in-situ' then it is not within the scope. However, if it is coded as C43 then it would be within the remit of FCT. This would be a local clinical decision. *Refer General section 4.1.4.*

First Treatments

4.10.4 What cannot be classed as first treatment for skin cancers (ie, cannot close the 31 and 62-day pathway)?

- Surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure).
- Sentinel Node Biopsy – this is a diagnostic staging procedure to determine whether the cancer has spread to the lymph nodes.
- Palliative or symptomatic care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment).

Miscellaneous

4.10.5 How should multiple Malignant Melanomas (MMs) be managed?

If a second/third MM was classed as a new primary (ie, not a recurrence) it would be a new cancer and should be reported separately in FCT. Whether or not an MM is classed as a new primary, or a recurrence is a clinical decision.

4.10.6 A consultant sees a patient on the 62-day FCT indicator and writes '? BCC' in the notes and wants to see the patient in 12 weeks for excision as he wants it to grow. Does the patient remain on FCT tracking?

In this case, as BCCs are not within the remit of FCT, the patient could come off the 62-day FCT indicator if they have been told that they do not have cancer or that they have a BCC (ie, if the clinician is willing to make a clinical diagnosis and inform the patient). If not, then the patient should continue to be tracked on the 62-day FCT indicator.

You can only remove a patient from the 62-day FCT indicator if they have been told that they do not have cancer.

4.10.7 A patient presents to their GP with a skin lesion. The GP refers the patient to secondary care. The referral is triaged as high suspicion of cancer, and 2-week wait and so is reported under the 62-day FCT indicator. What counts as first treatment?

i. An excision is performed which confirms malignant melanoma but with sufficiently wide margins and no further treatment is required.

The excision, even if intended for diagnostic purposes, would be considered the first treatment as it removed the entire tumour, and no further treatment is required.

ii. An excision is performed which confirms malignant melanoma with narrow margins. Decision is made that a further wide local excision will be carried out.

The intent of the initial excision is the key. If the lesion was suspicious and the excision was carried out for diagnostic purposes (an excision biopsy) this would not count as first treatment. The subsequent wide local excision would count as the first treatment.

If there was a clinical diagnosis of malignant melanoma prior to the excision and the intent of the excision was to treat but failed to achieve wide enough margins, then this could count as first treatment.
Refer General section 4.1.5.

4.10.8 A patient presents to their GP with a skin lesion. The GP undertakes an excision which is positive for malignant melanoma and refers the patient to secondary care. How is this managed?

Again, intent is the key. If the excision was carried out for diagnostic purposes and, following receipt of the results, the GP has referred for assessment and treatment in secondary care, then the referral may be triaged as high suspicion of cancer and 2-week wait and reported in the 62-day FCT indicator[34].

However, if the excision in primary care removed the tumour and the referral to secondary care is for specialist review and assurance, then the excision in primary care can be considered the first treatment and the patient not reported in FCT. Any further treatment within secondary care would be considered a subsequent treatment.
Refer General section 4.1.5.

[34] As per the High suspicion of cancer guidelines: 'Referrals with a positive fine needle aspiration and/or biopsy' http://nsfl.health.govt.nz/accountability/performance-and-monitoring/business-rules-and-templates-reporting/faster-cancer

4.11.0 Upper Gastro-Intestinal (UGI) Cancers (including Oesophageal, Stomach, Pancreatic, Liver)

Patients included / excluded from FCT

4.11.1 What cancers are included / excluded from FCT?

In Scope:

- ICD-10-AM 8th Edition codes: C15-C17, C22-C25.
- Gastrointestinal stromal tumours (GISTs) that are described as malignant, invasive or as having metastases coded to the relevant ICD-10-AM 'C' code for the part of the gastrointestinal tract involved.

Out of Scope:

- GISTs not specified as above, coded as borderline using the relevant 'D' code.

4.11.2 Could a moderately differentiated pancreatic endocrine neoplasm (insulinoma T2 G2 Mx) 'D' coded as a borderline malignancy be reported for FCT?

No. This would not be included in FCT if it was classified as 'in situ' (D coded) within ICD-10-AM 8th Edition.

4.11.3 How should rare neuroendocrine tumours be coded – the diagnosis is not always specific to pancreatic origin?

It is suggested that you code the primary site of origin of the tumour (ie, record the ICD-10-AM 8th Edition site as the primary site of origin) and not the fact that it is of a neuroendocrine type. For example, if it is a neuroendocrine tumour in the lung, code is as a C34. Although the tumours are called neuroendocrine, they do not necessarily arise in an endocrine site. If the primary site is genuinely not known, then use a "Malignant neoplasm of other and ill-defined sites" code (C76).

First Treatments

4.11.4 What <u>cannot</u> be classed as first treatment for UGI cancers (ie, cannot close the 31 or 62-day pathway)?

Pancreatic cancer

- Surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure).
- Insertion of pancreatic/biliary stent – if the planned first treatment is resection for pancreatic or related cancers (ampullary, duodenal and distal bile duct) and the patient requires a stent due to having to wait for the surgery.
- Insertion of pancreatic/biliary stent – for patients with mild obstructive jaundice (a serum bilirubin below 200 micromol/l) if local practice is that they do not require biliary stenting before resection if surgery and imaging are planned within 7-10 days.
- Palliative or symptomatic care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment).

Gastric/oesophago-gastric cancer

- Surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure).
- Jejunostomy to insert a feeding tube.
- Palliative or symptomatic care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment).

4.11.5 Is duodenal stenting prior to starting palliative chemotherapy classed as a first treatment?

The general rule is that a stent can only be classed as first treatment where the patient is unfit for other treatment. In this scenario the patient is having palliative chemotherapy and the stent is part of the palliative package of care. Given this, in this case, the stent can be reported as the first treatment.

4.11.6 Is a staging laparoscopy to determine whether a patient is suitable for major UGI surgery classed as first treatment?

No. The staging laparoscopy usually forms part of the diagnostic and treatment planning and would not count as the first treatment.

4.11.7 A patient was referred to a gastroenterology clinic for suspected cancer and was found to have two gastric ulcers at endoscopy. Biopsies have shown a type of gastric lymphoma related to Helicobacter Pylori infection in the stomach. The patient has started standard eradication therapy – is this classed as first treatment?

If this is treatment of the Helicobacter Pylori in the stomach before the cancer can be treated, it should not be classed as the first treatment. But if treatment of the Helicobacter Pylori is considered part of the cancer treatment, then it would be the first treatment.

4.11.8 Can Proton Pump Inhibitor (PPI) treatment be classed as a first treatment for an UGI cancer?

No – a proton pump inhibitor reduces the amount of acid made by the stomach and may be used alongside some cancer treatments such as imatinib and dasatinib to limit side effects. *Refer General section 4.1.6.*

Miscellaneous

Liver

4.11.9 How are liver transplants managed for FCT?

When the agreed treatment is a transplant the date of decision to treat would be when the patient agrees the care plan that includes the transplant and the date of first treatment would be the date the patient is added to the transplant list.

For the purposes of FCT, a transplant should only be considered first treatment if no other active anti-cancer treatment is given in the interim.

4.11.10 A UGI patient has an unknown primary cancer with liver and peritoneal metastases. The patient had an appendectomy which removed his appendix and surrounding fat which contained Squamous Cell Carcinoma. Can the appendectomy count as first treatment?

Yes. If you gave a first treatment not knowing what the primary was then that treatment is for metastases of unknown primary and would close the 31 and 62-day FCT pathway.

Pancreas

4.11.11 What cancer treatment modality does APC Argon Plasma Coagulation come under?

This would be classed as other (code 00).

UGI

4.11.12 A patient referred for a suspected Head & Neck cancer was triaged as HSCAN, and 2-week wait. This was confirmed and an oesophageal cancer was also found incidentally. First treatment for the head & neck cancer also treated the oesophageal cancer – how should this be recorded?

The treatment can be used to close both the 62-day FCT pathway for the head and neck cancer and the 31-day FCT pathway for the incidental oesophageal cancer that was found.

4.12.0 Urological Cancers (including Bladder, Prostate, Renal, Testicular, Upper Tract Transitional Cell)

Patients included / excluded from FCT

4.12.1 What cancers are included / excluded from FCT?

In Scope:

- ICD-10-AM 8th Edition codes: C66-C67 [Ureter/Bladder]
- ICD-10-AM 8th Edition code: C61 [Prostate]
- ICD-10-AM 8th Edition codes: C64-C65 [Renal/Kidney]
- ICD-10-AM 8th Edition code: C60 [Penile]
- ICD-10-AM 8th Edition code: C62 [Testicular]
- ICD-10-AM 8th Edition code: C63 [Other and unspecified male genital organs]
- ICD-10-AM 8th Edition code: C68 [Other and unspecified urinary organs].

Out of Scope:

- pTa – transitional call carcinoma as regarded as non-invasive [Bladder].

First Treatments

4.12.2 What cannot be classed as first treatment for urological cancers (ie, closing the 31 and 62-day pathway)?

- Surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure).
- Palliative or symptomatic care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment).

Bladder

4.12.3 Can Transurethral resection (TUR) biopsy of a bladder be classed as first treatment?

As the intent of a TUR biopsy is likely to be a diagnostic, it would only count as a first treatment if the tumour is effectively removed by the procedure. *Refer General section, paragraph 1.5.*

4.12.4 Does a TURBT procedure (Transurethral Resection of Bladder Tumour) count as a first treatment?

If the intent of the TURBT was to treat (including to de-bulk the tumour) rather than for diagnostic purposes, then it can be counted as a first treatment and close the FCT pathway. *Refer General section 4.1.5.*

4.12.5 If a patient has a suspected bladder tumour and is given mitomycin C post operatively without a histological confirmation, do we count the TURBT and Mitomycin C as treatments?

If the patient has been given a clinical diagnosis of cancer and has agreed to be treated via TURBT and mitomycin then these can both be counted as treatments. If the patient has not been given a cancer diagnosis and these procedures are part of diagnosis and staging, then they would only count if cancer was subsequently diagnosed, and the procedures had in effect treated the cancer.

Prostate

4.12.6 Would TURP (Transurethral Resection of the Prostate) be classed as a first treatment?

If the intent of the TURP was to treat (including to de-bulk the tumour) rather than for diagnostic purposes, or if the TURP was carried out for benign disease and cancer is found incidentally and has, in effect, been treated by the TURP, then it can be counted as a first treatment and close the FCT pathway. *Refer General section 4.1.5.*

4.12.7 When can non-intervention management be classed as a first treatment for prostate cancer?

Non-intervention management ('05') can be recorded as the first treatment in FCT where a diagnosis has been reached but it is not clinically appropriate, or the patient has not agreed to any active treatment at that time and is instead being monitored until a point when it is clinically appropriate, or the patient agrees to active treatment. This is referred to as "a period of active management not unmanaged non-treatment".

Active monitoring is not to be used while waiting for a diagnosis to be confirmed or staging to be completed. Nor is it to be used to allow for thinking time or to address capacity issues that mean the proposed therapeutic treatment would not be available in within the 62- or 31-days.

If a prostate patient has a tumour that is not causing any significant problems and they decide they don't want to pursue active treatment immediately but have the cancer kept under check by repeat PSA, the first treatment could be recorded as non-intervention management closing the FCT pathway[35].

[35] Refer *Guidance on Using Active Surveillance to Mange Men with Low-risk Prostate Cancer (2015)* available at: https://www.health.govt.nz/publication/guidance-using-active-surveillance-manage-men-low-risk-prostate-cancer

4.12.8 Some prostate patients receive zoledronic acid prior to radiation therapy. Is this classed as a first treatment?

If the zoledronic acid is prescribed as palliative or symptomatic care with no other anti-cancer treatment planned, then it could be classed as the first treatment. If it is prescribed prior to radiation therapy, it is not a first treatment.

