The Cancer Services Collaborative 'Improvement Partnership'

The 'how to' guide:

Achieving Cancer Waiting Times

Produced in association with The National Cancer Waits Project and The Cancer Action Team

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Section 1

How to use this package

The 'How To' Guide for achieving cancer waiting times

Based on service improvement evidence from the Cancer Services Collaborative 'Improvement Partnership' (CSC'IP') and learning from cancer waiting times monitoring.

Introduction

Welcome to the "How To" Guide which has been compiled specifically to support local clinical teams to improve their cancer services in line with the requirements of the NHS Cancer Plan – 2000, focussed on the patient/carer experience and achieving waiting times targets by December 2005.

The "How To" Guide seeks to provide organisational leaders with tools to assist in understanding their current position and provides local teams with a range of materials, including practical tools and methods, evidence-based high-impact changes, case-studies, and signposting for more detailed information resources.

The "How To"Guide draws on evidence generated by the Cancer Services Collaborative 'Improvement Partnership' (CSC'IP') from 2001 onwards, and is the result of the CSC'IP' Service Improvement Leads and Facilitators working with hundreds of clinical teams across the NHS to facilitate service redesign.

Aims of The "How To" Guide

- To enable NHS organisations to assess their overall position and to identify key priorities for service improvement
- To support local teams in accelerating the pace of change to improve cancer waiting times performance by implementing best practice, both in terms of data collection and service improvement
- To ensure the 'right' changes are put in place; Changes that are patient-focussed, have a high impact and importantly are sustainable. These are defined as the 'High Impact Changes that can be applied to cancer'.

Using The "How To" Guide

It is intended that the "How to" Guide can be used by any member of staff involved in the delivery of improved cancer waiting times. This might include:

- Senior leaders/lead directors for cancer waiting times.
- Clinical staff.
- Managerial staff.
- Service improvement staff.
- Staff responsible for cancer data.

It is not intended that this Guide be read from cover to cover, but that relevant sections be accessed as required. If necessary, each section can be used in isolation.

The loose-leaf format of the ring-binder is designed so that sections can be taken out as required for a tailored approach.

The Guide has 4 key components outlined below:

Section 2: Understanding where you are

Most useful for senior leaders and clinical teams.
How to assess, understand and prioritise areas of greatest need.

Focussed on areas that present greatest challenges and/or impact on large volumes of patients.

- We recommend as a priority that the high-volume tumours of colorectal, urology and lung be considered first, and that key constraints be the primary focus.

Teams can either work through this section to assess position, or if there is already clarity as to where the challenges are teams can move directly to the appropriate pathway sections.

Section 3: Data: Quality and completeness

Most useful for data and performance staff.
How to improve data quality and completeness.

Section 4: Implementing change

Useful for any member of staff seeking to implement change.
'Top tips' for implementing change.

Sections 5 – 9

Most useful for clinical teams and service improvement staff.
How to make improvements focusing on key stages in the patient pathway: referral; diagnostics; multidisciplinary team working and treatment; and follow-up. Gives recommendations regarding the changes to make, and provides illustrative casestudies.

Section 10

The final section provides signposting for additional materials, and a glossary of terms.

Section 2

Understanding where you are

Introduction

This section describes tools which can be used to:

- Establish a baseline position on cancer waits.
- Assess what needs to be done to achieve targets.
- Decide where resources need to be targeted.

Tool 1
Trust leadership self-assessment tool

Tool 2
Tumour specific self assessment tools
2A Urogical cancer
2B Lung cancer
2C Colorectal cancer

Tool 3
Diagnostic services self-assessment tools
3A Endoscopy
3B Radiology

Tool 4
Effective multi-disciplinary team working

Tool 5
Pathway mapping tool

Tool 1: Senior leadership self-assessment

This tool aims to stimulate useful, honest and thought provoking discussion, allowing time for reflection in order to help indicate to the Trust the position and requirements needed to deliver the cancer waiting times targets by December 2005. It is intended that a team approach be adopted when completing this assessment.

Instructions:

For each of the following statements assess how you would rate your Trust .

- Score 0 points - Do not know.
- Score 1 point - Disagreement with the statement (i.e. the statement is **not at all true** of your Trust).
- Score 2 points - Agreement with the statement (i.e. the statement **is true** of your Trust.

Leadership

Score

1. As Chief Executive you are fully aware of your Trust's cancer waiting times performance for both the 31 & 62-day targets.

2. The Executive Leader for cancer waiting times has clear responsibility and accountability for delivery.

3. The Executive Leader for service improvement has clear responsibility and accountability for delivery of cancer specific high impact changes.

4. The Trust Board understands the nature and magnitude of service improvement and fully understands the relevance of implementing high impact change principles across the Trust to improve cancer waiting times performance.

5. There is a shared vision for the future of Cancer Services held by the SHA, PCT, Cancer Network, Trust and clinical departments.

6. The Trust has an agreed strategy and action plan for delivering cancer waiting times including the adoption of service improvement cancer specific high impact changes.

7. The Trust is prepared and able to commit as soon as possible the financial and human resources, and the time required to make service improvement succeed.

Readiness

Score

8. Clinical teams are aware of the Cancer High Impact Changes and are committed to adopting them to deliver achieving the cancer waiting times

9. Department managers are aware of the Cancer High Impact Changes and are committed to adopting them to deliver achieving the cancer waiting times.

10. The Trust has none of the complacency that comes after a prolonged period of success.

11. The Trust is free of the scepticism and ambivalence that is often associated with service improvement.

12. The Trust places a high value on serving patients and has a deep understanding and awareness of patients' views about cancer services.

13. The Trust is fully aware of its potential for making improvement and the benefits of spreading best practice.

14. Key support functions within the Trust such as finance, HR, data collection, IT and performance management are positive about the prospect of sustainable service improvement in cancer services and are capable of an innovative response to its demands for achieving the cancer waiting times.

15. The Trust's experience of service improvement and quality initiatives has created an environment that is receptive to change.

16. Management/performance systems and performance goals and accountability have been established

17. The Trust Board is fully aware of the "real" cancer waiting times position from receiving monthly accurate and complete data.

18. From the information received the Trust Board can identify the greatest areas of concern including:
a. Blockages (bottlenecks).
b. Breaches.
c. The impact of service improvement.

19. The Trust has the knowledge, skills and expertise in service improvement and high impact change implementation to achieve the cancer waiting times.

Delivery

Score

20. The Trust has implemented Cancer High Impact Changes.

21. The Trust has robust demand management systems in place.

22. Referral protocols for all tumour sites are agreed with the local PCTs and the Network Tumour Sites Specific groups.

23. The cancer patients pathways for all tumours are clearly defined and agreed across the Trust.

24. The Trust has a robust booking and scheduling system in place that provide patients with certainty and choice throughout the stages of the cancer journey.

25. The Cancer High Impact Changes have been implemented across all stages of all tumour site pathways.

Breast

Colorectal

Upper GI

Urology

Lung

Gynaecology

Head & Neck

Skin

Haematology

Score

26. The Trust is confident it will deliver the cancer waiting times targets as required by December 2005

Assessing your scores.

Please enter your scores

	Question numbers	Your score	Score required for delivery of cancer waiting times targets
Leadership	1 to 7		14
Readiness	8-19		24
Delivery	20-26		30
Total			68

So how did you score?

If you scored 68 you should be:

- Well positioned to deliver cancer waiting times – but keep your eye on the ball and ask yourself the question: "Does this assessment support your waiting time position?"
- Check that your waiting time position continues to improve and has not become stagnant.

So your score was not high enough?

If your score is below 68 you should take steps to re-address the situation. On the next page are further self -assessment tools and templates to help you.

Tool 2: **Tumour-specific assessment**

Teams should complete the following tick-boxes. Depending on the responses given, teams should then move to subsequent sections for further information about high impact changes.

A: Urology self-assessment against High Impact Changes

One referral route into the system (streamline referral)	Nothing planned	In progress	Implemented
Develop appropriate referral criteria with primary care within the NICE guidance on referral for suspected cancer.	☐	☐	☐
Agreed patient pathway across the Trust for the 5 main urology cancers, Audit and identify referral patterns for patients referred for all main urology cancers.	☐	☐	☐
PSA guidance to GPs following testing.	☐	☐	☐
Implemented electronic or faxed referral for urgent suspected cancer referrals.	☐	☐	☐
Single point of contact for referral.	☐	☐	☐
Pooling of all referrals with appropriate triage to sub specialists.	☐	☐	☐
Reducing the steps to Diagnosis: Straight to Test			
Rapid access haematuria clinics Rapid access prostate assessment clinics.	☐	☐	☐
Pre-booked diagnostic test prior to 1st appointment.	☐	☐	☐
Single-visit clinics with combined tests/single preparation.	☐	☐	☐
Pooled referrals and single queues. Segmentation where appropriate, avoid carve-out.	☐	☐	☐
Standardised referral protocols and reporting.	☐	☐	☐
Booking and scheduling systems including waiting list validation, and DNA and A/leave policy.	☐	☐	☐
Extended roles: Nurse-led clinics. Nurse surveillance cystoscopy service. Ultrasonographer led prostate assessment clinics including TRUS and Biopsy.	☐	☐	☐
Timely reporting and access to results – maximise use of technology.	☐	☐	☐
Diagnosis followed by immediate staging and intervention where appropriate.	☐	☐	☐

A: Urology self-assessment against High Impact Changes (continued)

Treatment undertaken by "the right person at the right time in the right place"	Nothing planned	In progress	Implemented
MDT meetings. Review cancer waiting times in the MDT. Review breaches.	☐	☐	☐
Joint clinics urologist & oncologist.	☐	☐	☐
Team based approach.	☐	☐	☐
Theatre booking and scheduling.	☐	☐	☐

B: Lung self-assessment against High Impact Changes

One referral route into the system (streamline referral)	Nothing planned	In Progress	Implemented
Develop appropriate referral criteria with primary care within the NICE guidance on referral for suspected cancer.	☐	☐	☐
Agreed patient pathway across the Trust.	☐	☐	☐
Audit and identify referral patterns for patients referred for lung cancer.	☐	☐	☐
Implemented electronic or faxed referral for urgent suspected cancer referrals.	☐	☐	☐
Well-publicised single point of contact for referral.	☐	☐	☐
Pooling of all urgent referrals.	☐	☐	☐
Reducing the steps to Diagnosis: Straight to Test			
Open access to chest X-ray from primary care with rapid reporting of abnormal films.	☐	☐	☐
Reports faxed to GP and direct referral to lung cancer team, (triggering automatic referral).	☐	☐	☐
CT scan in appropriate patients prior to first outpatient appointment. Common CT examination protocols.	☐	☐	☐
Standardised referral protocols and reporting formats.	☐	☐	☐
Clear planning of diagnostic/staging pathway. Single visit clinics for diagnostic tests bronchoscopy and CT scan.	☐	☐	☐
Pooled referrals and single queue. Segmentation where appropriate – avoid "carve-out".	☐	☐	☐

B: Lung self-assessment against High Impact Changes (continued)

Reducing the steps to Diagnosis: Straight to Test (continued)	Nothing planned	In progress	Implemented
Booking and scheduling systems (including waiting list validation, DNA and annual Leave policy). Consider benefit of an MDT member acting as a tracker to ensure patient progressing on pathway.	☐ ☐	☐ ☐	☐ ☐
Timely and accurate reporting and access to results – maximise use of technology.	☐	☐	☐
Treatment undertaken by "The right person at the right time in the right place"			
All relevant members of MDT available for meetings Review cancer waiting times for each patient during MDT Review breaches monthly.	☐	☐	☐
Rapid communication with GP following MDT meeting.	☐	☐	☐
Joint clinics with respiratory physician, thoracic surgeon and oncologist.	☐	☐	☐
Pre-book onward steps in the pathway and give patient/carer contact number.	☐	☐	☐
Nurse/AHP clinics e.g. for patients with haemoptysis and normal CXR, follow-up for agreed patient groups.	☐	☐	☐
Team based approach with regular audit of performance and outcomes.	☐	☐	☐
Theatre booking and scheduling.	☐	☐	☐

