# FCT indicators data definitions and business rules – what's changed?

**FINAL - March 2014**

## Contents

## The two previous FCT documents have been merged

The following two documents (last versions of both were released in October 2012) have been merged into one document called *Faster cancer treatment indicators: Business rules and data definitions*:

- data definitions for the faster cancer treatment indicators
- business rules for the faster cancer treatment indicators.

This decision was made to:

- prevent duplication of information
- make it easier for users to easily find information by having the material in one place.

## Collection and reporting of data to calculate the 14 day indicator is no longer required

The collection of data to calculate the 14 day indicator (previously known as Indicator 2 -tracking the patient from urgent referral with a high suspicion of cancer flag to first specialist assessment (FSA)) is no longer required.

Fields relating to this indicator:

- date of FSA
- delay code for the 14 day indicator

should no longer be included in the data file.

Many DHBs already have systems in place to collect FSA information, and may well continue to collect it for service monitoring purposes – however, the Ministry no longer requires it to be reported.

This decision was made because:

- there were inconsistencies around the *type* of service that should be collected for this data-point with different DHBs having different service models and data collection systems and the ability of comparing like-with-like across DHBs seemed unlikely
- it was often difficult to collect 14 day indicator data for patients who were fast-tracked or received direct access to diagnostic tests
- phase 1 of the National Patient Flow (NPF) project is commencing in July 2014. Phase 1 is concentrating on collecting data from referral to FSA, and the Cancer Services team has been working alongside their NPF colleagues to ensure that data to inform this timeline will be available once Phase 1 is implemented

- in future, the definition of 'FSA'[1] will be aligned with the NPF project, which will promote consistency across the country.

## We're no longer referring to the indicators as '1' and '3'

The two remaining FCT indicators have been renamed. Indicator 1 is now referred to as the 62 day indicator. Indicator 3 is now known as the 31 day indicator.

This decision was made because:

- the new names make it more obvious as to the part of the pathway the indicator relates to
- removal of the requirement to report data to the Ministry on the 14 day faster cancer treatment indicator (Indicator 2) resulted in the numbering of the other two indicators being inconsistent.

## The 62 day indicator will become the new cancer services health target

The 62 day faster cancer treatment indicator will be introduced as the new cancer services health target in the 2014/15 financial year. The 62 day faster cancer treatment indicator health target will replace the current Shorter waits for cancer treatment – radiotherapy and chemotherapy health target. The current target will move to a Policy Priority measure and will continue to be monitored by the Ministry.

While DHBs are required to report data for calculation of the 31 day indicator, the Ministry suggests that DHBs focus on improving the quality and completeness of the 62 day indicator data as a priority.

## There is no longer a requirement for a confirmed diagnosis of cancer at decision-to-treat

It is no longer essential for a patient to have a confirmed diagnosis of cancer at decision-to-treat. Previously a patient was excluded from the FCT data reporting if the patient didn't have a confirmed diagnosis at decision-to-treat. However, the new indicator definitions no longer make reference to this. The requirement now focuses on a patient having received a cancer treatment. If a patient receives a first treatment for cancer, this implies that there was an 'intent to treat as cancer' or a 'working diagnosis of cancer' at the time of decision-to-treat.

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[1] The first assessment by a registered medical practitioner or nurse practitioner for a particular referral (or, with a self-referral, for a discrete episode). The healthcare user receives treatment, therapy, advice, diagnostic or investigatory procedures at a health care facility and leaves within three hours of the start of the consultation. Service is provided in a ward and/or at designated outpatient clinic. Excludes emergency department attendances and outpatient attendance for preadmission assessment/screening.

This decision was made because:

- feedback from DHBs and members of the FCT Expert Advisory Group[2] (EAG) highlighted the difficulties of identifying whether a confirmed diagnosis had been present at decision-to-treat
- removal of the need to have a confirmed diagnosis of cancer at decision-to-treat simplifies the data collection process (in most cases)
- Some patients are treated for cancer and following their treatment do not then go on to receive a cancer diagnosis. These patients should be manually removed from the FCT data at the time of reporting to the Ministry as they will not have a valid primary diagnosis code.