4.12.9 Is radiation therapy to a male patient to prevent or reduce breast growth and tenderness caused by prostate cancer treatment reportable as a first treatment?

This is not in itself a cancer treatment and therefore cannot be classed as a first treatment.

Renal

4.12.10 Can a renal stent be classed as first treatment?

The general rule is that a stent can only be classed as first treatment where there is no other anti-cancer treatment planned. Otherwise, it is an enabling treatment. *Refer General section 4.1.6.*

4.12.11 Would a 'nephrostomy' be counted as a first treatment?

A nephrostomy is an operation similar to a colostomy but for the collection of urine. If this is the only 'treatment' the patient is to receive (i.e., as palliative care with no other active treatment planned) it can be classed as a first treatment and although it is palliative in intent, it would be recorded as surgery. If any other active treatment is planned, it is not a first treatment.

Miscellaneous

Bladder

4.12.12 A patient is referred and triaged as HSCAN, and 2-week wait for bladder cancer, but nothing is found. A PSA is taken prompting further investigations for prostate cancer. Could the original referral for suspected bladder cancer be closed and a new non-urgent referral opened for the prostate cancer?

No, the patient was referred with a high suspicion of cancer and the investigations are part of the same pathway of care. If cancer is diagnosed this would need to be treated within 62 days of receipt of the initial referral. *Refer General section 4.1.12.*

Prostate

4.12.13 The delay needed between TRUS biopsy and MRI makes the 62-day FCT indicator difficult to achieve for prostate cancer – how should this be managed?

The target achievement levels take into account that some patients will not be clinically fit enough to receive treatment within the timeframes. If this was the significant delay that contributed to the patient breaching the 62-day indicator, the delay could be coded as a clinical consideration breach.

4.12.14 If a clinician prefers to carry out a repeat PSA in a few months rather than offer a TRUS/biopsy would the patient remain on the 62-day FCT tracking until cancer is diagnosed or ruled out?

Yes. The clinician has not ruled out cancer and wishes to repeat a diagnostic test after a given period of time. Once a patient is being tracked on the 62-day FCT

indicator they do not come off until they receive their first cancer treatment (or other management), or they are found not to have cancer or a recurrence.

4.12.15 If a patient has come in with only one moderately high PSA, the consultant will usually repeat the PSA test in 8 weeks' time unless it is extremely obvious it is prostate cancer. The consultant leaves eight weeks between tests to ensure that the patient does not have any infection that can lead to the PSA rising. How is this managed under FCT?

As in 12.15 above, once the FCT pathway has started it is not possible to adjust it because the patient needs to wait (for clinical reasons) between tests. The FCT indicators take into account that some patients will not be clinically fit to receive treatment within the timeframes.

4.12.16 If, after a second PSA test, a consultant cannot categorically say that the patient does or does not have cancer, how is this managed in FCT?

If there is diagnostic uncertainty the patient stays on FCT tracking. The patient would only come off tracking if they were informed that they did not have cancer. This would be a clinical decision, ie, the consultant is prepared to tell the patient and document in their notes that they do not have cancer.

If the consultant makes a clinical diagnosis of cancer and/or proceeds with treatment for cancer, then the patient should be tracked to first treatment. *Refer General section 4.1.12.*

4.12.17 Patients require a Volume Study prior to implantation of low-dose Radiation therapy seeds for brachytherapy – how does the volume study relate to FCT?

The volume study is part of the preparation and does not count as the first treatment. *Refer General section 4.1.6.* The date of the implantation of the seeds would be the start of the treatment and close the 31 and/or 62-day FCT pathway.

4.12.18 How should patients who require 3 months of hormones prior to radiation therapy be managed for FCT?

As the hormone therapy is integral to the treatment plan this can be counted as the first treatment and end the FCT pathway. *Refer General section 4.1.6.*

4.12.19 Quite high numbers of suspected prostate cancer patients are referred in with an elevated PSA (only one test) that have a urinary tract infection (UTI), and thus need antibiotics to treat the infection prior to having the prostate biopsied. The period realistically before these patients can be biopsied would be 2-4 weeks. Could the patient be recorded as having no cancer diagnosed and the GP informed to treat with antibiotics prior to re-referring if PSA is still raised?

There is still a potential suspected cancer and so the patient should remain on the FCT pathway. The FCT indicators take into account that some patients will not be clinically fit to receive treatment within the timeframes. It is not considered good practice to send the patient back to the GP to re-test and re-refer.

4.12.20 A patient was suspected to have prostate cancer but because of his age (90 years) he did not want a TURP and so there was no definitive diagnosis. He was treated with Lucrin injections. How is his managed?

Although there was no pathological diagnosis of cancer, there was a clinical diagnosis, and the patient was treated as for cancer. Therefore, the patient should be monitored under FCT with the date of the Lucrin injection the date of first treatment.

Section 5: Use Cases

How to read the use cases

The use cases have been divided into three sections:

1. 62-day and 31-day indicator use cases.
2. 31-day indicator only use cases.
3. use cases that are not reported.

Each use case has a case history that describes the patient's cancer pathway. The case history section is followed by a table showing the data that would be reported to the Te Whatu Ora National Collections. A table giving the rationale and the page numbers in section one is also included. Colour coding has been used to link the part of the case history that relates to the reported data. If there is no reported data, there is no colour coding.

The use cases are fictitious and are structured to highlight how the FCT business rules and data definitions should be applied. The need to highlight certain attributes means that these cases may not reflect usual clinical practice.
(M = Mandatory)

62-day and 31-day Indicator Use Cases

Surgery as the first treatment use case (62-day and 31-day indicators)

Date	Day count		Activity
	62	31	
26/09/2022	0		A referral is received from a primary care general practitioner. Patient is a 38-year-old male and has some abdominal pain with occasional rectal bleeding.
28/09/2022	2		Triaged by gastroenterology service as needing to be seen within two weeks with a high suspicion of cancer.
07/10/2022	11		Colonoscopy performed and changes consistent with cancer were observed. Tissue sample sent for histology. The patient was internally referred to a colorectal surgeon.
15/10/2022	19		Histology report confirms cancer of the colon.
21/10/2022	25		Attended at colorectal clinic first specialist assessment (FSA). Diagnosis discussed with patient.
23/10/2022	27		The patient's case was presented at the colorectal cancer multidisciplinary meeting (MDM). The MDM treatment recommendation was for surgery.
01/11/2022	36	0	The patient is seen in a follow-up colorectal clinic, MDM treatment option is discussed, and the patient agrees to have surgery. A theatre booking is requested.
01/12/2022	66	30	Patient was admitted as an inpatient under colorectal surgeon.

02/12/2022	67	31	Surgery: right hemicolectomy with anastomosis carried out.	FCT indicator pathway stops here
16/12/2022			Follow-up visit with colorectal surgeon.	
30/12/2022			Patient has FSA with medical oncology and accepted for chemotherapy.	
14/01/2023			Admitted as day case for insertion of vascular access device.	
29/01/2023			Chemotherapy education.	
30/01/2023			Adjuvant post-operative chemotherapy starts.	

Reported data for surgery as the first treatment (62-day and 31-day indicators)

Record type	M	A
National Health Index (NHI) number	M	AAANNNN
First name		
Family name		
Date of birth	M	19061984
Sex	M	M
District of domicile	M	121
Date of diagnosis		15102022
Primary site ICD-10-AM 8th Edition	M	C18
Date of receipt of referral	M	26092022
Hospital of receipt of referral	M	121
Date patient informed of diagnosis		21102022
Date of first multidisciplinary meeting (MDM)		23102022
Date of decision-to-treat	M	01112022
Date of first treatment	M	02122022
Type of first treatment	M	01
Hospital of service for first treatment	M	121
Source of referral		01
Clinician defined suspicion of cancer	M	30
2-week flag	M	1
Delay code 62		3
Delay code 31		

Criteria	Result	Rationale	Reference in FCT data definitions document
Eligible for 62-day indicator	Yes	High suspicion of cancer and needs to be seen within 2 weeks	Pages 12, 25 and 29
Eligible for 31-day indicator	Yes	Patient has not been treated for this cancer previously	Pages 13 and 25
Delay code 62	Yes	The patient did not receive treatment within the 62-day timeframe	Pages 8 and 29
Delay code 31	No	The patient received treatment within the 31-day timeframe	Pages 9 and 30

Note: If the date the patient agrees to treatment is not recorded use the date the surgical booking is requested.

Chemotherapy as the first treatment use case (62-day and 31-day indicators)

Date	Day count 62	Day count 31	Activity	
26/09/2022	0		A referral is received from a primary care general practitioner. Patient is a 38-year-old male and has some abdominal pain with occasional rectal bleeding.	
28/09/2022	2		Triaged by gastroenterology service as needing to be seen within two weeks with a high suspicion of cancer.	
07/10/2022	11		Colonoscopy performed and changes consistent with cancer were observed. The patient was internally referred to a colorectal surgeon.	
15/10/2022	19		Histology report confirms cancer of the colon.	
21/10/2022	25		Attended at colorectal clinic first specialist assessment (FSA). Diagnosis discussed with patient. Staging investigations show metastatic disease to liver and lung.	
23/10/2022	27		The patient's case was presented at the colorectal cancer multidisciplinary meeting (MDM). The MDM treatment recommendation was for a referral to medical oncology.	
01/11/2022	36		The patient is seen in a follow-up colorectal clinic, MDM treatment options are discussed, and the patient agrees to the proposed treatment pathway.	
12/11/2022	47	0	The patient is seen by medical oncology and agrees to chemotherapy.	
20/11/2022	55	8	The first dose of chemotherapy is given.	FCT indicator pathway stops here
05/3/2023			Patient reassessed and accepted for surgery, theatre booking request is sent.	

Reported data where chemotherapy is the first treatment (62-day and 31-day indicators)

Record type	M	A
National Health Index (NHI) number	M	AAANNNN
First name		
Family name		
Date of birth	M	19061984
Sex	M	M
District of domicile	M	121
Date of diagnosis		15102022
Primary site ICD-10-AM 8th Edition	M	C18
Date of receipt of referral	M	26092022
Hospital of receipt of referral	M	121
Date patient informed of diagnosis		21102022
Date of first multidisciplinary meeting (MDM)		23102022
Date of decision-to-treat	M	12112022
Date of first treatment	M	20112022
Type of first treatment	M	03
Hospital of service for first treatment	M	121
Source of referral		01
Clinician defined suspicion of cancer	M	30
2-week flag	M	1
Delay code 62		
Delay code 31		

Criteria	Result	Rationale	Reference in FCT data definitions document
Eligible for 62-day indicator	Yes	High suspicion of cancer and needs to be seen within 2 weeks	Pages 12, 25 and 29
Eligible for 31-day indicator	Yes	Patient has not been treated for this cancer previously	Pages 13 and 25
Delay code 62	No	The patient received treatment within the 62-day timeframe	Pages 8 and 29
Delay code 31	No	The patient received treatment within the 31-day timeframe	Pages 9 and 30

Note: In this case the patient agrees to a treatment pathway on 1/11/2013 however this is a proposed treatment, and it is being explained by a service that will not be delivering the proposed treatment. It is best to use the date (12/11/2013) when the patient is seen by medical oncology (the service that is delivering the treatment) and agrees to chemotherapy. On 12/11/2013 medical oncology has also accepted the patient as being suitable for chemotherapy.

