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Delivering 62 Day GP Cancer Waits in a Complex Landscape

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Overview

- The 62 day GP target
- Cancer pathways
- What causes ‘breaches’?
- Good practice and ways to improve
- ‘Unavoidable’ breaches – what challenges do we face?
- Summary

The 62 day GP target

- The target specifies that cancer patients must start first definitive treatment within 62 days of receipt of a GP referral for suspected cancer
- Providers should deliver this for 85% patients
- Patients who are ‘first seen’ at one provider and first treated at another are shared 50/50 between the two providers

What happens in the 62 days?

- A first appointment
- Diagnostic tests – may be multiple, including radiology, histological and surgical tests
- Multi-Disciplinary Team discussion
- Appointments with patients to explain results, and plan treatment
- Planning and preparation for treatment
- Treatment itself

What does a 'pathway' look like?

- 'Cancer' is not one disease – huge variety of presentations and pathways
- Some cancers are more challenging to diagnose and treat than others
- The guidance recognises that not all specialities will deliver 85%, whilst others should attain higher – hopefully balancing out

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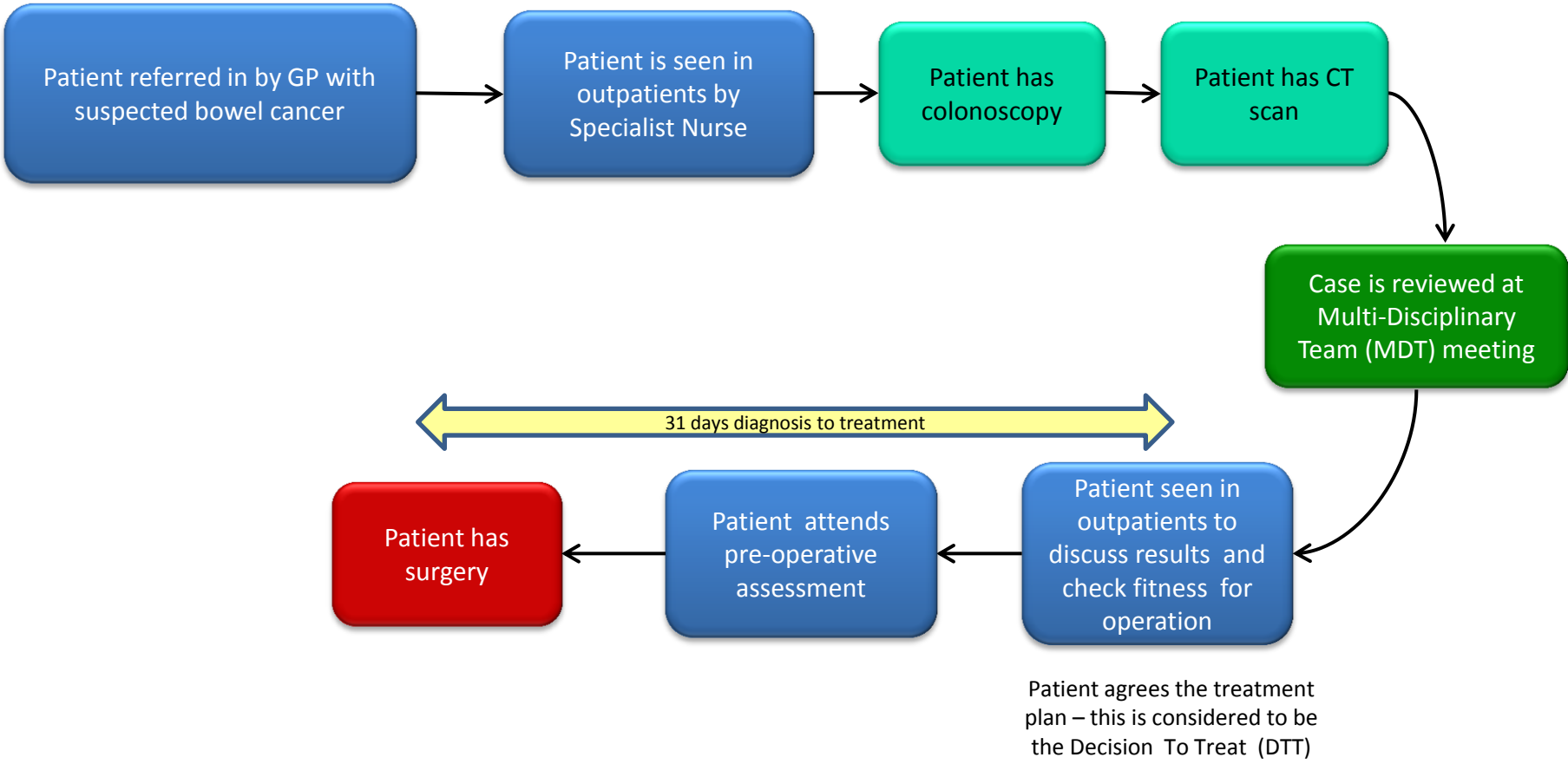
Simple bowel cancer pathway