C: Colorectal self-assessment against High Impact Changes

One referral route into the system (streamline referral)	Nothing planned	In progress	Implemented
Develop appropriate referral criteria with primary care within the NICE guidance on referral for suspected cancer.	☐	☐	☐
Agreed patient pathway across the Trust.	☐	☐	☐
Audit and identify referral patterns for patients referred for colorectal cancer.	☐	☐	☐
Implemented electronic or faxed referral.	☐	☐	☐
Single point of contact for referral.	☐	☐	☐
Pooling of all referrals within a structured system.	☐	☐	☐
Reducing the steps to diagnosis and staging: Straight to Test			
Single visit clinics with combined tests.	☐	☐	☐
Diagnostic tests prior to 1st OPA.			
Pooled referrals and single queue. Segmentation where appropriate - avoid "carve-out".	☐	☐	☐
Standardised tests and referral protocols and reporting.	☐	☐	☐
Booking and scheduling systems (including waiting list validation, DNA and A/Leave policy).	☐	☐	☐
Agreed protocols for tests and imaging Common CT protocols and reporting formats.	☐	☐	☐
Extended roles: Radiographer performing and reporting barium enemas. Advanced practitioner undertaking specimen cut-up. Nurse-led family history clinic. Nurse led flexible sigmoidoscopy clinics.	☐	☐	☐
Timely reporting and access to results – maximum use of technology.	☐	☐	☐
Diagnosis followed by immediate staging and intervention where appropriate.	☐	☐	☐
Written patient information available about colorectal cancer and about proposed staging tests.	☐	☐	☐
Treatment undertaken by "the right person at the right time in the right place"			
MDT meeting. Review cancer waiting times in the MDT. Review breaches.	☐	☐	☐
Joint clinics surgery & oncology.	☐	☐	☐
Pooled surgical referrals team based approach.	☐	☐	☐
Theatre scheduling.	☐	☐	☐
Day case patients on day case lists.			

Tool 3
Diagnostic self-assessment

Tool 3A: Endoscopy Unit Global Rating Scale

Introduction

The purpose of the Endoscopy Global Rating Scale is to assist endoscopy units to obtain a patient-centred view of their service and to map changes in response to local and national training and service improvement initiatives. A modified web-enabled version is now available and can be viewed at www.grs.nhs.uk

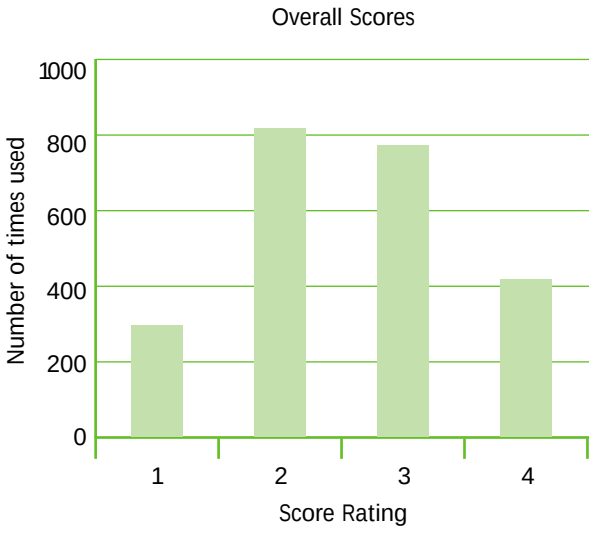
The first "census" of endoscopy units was held on 3rd September 2004 and the responses to the Global Rating Scale were anonymised. Each unit has been given feedback from the first survey on how they compared with other units locally and across the rest of England. We recommend that each unit should use this survey to focus and drive forward service improvement within their department. The ultimate aim is to systematically improve the whole endoscopy service.

Process

It was recommended that the clinical and nurse lead for each unit score the scale together. Each item of the scale has four statements that describe an aspect of the service and the leads were asked to select the 'descriptors' that best describe the level their service has achieved. A score of 1 being poor and a score of 4 being excellent. If there are varying levels of service in the unit then the score should reflect the lowest level that currently exists, not the best or average. E.g. If one of the clinical teams routinely provides excellent aftercare instructions but others do not, then score this item according to the team that provides the lowest level of service.

Outcome of the September 2004 survey

Note: 1 is the lowest level



These are the overall scores for 90% of endoscopy units in England. The National Endoscopy Team and SHA Clinical leads aim by September 2005 to have no '1s' and 50% fewer '2s'.

Outcome of the September 2004 survey

Note: 1 is the lowest level

Your endoscopy unit will have already completed the global scoring questionnaire in September 2004 (attached for information only). Therefore, on behalf of your Trust, do you know:

1. What was your unit's score for each of the aspects of the endoscopy service?

2. What strengths and weaknesses have been identified?

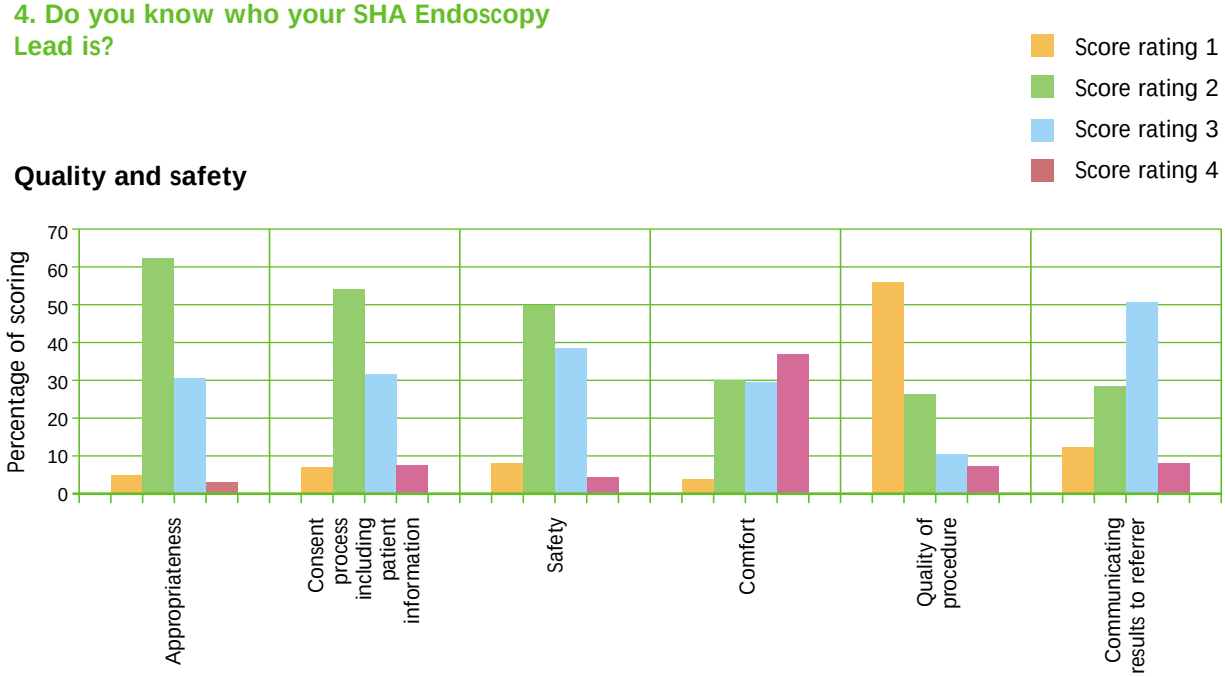
3. What actions have been taken to address low scores?

4. Do you know who your SHA Endoscopy Lead is?

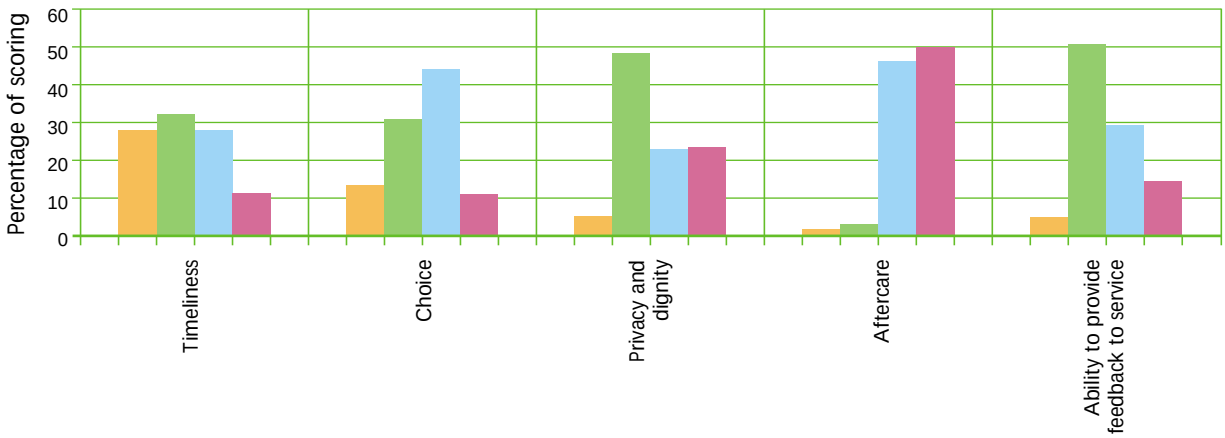
Suggested next steps:

- Find out the results of your assessment.
- If the assessment has not yet been completed, a revised version will be available in March 2005, via the SHA lead.
- Revisit action points and agree next steps
- Look at **Section 6** in The "How To" Guide for further practical advice on improving diagnostic services.

Quality and safety



Customer care



For information only

Endoscopy Unit Global Rating Scale (September 2004)

Quality and safety (a 'domain')

Score 1-4

Appropriateness (an 'item')

- No local guidelines or 'patient pathways' (a 'descriptor'). 1
- There are local guidelines or pathways for some but not all endoscopic techniques undertaken within the department (eg two-week wait, open-access endoscopy and flexible sigmoidoscopy, colonoscopy and surveillance colonoscopy). 2
- There are local guidelines or pathways for all endoscopic techniques undertaken within the department, some of which are audited each year. 3
- There are local guidelines or pathways for all endoscopic techniques undertaken within the department, all of which are audited at least once/year. 4

Consent process including patient information

- The majority of patients sign the consent form inside the procedure room with little prior information. 1
- There is good patient information but less than 80% of patients sign the consent form outside the procedure room. 2
- There is good patient information and greater than 80% of patients sign the consent form outside the procedure room.3
- There is good patient information (reviewed regularly by patients), all patients sign the consent form outside the procedure room and there is a local policy of withdrawal of consent during procedures. 4

Safety

- Adverse events are reviewed but not acted upon. 1
- Adverse events are reviewed and acted upon. 2
- Adverse events are reviewed, acted upon and then monitored to ensure the action has been effective. 3
- There is prospective monitoring of at least five key expected adverse events (eg use of reversal agents, oesophageal perforation, post-polypectomy complications, unplanned admissions and deaths) with regular review and, where necessary, change in procedures. 4

Score 1-4

Comfort

- There is no monitoring of patient comfort. 1
- Patient comfort is monitored by nursing staff and/or patients but not reviewed regularly. 2
- Patient comfort is monitored by nursing staff and/or patients and reviewed regularly. 3
- Patient comfort is monitored routinely by nursing staff and patients. Endoscopic performance and sedation levels are reviewed if patients are experiencing excessive levels of discomfort. 4