Concurrent radiation and chemotherapy treatments use case (62-day and 31-day indicators)

Date	Day count 62	Day count 31	Activity	
26/09/2022	0		A referral is received from a primary care general practitioner. Patient is a 38-year-old male and has some abdominal pain with occasional rectal bleeding.	
28/09/2022	2		Triaged by gastroenterology service as needing to be seen within two weeks with a high suspicion of cancer.	
07/10/2022	11		Colonoscopy performed and changes consistent with cancer were observed. Tissue sample sent for histology. The patient was internally referred to a colorectal surgeon.	
15/10/2022	19		Histology report confirms cancer of the rectum.	
21/10/2022	25		Attended at colorectal clinic first specialist assessment (FSA). Diagnosis discussed with patient.	
23/10/2022	27		The patient's case was presented at the colorectal cancer multidisciplinary meeting (MDM). The MDM treatment recommendation was for the patient to have pre-operative radiation therapy with concurrent chemotherapy followed by surgery.	
01/11/2022	36		The patient is seen in a follow-up colorectal clinic, MDM treatment options are discussed and the patient agrees to the proposed course of treatment. The patient is referred to radiation oncology and medical oncology.	
12/11/2022	47		The patient reviewed by radiation oncology and agrees to radiation therapy.	
13/11/2022	48	0	The patient reviewed by medical oncology and agrees to chemotherapy.	
20/11/2022	55	7	Radiation therapy and chemotherapy treatments are started.	FCT indicator pathway stops here
05/01/2023			Patient reassessed and accepted for surgery, theatre booking request is sent.	

Reported data for concurrent radiation and chemotherapy treatments (62-day and 31-day indicators)

Record type	M	A
National Health Index (NHI) number	M	AAANNNN
First name		

Family name		
Date of birth	M	19061984
Sex	M	M
District of domicile	M	121
Date of diagnosis		15102022
Primary site ICD-10-AM 8th Edition	M	C20
Date of receipt of referral	M	26092022
Hospital of receipt of referral	M	121
Date patient informed of diagnosis		21102022
Date of first multidisciplinary meeting (MDM)		23102022
Date of decision-to-treat	M	13112022
Date of first treatment	M	20112022
Type of first treatment	M	09
Hospital of service for first treatment	M	121
Source of referral		01
Clinician defined suspicion of cancer	M	30
2-week flag	M	1
Delay code 62		
Delay code 31		

Criteria	**Result**	**Rationale**	**Reference in FCT data definitions document**
Eligible for 62-day indicator	Yes	High suspicion of cancer and needs to be seen within 2 weeks	Pages 12, 25 and 29
Eligible for 31-day indicator	Yes	Patient has not been treated for this cancer previously	Pages 13 and 25
Delay code 62	No	The patient received treatment within the 62-day timeframe	Pages 8 and 29
Delay code 31	No	The patient received treatment within the 31-day timeframe	Pages 9 and 30

Note: When concurrent treatment is planned a decision to treat should be recorded for each modality in the hospital's patient management system. To calculate the:

- **31-day indicator** use the last decision to treat date and the first treatment date of either of the two modalities
- **62-day indictor** use the date the referral was received and the first treatment date.

Metastatic cancer including a hospital admission use case (62-day and 31-day indicators)

Date	Day count 62	Day count 31	Activity	
26/09/2022	0		A referral is received from a primary care general practitioner. Patient has suspicious lump in his neck.	
26/09/2022	0		Triaged by ear, nose and throat (Otorhinolaryngology) service as needing to be seen within two weeks and having a high suspicion of cancer.	
07/10/2022	11		First specialist assessment (FSA). At the FSA the clinician arranged for the necessary investigations to be performed.	
07/10/2022	11		A fine needle aspiration (FNA) was performed.	
21/10/2022	25		FNA reported as metastatic adenocarcinoma of possible pulmonary origin.	
23/10/2022	27		The patient was referred to respiratory medicine with cancer.	
01/11/2022	36		Attended at respiratory clinic FSA. Diagnosis discussed with patient.	
04/11/2022	39		The patient's case was presented at the thoracic cancer multidisciplinary meeting (MDM). At the MDM the patient was recommended for palliative chemotherapy to be seen post staging CT scan.	
04/11/2022	39		Mid-afternoon the patient presented to hospital acutely unwell and was admitted under Medical Oncology. A CT scan was performed urgently, and the patient was reviewed by Radiation Oncology and accepted for palliative radiation therapy.	
05/11/2022	40	0	Patient agrees to have radiation therapy and treatment planning is completed.	
06/11/2022	41	1	Radiation therapy was given.	FCT indicator pathway stops here

Reported data for metastatic cancer including a hospital admission (62-day and 31-day indicators)

Record type	M	A
National Health Index (NHI) number	M	AAANNNN
First name		
Family name		

Date of birth	M	19061976
Sex	M	M
District of domicile	M	121
Date of diagnosis		21102022
Primary site ICD-10-AM 8th Edition	M	C34
Date of receipt of referral	M	26092022
Hospital of receipt of referral	M	121
Date patient informed of diagnosis		01112022
Date of first multidisciplinary meeting (MDM)		04112022
Date of decision-to-treat	M	05112022
Date of first treatment	M	06112022
Type of first treatment	M	02
Hospital of service for first treatment	M	121
Source of referral		01
Clinician defined suspicion of cancer	M	30
2-week flag	M	1
Delay code 62		
Delay code 31		

Criteria	**Result**	**Rationale**	**Reference in FCT data definitions document**
Eligible for 62-day indicator	Yes	High suspicion of cancer and needs to be seen within 2 weeks	Pages 12, 25 and 29
Eligible for 31-day indicator	Yes	Patient has not been treated for this cancer previously	Pages 13 and 25
Delay code 62	No	The patient received treatment within the 62-day timeframe	Pages 8 and 29
Delay code 31	No	The patient received treatment within the 31-day timeframe	Pages 9 and 30

Note: Even though this patient has metastatic cancer as the patient has not been treated for cancer previously this case is included in the FCT reporting.

Patient care is accessed across multiple Hospitals use case (62-day and 31-day indicators)

Date	Day count 62	Day count 31	Activity	
26/09/2022	0		A referral is received from a primary care general practitioner. Patient is a 60-year-old woman who has a persistent cough with some haemoptysis. A chest X-ray has been ordered.	
28/09/2022	2		Triaged by respiratory medicine service as needing to be seen within two weeks and with a high suspicion of cancer. X-ray report is suspicious of cancer.	
07/10/2022	11		First specialist assessment (FSA). The patient seen by a visiting clinician at a first specialist assessment in their local hospital (District of domicile). At the FSA the clinician arranged for the necessary investigations to be performed.	
15/10/2022	19		Test result reports including biopsy results are available from the laboratory.	
16/10/2022	20		Clinical nurse specialist phones patient to discuss results and referral to Thoracic Surgeon at the regional hospital.	
21/10/2022	25		FSA: the patient sees thoracic surgeon at the regional hospital. Test results reviewed and the diagnosis of cancer and role of surgery as a treatment option is discussed with patient.	
23/10/2022	27	0	The patient phones clinic agreeing to have surgery. A theatre booking is requested.	
24/10/2022	28	1	The patient's case is presented at the thoracic cancer multidisciplinary meeting (MDM). At the MDM, surgery is confirmed as the best treatment option.	
01/11/2022	36	9	Patient admitted as an inpatient under thoracic surgeon at the regional hospital.	
02/11/2022	37	10	Patient has surgery and the lung tumour is removed.	FCT indicator pathway stops here
22/11/2022			Patient has an outpatient follow-up at local HOSPITAL.	

Reported data patient care is accessed across multiple Hospitals (62-day and 31-day indicators)

Record type	M	A
National Health Index (NHI) number	M	AAANNNN
First name		
Family name		

Date of birth	M	19061962
Sex	M	F
District of domicile	M	093
Date of diagnosis		15102022
Primary site ICD-10-AM 8th Edition	M	C34
Date of receipt of referral	M	26092022
Hospital of receipt of referral	M	093
Date patient informed of diagnosis		16102022
Date of first multidisciplinary meeting (MDM)		24102022
Date of decision-to-treat	M	23102022
Date of first treatment	M	02112022
Type of first treatment	M	01
Hospital of service for first treatment	M	091
Source of referral		01
Clinician defined suspicion of cancer	M	30
2-week flag	M	1
Delay code 62		
Delay code 31		

Criteria	**Result**	**Rationale**	**Reference in FCT data definitions document**
Eligible for 62-day indicator	Yes	High suspicion of cancer and needs to be seen within 2 weeks	Pages 12, 25 and 29
Eligible for 31-day indicator	Yes	Patient has not been treated for this cancer previously	Pages 13 and 25
Delay code 62	No	The patient received treatment within the 62-day timeframe	Pages 8 and 29
Delay code 31	No	The patient received treatment within the 31-day timeframe	Pages 9 and 30

Palliative (best supportive) care as treatment use case (62-day and 31-day indicators)

Date	Day count 62	Day count 31	Activity	
26/09/2022	0		A referral is received from a primary care general practitioner (GP). Patient is a 60-year-old woman who has a suspicious lump in her neck.	
27/09/2022	1		Triaged by ear, nose and throat (otorhinolaryngology) service, as needing to be seen within two weeks and as having a high suspicion of cancer.	
07/10/2022	11		First specialist assessment (FSA). At the FSA the clinician arranged for the necessary investigations to be performed.	
07/10/2022	11		A fine needle aspiration (FNA) was performed	
14/10/2022	20		FNA reported as metastatic adenocarcinoma consistent with pulmonary origin.	
16/10/2022	27		The patient was internally referred to respiratory medicine and a CT scan is requested.	
01/11/2022	36		Respiratory clinic FSA. Diagnosis is discussed with patient.	
04/11/2022	39		The patient's case was presented at the thoracic cancer multidisciplinary meeting (MDM). At the MDM, as the patient's disease is wide-spread, palliative care is recommended.	
05/11/2022	40	0	Patient attends a follow-up visit. MDM recommendations are discussed, and patient agrees to be referred to a community based palliative care service close to the patient's home.	
06/11/2022	41	1	A referral letter is sent to the palliative (best supportive) care service, with copy to the patient's GP. The patient is discharged back to the care of their GP. NB GP is also an appropriate provider of best supportive care.	FCT indicator pathway stops here
01/04/2023			Patient presents at the emergency department with severe back pain. Tests show mass pressing on spinal cord. Referred to radiation oncology service, patient is seen, and palliative radiation treatment is agreed.	
02/04/2023			Planning for palliative radiation treatment completed and first dose given.	

Reported data for palliative (best supportive) care case (62-day and 31-day indicators)

Record type	M	A
National Health Index (NHI) number	M	AAANNNN
First name		
Family name		
Date of birth	M	19061962
Sex	M	F
District of domicile	M	081
Date of diagnosis		14102022
Primary site ICD-10-AM 8th Edition	M	C34
Date of receipt of referral	M	26092022
Hospital of receipt of referral	M	081
Date patient informed of diagnosis		01112022
Date of first multidisciplinary meeting (MDM)		04112022
Date of decision-to-treat	M	05112022
Date of first treatment	M	06112022
Type of first treatment	M	06
Hospital of service for first treatment	M	081
Source of referral		01
Clinician defined suspicion of cancer	M	30
2-week flag	M	1
Delay code 62		
Delay code 31		

Criteria	Result	Rationale	Reference in FCT data definitions document
Eligible for 62-day indicator	Yes	High suspicion of cancer and needs to be seen within 2 weeks	Pages 12, 25 and 29
Eligible for 31-day indicator	Yes	Patient has not been treated for this cancer previously	Pages 13 and 25
Delay code 62	No	The patient received treatment within the 62-day timeframe	Pages 8 and 29
Delay code 31	No	The patient received treatment within the 31-day timeframe	Pages 9 and 30

Note: In cases such as this the patient has already had a definitive treatment decision (ie, palliative/best supportive care) agreed and implemented. Any further treatments required for subsequent symptoms, for example the patient's primary health care professional referred the patient for palliative radiation treatment or subsequently is referred for surgery; are **not** the first treatment for this cancer. See also the Date of first treatment definition page 24.