62-day wait– referral to treatment



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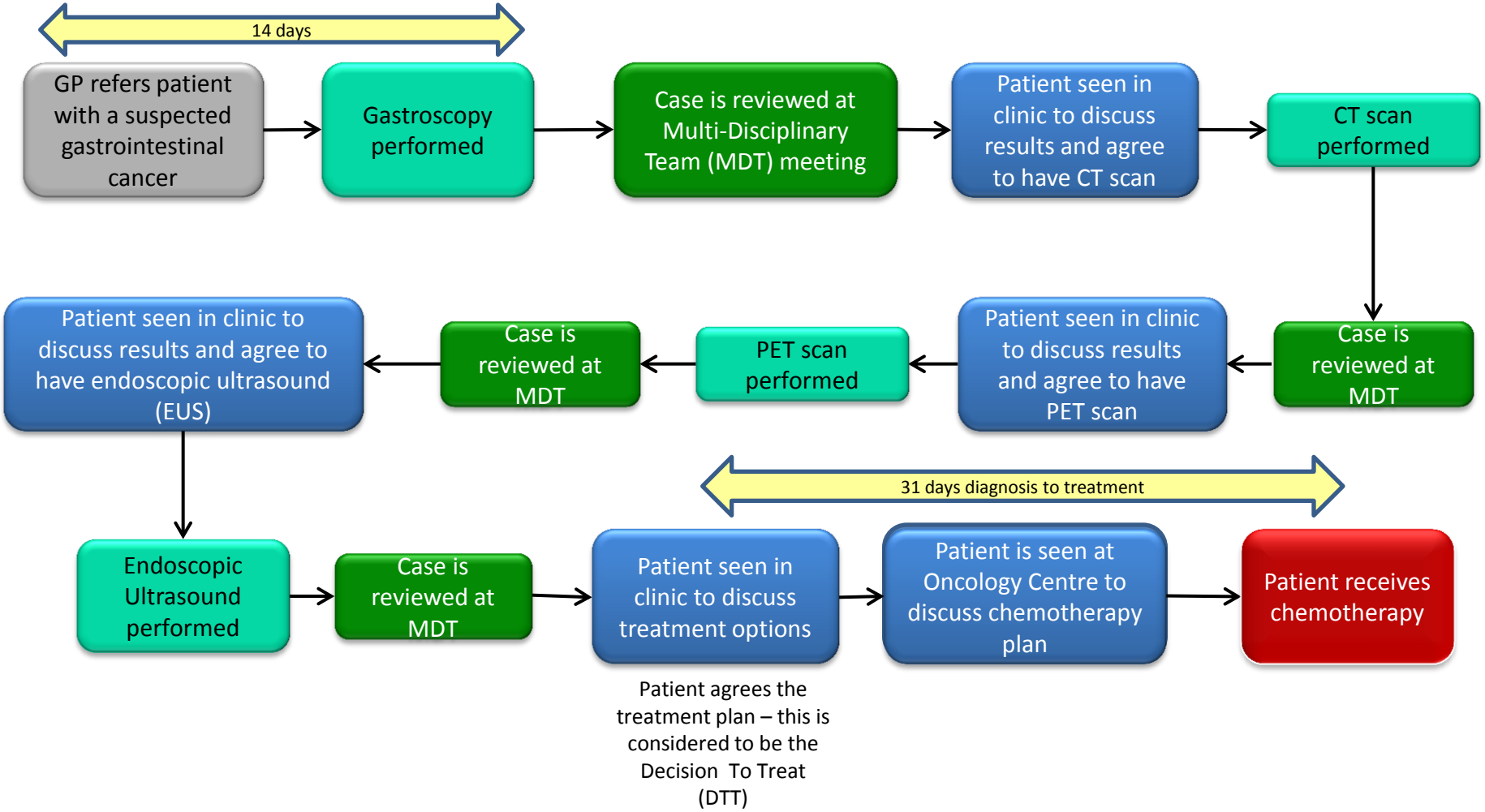
A typical OG cancer pathway

