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
Simple bowel cancer pathway

62-day wait– referral to treatment

Patient referred in by GP with suspected bowel cancer

Patient is seen in outpatients by Specialist Nurse

Patient has colonoscopy

Patient has CT scan

Case is reviewed at Multi-Disciplinary Team (MDT) meeting

31 days diagnosis to treatment

Patient has surgery

Patient attends pre-operative assessment

Patient seen in outpatients to discuss results and check fitness for operation

Patient agrees the treatment plan – this is considered to be the Decision To Treat (DTT)
A typical OG cancer pathway

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

14 days

GP refers patient with a suspected gastrointestinal cancer → Gastroscopy performed → Case is reviewed at Multi-Disciplinary Team (MDT) meeting → Patient seen in clinic to discuss results and agree to have CT scan → CT scan performed

Patient seen in clinic to discuss results and agree to have endoscopic ultrasound (EUS) → Patient is seen at BHOC and treatment plan agreed

Case is reviewed at MDT → Patient seen in clinic to discuss results and agree to have PET scan → Patient is seen at Oncology Centre to discuss chemotherapy plan → Patient receives chemotherapy

Patient agrees the treatment plan – this is considered to be the Decision To Treat (DTT)

31 days diagnosis to treatment
What causes ‘breaches’?

<table>
<thead>
<tr>
<th>Avoidable Factors</th>
<th>Unavoidable factors</th>
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<tbody>
<tr>
<td>Insufficient capacity</td>
<td>Patient choice</td>
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<tr>
<td>Cancellations (hospital initiated)</td>
<td>Medical deferrals</td>
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<td>Administrative errors</td>
<td>Complexity</td>
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<td>Poor planning/timing</td>
<td>Casemix</td>
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<td>Delays in reporting of results</td>
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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?