NCIN Head & Neck TSSG
Clinical Chairs workshop

Going Further On Cancer Waits
&
MDT Effectiveness

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Cheryl Cavanagh National Cancer Action Team

WHAT WILL BE COVERED

GFOCW

- Quick recap of standards & 'counting'
- Issues to consider - views from a Head & Neck cancer perspective would be welcome

MDT Development Programme

- Key issues from questionnaire
- Next steps

Going Further On Cancer Waits (GFOCW)

CANCER WAITS STANDARDS

3 Original CWT standards

- 2ww – urgent GP referral for suspected cancer
- 31d – first treatment
- 62d – urgent GP referral to treatment (31d for some groups)

4 GFOCW standards now in operation (from 1 Jan 09):

- 62 day – NHS cancer screening programmes
- 62 day – consultant upgrades
- 31 day – subsequent treatment (surgery)
- 31 day – subsequent treatment (drug treatment)

3 GFOCW standards to follow:

- 2ww – all pts with breast symptoms (1 Jan 2010)
- 31 day – radiotherapy (1 Jan 2011)
- 31 day – other treatments (1 Jan 2011)

Note: 2ww/62d start date has changed from GP decision to refer

NEW PAUSE MODEL

- From 1 January 2009, only two types of pause allowed:
  - DNA initial outpatient appointment
  - decline 'reasonable' offer of admitted treatment
- Pauses are no longer allowed:
  - when a patient defers a 2ww appointment;
  - during the diagnostic phase of the 62-day period;
  - for waits for non-admitted treatment;
  - for any medical suspensions.
- Areas where pauses would previously have been allowed have been taken into account in revised operational tolerances/standards

Q1 PERFORMANCE & OPERATIONAL THRESHOLDS

Vital Signs Reference	Standard	Performance	Operational Tolerance
EXC05	All Cancer Two Week Wait	94.1%	93%
EXC06	All Cancer 31-Day First Treatment	98.1%	96%
EXC07	All Cancer 62-Day (Urgent Referral to Treatment)	86.0%	85%
VSA11-B	31-Day Subsequent Treatment (Surgery)	95.1%	94%
VSA11-A	31-Day Subsequent Treatment (Anti-Cancer Drug Regimen)	99.2%	98%
VSA13-A	62-Day Wait (Screening Service Referral to Treatment)	94.5%	90%
VSA13-B	62-Day Wait (Consultant Upgrade to Treatment)	94.7%	-

PERFORMANCE ON LIVE STANDARDS

- Above tolerance at a national level BUT there will be some individual Trusts that are struggling – do we know why?

- Using 62d standard as an example:
  - are inter provider transfers an issue?
  - are specific tumour pathways an issue?
  - are patient pathways proactively managed?
  - how were adjustments previously used?

62d CLASSIC – POSITION FOR HEAD & NECK IN Q1

- Trust Performance is not assessed nationally at tumour level.
- Threshold is for all tumours taken together – some tumour types should exceed it others unlikely to achieve it.
- National Head & Neck performance was 84.5% against national tolerance of 85%.

62D CLASSIC – POSITION FOR HEAD & NECK IN Q1

- **714 patients had FDT ending a 62d Head & Neck cancer pathway in Q1.**

- **140 Trusts reported treating these 62d H&N cancer patients in Q1 and of these:**
  - **98 Trusts were above 85% tolerance**
  - **42 Trusts were below 85% tolerance**

- **Of the 140 Trusts:**
  - **117 reported on less than 10 patients**
  - **22 reported on 10-19 patients**
  - **only 1 reported seeing 20+ patients**

- **Of 23 trusts reporting on > 10 pts 13 were below tolerance (range 50.0-84.0%):**

GENERAL ISSUES TO CONSIDER

- **2ww:**
  - Local access policies need to be in line with CWT rules and 'the spirit of the rules'
  - Communication between GPs & patients and between primary & secondary care

- **31d FDT**
  - Active monitoring is not a substitute for 'thinking time'

- **62d upgrade:**
  - Are consultants aware they can do this?
  - Are their local processes in place to support this when needed?

- **31d Subsequent radiotherapy (non-live standard):**
  - Data completeness is a concern so performance data cannot be relied on (yet)

How can NCIN H&N SSCRG help with GFOCW?