Haematological cancer with an acute admission use case (62-day and 31-day indicators)

Date	Day count 62	Day count 31	Activity	
18/09/2022			A 45-year-old female presents at hospital emergency department acutely unwell. The patient is admitted under general medicine for investigations.	
21/09/2022			Following further tests, the patient is discharged, and a referral is sent to haematology outpatients with a high suspicion of cancer.	
23/09/2022	0		Referral is received in haematology outpatients.	
23/09/2022	0		Triaged as needing to be seen within two weeks with a high suspicion of cancer.	
27/09/2022	4		Preliminary laboratory results are suggestive of a B cell lymphoma.	
27/09/2022	4		The patient is rung and requested to come into hospital. On arrival patient is admitted under haematology.	
30/09/2022	7		Patient discharged post biopsy.	
03/10/2022	11		Diagnosis of Hodgkin's lymphoma is confirmed on biopsy.	
08/10/2022	16	0	Treatment plan discussed and agreed with patient.	
09/10/2022	17	1	First chemotherapy treatment given.	FCT indicator pathway stops here

Reported data for haematology with an acute admission case (62-day and 31-day indicators)

Record type	M	A
National Health Index (NHI) number	M	AAANNNN
First name		
Family name		
Date of birth	M	19061977
Sex	M	F
District of domicile	M	022
Date of diagnosis		03102022
Primary site ICD-10-AM 8th Edition	M	C81
Date of receipt of referral	M	23092022

Hospital of receipt of referral	M	022
Date patient informed of diagnosis		
Date of first multidisciplinary meeting (MDM)		
Date of decision-to-treat	M	08102022
Date of first treatment	M	09102022
Type of first treatment	M	03
Hospital of service for first treatment	M	022
Source of referral		05
Clinician defined suspicion of cancer	M	30
2-week flag	M	1
Delay code 62		
Delay code 31		

Criteria	Result	Rationale	Reference in FCT data definitions document
Eligible for 62-day indicator	Yes	High suspicion of cancer and needs to be seen within 2 weeks	Pages 12, 25 and 29
Eligible for 31-day indicator	Yes	Patient has not been treated for this cancer previously	Pages 13 and 25
Delay code 62	No	The patient received treatment within the 62-day timeframe	Pages 8 and 29
Delay code 31	No	The patient received treatment within the 31-day timeframe	Pages 9 and 30

Note: In this case the initiating event is the referral to haematology outpatients not the initial hospital admission. The referral is processed and triaged within haematology outpatients. The level of suspicion of cancer and the need to be seen within two weeks are determined and recorded in the hospital's system.

Patient pathway starts outside the New Zealand health system use case (62-day and 31-day indicators)

Date	Day count 62	Day count 31	Activity
			A New Zealand citizen is completing a six-month contract for work in Australia when she discovers a lump in her breast. She visits a local Australian doctor who orders a mammogram which when reported indicates a probable cancer. The patient decides to finish work early and return to her home in New Zealand. The Australian doctor documents the findings in a letter to the patient's New Zealand based general practitioner (GP).

28/09/2022	0		A referral from the New Zealand GP, with a copy of the Australian findings, is received and triaged by New Zealand Hospital Breast service as needing to be seen within two weeks and with a high suspicion of cancer.	
07/10/2022	9		Hospital breast clinic first specialist assessment (FSA): At the FSA the clinician arranges for the necessary investigations to be performed.	
07/10/2022	9		A core biopsy is performed.	
10/10/2022	12		Tests confirm carcinoma of the breast.	
23/10/2022	25		Attended Hospital breast clinic. Diagnosis discussed with patient as well as possible options for treatment.	
30/10/2022	32		The patient's case was presented at the breast cancer multidisciplinary meeting (MDM). The MDM recommends surgery.	
31/10/2022	33	0	Patient attends a breast clinic and agrees to have surgery.	
11/11/2022	44	11	Surgery, patient has a partial mastectomy.	FCT indicator pathway stops here
16/12/2022			Patient is referred to radiation oncology for radiation therapy.	
17/12/2022			Triaged by radiation oncology.	
20/12/2022			Radiation oncology clinic visit and agrees to radiation therapy.	
28/12/2022			Radiation therapy started.	

Reported data patient pathway starts outside the New Zealand health system use case (62-day and 31-day indicators)

Record type	M	A
National Health Index (NHI) number	M	AAANNNN
First name		
Family name		
Date of birth	M	19061969
Sex	M	F
District of domicile	M	022
Date of diagnosis		10102022
Primary site ICD-10-AM 8th Edition	M	C50
Date of receipt of referral	M	28092022

Hospital of receipt of referral	M	022
Date patient informed of diagnosis		23102022
Date of first multidisciplinary meeting (MDM)		30102022
Date of decision-to-treat	M	31102022
Date of first treatment	M	11112022
Type of first treatment	M	01
Hospital of service for first treatment	M	022
Source of referral		01
Clinician defined suspicion of cancer	M	30
2-week flag	M	1
Delay code 62		
Delay code 31		

Criteria	Result	Rationale	Reference in FCT data definitions document
Eligible for 62-day indicator	Yes	High suspicion of cancer and needs to be seen within 2 weeks	Pages 12, 25 and 29
Eligible for 31-day indicator	Yes	Patient has not been treated for this cancer previously	Pages 13 and 25
Delay code 62	No	Patient received treatment within the 62-day timeframe	Pages 8 and 29
Delay code 31	No	The patient received treatment within the 31-day timeframe	Pages 9 and 30

Note: While this case starts with the patient in Australia a diagnosis of cancer has not been confirmed and no treatment was started outside New Zealand. The patient is eligible for publicly funded treatment in New Zealand and the referral is from a New Zealand based GP. Therefore, the patient is eligible for inclusion in the FCT indicator reporting.

First surgical treatment is not completed use case (62-day and 31-day indicators)

Date	Day count 62	Day count 31	Activity
26/09/2022	0		A referral is received from a primary care general practitioner (GP). Patient is a 48-year-old male and has some abdominal pain with occasional rectal bleeding.
28/09/2022	2		Triaged by gastroenterology service as needing to be seen within two weeks with a high suspicion of cancer.

07/10/2022	11		Colonoscopy performed and changes consistent with cancer were observed. Tissue sample sent for histology. Probable diagnosis discussed with patient. The patient was referred to a colorectal surgeon.	
15/10/2022	19		The histology report confirms cancer of the colon.	
21/10/2022	25		Attended at colorectal clinic first specialist assessment (FSA). Diagnosis discussed with patient.	
23/10/2022	27		The patient's case was presented at the colorectal cancer multidisciplinary meeting (MDM). The MDM treatment recommendation was for surgery.	
01/11/2022	36	0	The patient is seen in a follow-up colorectal clinic, MDM treatment option is discussed and the patient agrees to have surgery. A theatre booking is requested.	
01/12/2022	66	30	Patient was admitted as an inpatient under colorectal surgeon.	
02/12/2022	67	31	Patient sent to theatre. In theatre the patient has a cardiac arrest on the operating table. Surgery does not proceed. The scheduled theatre time is spent stabilising the patient.	FCT indicator pathway stops here
02/12/2022			Patient is transferred to coronary care unit.	
04/12/2022			Patient discharged home.	
22/12 /2022			Patient readmitted for surgery under colorectal surgeon.	
23/12/2022			Surgery: right hemicolectomy with anastomosis is carried out.	
08/01/2023			Follow-up visit with colorectal surgeon and is referred to medical oncology for adjuvant chemotherapy.	

Reported data for First surgical treatment is not completed use case (62-day and 31-day indicators)

Record type	M	A
National Health Index (NHI) number	M	AAANNNN
First name		
Family name		
Date of birth	M	19061974
Sex	M	M
District of domicile	M	121
Date of diagnosis		15102022
Primary site ICD-10-AM 8th Edition	M	C18

Date of receipt of referral	M	26092022
Hospital of receipt of referral	M	121
Date patient informed of diagnosis		21102022
Date of first multidisciplinary meeting (MDM)		23102022
Date of decision-to-treat	M	01112022
Date of first treatment	M	02122022
Type of first treatment	M	01
Hospital of service for first treatment	M	121
Source of referral		01
Clinician defined suspicion of cancer	M	30
2-week flag	M	1
Delay code 62		3
Delay code 31		

Criteria	Result	Rationale	Reference in FCT data definitions document
Eligible for 62-day indicator	Yes	High suspicion of cancer and needs to be seen within 2 weeks	Pages 12, 25 and 29
Eligible for 31-day indicator	Yes	Patient has not been treated for this cancer previously	Pages 13 and 25
Delay code 62	Yes	The patient did not receive treatment within the 62-day timeframe	Pages 8 and 29
Delay code 31	No	The patient received treatment within the 31-day timeframe	Pages 9 and 30

Note: If the date the patient agrees to treatment is not recorded use the date the surgical booking is requested. A discussion with the Royal Australasian College of Surgeons, New Zealand National Office, confirmed that as the patient was on the operating table when the patient had a cardiac arrest the operation can be said to have started. In this case surgery is valid a first treatment see Type of first treatment definition page 25.

31-day Indicator Only Use Cases

An acute admission use case (31-day indicator only)

Date	Day count 62	Day count 31	Activity	
18/09/2022			A 45-year-old female presents at hospital emergency department acutely unwell. The patient is admitted under general medicine for investigations.	
21/09/2022			Following further tests, the patient is discharged, and a referral is sent to haematology outpatients with a high suspicion of cancer.	
23/09/2022			Referral is received in haematology outpatients, but the referral is not triaged immediately.	
24/09/2022			Preliminary laboratory results are reported. These preliminary results are suggestive of B cell lymphoma.	
24/09/2022			The patient is rung and requested to come into hospital. On arrival patient is admitted under haematology.	
30/09/2022			Patient discharged post biopsy with arrangements in place for further staging investigations required to determine a definitive treatment plan.	
03/10/2022			Diagnosis of Hodgkin's lymphoma is confirmed on biopsy.	
08/10/2022		0	Treatment plan discussed and agreed with patient.	
09/10/2022		1	First chemotherapy treatment given.	FCT indicator pathway stops here

Reported data for an acute admission case (31-day indicator only)

Record type	M	A
National Health Index (NHI) number	M	AAANNNN
First name		
Family name		
Date of birth	M	19061977
Sex	M	F
District of domicile	M	022
Date of diagnosis		03102022
Primary site ICD-10-AM 8th Edition	M	C81
Date of receipt of referral		21092022
Hospital of receipt of referral		022

Date patient informed of diagnosis		
Date of first multidisciplinary meeting (MDM)		
Date of decision-to-treat	M	08102022
Date of first treatment	M	09102022
Type of first treatment	M	03
District of service for first treatment	M	022
Source of referral		05
Clinician defined suspicion of cancer		
2-week flag		
Delay code 62		
Delay code 31		

Criteria	Result	Rationale	Reference in FCT data definitions document
Eligible for 62-day indicator	No	Although referred with a high suspicion of cancer the referral was not triaged	Pages 12, 25 and 29
Eligible for 31-day indicator	Yes	Patient has not been treated for this cancer previously	Pages 13 and 25
Delay code 62	No	As the patient is not eligible for the 62-day indicator no delay code is reported	Pages 8 and 29
Delay code 31	No	The patient received treatment within the 31-day timeframe	Pages 9 and 30

Note: In this case the referral had not been processed and triaged within haematology outpatients. As this triage has not been completed (and not been recorded in the system) the level of suspicion of cancer and the need to be seen within two weeks has not been determined. The impact of test results overtakes the triage process and the patient is not included in the 62-day indicator.

