Urology NSSG Leads Meeting

MDT Development Work Programme

&

Cancer Waits

2 July 2010

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MDT Development Work Programme

What Will Be Covered?

- Brief reminder about survey
- Characteristics of an Effective MDT
- National & Local Action
- How you can help?

Survey: Background

- Survey ran for ~6wks (early 2009)
- 2054 MDT core & extended members responded plus ~200 other stakeholders
- Good mix of professional groups and representation from different tumour areas

Survey: 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
- Patient views should be presented by someone who has met the patient

Report plus background analysis available: www.ncin.org.uk/mdt

Survey: Urology Tumour Specific Issues

- **Of the 51% (1339) of professionals covering 1 MDT 10% (134) were <u>just</u> members of urology MDTs. Of these:**
  - **29.9% reported spending < 30 mins on prep for meeting, 23.1% btw 30-60mins; & 21.4% >90 mins**
  - **35.0% thought 90-120 mins was the max length an MDM should be; 22.8% thought 60-90 mins; & 27.6% felt an MDM should be 'as long as required';**
  - **33.3% thought the optimum no. of urology cases to consider at an MDM was between 16-25 cases with 24.6% thinking is was 26-35 cases.**

Survey: Urology Tumour Specific Issues (..2)

- **Little difference in views on other questions btw tumour areas. A few areas where urology mbrs slightly more or less likely than others to agree or disagree with certain statements:**
  - **least likely to report having real time recording of treatment proposals to a database (36% vs 55% gynae vs 39% all)**
  - **least likely to agree that the MDT should be notified if treatment recommendations not adopted (82% vs 99% H&N vs 90% all)**
  - **most likely to agree that MDTs result in increased proportion of patients considered for trials (93% vs 78% haem vs 86% all)**
  - **highest proportion of members reporting spending no time preparing for meetings!!! (17% vs 4% gynae vs 9% all)**

Characteristics of an Effective MDT

- **Built on survey plus views of stakeholders who attended workshops and other meetings during 2009.**

- **Issued characteristics of an effective MDT based around 5 themes:**
  - **The team**
  - **Meeting infrastructure**
  - **Meeting organisation & logistics**
  - **Patient-centred clinical-decision making**
  - **Team governance**

MDT Development: National Action..1

- Liaising with peer review team about incorporating some characteristics into peer review
- Piloting self assessment & feedback tool for issues like team working & leadership
- Identifying potential content for MDT development & support package

MDT Development: National Action..2

- Issuing DVD to highlight impact of different working practices/behaviours on MDT working
- Developing toolkit to share local practice
- Costing work with DH

MDT Development: Local Action

- **MDTs & those involved with MDTs encouraged to:**
  - **Consider how they compare to the characteristics;**
  - **Start discussions within MDT and with Trusts about how they can come in line with the characteristics – use document as a lever locally (until national tools available).**

How NSSG leads can help?

- Ensure Trusts & MDTs are aware of the characteristics
- Encourage MDTs to consider themselves against characteristics locally
- Identify ‘volunteer’ MDTs for pilot work
- Share local practice for toolkit
- Cascade messages/ products from programme to local MDTs
- Other suggestions?

Any questions?

Cancer Waits
An Update

CANCER WAITS

- **Need to ensure all pts with suspected/confirmed cancer have appts, tests and treatments in a timely fashion.**

- **A no. of pathways support this – those related to urology:**

  - **2 weeks – urgent GP referral for sus. cancer to 1st hosp. ass.**

  - **31 day – DTT to first treatment**
  - **31 day – DTT/ECAD to subsequent treatment**

  - **62 day – urgent GP referral to trtment (31d for testicular)**
  - **62 day – consultant upgrades**

NEW PAUSE MODEL

- **From 1 Jan 09, two types of pause allowed:**
  - **DNA initial outpatient appointment**
  - **decline 'reasonable' offer of admitted treatment**

- **Pauses are no longer allowed:**
  - **when a patient defers their first appointment;**
  - **during the diagnostic phase;**
  - **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 standards.**

Q1 – Q4 PERFORMANCE & OPERATIONAL STANDARDS

Pathway	Performance				Op. Std
	Q1	Q2	Q3	Q4	
2 week	94.1%	94.4%	95.6%	95.6%	93%
31d (FDT)	98.1%	98.0%	98.4%	98.4%	96%
31d sub (surgery)	95.1%	95.7%	97.1%	97.0%	94%
31d sub (drugs)	99.2%	99.5%	99.7%	99.5%	98%
62d (urgent GP)	86.0%	85.7%	86.6%	86.7%	85%
62d (screening)	94.5%	93.7%	94.4%	93.9%	90%
62d (upgrade)	94.7%	93.8%	94.9%	93.7%	-

62 DAY PATHWAY: PERFORMANCE

- Above tolerance at a national level BUT there are individual Trusts that are struggling – urology pathways (prostate) anecdotally quoted as a particular issue
- Trust Performance is not assessed nationally at tumour level. Op std is for all tumours taken together – some tumour types should exceed it others unlikely to
- National urology performance was 79.3% in Q1 & Q2 & 81.9% in Q3 against 85% tolerance.
- Does this 'feel' right for urological cancers?

62 DAY POSITION FOR UROLOGICAL CANCERS IN Q1-3

- ~5400 patients having FDT ending a 62d urological cancer pathway per quarter (range 4900-5750 for Q1-Q3).

- ~154 Trusts report treating 62d urological cancer patients each quarter (majority report on 20+ patients)

- Of Trusts reporting on 20+ pts:
  - 63 were below 85% tolerance in Q1
  - 67 were below 85% tolerance in Q2
  - 59 were below 85% tolerance in Q3

- Of these, 41 were below tolerance in Q1, Q2 & Q3

What are the issues for urological cancers….?

- **Is prostate the problem pathway or are there others?**

- **What are the prostate specific issues:**
  - **Wait between TRUS biopsy & MRI shouldn't be - taken into account in op. std**
  - **Delays due to patient choice eg thinking time shouldn't be – taken into account in op. std**
  - **What are the other issues we need to be aware of?**

Other Issues – Active Monitoring?

For cancer waits, active monitoring is:

- **where a diagnosis has been reached but it is not appropriate to give any active treatment at that point in time but an active treatment is still intended/ may be required at a future date.**
- **the patient is therefore monitored until a point in time when they are fit to receive, or it is appropriate to give, an active treatment.**
- **a patient would have to agree that they are choosing to be actively monitored for a period of time rather than receive alternative treatment.**

It is not to be used for thinking time.

Active monitoring – Examples of what it is & isn't!

- if a patient with suspected prostate cancer needs repeat PSAs before a diagnosis can be confirmed this is not active monitoring

- if a prostate patient is offered a range of treatments and wants to take a couple of weeks to think about the options this is not active monitoring

- if a prostate patient is to have a treatment and the waiting time for this would mean they would wait more than 31/62d days it is not appropriate to record the treatment as active monitoring while they await their formal treatment

- if a prostate patient has a tumour that is not causing any significant problems and they decide that they don't want to pursue active treatment immediately but have the cancer kept under review by repeat PSA this would be active monitoring.

Active monitoring (AM) – Position for urological cancers

- Is AM being used appropriately for urological cancers eg. not just to end 62 day pathways early?
- If AM is used inappropriately it could mask problems else where in the pathway
- National figures do not imply AM used inappropriately for urological cancers (ie. levels of AM not significantly increased since rules changed) :
  - Q3 2008/09 – 13.6% of AM was urological
  - Q4 2009/10 – 17.5% Of AM was urological
- Anecdotally some clinicians have expressed concern …is there anything to worry about?

Other issues - pTa….?

- Case made to DH to include pTa within remit of cancer waits
- Cancer Waits Advisory Board supportive
- Awaiting confirmation of how this will be taken forward

How can NSSG leads help….?

- Identify issues that may impact on urology waits performance at national level we need to be aware of & let us know….

- Act as source of support/advice for Trusts or networks struggling with waits pathways for urological cancers ie. do you have successful pathways you can share?

Any questions?