- Sense check ie. is national & local H&N performance for CWT standards what you would expect?
- Advice on issues that may impact on H&N performance at national level on any or all of the standards?
- Source of support/advice for Trusts/networks struggling with standard(s) for H&N
- Sounding board for H&N-specific CWT queries and/or NCAT H&N-specific waits guidance

MDT Development Work Programme

Survey - Background

- Survey ran for ~6wks (30 Jan – 16 Mar 09)
- Sent to MDT members via Cancer Networks and Cancer Service Managers.
- 52 ?s covering perceptions and facts (22 multiple choice, 9 fact based & 21 free text).
- Presenting responses from MDT core & extended members (2054)

Survey Participants: By Professional Group

- 53% Doctors of which:
  - 16% Surgeons
  - 8% Oncologists
  - 6% Radiologists
  - 6% Histo/cyto pathologists
- 26% Nurses
- 15% MDT Co-ordinators
- 4% AHPs
- 2% Other (e.g. admin / managerial)

- Just under half were members of multiple MDTs:
  - 51% were members of only 1 MDT
  - 27% were members of 2 MDTs
  - 12% were members of 3 MDTs
  - 6% were members of 4 MDTs
  - 5% were members of more than 5 MDTs!

Survey: Overall Finding

- Very high consensus on what is important for effective MDT functioning.
- Very little difference between views of different professional groups or members of different tumour MDTs.
- General agreement that:
  - a means of self assessment is needed for MDTs
  - a variety of support tools/mechanisms need to be available.

CHARACTERISTICS OF AN EFFECTIVE MDT: THEMES

- **The Team:**
  - Membership & attendance (99%)
  - Team working (99%)
  - Leadership (95%)
  - Development & training (78%)

- **Meeting Organisation & Logistics:**
  - Organisation / admin during meeting (98%)
  - Preparation for MDT meetings (96%)

- **Infrastructure:**
  - Technology (availability & use) (93%)
  - Physical environment of venue (78%)

- **Clinical decision making:**
  - Case management & process (99%)
  - Patient centre care / co-ordination of services (93%)

- **Team governance:**
  - Data collection, analysis & audit (90%)
  - Clinical Governance (84%)

SOME KEY FINDINGS

- MDTs need support from their Trusts
- MDT members need protected time for preparation, travel & attendance at meetings
- Leadership is key to effective team working
- Dedicated MDT meeting rooms should be the gold standard with robust and reliable technology
- MDTs have a role in data collection
- All clinically appropriate options (incl trials) should be considered even if not offered locally
- Patient views should be presented by someone who has met the patient

Survey: H&N Tumour Specific Issues

- Of the 51% (1339) of professionals covering 1 tumour type 8% (109) were just members of Head & Neck MDTs. Of these:
  - 44.4% reported spending < 30 mins on prep for meeting, 25.6% btw 30-60mins and 15.9% >90 mins;
  - 43.8% thought 60-90 mins was max time a meeting should last with 28.1% wanting 'as long as required';
  - 56.3% thought the optimum no. of H&N cases to consider at a meeting was up to 15 and 36.8% thought is was 16-25 cases.

Survey: H&N Tumour Specific Issues (..2)

- In terms of views on other questions there was little difference btw tumour areas although there were a few areas where H&N members were slightly more or less likely than those from other tumour areas to agree or disagree with certain statements. For example:

- Most likely to rate 'patient centred care/co-ordination of service' as important domain (97%)

- Most likely to agree that MDTs result in:
  - improved survival (91%)
  - Increased proportion of patients being staged (95%)

Survey: H&N Tumour Specific Issues (..3)

- Most likely to think the same individual should chair the MDT on a regular basis (92%)
- Least likely to agree that chair should be a doctor (45%)
- Most likely to agree that:
  - chair needs specific training to support them in this role (88%)
  - a formal induction process for new members would be useful (61%)
  - being an MDT member improved job satisfaction (87%)
  - there is a need for tools to support self assessment & performance appraisal (93%)
- Most likely to want an awayday with own team (71%)

Survey: H&N Tumour Specific Issues (..4)

- Least likely to report having real time recording of treatment proposals to a database (36%)
- Most likely to report having access to v/c facilities (62%)
- Most likely to agree that:
  - case summaries should be circulated prior to meeting (77%)
  - documented decisions should be projected for mbrs to view (86%)
  - oncologists should not make treatment decisions on patients with recurrence/progressive disease without MDT support (99% vs ~61%)
  - MDT should be notified if treatment recommendations not adopted (99%)
  - a named individual in MDT should take responsibility for identifying a key worker for the patients (92%)

Next Steps

- Report plus background analysis available: www.ncin.org.uk/mdt
- Issue characteristics of an effective MDT based on findings
- Pilot approaches to self assessment & feedback
- Identify potential content for MDT development package
- Develop MDT DVD to highlight in an entertaining & informative way impact of poor working practices, poor working environments, poor technology and unhelpful behaviours!
- Develop toolkit including:
  - examples of local practice to build and expand on locally if desired.
  - national products such as: checklists, proformas, specifications & templates for local adaptation as required.

How can NCIN H&N SSCRG help MDT Programme?

- Identify ‘volunteer’ MDTs for pilot work
- Share local practice for toolkit
- Cascade messages/products from programme to local MDTs

Any questions or Issues you want to raise on GFOCW or MDT Development?