Cancer discovered during surgery use case (31-day indicator only)

Date	Day count 62	Day count 31	Activity
04/11/2022			Mid-afternoon a patient presents at hospital emergency department acutely unwell. Patient is admitted under general surgery. A CT scan is performed urgently, and several gall stones are found. Surgery for an acute cholecystectomy is scheduled.
05/11/2022			Patient has a cholecystectomy. However, during surgery, the liver appeared visually abnormal, and a sample of the abnormal tissue is removed and sent for histology.
08/11/2022			The histology report states metastatic cancer of probable pulmonary origin.

08/11/2022		The patient was internally referred to and referral received by medical oncology. Further tests are carried out.	
20/11/2022		Patient discharged from hospital.	
30/11/2022		The patient's case was presented at the thoracic cancer multidisciplinary meeting (MDM). At the MDM the patient was recommended for palliative chemotherapy.	
10/12/2022	0	Patient has a medical oncology clinic visit and agrees to chemotherapy.	
23/12/2022	13	Chemotherapy started.	FCT indicator pathway stops here

Reported data for cancer discovered during surgery (31-day indicator only)

Record type	M	A
National Health Index (NHI) number	M	AAANNNN
First name		
Family name		
Date of birth	M	19061969
Sex	M	F
District of domicile	M	022
Date of diagnosis		08112022
Primary site ICD-10-AM 8th edition	M	C34
Date of receipt of referral		08112022
Hospital of receipt of referral		022
Date patient informed of diagnosis		
Date of first multidisciplinary meeting (MDM)		
Date of decision-to-treat	M	10122022
Date of first treatment	M	23122022
Type of first treatment	M	03
Hospital of service for first treatment	M	022
Source of referral		05
Clinician defined suspicion of cancer		
2-week flag		
Delay code 62		
Delay code 31		

Criteria	Result	Rationale	Reference in FCT data definitions document
Eligible for 62-day indicator	No	Cancer is found incidentally during surgery. No triage is recorded in the system so the level of suspicion of cancer and the need to be seen within two weeks have not been triggered for the 62-day indicator	Pages 12, 25 and 29
Eligible for 31-day indicator	Yes	Patient has not been treated for this cancer previously	Pages 13 and 25
Delay code 62	No	As the patient is not eligible for the 62-day indicator no delay code is reported	Pages 8 and 29
Delay code 31	No	The patient received treatment within the 31-day timeframe	Pages 9 and 30

A melanoma diagnosis with excision in primary care use case (31-day indicator only)

Date	Day count 62	Day count 31	Activity	
19/12/2022			A 30-year-old female patient presents to general practitioner (GP) who removes suspicious skin lesion.	
23/12/2022			The lab report diagnoses the lesion as melanoma with comment “completely but narrowly excised”.	
7/01/2023			Hospital receives a referral from the GP to the surgical department. The patient has a confirmed cancer and needs to be seen quickly.	
10/01/2023			Patient triaged and confirmed as needing to be seen within two weeks.	
22/01/2023		0	Surgical first specialist assessment (FSA). The need to “re-excise the lesion” is discussed. Patient agrees to the re-excision.	
23/01/2023		1	A theatre booking request is sent.	
20/03/2023		57	Patient receives wider excision for melanoma.	FCT indicator pathway stops here
24/03/2023			Lab reports lesion excised with good clear margins.	

Reported data for melanoma diagnosis with excision in primary care (31-day indicator)

Record type	M	A
National Health Index (NHI) number	M	AAANNNN
First name		
Family name		
Date of birth	M	19061992
Sex	M	F
District of domicile	M	022
Date of diagnosis		23122022
Primary site ICD-10-AM 8th Edition	M	C43
Date of receipt of referral		7012023
Hospital of receipt of referral		022
Date patient informed of diagnosis		
Date of first multidisciplinary meeting (MDM)		
Date of decision-to-treat	M	22012023
Date of first treatment	M	20032023
Type of first treatment	M	01
Hospital of service for first treatment	M	022
Source of referral		01
Clinician defined suspicion of cancer		10
2-week flag		1
Delay code 62		
Delay code 31		3

Criteria	Result	Rationale	Reference in FCT data definitions document
Eligible for 62-day indicator	No	Even though the patient needed to be seen within 2 weeks the patient has a confirmed cancer and so did not have a high suspicion of cancer	Pages 12, 25 and 29
Eligible for 31-day indicator	Yes	The original procedure was an excision biopsy likely to be for diagnostic purposes. The patient requires treatment based upon the results of that diagnostic test. The patient has not been definitively treated for this cancer previously	Pages 13 and 25
Delay code 62	No	As the patient is not eligible for the 62-day indicator no delay code is reported	Pages 8 and 29
Delay code 31	Yes	The patient did not receive treatment within the 31 days	Pages 9 and 30

Note: If the GP had excised the melanoma with sufficiently wide margins and no re-excision was required then the GP's excision would have been the first treatment for that particular cancer. It is unclear whether the GP intended the excision to be a treatment or test. As a general principle when in doubt it is better to include a case in FCT reporting rather than exclude.

Final cancer diagnosis differs from working diagnosis use case (31-day indicator)

Date	Day count 62	Day count 31	Activity	
28/09/2022	0		A referral, from GP is received. The referral is triaged by Hospital breast service as needing to be seen within two weeks and with a high suspicion of cancer.	
07/10/2022	9		Hospital breast clinic first specialist assessment (FSA). At the FSA the clinician arranges for the necessary investigations to be performed.	
07/10/2022	9		A core biopsy is performed.	
10/10/2022	12		Tests show ductal carcinoma in-situ (DCIS) of the breast (not included in FCT reporting).	
23/10/2022			Attended a hospital breast clinic. Diagnosis discussed with patient and as well as possible options for treatment.	
30/10/2022			The patient's case was presented at the breast cancer multidisciplinary meeting (MDM). The MDM recommends surgery.	
31/10/2022			Patient attends a breast clinic and agrees to have surgery.	
11/11/2022		0	Surgery; patient has a partial mastectomy.	FCT indicator pathway stops here
18/11/2022			Laboratory reports the surgical specimen as invasive cancer (C50).	
16/12/2022			Patient is referred to radiation oncology for radiation therapy.	
17/12/2022			Triaged by radiation oncology and radiation therapy is recommended.	
20/12/2022			Radiation oncology clinic visit and patient agrees to radiation therapy.	
28/01/2023			Radiation therapy started.	

Reported data for final cancer diagnosis differs from working diagnosis (31-day indicator)

Record type	M	A
National Health Index (NHI) number	M	AAANNNN
First name		
Family name		
Date of birth	M	19061969

Sex	M	F
District of domicile	M	022
Date of diagnosis		18112022
Primary site ICD-10-AM 8th Edition	M	C50
Date of receipt of referral		28092022
Hospital of receipt of referral		022
Date patient informed of diagnosis		23102022
Date of first multidisciplinary meeting (MDM)		30102022
Date of decision-to-treat	M	31102022
Date of first treatment	M	11112022
Type of first treatment	M	01
Hospital of service for first treatment	M	022
Source of referral		01
Clinician defined suspicion of cancer		30
2-week flag		1
Delay code 62		
Delay code 31		

Criteria	Result	Rationale	Reference in FCT data definitions document
Eligible for 62-day indicator	No	Patient is triaged as a high suspicion of cancer and a need to be seen within 2 weeks. However, the provisional diagnosis of DCIS at treatment excludes the patient from this indicator	Pages 12, 25 and 29
Eligible for 31-day indicator	Yes	Patient has not been treated for this cancer (C50) previously	Pages 13 and 25
Delay code 62	No	As the patient is not eligible for the 62-day indicator no delay code is reported	Pages 8 and 29
Delay code 31	No	The patient received treatment within the 31-day timeframe	Pages 9 and 30

Note: In this case the patient diagnosis has changed from DCIS, an ICD-10-AM 8th Edition D-code excluded from FCT reporting to C50 which is included in FCT reporting. As the treatment given was based on the core biopsy diagnosis of DCIS, the patient would not be on the 62-day pathway and considered to be less urgent than other cases. The final histological diagnosis was incidental and not expected. In this situation the decision to treat date and date of first treatment are the same. This case is included in the 31-day FCT reporting.

Prostate cancer user case (31-day indicator only)

Date	Day count 62	Day count 31	Activity	
19/12/2022			A referral is received by the Urology service from a primary care general practitioner (GP) for an asymptomatic 64-year-old patient presenting with an elevated PSA and inconclusive findings on examination.	
20/12/2022			Patient triaged as having a high suspicion of cancer but there is no need to be seen within two weeks.	
07/01/2023			Patient attends a first specialist assessment where an examination identifies an abnormal prostate. A TRUS biopsy for histology is planned.	
13/01/2023			Patient phones the urology clinic and after discussion with a clinical nurse specialist agrees to have the TRUS biopsy.	
03/03/2023			A TRUS biopsy is performed.	
10/03/2023			Histology report confirms prostate cancer.	
12/03/2023		0	Patient seen at follow-up urology clinic. Treatment plan is agreed.	
12/03/2023		0	Treatment agreed to is active surveillance by a urologist.	FCT indicator pathway stops here
14/03/2023			A letter outlining the plan is sent to the patient and the patient's GP.	

Reported data for case with prostate cancer (31-day indicator)

Record type	M	A
National Health Index (NHI) number	M	AAANNNN
First name		
Family name		
Date of birth	M	19061958
Sex	M	M
District of domicile	M	011
Date of diagnosis		10032023
Primary site ICD-10-AM 8th Edition	M	C61
Date of receipt of referral		19122022
Hospital of receipt of referral		011
Date patient informed of diagnosis		

Date of first multidisciplinary meeting (MDM)		
Date of decision-to-treat	M	12032023
Date of first treatment	M	12032023
Type of first treatment	M	05
Hospital of service for first treatment	M	011
Source of referral		01
Clinician defined suspicion of cancer		30
2-week flag		0
Delay code 62		
Delay code 31		

Criteria	Result	Rationale	Reference in FCT data definitions document
Eligible for 62-day indicator	No	The patient has a high suspicion of cancer but did not need to be seen within two weeks	Pages 12, 25 and 29
Eligible for 31-day indicator	Yes	Patient has not been treated for this cancer previously	Pages 13 and 25
Delay code 62	No	As the patient is not eligible for the 62-day indicator no delay code is reported	Pages 8 and 29
Delay code 31	No	The patient received treatment within the 31 day timeframe	Pages 9 and 30

A known cancer referral use case (31-day indicator only)

Date	Day count 62	Day count 31	Activity
01/06/2022			A 44-year-old male patient who has been under the infectious diseases team's care in a tertiary Hospital is noted to have two small leukoplakic lesions on his left side of his tongue.
28/06/2022			Lesions are biopsied.
30/06/2022			Lab report states that sample shows inflammation only in the anterior specimen and early invasive squamous cell carcinoma in the posterior specimen. Patient is referred back to District of domicile by tertiary Hospital
10/07/2022			A referral and a copy of the lab results are received by District of domicile. The referral is triaged as needing to be seen within two weeks with a confirmed cancer.