Quality of the procedure

- There is no monitoring of quality indicators .1
- There is monitoring of at least five key quality indicators (e.g. re-bleeding after endotherapy, caecal intubation rate, polyp detection rate, quality of bowel prep, ERCP cannulation rate) but no review process . 2
- There is monitoring and regular review of key quality indicators. 3
- There is monitoring and regular review of key quality indicators. Action is taken if indicators are below accepted standards. 4

Communicating Results to Referrer (including in-patient procedures)

- Referrers wait more than 10 working days to receive results. 1
- Referrers wait more than 5 working days to receive results. 2
- Results are sent by post on the same day as the procedure. 3
- Results are transmitted electronically (fax or email) on the same day as the procedure or placed in the hospital file (for inpatients). 4

Timeliness

All waiting times refer to the longest wait within the department for any procedure and do not include delays occurring as a result of patient choice:

- Waits exceed 4 weeks for urgent procedures and/or 26 weeks for routines. 1
- Waits are within 4 weeks for urgent procedures and within 26 weeks for routines.2
- Waits are within 2 weeks for urgent procedures and within 13 weeks for routines.3
- Waits are within 2 weeks for urgent procedures and within 6 weeks for routines. 4

Score 1-4

Choice

- Patients have no choice about their appointment – there is no booking. 1
- Up to 50% of patients are either fully or partially booked. 2
- Up to 100% of patients are either fully or partially booked. 3
- All patients are fully booked. 4

Privacy and dignity

- There is no facility to talk to patients privately. 1
- Private discussions with patients can occur but facilities are limited and most conversations occur within earshot of other patients or relatives. 2
- The majority of patients have discussions about their clinical care, including consent, beyond the hearing of other patients. 3
- All patients have discussions about their clinical care privately. They are treated with dignity (eg mindful of state of undress etc) by all staff. 4

Aftercare

- Patients are discharged from endoscopy without knowing the outcome of the procedure or plans for further management. 1
- Patients are discharged without knowing either the outcome or plans for further review. 2
- Patients are discharged knowing the outcome and future plans but with little additional information and without an appointment when one is required. 3
- Patients are discharged knowing the outcome, with appropriate information, future plans and a date for review when one is required. 4

Ability to provide feedback to the service

- No response to patient complaints or attempts to gather patient feedback. 1
- Patient complaints lead to a sustained change in practice. 2
- Patient complaints lead to a sustained change in practice. Patient feedback is gathered prospectively but is not always acted upon. 3
- Patient feedback, gathered prospectively by at least two methods, leads to sustained changes in practice. 4

Score 1-4

Retention and recruitment of staff

Staff development

- Endoscopy staff do not receive appraisal (IPR). 1
- Endoscopy staff receive appraisal (IPR), but not regularly. 2
- Endoscopy staff receive appraisal (IPR) regularly but identified learning needs receive minimal support. 3
- Endoscopy staff receive appraisal (IPR) regularly. Learning needs are fully supported and there is regular review to ensure that the support has addressed the learning need. 4

Tool 3B: Radiology self-assessment

Introduction

If your assessment indicates that radiology services are a perceived or an actual bottleneck to achieving cancer waiting times it is vital to identify precisely where the problems exist and to work with the departments to overcome them. The assessment tool for Radiology should focus on areas for service improvement. The units themselves must identify the constraints and joint working with all involved in the delivery of care is vital for success.

Assessing where you are

The following questions can be very useful:

Leadership and clinical engagement

Do you have strong clinical and managerial leadership for your service improvement strategy?

Do you have clinicians fully engaged in service redesign?

Performance and data capture

Do you have a robust system for monitoring and managing waiting lists?

Do you have a robust system for collecting capacity, demand, activity and backlog data?

Do you record DNA and cancellation rates and understand the reasons for cancellations?

Can you meet the cancer waiting times targets and ensure that no other group of patients are disadvantaged?

Are you able to meet the 18 week referral to treatment target?

Are there issues with turnaround times for reports or problems with timely access to reports?

Referral, access and choice

Do you have agreed referral protocols for health care communities across primary and secondary care?

Do you have integrated referral pathways, one stop clinics or straight to test services in place?

Do you have multiple queues and different priority slots (carve out) for different clinical conditions?

Have you implemented full and or partial booking for patients in all modalities?

Decision making

Is Radiology represented at all MDT meetings ?

Patient involvement

Do you involve patients in service planning and redesign?

Staff investment

Have you implemented or maximised skill mix opportunities across all disciplines ?

Are there opportunities in place for role extension and redesign with adequate training needs identified?

Next steps

Please refer to Section 6 for an in-depth look at the high impact changes for radiology, tools for success and case studies.

Tool 4: Multi-disciplinary team self-assessment

Cancer waiting time and pathway management

Introduction

Many patients with cancer need to go through multiple steps between referral and first treatment. In order for patients to start treatment within the appropriate timescale it is important that:

- the care pathway is pro actively managed
- the MDT is fully aware of the waiting times position for their patients
- there is good communication between clinical teams.

This self-assessment aims to help the multi-disciplinary teams to check that the basics are in place to ensure that patients receive treatment within the national cancer waiting times targets.

	Yes	No
All new patients are discussed at MDT.	☐	☐
Patient pathways are agreed within the team with identified timescales for the key stages of the patient's journey	☐	☐
Cancer waiting times data is collected at MDT.	☐	☐
A member of the MDT has the responsibility for monitoring the 31/62 day period.	☐	☐
The MDT is aware of the bottlenecks in the system and relevant plans to avoid delays are made.	☐	☐
Breaches are monitored and discussed at MDT.	☐	☐
Trigger systems are in place to avoid breaches.	☐	☐
Systems are in place to navigate the patient along the care pathway within the cancer waiting times.	☐	☐
Communication systems are in place to alert relevant specialists teams/tertiary centres within a realistic timescale of the clinical diagnosis being made. E.g. 5 working days (including radiologic and endoscopic diagnosis).	☐	☐
The MDT meeting receives regular monthly reports on 31 & 62 days waiting times positions.	☐	☐

A detailed colorectal checklist for multi-disciplinary teams can be found at www.modern.nhs.uk/cancer/mdt

Tool 5.

Reviewing the pathway: mapping your last 10 patients

Collecting journey times for the last ten patients along the pathway may help visually to show specific areas that need to be addressed, the template was originally designed for upper GI. The principles can be adapted to provide an effective tool to be used at a local level for all cancers.

- Collect information on your last ten patients' journey times (this should not only include the two week wait patient). Note: Some of the key dates along the pathway will already be recorded on the Cancer Waiting Times database (CWT db)
- Identify a person who is proficient in Excel to input the data using the principles identified in the upper GI template and adapt to your local needs
- If you require a more detailed analysis of the individual patient's journey, a one patient journey template is recommended

Template of detailed analysis of Individual patient journey times

Template can be downloaded from website
www.modern.nhs.uk/cancer/uppergi

Recommendations for using the template

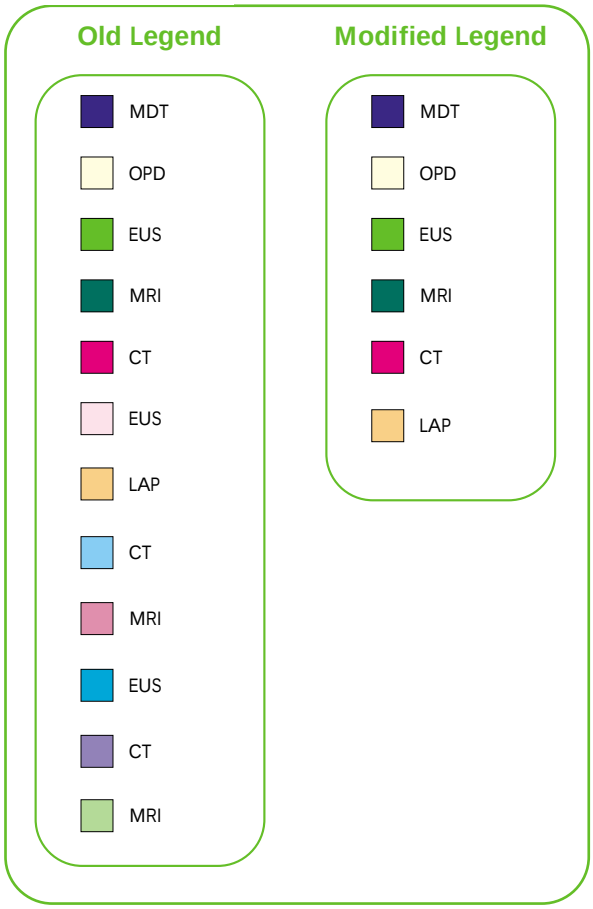
Due to variation in patient pathways, there will be multiple columns with identical headings e.g. multiple CT, EUS columns etc. The resulting graph is visually confusing and difficult to analyse as each pathway requires cross-referencing to a complex legend, which can in some cases display 30+ items with multiple duplications.

To assist in presenting these graphs in a more beneficial format the following process is suggested:

1. On completion of the graph, ensure that every identical procedure is presented in the same format e.g. blue for EUS, red for CT etc
2. Modify the legend to eliminate repetitions of identical procedures i.e. the modified legend should display only one instance of each procedure (see fig. 1)
B: These modifications alter the layout and presentation only, they do not in any way alter the data.

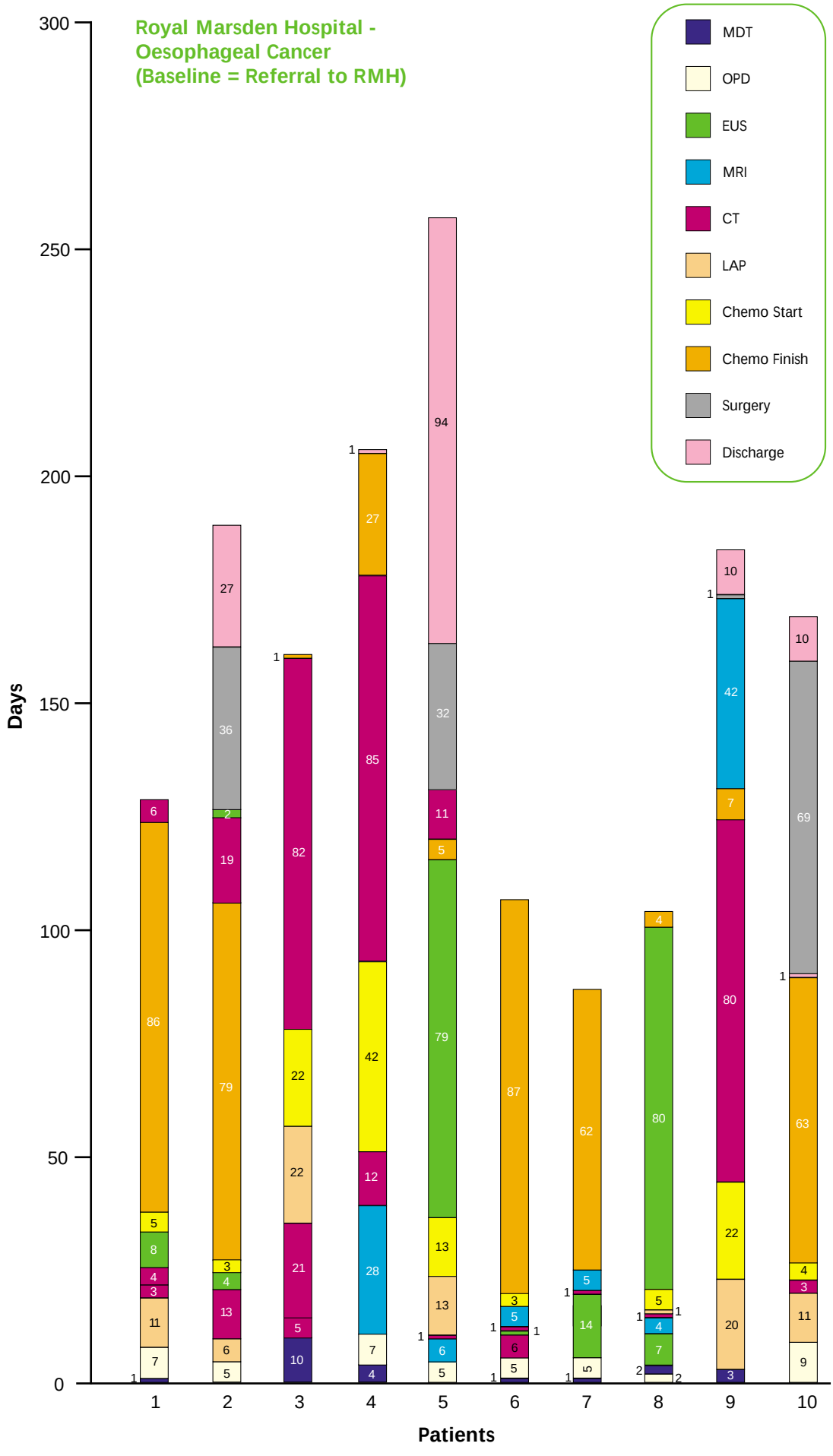
(See glossary of terms)

