

**NCIN Upper GI TSSG
Clinical Chairs workshop**

**Going Further On Cancer Waits
&
MDT Effectiveness**

18 November 2009

Cheryl Cavanagh National Cancer Action Team

GFOCW

- Quick recap of standards & 'counting'
- Issues to consider - views from a UGI 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%	-

- 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?

- **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 UGI performance was 87.3% but 43 Trusts were below 85% tolerance (performance range 50.0—83.3%)**

- **1416 patients had FDT ending a 62d UGI cancer pathway in Q1.**
- **152 Trusts reported treating these 62d UGI cancer patients in Q1. Of these:**
 - 97 reported on less than 10 patients
 - 55 reported on 10-19 patients
 - 14 reported on 20+ patients
- **22 of 55 trusts reporting on 10+ pts were below tolerance (range 53.3-81.4%):**

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 UGI SSCRG help with GFOCW?

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

- **Of the 51% (1339) of professionals covering 1 tumour type 9% (124) were just members of UGI MDTs. Of these:**
 - **27.3% reported spending >90 mins preparing for an MDT with 26.4% spending < 30 mins. The rest spent btw 30-90mins except 5.5% who did no prep**
 - **28.3% thought 60-90 mins was max time a meeting should last, 23.9% wanted 'as long as required' and 23.0% up to 1 hour**
 - **42.5% thought the optimum no. of UGI cases to consider at a meeting was up to 15 and 27.4% thought it was 16-25 cases**

- **In terms of views on other questions there was little difference btw tumour areas though UGI MDT members were most likely to:**
- **agree that a team could be highly effective irrespective of personalities (83%)**
 - **agree that a formal induction process for new members would be useful (61%)**
 - **want team assessment tools (90% yes or perhaps)**

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 UGI 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?**