17/07/2022		Patient attends a first specialist assessment. A CT scan of head and neck and an X-ray panorex are requested.	
05/08/2022		CT scan of head and neck and X-ray panorex are completed.	
09/08/2022		Ear, nose and throat (otorhinolaryngology) multidisciplinary meeting (MDM) recommends proceeding with surgery.	
09/08/2022	0	Patient agrees to have the surgery.	
25/09/2022	47	Patient has surgery to remove lesions.	FCT indicator pathway stops here

Reported data for known cancer referral (31-day indicator)

Record type	M	A
National Health Index (NHI) number	M	AAANNNN
First name		
Family name		
Date of birth	M	19051978
Sex	M	M
District of domicile	M	011
Date of diagnosis		30062022
Primary site ICD-10-AM 8th Edition	M	C02
Date of receipt of referral		10072022
Hospital of receipt of referral		011
Date patient informed of diagnosis		
Date of first multidisciplinary meeting (MDM)		09082022
Date of decision-to-treat	M	09082022
Date of first treatment	M	25092022
Type of first treatment	M	01
Hospital of service for first treatment	M	011
Source of referral		06
Clinician defined suspicion of cancer		
2-week flag		
Delay code 62		
Delay code 31		3

Criteria	Result	Rationale	Reference in FCT data definitions document
Eligible for 62-day indicator	No	The patient has a confirmed cancer and so did not have a high suspicion of cancer	Pages 12, 25 and 29
Eligible for 31-day indicator	Yes	Patient has not been treated for this cancer previously	Pages 13 and 25
Delay code 62	No	As the patient is not eligible for the 62-day indicator no delay code is reported	Pages 8 and 29
Delay code 31	Yes	The patient did not receive treatment within the 31 days	Pages 9 and 30

Young adult with an acute admission use case (31-day indicator only)

Date	Day count 62	Day count 31	Activity	
18/09/2022			A 15-year-old female (date of birth 22/09/2007) is admitted acutely unwell. The patient is admitted under general medicine for investigations.	
21/09/2022			Chest X-ray shows a mediastinal mass and subsequent CT scan additional widespread lymphadenopathy.	
23/09/2022			Following testing the patient is transferred under the care of medical oncology.	
27/09/2022			Patient discharged post biopsy.	
29/09/2022			Diagnosis of Hodgkin's lymphoma is reported on biopsy result.	
30/09/2022		0	Treatment plan discussed with patient and family (note the patient is now 16 years old).	
03/10/2022		3	First chemotherapy treatment given (note the patient is now 16 years old).	FCT indicator pathway stops here

Reported data for young adult with an acute admission case (31-day indicator only)

Record type	M	A
National Health Index (NHI) number	M	AAANNNN
First name		
Family name		
Date of birth	M	22062007
Sex	M	F

District of domicile	M	022
Date of diagnosis		29092022
Primary site ICD-10-AM 8th Edition	M	C81
Date of receipt of referral		
Hospital of receipt of referral		
Date patient informed of diagnosis		
Date of first multidisciplinary meeting (MDM)		
Date of decision-to-treat	M	30092022
Date of first treatment	M	03102022
Type of first treatment	M	03
Hospital of service for first treatment	M	022
Source of referral		
Clinician defined suspicion of cancer		
2-week flag		
Delay code 62		
Delay code 31		

Criteria	Result	Rationale	Reference in FCT data definitions document
Eligible for 62-day indicator	No	This patient was admitted acutely. There was no triage of a referral recorded in the system. The high suspicion of cancer and the need to be seen within two weeks were not determined / recorded so the 62-day indicator criteria are not met	Pages 12, 25 and 29
Eligible for 31-day indicator	Yes	Patient has not been treated for this cancer previously and turned 16 prior to treatment and is under the care of adult services.	Pages 13 and 25
Delay code 62	No	As the patient is not eligible for the 62-day indicator no delay code is reported	Pages 8 and 29
Delay code 31	No	The patient received treatment within the 31-day timeframe	Pages 9 and 30

Note: If this patient was 15 years old at the time of treatment, she would not be included in the FCT reporting.

Clinical trial use case (31-day indicator only)

Date	Day count 62	Day count 31	Activity
16/09/2022			A 55-year-old male patient presents at hospital emergency department acutely unwell. Patient is admitted under general medicine for investigations.
17/09/2022			Patient is referred internally (as an inpatient) to a haematologist with a high suspicion of cancer. Further tests are carried out.

19/09/2022		Patient diagnosed with chronic myeloid leukaemia.	
19/09/2022		Patient informed of diagnosis, treatment options are discussed, including participation in a clinical treatment trial.	
20/09/2022	0	Patient signs consent form to participate in a clinical trial.	
20/09/2022	0	Patient signs consent form to participate in a clinical treatment trial.	FCT indicator pathway stops here
23/09/2022		Patient discharged from inpatient stay.	
09/10/2022		Patient is not accepted on to the clinical trial.	
11/10/2022		Treatment plan is revised and discussed with patient.	
25/10/2022		First chemotherapy treatment is given.	

Reported data for clinical trial (31-day indicator)

Record type	M	A
National Health Index (NHI) number	M	AAANNNN
First name		
Family name		
Date of birth	M	19061967
Sex	M	M
District of domicile	M	011
Date of diagnosis		19092022
Primary site ICD-10-AM 8th Edition	M	C92
Date of receipt of referral		
Hospital of receipt of referral		011
Date patient informed of diagnosis		19092022
Date of first multidisciplinary meeting (MDM)		
Date of decision-to-treat	M	20092022
Date of first treatment	M	20092022
Type of first treatment	M	10
Hospital of service for first treatment	M	011
Source of referral		
Clinician defined suspicion of cancer		
2-week flag		
Delay code 62		
Delay code 31		

Criteria	Result	Rationale	Reference in FCT data definitions document
Eligible for 62-day indicator	No	This patient was admitted acutely. The referral identified was internal and no triage of this referral was recorded in the system. The high suspicion of cancer and the need to be seen within two weeks were not determined / recorded so the 62-day indicator criteria are not met	Pages 12, 25 and 29
Eligible for 31-day indicator	Yes	Patient has not been treated for this cancer previously	Pages 13 and 25
Delay code 62	No	As the patient is not eligible for the 62-day indicator no delay code is reported	Pages 8 and 29
Delay code 31	No	The patient received treatment within the 31-day timeframe	Pages 9 and 30

Note: Clinical trials that are considered a first treatment are those trials that focus on trialling a type of treatment rather than focusing on other aspects of care.

A diagnosis that transforms into cancer use case (31-day indicator only)

Date	Day count 62	Day count 31	Activity
17/09/2021			A 53-year-old male patient is referred by a primary care general practitioner with chronic fatigue.
25/09/2021			Patient is triaged by general medicine and booked for a first specialist assessment (FSA). There is no high suspicion of cancer and no need to be seen within two weeks. Patient is contacted and tests are arranged.
02/10/2021			Patient test results indicate a myeloproliferative disorder (an ICD-10-AM 8th Edition D-code).
20/10/2021			General medicine FSA: patient informed of diagnosis, a management plan is discussed, and further tests ordered.
30/09/2021			Bone marrow biopsy performed.
20/02/2022			Monitoring blood screening is carried out.
18/08/2022			Monitoring blood screening is carried out.
20/02/2023			Monitoring blood screening is carried out.
20/03/2023			Monitoring blood screening is carried out.
22/04/2023			Monitoring blood screening is carried out.
05/05/2023			Bone marrow biopsy performed.
08/05/2023			Patient is diagnosed with acute myeloid leukaemia.

12/05/2023		The change in diagnosis is discussed and a treatment plan is agreed with patient.	
12/05/2023	0	Patient agrees to proceeding with chemotherapy treatment.	
14/05/2023	2	First chemotherapy treatment given.	FCT indicator pathway stops here

Reported data for a diagnosis that transforms into cancer (31-day indicator)

Record type	M	A
National Health Index (NHI) number	M	AAANNNN
First name		
Family name		
Date of birth	M	19061968
Sex	M	M
District of domicile	M	011
Date of diagnosis		08052023
Primary site ICD-10-AM 8th Edition	M	C92
Date of receipt of referral		
Hospital of receipt of referral		011
Date patient informed of diagnosis		12052023
Date of first multidisciplinary meeting (MDM)		
Date of decision-to-treat	M	12052023
Date of first treatment	M	14052023
Type of first treatment	M	03
Hospital of service for first treatment	M	011
Source of referral		
Clinician defined suspicion of cancer		
2-week flag		
Delay code 62		
Delay code 31		

Criteria	Result	Rationale	Reference in FCT data definitions document
Eligible for 62-day indicator	No	Patient was not referred (and not triaged) with a high suspicion of cancer and a need to be seen within 2 weeks	Pages 12, 25 and 29
Eligible for 31-day indicator	Yes	Patient has not been treated for this cancer previously	Pages 13 and 25
Delay code 62	No	As the patient is not eligible for the 62-day indicator no delay code is reported	Pages 8 and 29
Delay code 31	No	The patient received treatment within the 31-day timeframe	Pages 9 and 30

Note: Myeloproliferative disorders are ICD-10-AM 8th Edition D-codes, and these codes are not included in the FCT indicator reporting. However, when the disorder transforms into a different state and a new diagnosis is made (eg, acute myeloid leukaemia) the case is included in the FCT indicator reporting.

Cases That Are Not Reported

Patient receives a private treatment and public adjuvant[§] treatment use case (case not reported)

Date	Day count 62	Day count 31	Activity
26/09/2022			A referral is received from a primary care general practitioner for a patient who has a suspicious lump in her breast.
28/09/2022			Triaged by breast service as needing to be seen within two weeks and as having a high suspicion of cancer.
07/10/2022			Hospital breast clinic first specialist assessment (FSA). At the FSA the clinician arranged for the necessary investigations to be performed.
			[§] Adjuvant treatment is treatment that is given in addition to the primary, main or initial treatment
07/10/2022			A fine needle aspiration (FNA) was performed.
10/10/2022			FNA report confirms cancer.
23/10/2022			Attended at Hospital breast clinic. Diagnosis is discussed with patient and as well as possible options for treatment.
25/10 2022			Patient elects to see a breast surgeon privately.
30/10/2022			The patient's case was presented at the breast cancer multidisciplinary meeting (MDM). The MDM recommends surgery.
01/11/2022			**Patient has a partial mastectomy at the local private hospital.**
05/12/2022			Patient is referred to medical oncology for chemotherapy by the private breast surgeon.
06/12/2022			Triaged by medical oncology and accepted for chemotherapy.
10/12/2022			Medical oncology clinic visits and accepted for chemotherapy.
12/12/20222			Chemotherapy started.

Criteria	Result	Rationale	Reference in FCT data definitions document
Eligible for 62-day indicator	No	As this **patient had her first treatment for this cancer privately** this case is not eligible for inclusion in the reporting	Pages 12, 25 and 29
Eligible for 31-day indicator	No	The **patient had her first treatment for cancer privately**	Pages 13 and 25
Delay code 62	No	Patient is not eligible for the 62-day indicator	Pages 8 and 29
Delay code 31	No	Patient is not eligible for the 31-day indicator	Pages 9 and 30

Note: If the patient was referred for post-operative radiation therapy the results would be the same.

Reported data for case which receives a private treatment and public adjuvant treatment

This patient would not be reported as part of the faster cancer treatment indicator reporting.

Suspicion of cancer but no cancer is found use case (case not reported)

Date	Day count 62	Day count 31	Activity
26/09/2022			A referral is received from a primary care general practitioner (GP). Patient has a persistent cough with some haemoptysis. A chest X-ray has been ordered.
28/09/2022			Triaged by respiratory medicine service as needing to be seen within two weeks and with a high suspicion of cancer. X-ray report is suspicious of cancer.
07/10/2022			First specialist assessment (FSA). At the FSA the clinician arranged for the necessary investigations to be performed.
17/10/2022			**Results of investigations are consistent with pneumonia.**
04/11/2022			No other test results suggest cancer.
05/11/2022			Follow-up visits with respiratory medicine. Test results are discussed with patient who is discharged back to GP.
06/11/2022			A discharge letter is sent to patient's GP.