## The term 'urgent referral' is no longer being used

Previously, to be included in the 62 day indicator, a patient would have been referred *urgently* with a high suspicion of cancer. The new data definitions and business rules no longer refer to the 'urgency' of a referral.

The new data definitions and business rules document states that to be considered as being eligible for inclusion in the 62 day indicator, a patient must have a need to be seen within two weeks. A new 2 week flag field is being used to record this, and is further explained on the following page.

This decision was made because:

- feedback from DHBs highlighted that the term 'urgent' is defined differently between DHBs and is also variable amongst different tumour types
- the concept of a patient needing to be seen within two weeks (at the discretion of the triaging clinician) will help encourage a more consistent approach to patients being included in the 62 day indicator.

## The SCAN field

An additional field has been included to the data requirements for reporting the 62 day indicator; this is known as the SCAN field (the clinician defined **S**uspicion of **CAN**cer field):

- this field should be set to '30' for all those records where the triaging clinician decides that the patient has a high suspicion of cancer.
- if there is no such suspicion, the field is set to '20' and this patient's record will not be included in calculations for the 62 day indicator. However, if appropriate fields are available this patient may be included in calculations for the 31 day indicator
- if the patient already has a confirmed pathological diagnosis of cancer at the point of triage then this field should be set to '10'.

[2] The purpose of the FCT EAG is to provide technical advice to the Ministry of Health, on the issues arising from the faster cancer treatment indicator reporting, data definitions and business rules and to assist with improving these.

This decision was made because:

- Ministry analysts were assuming that all records with a referral date should be included in the 62 day indicator. This may not be appropriate as the referral may not have had a high suspicion of cancer. The addition of the SCAN field should make it easy to include only valid records in the 62 day analyses
- the ability to identify patients who have a confirmed diagnosis of cancer at triage enables these records to be removed from the 62 day indicator analyses. Tracking patients with a known cancer at referral is not currently required however analysing the flow of such patients will be useful in future.

If a record has been set to either '10' or '20' it will not be included in the calculation for the 62 day indicator, and there is no mandated need to report the referral date for that patient in the FCT indicators data.

However, all patients who have a '10' reported (ie, have a confirmed cancer at triage) should be captured in the 31 day indicator data.

Some patients who are reported as '20' (ie, triaged as not having a high suspicion of cancer) may go on to be diagnosed with cancer and require treatment, and such patients should be reported in the 31 day indicator data.

This field aligns with the requirements drafted in the National Patient Flow documentation as at 28 February 2014.

## The 2 Week flag

The 2 Week flag field (2W) will replace the previous 'urgency of referral' field.

This decision was made because:

- Ministry analysts were assuming that all records with a referral date should be included in the 62 day indicator. This may not be appropriate as the referral may not have been urgent. The addition of the 2W flag should make it easy to include only valid records in the 62 day indicator analyses.

This field should be set to '1' (ie, yes) for all records where the triaging clinician decides that the patient needs to be seen within two weeks.

If the patient does not need to be seen within two weeks, the field should be set to '0' (ie, no) and the patient's record will not be included in the calculations for the 62 day indicator.

If a record has been set to '0' it will not be included in the calculation for the 62 day indicator, and there is no mandated need to report the referral date for that patient in the FCT indicators data.

Some patients who are reported as ‘0’ (ie, triaged as not needing to be seen within two weeks) will go on to require treatment, and such patients should be reported in the 31 day indicator data.

## The number of fields in the text file and the structure of the text file has changed

The new file structure has the name V02.0. There will be 22 fields in the text file (compared to 23 previously).

The following fields have been permanently removed:

- Date of FSA
- Delay code 2.

The following field has been added:

- Clinician defined suspicion of cancer (SCAN).

The following fields have been replaced:

- Urgency of referral has been replaced with 2W flag
- Delay code 1 has been replaced with Delay code 62
- Delay code 3 has been replaced with Delay code 31.

