NCIN Lung TSSG
Clinical Chairs workshop

Going Further On Cancer Waits
&
MDT Effectiveness

8 January 2010

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WHAT WILL BE COVERED

GFOCW

- Quick recap of standards & 'counting'
- Issues to consider - views from a lung cancer perspective 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)

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)

2 GFOCW standards to follow:

- 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 & Q2 PERFORMANCE & OPERATIONAL THRESHOLDS

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

62 DAY (CLASSIC): LUNG PERFORMANCE

- Above tolerance at a national level BUT there are individual Trusts that are struggling - is the lung cancer pathway a particular issue?
- 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 Lung performance was 87.4% in Q1 & 80.5% in Q2 against 85% tolerance.

62D CLASSIC – POSITION FOR LUNG CANCER IN Q1 & Q2

- 2327 & 2680 patients had FDT ending a 62d Lung cancer pathway in Q1 & Q2 respectively.

- 159 & 158 Trusts reported treating these 62d lung cancer patients in Q1 & Q2 and of these:
  - 109 & 76 Trusts were above 85% tolerance in Q1 & Q2
  - 50 & 82 Trusts were below 85% tolerance in Q1 & Q2

- Of the Trusts seeing lung patients:
  - 68 & 58 reported on less than 10 patients in Q1 & Q2
  - 47 & 49 reported on 10-19 patients in Q1 & Q2
  - 44 & 51 reported seeing 20+ patients in Q1 & Q2

- Of the Trusts reporting on > 20 pts 17 were below tolerance in both Q1 & Q2

How can NCIN Lung SSCRG help with GFOCW?

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

- **Of the 51% (1339) of professionals covering 1 tumour type 11% (146) were just members of Lung MDTs. Of these:**
  - **37.7% reported spending < 30 mins on prep for meeting, 30.8% btw 30-60mins and 22.3% >90 mins;**
  - **46.6% thought 60-90 mins was max time a meeting should last with 18.8% wanting 'as long as required';**
  - **50.0% thought the optimum no. of lung cases to consider at a meeting was up to 15 and 33.6% thought is was 16-25 cases.**
  - **All reported having MDT co-ordinators (100%)**
  - **Most likely to report having a designated data collector (68%)**

Survey: Lung 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 lung members were slightly more or less likely than those from other tumour areas to agree or disagree with certain statements. For example:**
  - **Least likely to agree that professional support for MDT is readily available (72%)**
  - **Most likely to agree that chair needs specific training to support them in this role (69%)**
  - **Least likely to think a formal induction process for new members would be useful (48%)**

Survey: Lung Tumour Specific Issues (..3)

- Most likely to consider SPC attendance at all meetings essential (69% vs 20-21% for breast & haem)
- Least likely to agree with statement that 'SPC is not needed if there are mechanisms to access this support when needed' (57% vs 94% breast)
- Least likely to agree that all patients with recurrence/progressive disease should be discussed by an MDT (67% vs 79-98% for other tumour groups)
- Least likely to agree with statement that 'oncologists should not be able to make treatment decisions on patients with recurrence/progressive disease without MDT support' (40% vs ~61%)

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?