Criteria	Result	Rationale	Reference in FCT data definitions document
Eligible for 62-day indicator	No	The patient has a high suspicion of cancer and needs to be seen within 2-weeks, but **patient does not have a diagnosis of cancer and does not receive a treatment for cancer**	Pages 12, 25 and 29
Eligible for 31-day indicator	No	**Patient does not have a diagnosis of cancer and does not receive a treatment for cancer**	Pages 13 and 25
Delay code 62	No	Patient is not eligible for the 62-day indicator	Pages 8 and 29
Delay code 31	No	Patient is not eligible for the 31-day indicator	Pages 9 and 30

Reported data for case with suspected cancer

This patient would not be reported as part of the faster cancer treatment indicator reporting.

Non-malignant or low-grade tumours use case (case not reported)

Date	Day count 62	Day count 31	Activity
17/09/2022			**A referral is received from the screening unit for a patient with a suspicious lump in her breast.**
20/09/2022			Triaged by Hospital breast service as needing to be seen within two weeks and as having a high suspicion of cancer. The necessary investigations are ordered.
02/10/2022			**Tests confirm ductal carcinoma in situ (DCIS).**
09/10/2022			First specialist assessment (FSA). Diagnosis is discussed with patient as well as possible options for treatment. Patient needs an anaesthetic assessment before a decision on treatment can be made.
10/10/2022			The patient's case was presented at the breast cancer multidisciplinary meeting (MDM). At the MDM, surgery is the recommended treatment option.
23/10/2022			Patient attended Hospital breast clinic and agreed to surgery but wishes to be considered for immediate reconstruction.
01/11/2022			Referral sent requesting an assessment regarding patient suitability for immediate reconstruction.
19/12/2022			Patient has a mastectomy followed by reconstruction.

Criteria	Result	Rationale	Reference in FCT data definitions document
Eligible for 62-day indicator	No	Patient has been referred from a **screening unit. Patient has DCIS (D05) which is a primary diagnosis that is excluded from FCT reporting**	Pages 12, 25 and 29
Eligible for 31-day indicator	No	**Patient has DCIS (D05) which is a primary diagnosis that is excluded from FCT reporting**	Pages 13 and 25
Delay code 62	No	Patient is not eligible for the 62-day indicator	Pages 8 and 29
Delay code 31	No	Patient is not eligible for the 31-day indicator	Pages 9 and 30

Reported data for case with non-malignant or low-grade tumour

This patient would not be reported as part of the faster cancer treatment indicator reporting.

Aggressive malignant neoplasm of the skin use case (case not reported)

Date	Day count 62	Day count 31	Activity
16/01/2023	0		A referral is received from a primary care general practitioner (GP) for a patient with an unusual skin lesion that could be cancerous.
17/01/2023	1		Patient is triaged as needing to be seen within two weeks and as having a high suspicion of cancer.
30/01/2023	14	0	Surgical first specialist assessment (FSA): treatment options are discussed. Patient agrees to excision of the lesion.
31/01/2023	15	1	A theatre booking request is sent.
17/03/2023	**60**	**18**	**Patient receives a wide excision of the skin lesion.**
24/03/2023			**Lab reports a basal cell carcinoma (C44) and no residual lesion.**

Criteria	Result	Rationale	Reference in FCT data definitions document
Eligible for 62-day indicator	No	The patient has a high suspicion of cancer and needs to be seen within 2-weeks but this **patient has a primary diagnosis that is excluded from FCT reporting**	Pages 12, 25 and 29
Eligible for 31-day indicator	No	This **patient has a primary diagnosis that is excluded from FCT reporting**	Pages 13 and 25
Delay code 62	No	Patient is not eligible for the 62-day indicator	Pages 8 and 29
Delay code 31	No	Patient is not eligible for the 31-day indicator	Pages 9 and 30

Reported data for aggressive malignant neoplasm of the skin

This patient would not be reported as part of the faster cancer treatment indicator reporting.

Suspected prostate cancer use case (case not reported)

Date	Day count 62	Day count 31	Activity
19/12/2022			A primary care general practitioner (GP) refers a 70-year-old patient who presents with difficulty passing urine, an elevated PSA and inconclusive findings on examination, to the urology service.
20/12/2022			Patient triaged as having a high suspicion of cancer but there is no need to be seen within two weeks.
07/01/2023			Patient attends a first specialist assessment where an examination identifies a suspicious prostate. A TRUS biopsy for histology is planned.
10/01/2023			Patient phones the urology clinic and after discussion with a clinical nurse specialist declines the TRUS biopsy.
12/01/2023			Treatment plan changes to regular surveillance of PSA by GP with re-referral range identified by urologist. A letter outlining the plan is sent to the patient and the patient's GP.

Criteria	Result	Rationale	Reference in FCT data definitions document
Eligible for 62-day indicator	No	There was **no need for the patient to be seen within 2 weeks** even though there was a high suspicion of cancer. **The patient has not been treated for cancer**	Pages 12, 25 and 29
Eligible for 31-day indicator	No	No diagnosis of cancer has been made there remains a suspicion of cancer. **The patient has not been treated for cancer**	Pages 13 and 25
Delay code 62	No	Patient is not eligible for the 62-day indicator.	Pages 8 and 29
Delay code 31	No	Patient is not eligible for the 31-day indicator.	Pages 9 and 30

Reported data for case with suspected prostate cancer

This patient would not be reported as part of the faster cancer treatment indicator reporting.

Appendix A: Hospital Acronyms for File Naming

HOSPITAL 3 letter acronym	HOSPITAL_Description
NHL	Northland
YTM	Waitemata
AHC	Auckland
SAH	Counties Manukau
HYK	Waikato
LLH	Lakes
BOP	Bay of Plenty
TRW	Tairawhiti
HBH	Hawkes Bay
THL	Taranaki
PNH	MidCentral
GHW	Whanganui
CCH	Capital and Coast
HVH	Hutt Valley
YRR	Wairarapa
NMH	Nelson Marlborough
WCO	West Coast
CHC	Canterbury
HSC	South Canterbury
SRN	Southern

Appendix B: Primary Site ICD-10-AM 8th Edition Codes

The ICD-10-AM 8th Edition[†] codes should be recorded to the third digit for all cancers. The codes to be reported are provided in the following table. Note that D codes are excluded from the FCT indicators because they relate to cancers that are low-risk, or non-invasive, or non-malignant, or low-grade, asymptomatic or indolent.

ICD-10-AM 8th Edition Source: Independent Health and Aged Care Pricing Authority.

ICD-10-AM 8th Edition codes to third digit	Description	Cancer site group[ø]	Effective date
C00	Malignant neoplasm of lip	Head and neck	01/01/2012
C01	Malignant neoplasm of base of tongue	Head and neck	01/01/2012
C02	Malignant neoplasm of other and unspecified parts of tongue	Head and neck	01/01/2012
C03	Malignant neoplasm of gum	Head and neck	01/01/2012
C04	Malignant neoplasm floor of mouth	Head and neck	01/01/2012
C05	Malignant neoplasm of palate	Head and neck	01/01/2012
C06	Malignant neoplasm other and unspecified parts of the mouth	Head and neck	01/01/2012
C07	Malignant neoplasms of parotid gland	Head and neck	01/01/2012
C08	Malignant neoplasm other and unspecific part of salivary gland	Head and neck	01/01/2012
C09	Malignant neoplasm of tonsil	Head and neck	01/01/2012
C10	Malignant neoplasm of oropharynx	Head and neck	01/01/2012
C11	Malignant neoplasm of nasopharynx	Head and neck	01/01/2012
C12	Malignant neoplasm of pyriform sinus	Head and neck	01/01/2012
C13	Malignant neoplasm of hypopharynx	Head and neck	01/01/2012
C14	Malignant neoplasm of other and ill-defined sites in the lip, oral cavity and pharynx	Head and neck	01/01/2012
C15	Malignant neoplasm of oesophagus	Upper gastrointestinal	01/01/2012
C16	Malignant neoplasm of stomach	Upper gastrointestinal	01/01/2012
C17	Malignant neoplasm of small intestine	Upper gastrointestinal	01/01/2012
C18	Malignant neoplasm of colon	Lower gastrointestinal	01/01/2012
C19	Malignant neoplasm of rectosigmoid junction	Lower gastrointestinal	01/01/2012
C20	Malignant neoplasm of rectum	Lower gastrointestinal	01/01/2012
C21	Malignant neoplasm of anus and anal canal	Lower gastrointestinal	01/01/2012
C22	Malignant neoplasm of liver and intrahepatic bile ducts	Upper gastrointestinal	01/01/2012
C23	Malignant neoplasm of gallbladder	Upper gastrointestinal	01/01/2012
C24	Malignant neoplasm of other and unspecific parts of biliary tract	Upper gastrointestinal	01/01/2012
C25	Malignant neoplasm of pancreas	Upper gastrointestinal	01/01/2012
C26	Malignant neoplasm of other and ill-defined digestive organs	Lower gastrointestinal	01/01/2012
C30	Malignant neoplasm of nasal cavity and middle ear	Head and neck	01/01/2012
C31	Malignant neoplasm of accessory sinuses	Head and neck	01/01/2012
C32	Malignant neoplasm of larynx	Head and neck	01/01/2012
C33	Malignant neoplasm of trachea	Lung	01/01/2012
C34	Malignant neoplasm of bronchus and lung	Lung	01/01/2012
C37	Malignant neoplasm of thymus	Other	01/01/2012
C38	Malignant neoplasm of heart, mediastinum and pleura, heart	Lung	01/01/2012
C39	Malignant neoplasm of other and ill-defined sites in the respiratory system and intrathoracic organs	Lung	01/01/2012

ICD-10-AM 8th Edition codes to third digit	Description	Cancer site group[ø]	Effective date
C40	Malignant neoplasm of bone and articular cartilage of limbs	Sarcoma	01/01/2012
C41	Malignant neoplasm of bone and articular cartilage of other and unspecific sites	Sarcoma	01/01/2012
C43	Malignant melanoma of skin	Skin	01/01/2012
C45	Mesothelioma	Lung	01/01/2012
C46	Kaposi's sarcoma	Sarcoma	01/01/2012
C47	Malignant neoplasm of peripheral nervous and autonomic nervous system	Brain/CNS	01/01/2012
C48	Malignant neoplasm of retroperiotneum or peritoneum	Sarcoma	01/01/2012
C49	Malignant neoplasm of other connective or soft tissue	Sarcoma	01/01/2012
C50	Malignant neoplasm of breast	Breast	01/01/2012
C51	Malignant neoplasm of vulva	Gynaecological	01/01/2012
C52	Malignant neoplasm of vagina	Gynaecological	01/01/2012
C53	Malignant neoplasm of cervix uteri	Gynaecological	01/01/2012
C54	Malignant neoplasm of corpus uteri	Gynaecological	01/01/2012
C55	Malignant neoplasm of uterus, part unspecified	Gynaecological	01/01/2012
C56	Malignant neoplasm of ovary	Gynaecological	01/01/2012
C57	Malignant neoplasm of other and unspecified female genital organs	Gynaecological	01/01/2012
C58	Malignant neoplasm of placenta	Gynaecological	01/01/2012
C60	Malignant neoplasm of penis	Urological	01/01/2012
C61	Malignant neoplasm of prostate	Urological	01/01/2012
C62	Malignant neoplasm of testis	Urological	01/01/2012
C63	Malignant neoplasm of other and unspecified male genital organs	Urological	01/01/2012
C64	Malignant neoplasm of kidney, except renal pelvis	Urological	01/01/2012
C65	Malignant neoplasm of renal pelvis	Urological	01/01/2012
C66	Malignant neoplasm of ureter	Urological	01/01/2012
C67	Malignant neoplasm of bladder	Urological	01/01/2012
C68	Malignant neoplasm of other and unspecified urinary organs	Urological	01/01/2012
C69	Malignant neoplasm of eye and adnexa	Brain/CNS	01/01/2012
C70	Malignant neoplasm of meninges	Brain/CNS	01/01/2012
C71	Malignant neoplasm of brain	Brain/CNS	01/01/2012
C72	Malignant neoplasm of spinal cord, cranial nerves and other parts of central nervous system	Brain/CNS	01/01/2012
C73	Malignant neoplasm of thyroid gland	Head and neck	01/01/2012
C74	Malignant neoplasm of adrenal gland	Other	01/01/2012
C75	Malignant neoplasm of other endocrine glands and related structures	Other	01/01/2012
C76	Malignant neoplasm of other and ill-defined sites	Other	01/01/2012
C80	Malignant neoplasm without specification of site	Other	01/01/2012
C81	Hodgkin's disease	Haematological	01/01/2012
C82	Follicular lymphoma	Haematological	01/04/2014
C83	Diffuse non-Hodgkin's lymphoma	Haematological	01/01/2012
C84	Peripheral and cutaneous T-cell lymphomas	Haematological	01/01/2012
C85	Other and unspecified types of non-Hodgkin's lymphoma	Haematological	01/01/2012
C86	Other specified types of T/NK-cell lymphoma	Haematological	01/04/2014
C88	Malignant immunoproliferative diseases	Haematological	01/01/2012
C90	Multiple myeloma and malignant plasma cell neoplasms	Haematological	01/01/2012