The text file should now contain the following fields in the following order.

| |
|---|
| Record type |
| National Health Index (NHI) number |
| First name |
| Family name |
| Date of birth |
| Sex |
| DHB of domicile |
| Date of diagnosis |
| Primary site ICD10 |
| Date of receipt of referral |
| DHB of receipt of referral |
| Date patient informed of diagnosis |
| Date of first multidisciplinary meeting (MDM) |
| Date of decision-to-treat |
| Date of first treatment |
| Type of first treatment |
| DHB of service for first treatment |
| Source of referral |
| SCAN |
| 2 Week flag |
| Delay code 62 |
| Delay code 31 |

An explanation of the structural requirements of the text file and the precise field names required can be found in the new data definitions and business rules document.

The new text file structure will be labelled V02.0, and will need to be tested to ensure processes (at both the DHB and Ministry ends) work adequately. Each DHB will be required to submit a test file (containing a few rows of dummy data) by 30 May 2014.

## Data must be submitted monthly

As of 1 July 2014 all FCT data must be reported monthly. The previous requirement allowed DHBs to report quarterly *or* monthly.

Data must therefore be submitted on the 20th of each month, following the reporting month.

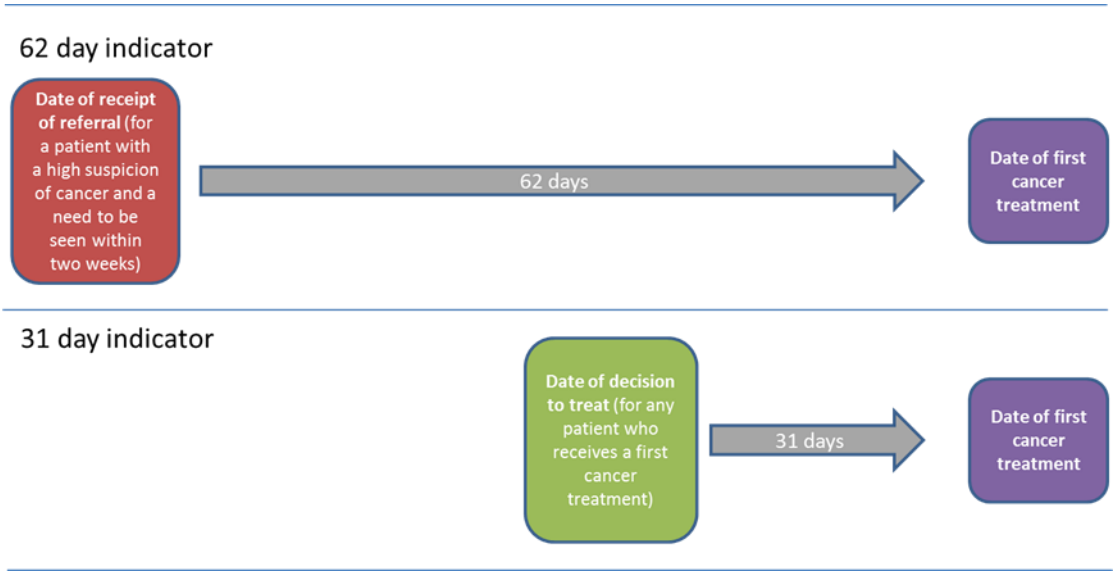
This decision was made because:

- Ministry staff will require additional time to load and check the quality of data in the submissions (and report back to DHBs with any issues) prior to reporting data for the new quarterly health target.

DHBs can continue to report data on a monthly or quarterly basis up to July 2014.

## The indicator diagram has been redesigned

The 14 day indicator (Indicator 2) has been removed. The diagram also makes it more obvious that the 31 day indicator relates to all patients being treated with cancer (irrespective of whether they were referred with a high suspicion of cancer and had a requirement to be seen within two weeks).



## Continued exclusion of patients with a primary diagnosis of DCIS

ICD10 code D05 – *intraductal carcinoma in situ of breast* (also known as DCIS) continues to be excluded from the list of primary diagnoses that are valid for inclusion in the FCT reporting.

This is in alignment with:

- BreastScreen Aotearoa
- Cancer registration guidelines

## Continued exclusion of patients with a primary diagnosis of non-melanoma skin cancer

After discussion, ICD10 code C44 – *other and unspecified malignant neoplasms of skin* continues to be excluded from the FCT reporting for both the 62 day and 31 day indicators.