Fig.1



References

The Belfry Plan is available at:
www.modern.nhs.uk/cancer/uppergi


Royal Marsden Hospital -
Oesophageal Cancer
(Baseline = Referral to RMH)
MDT
OPD
EUS
MRI
CT
LAP
Chemo Start
Chemo Finish
Surgery
Discharge
Days
Patients
0
50
100
150
200
250
300
1
2
3
4
5
6
7
8
9
10

3. More detailed work on an individual patient can highlight precise details of the journey, which allows specific areas for service improvement to be identified.

Detailed template for one patient's journey

Section 2

Additions

Upper Gi Self assessment against High Impact Changes

One referral route into the system (streamline referral)	Nothing planned	In Progress	Implemented
Develop appropriate referral criteria with Primary Care within the NICE Guidlines in Dyspepsia management	☐	☐	☐
Agreed patient pathway across the Trust	☐	☐	☐
Audit and identify referral patterns for patients referred for Upper GI cancer	☐	☐	☐
Implemented electronic or faxed referral	☐	☐	☐
Pooling of all referrals within a structured system	☐	☐	☐
Reducing the steps to Diagnosis and Staging			
Direct to Diagnostics For an Upper GI endoscopy for suspected oesophageal or gastric cancer For an ultrasound for suspected pancreatic cancer	☐	☐	☐
Pooling of endoscopy	☐	☐	☐
Standardised tests and referral protocols	☐	☐	☐
Booking and scheduling systems (inc. waiting list validation, DNA and A/L policy)	☐	☐	☐
Standardised computed Tomography (CT) and endoscopy reporting	☐	☐	☐
Agree Network-wide imaging protocols	☐	☐	☐
Agree mechanism in place to ensure transfer of images with all patients	☐	☐	☐
Timely reporting and access to results – maximum use of technology	☐	☐	☐
Map the flows of information delivery across the care pathway and develop information protocols	☐	☐	☐
Treatment			
MDT Meetings	☐	☐	☐
MDT Tracker/co-ordinator	☐	☐	☐
Review cancer waiting times in the MDT	☐	☐	☐
Review Breaches	☐	☐	☐
Standardised referral mechanisms between Primary, Secondary and Tertiary Care	☐	☐	☐

Upper Gi Self assessment against High Impact Changes (cont.)

One referral route into the system (streamline referral)	Nothing planned	In progress	Implemented
Check list for implementation of inter hospital transfer protocol			
Inter Hospital working protocol agreed and in place	☐	☐	☐
Key roles of staff identified within the protocol	☐	☐	☐
Methods of communication agreed	☐	☐	☐
Plans in place for any staff training required	☐	☐	☐
Ongoing monitoring/audit system in place	☐	☐	☐
Identification of baseline information requirements	☐	☐	☐
Proforma/database available for information transfer	☐	☐	☐
Morbidity Protocols	☐	☐	☐
EUS Capacity and demand (in terms of equipment and manpower)	☐	☐	☐
Agreed protocols across units/centres	☐	☐	☐
Who decides when to do the EUS?	☐	☐	☐
How many people are trained to do EUS what backup is there for A/L / sickness	☐	☐	☐
ERCP and MRCP Capacity and Demand (for Pancreatic cancer)	☐	☐	☐
Theatre/ITU scheduling	☐	☐	☐
Whole system redesign endoscopy-complete Global Rating Scale	☐	☐	☐

‘How To’ Guide Additions

Introduction

The ‘How To’ Guide was published in February 2005. Building on increased learning and sharing of best practice, this pack contains further tools and case study material for you to insert into your guides.

The original guide can be obtained from: www.modern.nhs.uk/cancer

Section 2 additions
Introduction

The information within this section is designed to assist you in establishing a baseline position and assessing actions needed for cancer waits delivery for:

- Dermatological cancers
- Haematological cancers
- Head and neck cancers

Skin Self Assessment: High Impact Changes

One referral route into the system (streamline referral)	Nothing planned	In progress	Implemented
Develop appropriate referral criteria with primary care within the NICE guidance on referral for suspected cancer			
Implemented electronic or faxed referral for urgent suspected cancer.			
Single point of contact for referral			
Agreed patient pathway across the Trust			
Audit and identify referral patterns of patients referred for skin cancer			
Pooling of all referrals			
Reducing the steps to Diagnosis and Staging: Straight to Test			
Rapid Access Diagnosis and Treatment clinics: See and Treat See and book appointment for treatment			
Standardised referral protocols and reporting			
Extended Roles; Nurses performing skin biopsies			
Timely reporting of histology and access to results			
Agreed protocols for imaging when required			
Treatment undertaken by 'the right person at the right time in the right place'			
MDT meeting Review cancer waiting times in the MDT Review breaches			
Team based approach with regular audit of performance and outcomes			
Pre book onward steps in pathway			
Joint clinics with dermatologists and surgeons			
Nurse led clinics			
Agreed follow up protocols across Primary and secondary care.			
Proactive patient pathway management i.e. patient tracking system			

Haematology Self Assessment: High Impact Changes

One referral route into the system (streamline referral)	Nothing planned	In progress	Implemented
Develop appropriate referral criteria with primary care within the NICE guidance on referral for suspected cancer			
Implemented electronic or faxed referral for urgent suspected cancer.			
Single point of contact for referral			
Agreed patient pathway across the Trust			
Pooling of all urgent referrals with appropriate triage to sub specialists			
Managed clinical capacity to accommodate urgent referrals			
Triage of non urgent referrals			
Audit of GP referrals			
Reducing the steps to Diagnosis: Straight to Test			
Rapid access for lymphadenopathy - Lump clinic - Pathway			
Clear diagnosis / staging pathway			
Timely reporting and access to results – maximum use of technology			
Single visit clinic/day :ward facility for investigation including bone marrow examination			
Integrated pathology report			
Treatment undertaken by 'the right person at the right time in the right place'			
MDT meeting Review cancer waiting times in the MDT Review breaches			
Team based approach with regular audit of performance and outcomes			
Pre book onward steps in pathway			
Joint clinics with dermatologists and surgeons			
Nurse led clinics			
Agreed follow up protocols across Primary and secondary care.			
Proactive patient pathway management i.e. patient tracking system			

Head & Neck self assessment

One referral route into the system (streamline referral)	Nothing planned	In progress	Implemented
Develop appropriate referral criteria with primary care within the NICE guidance on referral for suspected cancer			
Implemented electronic or faxed referral for urgent suspected cancer.			
Single point of contact for referral			
Agreed patient pathway across the Trust			
Audit of GP referrals			
Reducing the steps to Diagnosis and Staging: Straight to Test			
Rapid access for the investigation of lumps: - Pathway - Clinic			
Standardised referral protocols and reporting			
Clear diagnosis / staging pathway FNAC Biopsy / Endoscopy Radiology			
Standardised referral protocols and reporting			
Timely reporting and access to results – maximum use of technology			
Treatment undertaken by 'the right person at the right time in the right place'			
MDT meeting Review cancer waiting times in the MDT Review breaches			
Team based approach with regular audit of performance and outcomes			
Pre book onward steps in pathway Surgery Radiotherapy Chemotherapy			
Joint clinics surgeons & oncologists			
Pre assessment nurse/AHP clinics			
Theatre booking and scheduling			
Proactive patient pathway management i.e. patient tracking system			

Section 3

Data: Quality and completeness

The cancer waiting times targets, as specified in the NHS Cancer plan are:

By December 2005

- Maximum two month (62 days) wait from urgent GP referral to first treatment for all cancers.
- Maximum of one month (31 days) wait from diagnosis (measured as 'date of decision to treat') to first treatment for all cancers.

Completeness in recording data to monitor these targets varies widely between Trusts. In July - September 2004 only around a quarter of acute Trusts reported the expected numbers of cases. In total around 33,000 patients were recorded against the 31 day target, compared with an expectation of around 45,000 cases.

There are a number of reasons that some new diagnoses of cancer will not be reported on the cancer waiting times system. Some patients will be diagnosed at post-mortem or registered only on a death certificate notification. Additionally some patients will receive their first treatment in the private sector or will be referred directly to a hospice for care.

Cancer waiting times system (CWT-db)

Cancer Waiting Times information is collected on the national cancer waiting times system (CWT-db), which is hosted on the Open Exeter system by the NHS Information Authority (NHSIA). The CWT-db provides monthly and quarterly reports on cancer waiting times to Acute Trusts, PCTs, Cancer Networks, SHAs and Department of Health (DH). These reports are available on a provider basis and on a commissioner basis.

The reports show performance for each tumour type against each target, and include detailed reasons for breaches against each target.

The collection of Cancer Waiting Times data onto the CWT-db was mandated in June 2002 through DSCN 22/2002.

To gain access to the CWT-db a user is required to complete the User Access form. This needs to be signed off by your organisation's Caldicott Guardian and faxed to the NHSIA team.

User Access forms are available at:
www.nhsia.nhs.uk/nhsia/pages/products/vaprod/openexe/

Further information on security is available in the Cancer Waiting Times System Security document available at
http://www.nhsia.nhs.uk/cancer/pages/waiting/

Collecting the data: principles for success:

Data staff

- Identified lead at senior level for data collection for cancer waiting times.
- Dedicated staff time to capture and enter data on the system.
- Ensure cancer information staff work as part of each multi-disciplinary team and attend MDT meetings.

Data collection

- Gain clear understanding of current collection processes.
- Robust data capture systems in place agreed by clinical and managerial staff
- Make sure that each patient's position in relation to the 31 day and 62 day target is discussed at each MDT meeting.
- Ensure all members of the MDT understand the rules for suspensions, apply them correctly and record them in the patients notes so that appropriate adjustments can be made to waiting times.
- Implement prospective collection processes wherever possible to support the pro-active management of patients along their pathway.
- Data capture templates can be useful for systematically recording patient data (see end of section for sample template).

Validation and reporting

- Check that **all new cancer patients** are identified. Pathology and hospital information systems should also be cross-referenced against patients discussed at MDT. (See also MDT checklist in section 2 of this Guide).
- Review of clinical notes when required.
- Investigation of breaches discussed at multi-disciplinary team meetings, with performance staff and opportunities for service improvement identified.
- Use of Preview report and other data quality reports on CWT.
- Use NHS tracing service where NHS number is missing.

