NCIN Sarcoma TSSG
Clinical Chairs workshop

Effective MDT Work Programme
&
Going Further On Cancer Waits

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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.
- Asked views on MDT working [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
  - 9% Other doctors
- 26% Nurses
- 15% MDT Co-ordinators
- 4% AHPs
- 2% Other (e.g. admin / managerial)

- Just over half (51%) were members of 1 MDT only but:
  - 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!

SOME KEY FINDINGS FROM SURVEY

- 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
- A means of self assessment is needed for MDTs plus a variety of support tools/mechanisms.

Characteristics of an Effective MDT

- Very high consensus on what is important for effective MDT functioning.
- This has been built on at workshops and discussions with stakeholders.
- Now have a set of characteristics of an effective MDT.

CHARACTERISTICS OF AN EFFECTIVE MDT: THEMES

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

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

- **Meeting Organisation & Logistics:**
  - Scheduling of MDT meeting
  - Preparation for MDT meetings (96%)
  - Organisation / admin during meeting (98%)
  - Post MDT meeting/co-ordination of service

CHARACTERISTICS OF AN EFFECTIVE MDT: THEMES

- **Patient –Centred Clinical Decision-Making:**
  - **Who to discuss?**
  - **Patient centre care (93%)**
  - **Clinical- decision making process (99%)**

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

Survey: Survey 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 1% (15) were just members of Sarcoma MDTs .
- Numbers too low to draw any specific conclusions about views and perceptions of members of sarcoma MDTs.

Survey: Survey Tumour Specific Issues

- **Bearing in mind the low number (15) of sarcoma-specific responses the following is shown for interest only:**
  - **8 reported spending more than 90 minutes preparing for a meeting;**
  - **7 felt 90-120 minutes was the max length an MDT should be and 5 felt a meeting should be 'as long as required';**
  - **6 thought the optimum no. of sarcoma cases to consider at a meeting was 26-35 and 5 thought is was 16-25 cases.**

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 impact of different working practices & behaviours on MDT working
- 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 you can help……

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

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Any questions?

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): SARCOMA PERFORMANCE

- Above tolerance at a national level BUT there are individual Trusts that are struggling - is the sarcoma 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 sarcoma performance was 81.3% in Q1 & 67.5% in Q2 against 85% tolerance.

62D CLASSIC – POSITION FOR SARCOMA IN Q1 & Q2

- 96 & 117 patients had FDT ending a 62d sarcoma pathway in Q1 & Q2 respectively.
- 63 & 68 Trusts reported treating these 62d sarcoma cancer patients in Q1 & Q2 and of these:
  - 54 & 34 Trusts were above 85% tolerance in Q1 & Q2
  - 9 & 34 Trusts were below 85% tolerance in Q1 & Q2
- Of the Trusts seeing sarcoma patients:
  - only 1 reported on more than 10 patients in Q1 & 0 did in Q2
  - only 3 reported on 5+ patients in Q1 & only 4 did in Q2

How can NCIN Sarcoma SSCRG help with GFOCW?

- Are there issues that may impact on sarcoma waits performance at national level we need to be aware of – apart from impact of low numbers?
- Source of support or advice for Trusts or networks struggling with standard(s) for sarcoma ie. do you have successful pathways you can share?
- Sounding board for sarcoma-specific CWT queries and/or NCAT sarcoma-specific waits guidance

Any questions?