This decision was made because:

- the current NZ Cancer Registry and international protocol is to not register tumours coded to C44, regardless of their morphology. The choice not to include C44-coded tumours in the FCT indicator reporting aligns with this.

## Clarification around indolent or asymptomatic haematological malignancies

There has been confusion on which of the haematological malignancies should be included in the FCT indicator reporting. The Ministry is clarifying that all haematological cancers can (potentially) be recorded as part of the FCT indicators, irrespective of their morphology.

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 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 possibly be 'non-intervention management', but that record is still valid for inclusion in the 31 day indicator data.

This decision was made to:

- ensure consistency of data capture across the country

- align with the Minstry's Haematology Working Group's prioritisation criteria, which recommend that once a patient has been identified as needing treatment, that treatment should occur within one month.

## 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. This code has now been included in the list of ICD10 codes in Appendix B.

This decision was made because:

- all haematological cancers can now potentially be reported for FCT. This code had previously been excluded for being an indolent or asymptomatic cancer.

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.

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

A new ICD10 code has come online, and is now being registered in the New Zealand Cancer Registry. ICD10 (AM) version 8 now 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

To simplify the collection of data, 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.

However, if a patient is discharged from ED and referred to an outpatient clinic, that referral may then be valid for inclusion in the 62 day indicator (as long as the referral fits the criteria for inclusion).

In addition, if a patient is admitted following an ED attendance for a reason other than cancer, and are subsequently referred to an outpatient clinic with a high suspicion of cancer, that referral may then be valid for inclusion in the 62 day indicator (as long as the referral fits the criteria for inclusion).

All patients (including those entering the pathway through ED) who receive a first treatment for cancer, should be recorded in the 31 day indicator.

This decision was made:

- to ensure consistency in data capture across the country
- to continue focusing on the outpatient diagnostic pathway.

## Patients entering the treatment pathway through screening

Any patient whose primary tumour is identified through the breast or cervical screening programme is eligible for inclusion in the 31 day indicator only. This is also true for any cancer patient identified through the Bowel Screening Pilot in Waitemata DHB region. These patients should not be reported against the 62 day indicator. This remains unchanged from the previous business rules.

Some DHBs had previously been submitting records relating to screening patients for inclusion in the 62 day indicator.

This decision was made because:

- patients identified through a screening programme are asymptomatic. The patient will therefore have neither a high suspicion of cancer nor a need to be seen within two weeks when they enter the programme.
- The breast and cervical screening programmes both have formalised timeframes and monitoring mechanisms.

## Delay codes have been simplified

There are now only three options for delay codes (compared to the previous twelve options), they are:

- patient reason
- clinical consideration
- capacity constraint.

This decision was made because:

- feedback from DHBs and the EAG highlighted the difficulties in assigning delay codes, which is often a manual process that could be streamlined by having simpler codes to assign
- delay codes are now more in-line with the current Shorter waits for cancer treatment – radiotherapy and chemotherapy health target reporting and with NPF.

Although this field is currently non-mandatory, DHBs are strongly encouraged to report this information for all records that exceed the indicator timeframes. Collection of this data will aid future service provision for DHBs, by highlighting services that commonly experience delays.

It is intended that reporting of this field becomes mandatory in future. The timeframe for making this field mandatory will be reviewed in early 2015.

## Clarification around reporting first treatment when chemotherapy and radiotherapy occur concurrently

Chemotherapy and radiotherapy often occur on the same day. The new FCT data definitions and business rules now provides a *type of first treatment* option of 'concurrent radiation therapy and chemotherapy'.

This decision was made because:

- feedback from DHBs highlighted confusion with the treatment type to report when two types of treatment occur on the same day.

NB. 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 radiotherapy (or vice versa).

For concurrent treatment, the date of first treatment is the date on which either chemotherapy or radiotherapy 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

There has been confusion around the data point to capture for patients who are enrolled in an ethically approved clinical trial. The new data definitions and business rules document now allows a *type of 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 considered to be the date the patient consents to be put forward for the clinical trial.