- Trusts should upload data well before the 25th working day deadline. This allows time for validation and avoids technical hitches (some trusts aim for the 20th day). Once the report is run it will not change and cannot be updated retrospectively.
- Close working within Cancer Networks:
  - Sharing of good practice across trusts
  - Developing data transfer systems between trusts
  - Review progress of waiting times at Tumour Site Specific Groups

Benchmarking completeness of cancer waits

For the purposes of benchmarking overall completeness of Cancer Waiting Times (CWT-db) data we have categorised hospital trusts into three groups using the DH trust cluster groupings.

From a review of CWT data it is clear that some trusts are already achieving reasonable levels of data capture, whilst other trusts have yet to upload a significant quantity of data on the treatment of their cancer patients.
From this analysis we would expect "Large" trusts to collect at least 400 new records (new patients) a quarter, "Medium" trusts to collect at least 200 cases a quarter and "Small" trusts to collect at least 150 cases per quarter.

Cluster classification	Group benchmark
Acute Specialist (If Cancer Specialist).	Large 400
Acute Teaching London.	Large 400
Acute Teaching Outside London.	Large 400
Large Acute London.	Large 400
Large Acute Outside London.	Large 400
Medium Acute London.	Medium 200
Medium Acute Outside London.	Medium 200
Multi-service.	Small 150
Small Acute London.	Small 150
Small Acute Outside London.	Small 150

Some trusts may not meet these minimum benchmarks due to the local configuration of cancer services, for example if the first treatment of cancer is centralised at a single trust. An SHA or Cancer Network would need to highlight where this is the case locally.

Benchmarking information for each cancer network was sent in December 2004 to all network leads, SHA cancer leads and copied to Directors of Performance.

The National Cancer Waits Project team are happy to take any queries you might have on this. Please contact Andy McMeeking on Tel: 020 7188 4761 or andrew.mcmeeking@gstt.sthames.nhs.uk

Case studies on establishing robust data collection processes: The first case study illustrates a Trust approach and the second case study describes a Network-wide approach to improving cancer data collection.

Case Study 1: Portsmouth Hospitals NHS Trust

Cancer waiting times data collection made easy.

Introduction

Portsmouth is one of the biggest Trusts in the country, a large complex organisation working out of three main sites, with 8000 staff, serving a population that is approaching a million people. The trust had been preparing for the data collection targets well before they were implemented more than four years ago.

Local solutions

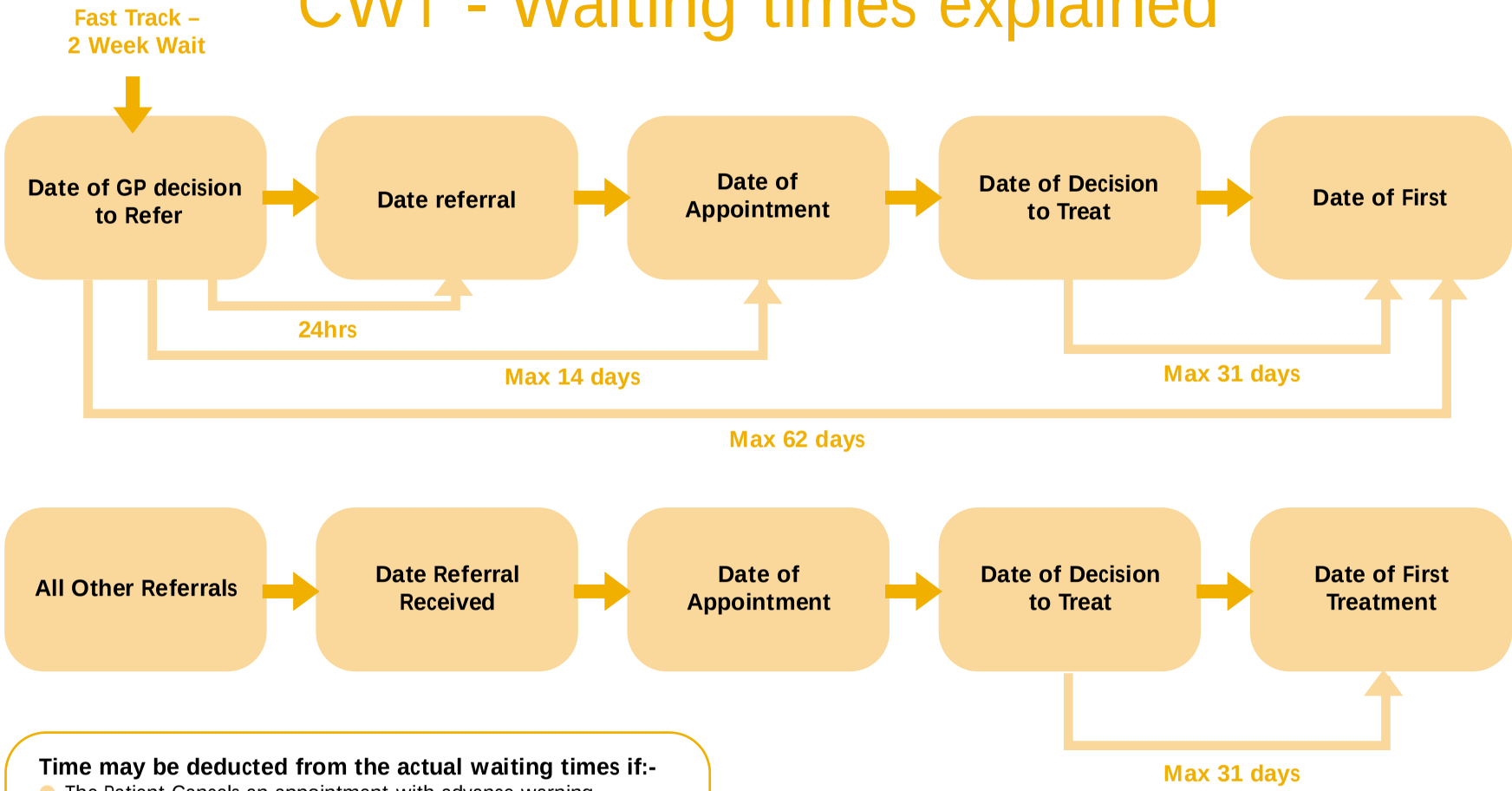
Some of the key factors that have helped the Cancer Waiting Times processes are:

- GPs from the 3 Primary Care Trusts (PCTs) that we serve came on board at an early stage.
- The GPs along with the hospital clinicians, owned and developed the Referral Proforma system.
- Appointments can be given quickly and recorded accurately.
- Active dialogue continues between the Trust and the PCTs, ensuring the Proformas are kept updated and used appropriately.
- Resources being provided for data collection in terms of staff and infrastructure.
- The Cancer Master Index has been the cornerstone of our cancer data collection; it draws data from HIS and Apex, the pathology database, allowing the data clerks to compile the cancer journey for each cancer patient, and will ultimately give us the facility to produce accurate, comprehensive and timely reports for all cancer specialties.
- Cancer Data Clerks are acknowledged as integral members of the Cancer Team.
- Cancer Data Clerks build links and work with a wide range of people including the Cancer Clinicians, Cancer Nurse Specialists, Cancer Team, Managers and Clerical staff.
- These links really help to make the challenging task of tracking of data as smooth as possible. Julia Fouracre, Gastro cancer data clerk says 'I get weekly pathology printouts, have a good relationship with the MDT Co-ordinator and regularly check the surgical wards'.
- Training courses hosted and run by Central South Coast Cancer Network, for staff connected with cancer data collection. These provide an important meeting forum allowing us not only to meet our opposite numbers from the other Trusts in the Network but also giving us the opportunity to exchange information and ideas.

Speciality reports are collated from the data clerks along with site-specific reports from the Cancer Master Index (CMI) to track new diagnoses, and also the Patient Administration System (PAS) to track appointments. Regular IT downloads provide a monthly extract of all the 2 week wait referrals, which are checked, and reasons for any breaches and recommend actions to prevent further breaches are looked at. This information is then submitted to the Cancer Waiting Times database, and reports compiled for the Trust and PCTs.

Portsmouth Hospital NHS Trust

CWT - Waiting times explained



Time may be deducted from the actual waiting times if:-

- The Patient Cancels an appointment with advance warning
- The Patient DNA for an appointment
- The patient defers an appointment
- The Patient is medically unfit for an appointment, procedure or treatment

Date of Decision to Treat – is the date that clinician and patient agreed on a course of treatment, even if that treatment cannot be given

The challenges continue, Portsmouth is now pressing ahead to ensure that the data systems help the Trust to meet the 31 and 62 day waiting times and booking targets.

The "bottom line" is the same as the top line – there is no secret to Cancer Waiting Times data collection success – teamwork, persistence, lots of preparation and sheer hard work comes to mind!

Penny Davies
Cancer Information Manager,
Cancer Services/Service Planning Department
Portsmouth Hospitals Trust,
Queen Alexandra Hospital

Case Study 2: Yorkshire Cancer Network

Successful Cancer Waiting Times Data Collection – A Network Approach

Co-ordination

Each Acute Trust in the Network has identified an Information Lead for Cancer Waiting Times. The Network also has an Information Lead with a responsibility for cancer waiting times.

The Yorkshire Cancer Network (YCN) together with the other Cancer Networks in the north of England began working together about a year before the final publication of the CWT DSCN (22/2002).

Information sharing

The Network approach has been very useful for encouraging consistency in data interpretation and also in agreeing data transfer policies between acute Trusts for patients being treated in tertiary centres. This work is still ongoing and a major revision to our transfer policy is currently being written based on the experience gained from almost two years of CWT data collection. The policy outlines the responsibilities for both diagnosing and treating Trusts as well as the submission of data to the CSC'IP'.

There is also a section relating to security and confidentiality. All electronic transfers of data will be done using public-private key encryption.

Resources

The most successful Trusts in collecting CWT data are those who employ several members of staff for data collection. Collection of CWT is a labour intensive process.

The YCN has been working with Trusts for several years to increase the number of cancer information staff and has even provided some limited financial support to each Trust to recruit information or MDT co-ordination staff.

The local Information Leads are responsible for training staff to collect CWT data. Training support is also provided by the Network Information Lead.

Retaining the services of good cancer information staff is an additional problem. As the process is so labour intensive the loss of even a single member of staff can have a significant effect on the performance and ability to collect the CWT data.

The Cancer Networks in the north of England have collaborated and produced a Handbook (www.ycn.nhs.uk/html/information/waitingtimes.htm) to support the implementation of the DSCN 22/2002.

Systems

The presence of a single integrated cancer information computer system is a major factor in the success of Trusts in collecting CWT data. The lack of a single system for collecting all cancer information including CWT data has complicated the process for a couple of the Trusts leading to gaps in the uploading of CWT data.

Using the information

Ultimately the only way to improve both the quality of the data collected and the quantity of the data is to use it.

The data collected by Trusts in Yorkshire Cancer Network is used in a number of different ways.

- Locally most if not all MDTs review their data monthly and undertake a detailed pathway analysis of all target breaches. This helps in identifying potential pathway bottlenecks and allows the Service Improvement Team to work with specific MDTs to improve their pathways based on real examples data.

- All Network site-specific groups and some cross-cutting groups review CWT data at each meeting. This stimulates discussion around the targets and allows for comparisons between Trusts and some general debate around ascertainment at a Network level. A number of groups have used the CWT data as a baseline for the collection of a more complete clinical data set and a few have started audits taking a more detailed look at the patients who breach trying to identify common reasons.

CWT information is also used extensively, internally by members of the Network Lead Team, the Service Improvement Team and the Research Network. Regular internal "stocktake" meetings focussing on each health community within the Network use CWT data as a basis for their discussion.

A more recent development has been to present the data to the Network User Partnership Group at their request. Sharing the information with patients and carers provided a new perspective on the data and helped remind us of the real reason for having the targets and collecting the data.