ICD-10-AM 8th Edition codes to third digit	Description	Cancer site group[ø]	Effective date
C91	Lymphoid leukaemia	Haematological	01/01/2012
C92	Myeloid leukaemia	Haematological	01/01/2012
C93	Monocytic leukaemia	Haematological	01/01/2012
C94	Other leukaemia of specified cell type	Haematological	01/01/2012
C95	Leukaemia of unspecified cell type	Haematological	01/01/2012
C96	Other and unspecified malignant neoplasms of lymphoid, haematopoietic and related tissue	Haematological	01/01/2012

[†] ICD-10-AM 8th Edition and subsequent Editions.
[ø] The cancer site group is used to group data for reporting purposes

Appendix C: Example of Escalation Procedure

Escalation Procedure

Faster cancer treatment (FCT) high suspicion of cancer (HSCAN) patients

Background

The FCT health target is:

90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks.

Purpose

Provides guidance to staff responsible for providing services to HSCAN patients so an escalation process can be triggered when delays in the timelines/pathway are identified and outside the control of the person.

Important timelines

The following are the timelines that need to be met. An escalation procedure should be triggered prior to the timelines being breached.

- All HSCAN patients should have their FSA[13] appointment within **14** days of receipt of referral. ***Escalate day 10 if FSA appointment has not been made*.**
- All HSCAN patients should be discussed at a multidisciplinary meeting (MDM) within **31** days of receipt of referral. Note: patients who are referred directly to palliative care service or refuse treatment may not be discussed at an MDM. ***Escalate day 20 if MDM referral has not been made*.**
- All HSCAN patients receive first treatment within **62** days. ***Escalate day 40 if no treatment date confirmed.*** Note: Treatment plan usually decided at MDM at 31 days.
- All cancer patients including HSCAN patients receive their first treatment within **31** days of decision to treat. ***Escalate day 25 if no treatment date confirmed.***
- If a patient has not received planned treatment within 90 days of initial referral, then refer back to MDM to determine if treatment is still applicable.

Strategies to reduce HSCAN delays

1. All HSCAN referrals should be triaged daily (if possible). Note: If a referral has not been triaged within 72 hours, the referral should be processed as HSCAN.
2. All HSCAN patients should be prioritised as urgent for all appointments.
3. The words HSCAN should be added to all urgent referrals and MDM proformas.
4. All services who receive an HSCAN patient referral should send an acknowledgment of receipt of referral to the referrer and/or referring service and a proposed date and/or timeframe for intervention.

[13] FSA can be direct access to endoscopy, bronchoscopy

5. An FCT reporting system should be established in *[location in system]* to track patients on the 62- and 31-day pathway until they receive their first treatment. This should include a tracking system for HSCAN patients from referral date to first treatment.
6. Each service has a designated person who will be responsible for ensuring HSCAN patients are moving through the hospital system within the above timeframes. The *[Service Manager, Cancer]* will allocate the responsibility to a *[Nominated staff member]* eg, FCT Tracker or Administrator, Clinical Nurse Specialist (CNS), cancer nurse coordinator (CNC).
7. *[Nominated staff member]*, will check *[patient information system]* to see when appointments are for the HSCAN patient. If patient is on target to meet timeline, no need to escalate case.
8. *[Nominated staff member]* reviews progress of FCT patients at least twice a week and provides oversight on the progress of all HSCAN patients and concerns regarding potential breaches to timelines to CNS or CNC.
9. CNS /CNC determines whether to escalate potential breaches to *[Clinical Nurse Manager (Cancer)]* and discusses an action plan to mitigate the potential timeline breach.
10. The patient's Lead Clinician should also be informed when patients are at risk of breaching the timelines.
11. If no progress is made with fast tracking *[(Service Manager (Cancer)]* weekly, to highlight patients close to breaching the escalation timeline with an action plan outlining steps to be taken for the patient to meet the timeline.
12. The *[Service Manager (Cancer)]* may need to liaise with other Managers eg, Surgical, Endoscopy, Gynaecology, Urology, Clinics to fast track a patient.
13. If agreed actions are not implemented due to for example resource constraints in service areas eg, theatre, the *[Service Manager (Cancer)]*, will escalate to the *[Lead Hospital and Specialist Services]*.
14. If the patient pathway cannot be expedited, the *[Service Manager (Cancer)]* will complete an incident form. Note: For some patients, clinical reasons, or patient choice, may contribute to the breach in the timeline. If this is evident, an incident form is not required.
15. FCT delays will be monitored and discussed at the monthly CSI/ FCT meetings to identify areas for service improvement.
16. FCT Key Performance Indicators (KPIs) reports should be developed to provide ongoing data for service improvement.

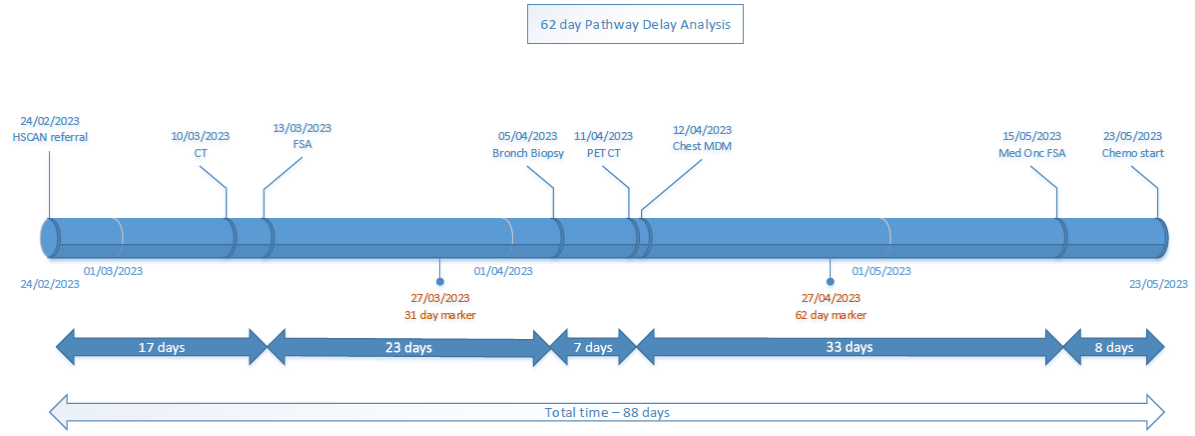
What is an action plan?

The action plan is an agreed set of steps that are immediately initiated to progress the HSCAN patient along the FCT pathway.

The following could be considered:

- Establish a definitive date for each intervention(s) ahead of time eg, at FSA, book for pre-admission and add to surgical waitlist. This can be cancelled if not required.
- Refer patient to another specialist within the specialty area if there is a capacity issue for a particular specialist.
- Negotiate with other services to prioritise the patient for an appointment.
- If internal service is unable to provide service, seek alternative service provider ie, outsource.
- Enlist the assistance of community support providers, if necessary, to provide transport or advocacy so the patient can attend the appointment.

Appendix D: Examples of Breach Analysis



Analysis of breach reasons:

Breach summary

NHI: [redacted]

Tumour stream: Lung

Number of days: 88 days

Ethnicity: Nz European

FSA within 14 days: No

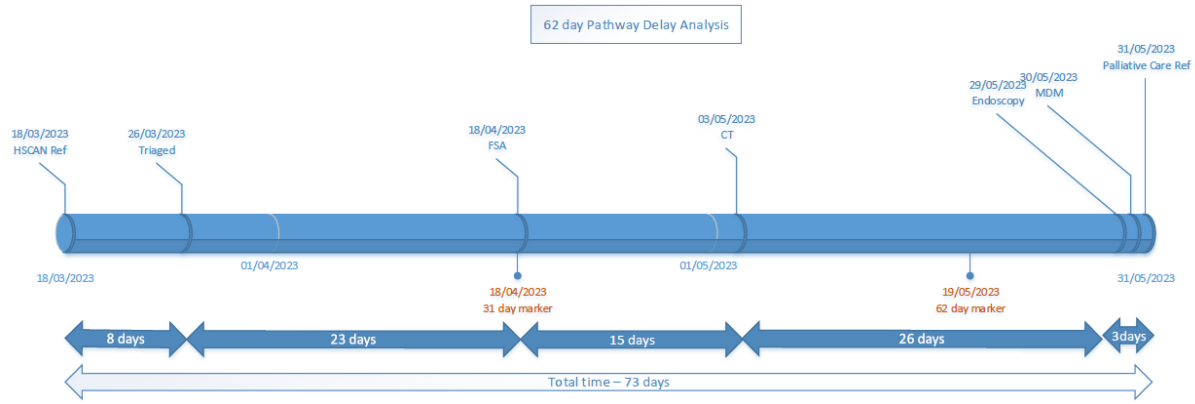
MDM within 31 days: No

Reported breach reason: Capacity Oncology

Specific delays occurred:

- ☐ Patient choice to delay
- ☐ DNA
- ☐ Non-routine staging or further investigation
- ☐ Clinical consideration (co-morbidities) or patient sickness
- ☐ Capacity constraint: administrative process
- ☐ Capacity constraint: FSA
- ☐ Capacity constraint: diagnostics
- ☐ Capacity constraint: staffing – unplanned, annual, sick leave
- ☐ Capacity constraint: preadmission and anaesthetic assessment
- ■ Capacity constraint: oncology
- ☐ Capacity constraint: theatre management
- ☐ Capacity constraint: clinic cancellation
- ☐ Capacity constraint: cyber-attack

Detail of Patient choice or Clinical consideration delay:



Analysis of breach reasons:

Breach summary

NHI: [redacted]

Tumour stream: Upper GI

Number of days: 73 days

Ethnicity: Pasifika

FSA within 14 days: No

MDM within 31 days: No

Reported breach reason: Capacity FSA

Specific delays occurred:

- ☐ Patient choice to delay
- ☐ DNA
- ☐ Non-routine staging or further investigation
- ☐ Clinical consideration (co-morbidities) or patient sickness
- ☐ Capacity constraint: administrative process
- ■ Capacity constraint: FSA
- ☐ Capacity constraint: diagnostics
- ☐ Capacity constraint: staffing – unplanned, annual, sick leave
- ☐ Capacity constraint: preadmission and anaesthetic assessment
- ☐ Capacity constraint: oncology
- ☐ Capacity constraint: theatre management
- ☐ Capacity constraint: clinic cancellation
- ☐ Capacity constraint: cyber-attack

Detail of Patient choice or Clinical consideration delay: