Colorectal NSSG Leads Meeting

Effective MDT Work Programme

&

Going Further On Cancer Waits

21 April 2010

Cheryl Cavanagh National Cancer Action Team

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: Colorectal Tumour Specific Issues

- Very little difference between views of different prof. groups or members of different tumour MDTs.

- Of the 51% (1339) of professionals covering 1 MDT 10% (134) were <u>just</u> members of colorectal MDTs. Of these:

  - 30.0% reported spending < 30 mins on prep for meeting, 27.5% btw 30-60mins and 21.7% >90 mins;

  - 30.0% thought 60-90 mins was max time a meeting should last, 29.2% felt a meeting should be 'as long as required', with 21.7% thinking up to one hour was the max length an MDT should be;

  - 45.8% thought the optimum no. of colorectal cases to consider was between 16-25 cases with 33.1% thinking is was up to 15.

Survey: Colorectal Tumour Specific Issues (..2)

- In terms of views on other questions there was little difference btw tumour areas. A few areas where colorectal mbrs slightly more or less likely than others to agree or disagree with certain statements:
  - Most likely to agree that professional support for MDT is readily available (82% vs 77% for all)
  - Least likely to agree documented decisions should be projected for members to view (73% vs 80% for all vs 88% for urology)
  - Least likely to agree that case summaries should be circulated prior to the meeting (50% vs 60% for all & 77% H&N)

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

- Liaising with peer review team about incorporating some characteristics into peer review
- Pilot self assessment & feedback tool for issues like team working & leadership
- Identify potential content for MDT development & support package
- Issue DVD to highlight impact of different working practices/behaviours on MDT working
- Develop toolkit to share local practice
- Costing work with DH

MDT Development: Local Action

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

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?

Going Further On Cancer Waits (GFOCW)

Very Quick Update!

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)**

5 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)**
- **2ww – all pts with breast symptoms (went live 1 Jan 2010)**

1 GFOCW standards to follow:

- **31 day – radiotherapy (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 standards.**

Q1 – Q3 PERFORMANCE & OPERATIONAL STANDARDS

Standard	Performance			Operational Standard
	Q1	Q2	Q3	
Original Standards				
2 week wait	**94.1%**	**94.4 %**	**95.6%**	**93%**
31 day (FDT)	**98.1%**	**98.0%**	**98.4%**	**96%**
62 day (classic)	**86.0%**	**85.7%**	**86.6%**	**85%**
GFOCW Standards				
31d sub (drugs)	**99.2%**	**99.5%**	**99.7%**	**98%**
31d sub(surgery)	**95.1%**	**95.7%**	**97.1%**	**94%**
62d(screening)	**94.5%**	**93.7%**	**94.4%**	**90%**
62d (upgrade)	**94.7%**	**93.8%**	**94.9%**	**-**

62 DAY (CLASSIC): PERFORMANCE

- Above tolerance at a national level BUT there are individual Trusts that are struggling - are the LGI cancer pathways a particular issue?
- National LGI performance was 81.7% in Q1, 77.3% in Q2 & 76.7% in Q3 against 85% tolerance.
- 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 – does this 'feel' right for LGI cancers?

62D CLASSIC – POSITION FOR LGI CANCERS IN Q3

- 2597 patients had FDT ending a 62d LGI cancer pathway in Q3.

- 155 Trusts reported treating these 62d LGI cancer patients in Q3 and of these:
  - 61 Trusts were above 85% tolerance
  - 94 Trusts were below 85% tolerance

- Of the Trusts seeing LGI patients in Q3:
  - 48 reported on less than 10 patients
  - 51 reported on 10-19 patients
  - 56 reported seeing 20+ patients

- Of the Trusts reporting on 20+ pts in Q1-3, 17 were below tolerance in each of these Quarters.

How you can help….?

- Are there issues that may impact on colorectal waits performance at national level we need to be aware of – 62d, 62d screening, other?

- Source of support or advice for Trusts or networks struggling with standard(s) for LGI cancers ie. do you have successful pathways you can share?

Any questions?