Work is currently underway with the local Cancer Registry to look at overall levels of ascertainment for all cancer sites.

Phillip Melling
Network Information Lead
Yorkshire Cancer Network

References

www.nhsia.nhs.uk/cancer/pages/waiting
www.ycn.nhs.uk/html/information/waitingtimes.htm

Sample data capture template:
Guys & St Thomas Hospital

Gynaecological cancer waiting times

Month of treatment: _____

Date form completed: _____

Patient included in monitoring report Y ☐ N ☐
If No, why? (e.g. private patient, recurrence etc)

_____

_____

_____

Case notes checked Y ☐ N ☐

Demographics

NHS Number _____

Hospital Number _____

Surname _____

First Name _____

DOB _____

Source _____

Uploaded to national CWT Database Y ☐ N ☐

If no – why?

_____

_____

_____

Referral details

Source of referral for out-patients
- ☐ 03 Referral from General Medical Practitioner
- ☐ 04 Referral from an A&E department
- ☐ 05 Self-referral
- ☐ 08 Other source of referral

Cancer referral decision date _____

Referral request received date _____

Cancer referral priority type:
- ☐ 01 Urgent referral for suspected Cancer from GP
- ☐ 02 Other referral source or urgency

Urgent cancer referral type:
- ☐ 09 Suspected gynaecological cancer date first seen

Organisation code (provider first seen):
- ☐ RJ100 GSTT
- ☐ Other hospital

Waiting time adjustment (First Seen)

_____

Waiting time adjustment reason (first seen):
- ☐ 1 No adjustment to waiting time
- ☐ 2 Patient cancellation
- ☐ 3 DNA
- ☐ 4 Patient choice

Waiting time calculation (referral to first seen)

_____

Delay reason comment (first seen)

_____

Delay reason referral to first seen (cancer):
- ☐ 01 Clinic cancellation
- ☐ 02 Outpatient capacity inadequate
- ☐ 03 Administrative delay
- ☐ 04 Not received within 24 hours
- ☐ 99 Other

Referral To specialist/diagnosis & decision to treat
cancer specialist referral date

Referring organisation code

First seen by specialist date (cancer)

Organisation code (provider first cancer specialist)

Clinical intervention date (first diagnostic test)

Organisation code (provider first diagnostic test)

MDT discussion indicator

Multi-disciplinary team discussion date

Cancer status
- ☐ 1 suspected cancer
- ☐ 2 diagnosis of cancer confirmed

Primary diagnosis (ICD 10)
- ☐ C51 Vulva
- ☐ C52 Vagina
- ☐ C53 Cervix
- ☐ C54 Endometrium
- ☐ C55 Uterus
- ☐ C56 Ovary
- ☐ C57 Other
- ☐ C58 Placenta

Tumour laterality

☐ L ☐ R ☐ B ☐ 9 Unknown

☐ 8 Not applicable

First definitive treatment
- ☐ 01 Surgery
- ☐ 02 Chemotherapy
- ☐ 03 Radiotherapy (Teletherapy)
- ☐ 04 Radiotherapy (Brachytherapy)
- ☐ 05 Specialist Palliative Treatment Course
- ☐ 06 Active Monitoring

Decision to treat date

Organisation code
(Provider decision to treat)

Waiting time adjustment (decision to treat)

Waiting time adjustment reason
(Decision to treat)
- ☐ 1 No adjustment to waiting time
- ☐ 2 Patient cancellation
- ☐ 3 DNA
- ☐ 5 Self deferral
- ☐ 6 Suspension – medical reasons
- ☐ 7 Suspension – patient reasons

Planned cancer treatment type
(First definitive)
- ☐ 01 Surgery
- ☐ 02 Teletherapy
- ☐ 03 Chemotherapy
- ☐ 04 Hormone therapy
- ☐ 05 Specialist Palliative Care
- ☐ 06 Brachytherapy
- ☐ 09 Active Monitoring
- ☐ 08 Other
- ☐ 99 Unknown

First Treatment

First definitive treatment date

Organisation code (provider first treatment)

Waiting time adjustment (tTreatment)

Waiting time adjustment reason (treatment)
- ☐ 1 No adjustment to waiting time
- ☐ 2 Patient cancellation
- ☐ 3 DNA
- ☐ 5 Self deferral
- ☐ 6 Suspension – medical reasons
- ☐ 7 Suspension – patient reasons

Waiting time calculation
(Decision To Treatment)

Waiting time calculation
(Referral To Treatment)

Delay reason comment
(Decision To Treatment)

Delay reason comment
(Referral to treatment)

Delay reason decision to treatment (cancer)

- ☐ 1 Clinic cancellation
- ☐ 2 Outpatient capacity inadequate (i.e. no cancelled clinic, but not enough Slots for this patient)
- ☐ 3 Administrative delay (e.g. failed to be rebooked after DNA, lost referral, etc)
- ☐ 4 Elective cancellation (for non-medical reason)
- ☐ 5 Elective capacity inadequate (patient unable to be scheduled for treatment within target time)
- ☐ 6 Delay to diagnostic test(s) (delay caused by wait for diagnostic test(s))
- ☐ 7 Complex diagnostic pathway (many, or complex, diagnostic tests required)
- ☐ 8 Delay due to referral between Trusts

Delay reason referral to treatment (Cancer)

- ☐ 1 Clinic cancellation
- ☐ 2 Outpatient capacity inadequate (i.e. no cancelled clinic, but not enough Slots for this patient)
- ☐ 3 Administrative delay (e.g. failed to be rebooked after DNA, lost referral, etc)
- ☐ 4 Elective cancellation (for non-medical reason)
- ☐ 5 Elective capacity inadequate (patient unable to be scheduled for treatment within target time)
- ☐ 6 Delay to diagnostic test(s) (delay caused by wait for diagnostic test(s))
- ☐ 7 Complex diagnostic pathway (many, or complex, diagnostic tests required)
- ☐ 8 Delay due to referral between Trusts

Comments:

1 Month wait =

2 Month wait =

Frequently asked Questions

"Cancer Waiting Targets – A Guide" provides a comprehensive collation of frequently asked questions and can be found at the reference below.

References

www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Cancer/fs/en

- HSC 2002/005 – overview, time scales revised.
- Cancer Waiting Targets – A guide – Q&A

http://www.nhsia.nhs.uk/cancer/pages/waiting/

- DSCN 22/2002 – Definitions/status of data items
- System Security Documents and User Access Forms
- User Manual for the database

Helpdesk - 01392 251 289

Cancer Data

www.performance.doh.gov.uk/cancerwaits/

National Contacts

NHSIA helpdesk
Tel: 01392 251 289
Andy McMeeking
Tel: 020 7188 4761
Email: Andrew.mcmeeking@gstt.sthames.nhs.uk
Sian Gordon-Brown
Tel: 020 7972 4906
Email: sian.gordon-brown@dh.gsi.gov.uk
Tim Hancox
Tel: 020 7972 4565
Email: timothy.hancox@dh.gsi.gov.uk

Section 3

Additions

Guidance on Adjustments for Cancer Waiting Times

1. There is already guidance on recording waiting times for the purposes of calculating inpatient waiting list and waiting time central returns. (See: Mark Morrison letter of 13 August 2002 "Measuring and Recording Waiting Times")

2. This existing guidance also applies to the recording of waiting times in the cancer waiting times database. This note provides some specific examples of adjustments in the cancer pathway.

3. In line with current guidance on waiting times an adjustment to the waiting time of a patient is applicable in the following circumstances.

- Patient cancelled an outpatient appointment
- Patient Did Not Attend (DNA) an outpatient appointment
- Patient defers an admission
- Suspension for patient reasons (often referred to as social suspension)
- Suspension for medical reasons

4. Patient cancelled an outpatient appointment

- If this is the first outpatient appointment the clock restarts from the date of the appointment the patient was offered but refused. The adjustment is the number of days from date of decision to refer to date of appointment the patient refuses. (i.e. clock is reset)
- If this is a follow-up appointment the adjustment is calculated as the number of days from the date the patient was last seen to the date of appointment the patient refuses.

Note: If the provider cancels the appointment then there is no affect on the waiting time.

5. Patient Did Not Attend (DNA) an outpatient appointment

- If this is the first outpatient appointment the clock restarts from the date of the appointment the patient did not attend. The adjustment is the number of days from date of decision to refer to date of DNA. (i.e. clock is reset)
- If this is a follow-up appointment the adjustment is calculated as the number of days from the date the patient was last seen to the date of appointment the patient did not attend.

6. Patient defers admission

- Patient is offered a reasonable date for admission but refuses. Provided the admission date was a reasonable one (i.e. there was a sufficient amount of notice and the provider took account of personal circumstances) this is described as a self-deferral. In such a case the waiting time is adjusted by the number of days from date of decision to treat to the date the admission was scheduled to take place.

Example

- A patient is contacted by the trust and offered an admission date for surgery to treat their breast cancer. At this time they declare that they are unable to attend on this date as they have booked a holiday. This is a patient deferral. In this case the period between the admission date they declined and the decision to treat date is to be removed by an adjustment.

Note: if the provider cancels the admission then there is no affect on the waiting time. (e.g. the 31 day target waiting times is calculated from the original decision to treat date)

7. Suspension for patient reasons (often referred as social suspensions)

The clock stops when

- When a patient has other commitments they wish to pursue prior to treatment or investigation (e.g. Holiday)
- When a patient requests a period of time to think (e.g. to decide on treatment options)
- When a patient requests a second opinion before making a decision on treatment. (The clock does not stop if the clinician requires a second opinion)
- Suspensions must be clearly recorded in the patient notes
- The position of any patient suspended must be reviewed regularly.

The clock does not stop

- When a patient chooses a treatment with a longer waiting time (e.g. radiotherapy rather than surgery)
- A patient should not be suspended once an admission date has been agreed, unless the date is later than normal due to the need to resolve other medical problems prior to treatment.

Examples

- A patient with cancer is seen by the oncologist and is suitable for a clinical trial. The patient is given the details and told he/she needs to make a choice about whether or not they wish to take part in the trial. This two-step process is good practice in terms of informed consent. Whilst taking the time to make the decision, the patient will be classed as suspended for patient reasons as he/she is technically unavailable for treatment. The clock starts again as soon as the patient has told the oncologist of their decision.

Note: Allowing patients time to consider treatment options is part of good clinical practice and is not confined to clinical trials.

- A young patient is advised that potentially curative treatment involves significant risk of serious side effects (which may include peri-operative death). The patient wishes to be referred for a second opinion to see if they might avoid these outcomes but yet still achieve cure. The patient is suspended for patient reasons as they have made themselves unavailable for treatment whilst seeking a second opinion.
- A patient is discussing their care-plan with a clinician and states (before any offer of an admission date is made) that they would like to take the holiday they have booked prior to treatment starting. As no offer of a TCI date had been made by the trust this can be classified as a suspension for patient reasons. The period which the patient has made themselves unavailable should be adjusted out of the calculated waiting time.

8. Suspension for medical reasons

The clock stops:

- When a patient is unavailable for admission for a period of time due to another medical condition that needs to be resolved
- When a patient is unavailable for a diagnostic or staging test or treatment due to another medical condition that needs to be resolved (e.g. reduce weight)
- Suspensions must be clearly recorded in the patient notes
- The position of any patient suspended must be reviewed regularly.