These decisions were made because:

- a clinical trial may involve multi-modality treatment
- the clinical trial may have pre-determined treatment timelines which may not fit with the FCT indicator timeframe, but once a patient enrols on a clinical trial that date is considered their treatment date. If (at a later stage) the patient is removed from the clinical trial, the date of enrolment is still considered the 'treatment date' for that patient, irrespective of whether the patient receives treatment outside of the trial.

## Children are now being excluded by age and also by service type

Previously, only patients under the care of adult services were included in the data reported for the FCT indicators.

Now, patients must be:

- 16 years or older on the day of first treatment **and**
- under the care of adult services

to be valid for inclusion in FCT reporting.

This decision was made:

- after discussion with DHBs and paediatric oncology services to ensure consistent reporting across the country.

## Automated return files will be provided

Currently, DHBs receive an email informing them that their file has been loaded into the FCT database. In future, automated return files that show the status of each record (whether it was loaded into the database, and reasons if not) will be returned to each DHB.

More details to follow.

## Records will be rejected if they contain errors

Up until now, all records have been loaded into the FCT database irrespective of data quality. All files submitted under version V02.0 will need to pass some data quality checks before each record is 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
- if the record is deemed to be a duplicate (based on the primary key of NHI and primary site)
- 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
- if there is a missing primary site, or the primary site is out of range.

## The date of decision-to-treat is no longer used to create the primary key

The previous version of the business rules stated that each FCT record was given its own unique identifier (a primary key) in the FCT database by combining the NHI, primary site of the cancer, and the date of decision-to-treat for that patient record.

The primary key no longer uses the date of decision-to-treat and is created from the NHI and primary cancer site only.

This decision was made because:

- The date of decision-to-treat changed for some records in subsequent data submissions, and duplicate records were being created in the database.

Now that the primary key is created from just two fields (NHI and primary site) it should result in less duplicate records being entered into the database.

However, it is now possible that a legitimate record - for a patient who has previously been registered in the FCT database with a particular cancer - could be unfairly rejected from the FCT database (if that patient was being registered with a second primary tumour of the same site code). This is a rare occurrence, however if it occurs please speak to your Ministry FCT contact who can ensure the legitimate duplicate record is not rejected from the FCT database.

## 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 in FCT indicator data. However, if a cancer has metastasised, but the primary site is unknown, this cancer should be reported under the IDC10 code for *malignant neoplasm without specification of site* (C80).

## IDC10 codes C77, C78 and C79 have been removed from the ICD10 code list

As no secondary cancer site code should be recorded for any FCT record, three site codes have been removed from the ICD10 code list in appendix D. These site codes are:

- C77 – Secondary and unspecified malignant neoplasms of lymph nodes of head, face and neck
- C78 – Secondary malignant neoplasm of respiratory and digestive organs
- C79 – Secondary malignant neoplasm of other sites.

If a patient has an unknown primary cancer site (with or without metastases) the patient's record should include a primary site code of C80 (malignant neoplasm without specification of site).

## Primary site codes now have an effective date

Appendix B of the FCT data definitions and business rules document shows the list of ICD10 codes that are valid for inclusion in FCT reporting. Each individual ICD10 code now has an effective date. Currently most of these effective dates are from 01/01/2012, meaning that these primary sites are valid for inclusion in FCT reporting from that date. The two exceptions are C82 and C86 which will be valid for inclusion from 01/04/2014.

It will therefore be simpler if there is a need to include additional site codes within the FCT reporting in future.

## Use cases

A selection of use cases, showing a variety of cancer pathway scenarios and how the FCT indicator data should be reported for each, will follow.

## When do these changes come online?

We appreciate that not all DHBs will have the ability to implement these changes immediately. However, DHBs are urged to implement these changes and transition to the new file structure as soon as possible.

Data must be collected using the new data definitions and business rules by 1 July 2014 at the latest.

In addition the new file structure must be in use by 1 July 2014 and should be labelled V02.0.

The Ministry should receive data for patients treated in July 2014 no later than 20 August 2014.

## All DHBs must submit test files by 30 May 2014

Test files (of dummy data) should be sent to the Ministry no later than 30 May 2014 to ensure that systems are working prior to the first submission of new data in the new format (V02.0) in August 2014.