62-day wait (GP referral) – referral to treatment



What causes ‘breaches’?

Avoidable Factors	Unavoidable factors
Insufficient capacity	Patient choice
Cancellations (hospital initiated)	Medical deferrals
Administrative errors	Complexity
Poor planning/timing	Casemix
Delays in reporting of results	

Much better to spend time solving these…

Than to spend time explaining these!

Good practice in pathways

- Manage with close tracking
- Use ‘one stop’ where possible
- Timing of tests where interdependent
- Flexibility with capacity
- Robust cover arrangements
- Good communication between teams
- Timed, ‘ideal’ pathways to help stay on track

Examples of recent pathway improvements

- One stop clinics in lung – diagnosis in a week
- One stop dental screening
- Internal 7 day target for first appointments
- Joint clinics between different disciplines
- Fast track lymph node biopsy protocol

What are the challenges?

- Patient choice
- Medical deferral
- Complexity
- Casemix
- Capacity
- Shared pathways

Patient choice

- Cannot apply patient choice pauses for outpatient treatments or for diagnostic tests
- Cannot adjust for DNAs (after first appointment) or patient cancellations
- Particular problem in some pathways e.g. head and neck
- Social changes – patients more confident to exert choice and question clinicians

Complexity – Procedures

- Advances and innovations can present pathway challenges
- Additional CT head scan now recommended for all curative intent lung cancer patients
- Rising popularity of CT colonoscopy
- IMRT (complex radiotherapy treatment) takes around 14 days to plan ('good practice' timescale, as per Royal College of Radiologists)

Complexity - patients

- Ageing population means we are seeing older patients, who often have more comorbidities
- Increasing ability to do more for patients with advanced disease and co-morbidities
- 47% OG cancer patients had at least one significant comorbidity, 9% had three or more (UH Bristol NOGCA data, 2013/14)
- Complex patients need more tests prior to treatment and may need more complex arrangements e.g. ITU bed, joint procedure

Medical deferral

- Patients with comorbidities or metastatic disease may need lengthy interventions e.g. heart surgery, brain surgery, before they can be treated
- Increasing numbers of patients with second cancers needing treatment/investigation first
- No adjustments for medical deferrals are allowed

Shared Pathways

- Late referrals major challenge for tertiary centres
- Patients shared 50/50 regardless of pathway
- Shared patients overall have longer pathways
- Transferring between Trusts adds admin complexity and risks
- Can increase patient choice delays

Casemix

- It is recognised that attaining the target by speciality is not possible or appropriate
- High performing specialities are expected to ‘bail out’ low performing ones
- Increasing centralisation in the NHS means more Trusts with an atypical casemix
- These Trusts work to the same targets

CWT Guidance

- We want to spend time improving pathways, not explaining unavoidable breaches
- Do the current rules enable us to truly reflect the timeliness of a Trust's services?
- Do the current rules enable a 'level playing field', to allow comparison and benchmarking?
- Are the current rules still fit for purpose for modern cancer services?

Summary

- There are many challenges to delivering 62 day cancer pathways
- Some ‘unavoidable’ factors (patient choice, medical deferral) are increasing
- We need to focus on designing excellent pathways
- Is the CWT guidance helping or hindering?