The clock does not stop:

- When the trust is unable to offer treatment within the required timescales.
- For a patient who requires repeat biopsies or scans because of uncertainty the first time round.
- In patients for whom there is genuine clinical uncertainty about the diagnosis and the clinician elects to observe the patient over (say) a three month period.
- A patient should not be suspended once an admission date has been agreed, unless the date is later than normal due to the need to resolve other medical problems prior to treatment

Examples

- Some cancer patients will have co-morbidities, which will require investigation and/or treatment prior to administering cancer treatment. For example a cancer patient with angina may be referred for a cardiology opinion prior to treatment. In this case the clock will only stop if the cardiology opinion is that the patient is medically unfit for cancer treatment. If the opinion is that the patient is fit for cancer treatment then the clock does not stop. Hence the clock does not stop whilst an opinion on the co-morbidity is being sought.
- Patients with severe frailty/cachexia related to the cancer. A patient who requires intensive nutritional support (e.g. through intravenous feeding or through nasogastric feeding) before they are fit for surgery. The clock stops for the period the patient is medically unfit for surgery, with the start date of this period of suspension being defined as the date when a medical opinion as to their being unfit for treatment was received.
- A patient with cancer also has COPD. He/she is technically suitable for surgical resection but considered in need of a medical opinion (in this case usually a respiratory physician). The respiratory physician confirms the patient is medically unfit for the surgery at that time (clock stops at this point) (see above) and wishes to institute a changed therapeutic regime to optimise their respiratory function before surgery. The patient is suspended until medically fit for the surgery.
- In prostate cancer following a transrectal ultrasound-guided biopsy there may be swelling of the prostate gland. This makes interpretation of MRI scans unreliable. Many clinicians would advocate that there should be a planned interval of up to 4 weeks between biopsy and MRI, as the gland swelling means the patient is medically unfit for the scan and so a medical suspension is appropriate. Where this is agreed in local clinical protocols and if the clinician agrees this with the patient, then an adjustment can be made to the waiting time for the period that the patient is unfit to progress to the scan. The patient notes need to make it clear that a medical suspension was necessary. Of course this must not be used to mask delays to MRI scans or subsequent delays to surgery.

PTL (Priority Target List) – A Clinicians' Guide

Clinicians have often had difficulty identifying where patients are in their pathway from referral through diagnosis to treatment. This can lead to long waits and delays in treating patients with life-threatening illnesses.

In September, trusts will start collecting more prospective waiting-time information about cancer patients, which will be available each week to help multidisciplinary clinical teams to:

- Identify the number of patients waiting along the pathway
- Identify patients, diagnosed with cancer who have not agreed a "decision-to-treat"
- Identify patients without first definitive-treatment dates (TCI dates where applicable)
- Identify the time remaining until patients may breach the cancer targets
- Identify patients who have not been treated within the targets (breaches)
- Identify patients treated within the 31day and 62 day cancer waiting times targets

Clinical teams are encouraged to use prospective monitoring and tracking methods to help them plan patient care and to ensure patients with cancer are treated in a timely fashion.

The PTL will identify cancer patients on diagnostic and treatment pathways and help Multidisciplinary clinical teams to review the progress of all their patients.

Further details of the pathway collection process are given in Appendix A

Appendix A
Data Collection

62-day target

1. All patients referred urgently to a trust under the two–week wait will remain on that trusts weekly PTL until:

a) A diagnosis of cancer is excluded

b) The patient is referred to another trust for investigation/treatment

Note, where there is diagnostic uncertainty, patients should remain on the PTL and may breach. This may be a clinical exception (see guidance on clinical exceptions).

2. Patients without a Decision-to-Treat (DTT)

All patients without a DTT will be monitored once they are 28days from their target date (Day 34 along the 62-day pathway). They will continue to be monitored each week.

Patients without a DTT and 14 days or less from their target date will be collected separately

Patients who pass their target date will be collected, including a figure for the number who passed their target date without a DTT in the last 7 days.

3. Those with a Decision to Treat (DTT)

All patients with a DTT who either have a treatment date that falls beyond the target date or have no treatment date, will be monitored once they are 14 days from their breach date (Day 48 along the 62-day pathway). They will continue to be monitored each week.

As above, patients who are 7 days or less from their breach date will be collected separately

4. Patients treated each week

Patients treated each week both within and outside the target time will be collected.

31-day wait

All patients will, by definition, have an agreed decision to treat

Data collection is per the 62-day target for patients with a DTT (Para 3 and 4)

Referral to other trusts

Patients, who are referred outside a trust, would not be included on the referring trusts PTL once referred. However as the patient received by the tertiary trust are still on the 62 day pathway they would still need to be included in that trusts prospective monitoring.

Trusts are encouraged to work with their cancer network disease site groups to ensure appropriate referral protocols and pathways are in place so patients may move in a seamless manner from one trust to another.

Well-specified protocols for the transfer of patient information should have been developed within networks.

Section 4

How to implement changes for cancer

There are some generic issues to be considered when implementing changes to improve cancer waiting times.

Before commencing any work find out what support and advice is available locally. This support may include:

- A local service improvement facilitator or Network Service Improvement Lead (can be contacted via your Cancer Network).
- Local Trust or Strategic Health Authority Modernisation Service improvement teams.
- Use the learning from others.
- Don't re-invent the wheel.
- Share best practice within your cancer network and wider.
- Access written information and case-studies from this document.
- Adopt and adapt to local need.
- These case studies are tried and tested and will deliver.

Experience has shown that the following points will aid the implementation and sustainability of the Cancer High Impact Changes.

Leadership and Ownership

- Gain clinical and managerial leadership and buy-in to redesign the service, both from the top of the organisation and within the specific department/speciality.

Understand the current situation

- Refer to Section 2 of this guide for self assessment tools.
- Be clear about your current baseline(s).
- Process mapping is an invaluable starting point.
- Capacity and demand studies. Keep it simple. Seek advice from your local capacity and demand expert. Refer to the Improvement Leaders Guide Series 1 - Matching Capacity and Demand.

Agree clear aims and measures at the start of the work

- Agree the scope, objectives, timescales, reporting and communication mechanisms.
- Decide on the start and end points for the part of the pathway on which you are working.
- Establish a few specific measures to demonstrate improvement (see the Improvement Leaders Guide Series 1 - Measurement for Improvement) - do not select too many.

Involve patients and carers in designing services

- Involve patients from the very beginning and at all stages. Work with any local patient partnership groups and PALS groups.
- Refer to the Improvement Leaders Guide Series 2 Involving Patients and Carers.

Test out new ideas and challenge thinking

- Encourage people to voice new ideas. Think of what we do now that may have seemed out of the question two years ago but is now accepted practice.
- Ask 'why' to establish the basis for the way things are currently done
- Use small scale testing of new ideas. (Plan, Do, Study, Act cycles (PDSA Cycles)). See Improvement Leaders Guide Series 1.
- Think about sustainability at the beginning of the redesign process and develop a strategy from the outset.

Initiate cross boundary and cross professional working

Work with:

- The Cancer Network Tumour Site Specific Groups as this should include all relevant organisations and professions.
- The local MDT.
- The local PCT's.
- The SHA and any initiatives they may have particularly in the area of diagnostics.

Design and implement standardised protocols to promote standardised care.

Design new/extended roles with the right training provision if applicable

There are three categories of roles that are making a significant difference for patients and staff:

- Administrative and clerical roles – extending these roles releases care givers from administrative duties and improves communication between providers and patients
- Assistant practitioners - developing assistant practitioner roles creates additional workforce capacity
- Advanced practitioners – experienced clinical professionals who have developed their theoretical knowledge and skill to a very high standard and may undertake certain tasks previously assigned to doctors

– Ensure that the most appropriate person is carrying out each role by assessing staff duties

– Explore the opportunities for role redesign and skill mix opportunities – in your locality who can you recruit?

– Refer to the Improvement Leaders Guide Series 3 Redesigning Roles

Measure progress continuously to monitor sustainability

Redesigning the service and implementing change is only the beginning of a continuous improvement cycle. The real challenge is sustaining and maintaining improved performance. Measurement identifies ongoing improvement or slippage and allows teams to celebrate their success or take early action to resolve the slippage. Ongoing measurement communicates that something remains a priority even after the 'project' phase. It also encourages the team to improve further.

- Select one or two key measures that the team feels reflects what they did and what needs to be sustained.
- Build these measures into an existing system within the organisation to ensure regular and automatic reporting.
- Use the measure to help identify at an early stage any influences that are affecting performance
- Identify if there is any seasonal variation in performance.
- Ensure there is a feedback loop of the measurement for all staff.
- Refer to Improvement Leaders Guide Series 1 Measurement for Improvement and Improvement Leaders Guide Series 2 Sustainability and Spread.

Communicate benefits to staff and patients

- Make this a priority. Change is difficult for everyone but good communication keeps everyone involved and avoids surprises.
- Do not rely on one method, face to face is always good.
- Ensure communication is two way - listen.
- Share improvements with all staff. Celebrate success to show how it can be done.

People to involve

Lead Director for Cancer Waiting Times.
Clinicians (including physicians, surgeons, nurses, etc.).
Administrative and support staff.
Cancer Service Improvement Facilitators (SIFs).
General / lead cancer managers.
Primary Care Cancer Leads.
Patient partnership group / PALS.
Trust Modernisation Lead.
Network Service Improvement Lead.
Strategic Health Authority cancer and. modernisation leads.

References

Modernisation Agency:
Improvement Leaders Guide (copies can be obtained from www.modern.nhs.uk).

Series 1	Process mapping analysis and redesign. Measurement for improvement matching capacity and demand.
Series 2	Involving patients and carers. Managing the human dimensions of change, working with individuals. Sustainability and spread. Setting up a collaborative.
Series 3	Redesigning roles Working with groups. Building and nurturing an improvement culture Working in systems.

Section 4

Additions

Improving waits in Skin cancer

The increasing volume of skin cancers is a significant challenge in meeting the cancer waiting times. However the high impact changes apply as they do to other cancers. Certain things are key to achieving sustainable waiting times and are important to put in place if not already there. The How to Guide can be applied to skin cancer as for other cancers. Begin with the self assessment tools for skin cancer and the multi-disciplinary team. Review the last ten patients along the pathway by using the template available at www.modern.nhs.uk/cancer/uppergi

The Multi-disciplinary Team

Two of the fundamentals without which cancer waiting times will not be sustainable are a functioning MDT and clearly defined agreed pathways. If you do not yet have a skin MDT this should be a priority. This will become a requirement when the NICE Improving Outcomes Guidance is published in January 2006

The MDT is essential to

- agree the pathway across primary, secondary and tertiary care
- discuss and analyse breaches

For further information refer to the Multi-disciplinary team working section in the How To Guide

Data

- The cancer waiting times apply to Malignant Melanoma and Squamous Cell Carcinoma – Basal Cell Carcinomas are not included.
- Skin cancers may be excised in varying settings - dermatology, plastic surgery, ENT, maxillo facial, care of the elderly, primary care. To ensure the MDT is aware of all cases as soon as possible agree with pathology that the skin MDT is automatically informed of all new diagnoses. This will assist with data completeness and ensure all patients receive timely and appropriate treatment.
- Be sure everyone who deals with skin cancer is clear on the waiting times definitions. Remember - the excision biopsy is the first definitive treatment if the intention was to excise the lesion regardless of whether the margins are clear.

For further information on data generally refer to the Data section in the How to Guide. For further clarification and examples of differing scenarios relating to Skin cancer visit wwwcancerimprovement.nhs.uk/skin

Key Changes

- Streamlined referral route, one point of entry /contact
- Clearly defined and agreed patient pathways
- Rapid access / one stop see, diagnose and treat (where appropriate) clinic
- Fully functional MDT
- Automatic notification of all new pathology to the MDT wherever/whoever initiated treatment
- Joint or parallel clinics with Dermatology / Plastic surgery

For case study examples view the Service Improvement Guide which will be on the website at wwwcancerimprovement.nhs.uk/skin in November

For more information or to discuss any issues in relation to your service in the first instance please contact Barbara Zutshi National Manager CSC'IP' Skin on 07900 223136 or email Barbara.zutshi@cscip,nhs.uk

Improving Waits in Haematological cancers

The 31 day wait in relation to haematological cancer is more or less achieved. The 62 day wait remains a challenge as many patients enter the system through a speciality other than haematology. However the high impact changes apply as they do to other cancers. Certain things are key to achieving sustainable waiting times and are important to put in place if not already there. The How to Guide can be applied to haematological cancer as for other cancers. Begin with the self assessment tools for haematological cancer and the multi-disciplinary team. Review the last ten patients along the pathway by using the template available at www.modern.nhs.uk/cancer/uppergi

The Multi-disciplinary Team

Two of the fundamentals without which cancer waiting times will not be sustainable are a functioning MDT and clearly defined agreed pathways. If you do not yet have a haematology MDT this should be a priority.

The MDT is essential to:

- agree the pathway across primary, secondary and tertiary care
- discuss and analyse breaches

Top Tip

Many patients with neck lumps enter the system through the head & neck team. Consider using the same MDT coordinator for the Haematology and Head & Neck MDT to ensure haematology are alerted early in the pathway to a possible haematological malignancy.

For further information refer to the Multi-disciplinary teamworking section in the How To Guide

Data

- The cancer waiting times apply only to leukaemia, lymphoma and myeloma
- Many patients with a haematological malignancy enter the system through a speciality other than haematology. To ensure the MDT is aware of all cases as soon as possible agree with pathology that the haematology MDT is automatically informed of all new diagnoses. This will assist with data completeness and ensure all patients receive timely and appropriate treatment.

For further information on data generally refer to the Data section in the How to Guide. For further clarification in respect to haematological cancers including information on appropriate ICD 10 codes to be used, see Data Collection for Cancer Waiting Times - Haematology at www.cancerimprovement.nhs.uk/haematology

Key Changes

- Fully functional MDT
- Clearly defined and agreed patient pathways
- Rapid access clinic for the referral of ‘lumps’ agreed and publicised with primary care or an agreed ‘lump’ pathway
- Direct notification of all new pathology to the MDT wherever / whoever initiated investigations
- Review follow up protocols, look at the opportunities for nurse led or telephone follow up

For more information or to discuss any issues in relation to your service in the first instance please contact Barbara Zutshi National Manager CSC’IP’ Skin on 07900 223136 or email Barbara.zutshi@cscip,nhs.uk

Improving cancer waits in the Endometrial pathway

Patients with endometrial cancer make up the majority of the urgent referrals within gynaecology, whose first treatment has to be provided within the 62-day target. The complexity of this pathway, presents a multitude of challenges for clinicians and managers endeavouring to meet the 31 and 62-day targets while also maintaining patient safety and quality of care. There are no easy solutions as changes within this pathway involve a number of stakeholders and many of the issues that need resolving sit within the clinical governance agenda. Only a small number of low risk endometrial cancers will be managed within the cancer units, the rest along with all other gynaecological malignancies are managed within specialist centres.

As with any service improvement the main aims are to:

- Improve access for all patients
- Understand the issues along the pathway in relation to the demand on the service and the capacity to meet this demand both at present and in the future.

Data completeness for reporting and audit is therefore essential.

While local circumstances vary, many Trusts experience delays due to lack of theatre capacity and hysterscopy support. We, therefore, suggest that it would be useful to consider several potential changes in service delivery.

These potential changes, which although complex to manage, will help to improve the overall journey time.

Endometrial Pathway Audit.

In order to assist clinical teams understand quickly where the bottlenecks exist within the endometrial pathway, Dr Andy Nordin Consultant Gynaeoncology Surgeon and CSC'IP' National Clinical Lead, has developed a very simple electronic mapping tool that allows easy analysis of the pathway and graphically illustrates the issues to be addressed. This tool is available at
http://www.kentandmedway.nhs.uk/professional_pages/clinical_governance/cancer_audits/endometrial_cancer_audit.asp
or via the main website
www.cancerimprovement.nhs.uk

We suggest that as a minimum six patient journeys are uploaded to this tool for analysis.

Key Changes

1. Provide ultrasound scanning and outpatient endometrial biopsy at a single visit.

2. Encourage all staff to attempt outpatient endometrial biposywhenever possible (when indicated and with patient consent.)

3.When outpatient endometrial biopsy not feasible or result equivocal, general anaesthesia hysterscopy within one week of first visit.

This may be achieved by:

- Persuading all gynaecologists to reserve one slot on all of their lists for hysterscopy.
- Use theatre capacity released by consultant leave to clear hysterscopy waits, middle grade medical staff could be utilised effectively in this role

4. Ensure there is a system in place to fast track patients with positive histology into the gynaeoncology clinics.

For more information or to discuss any issues in relation to your service. In the first instance please contact Marie Palmer National Manager CSC ' IP' Gynaecology on 07880725207 or email marie.palmer@cscip.nhs.uk

For general information on meeting the cancer waits please access our main website at www.cancerimprovement.nhs.uk and down load the "How to…." Guide – Achieving Cancer Waiting Times or view the Service Improvement guide also available on the main website.

Delivering and Sustaining Urology Cancer Waiting Times; ensuring a timely, quality and equitable service for patients

Do Today: Deliver Your Waiting Times

- Look at last 10 patient journeys and action system delays
- Proactive patient navigation through the system
- Validate waiting lists and control DNA's
- Implement booking and linked appointments
- Single pathways of care and pooling of patients within the service especially around urology diagnostics
- Parallel processing of diagnostic/staging tests

Do Next: Know Your Service

- Analyse your service; capacity and demand for the service concentrating on the key referral symptoms, diagnostics and treatment modalities
- Decide on your core business in collaboration with your health community, and agree the way forward for your service
- Create a vision and develop a phased business plan that prioritises the development and delivery of your service
- Consider the benefits of developing an integrated urology unit

Do Later: Deliver Your Vision

- Secure your delivery plan through service improvement and robust evidenced business planning
- Appropriate role redesign and competency based training and assessment
- Ensure synergy with 'Connections for Health' to support assessment and delivery of service
- Minimise variation in capacity and effectively manage demand
- Ensure there are robust and evaluated protocols with timelines around the transfer of patient care between organisations that promotes delivery of a seamless, streamlined, timely and quality service
- Evaluate process against the plan and the effectives of delivered service involving users and patients

Delivering and Sustaining Lung Cancer Waiting Times; ensuring a timely, quality and equitable service for patients

Do Now: Deliver Your Waiting Times

- Look at last 10 patient journeys and action system delays
- Proactive patient navigation through the system
- Validate waiting lists and control DNA's
- Implement booking and linked appointments
- CT scan where appropriate before first outpatient appointment
- Algorithm of potential management strategies at first MDT
- Single pathways and pooling of patients within the service

Do Next: Know Your Service

- Analyse your service; capacity and demand for the service concentrating on the key referral symptoms, diagnostics and treatment modalities
- Decide on your core business in collaboration with your health community, and agree the way forward for your service
- Standardise the pathways of care
- Create a vision and develop a phased business plan that prioritises the development and delivery of your service

Do Later: Deliver Your Vision

- Secure your delivery plan through service improvement and robust evidenced business planning
- Appropriate role redesign and competency based training and assessment
- Ensure synergy with 'Connections for Health' to support assessment and delivery of service
- Minimise variation in capacity and effectively manage demand
- Evaluate progress against plan and effectives of delivered service involving users and patients
- Ensure there are agreed, robust and evaluated protocols around transfer of care between organisations that promote a quality, timely and streamlined service

Section 5

Referral

This section outlines key changes that can reduce waiting times at the referral stage of the patient's journey.

Referral: General issues

- Good referral systems impact not just on patients diagnosed with cancer, but also on those with suspected cancer.
- A total of 123,390 referrals were received through the two week wait in quarter 2 of 2004/5.
- Only a proportion of these referrals result in the diagnosis of cancer with the figure varying for different tumours. Patients with suspected cancer are referred to acute settings through a wide variety of routes, with varying levels of urgency and by a multitude of different processes, and not always according to protocol.
- Patients may wait on one consultant's list whilst other consultants' lists within the team are shorter.
- Patients may be referred inappropriately when they should be managed in primary care, or in a worse case scenario patients wait in routine queues for weeks or months before being diagnosed with cancer.

It is crucial that we simplify and streamline referral processes to ensure patients get on the path to diagnosis speedily. This requires a co-ordinated approach across primary and secondary care with a strong emphasis on the patient pathway.

Key questions to ask

What is it like for a patient being referred to or within your trust?

Is the current referral pathway delaying their progress to treatment?

- Where are referrals received and how are they processed?
- Are there local and cancer network guidelines for the referral of patients with suspected cancer?

  If yes:
  – Review these in line with the trusts current practice

  If no:
  – Review relevant national guidelines, e.g. NICE Improving Outcomes Guidance for recommended referral protocols
- Are the majority of referrals received according to the guideline? If no ask why?
- How many queues are currently in operation?
- Is there regular feedback to primary care on referrals that fall outside of the agreed criteria?
- Is there regular feedback to the MDT on referrals?
- Do you know the current demand for referrals and the current capacity to deal with them?
- Are robust booking and scheduling systems in place?

Process Mapping, demand and capacity studies and robust data collection will help clarify the changes that need to take place.

The changes that will make the biggest difference

- Joint planning and protocols between primary and secondary care, taking account of national guidelines on who should be referred urgently and how referrals should be made.
- Streamlined referral route, single queue, one point of contact.
- Pooled referrals to balance consultant workloads and individual consultants waiting times.
- Clearly defined and agreed patient pathways.
- Robust booking and scheduling systems with a choice of date offered to the patient.
- Match capacity and demand
- Feedback to primary care and to each MDT on how the process is working

Examples of these changes are illustrated in the case studies at the end of the section

For lower GI cancers substantial work has been undertaken on developing diagnostic checklists and computerised support systems to aid appropriate referral. Details of this work can be found in the CSC'IP' - "Belfry Plan"[i]

Benefits of implementing changes in referral processes

Service delivery

- Demand managed more effectively
- Booked appointments with a choice of date
- Shorter waiting times through eliminating the number of queues and reducing complexity

Patient experience

- Booked appointments with a choice of date
- Shorter waiting times, equity of waiting times
- Reduced anxiety

Clinical outcomes

- Likelihood of earlier diagnosis through protocol driven care
- Understanding of true capacity and resource implications

Benefits for staff

- Reduction in time staff spend managing waiting lists and queues
- Increased staff morale

The following case studies illustrate the benefits of improving referral processes.

1. Direct Referral (Radiology to Lung)
   Royal Free Hampstead NHS Trust
2. Inappropriate Referral
   Birmingham Women's Health NHS Trust
3. Agreed Protocols (colorectal)
   Leicester University Hospitals
4. Electronic referral/booking (breast)
   Newcastle Upon Tyne NHS Trust

Case Study 1:

Royal Free Hampstead NHS Trust, North London Cancer Network.

Fast track referral system for suspected lung cancer patients.

What was the reason for the changes?

GPs referred patients for a chest X ray. If the X ray was found to be abnormal the report was sent to the GP and the GP would then refer the patient back to the chest clinic for an appointment. Patients could wait up to one month from the chest X ray until the first outpatient appointment and the GP was not aware of the appointment date.

How was the need for the change identified?

The problem was identified through process mapping the patient journey

Which change ideas were tested and worked?

Agreement was reached with the relevant parties that patients should be referred directly from radiology to the chest clinic when a suspicious X ray was found.

What were the implemented improvements?

- Patients now wait less than 14 days between chest X ray and the first outpatient appointment.
- This ensures patients get onto the right care pathway.
- The patient has a booked first appointment with certainty and choice.
- GPs are informed of the patient's appointment, improving communication between primary and secondary care.

What was the impact?

All patients with suspicious X rays are involved in this process.

What is the situation now?

Follow up discussions identified a need for patients entering through A&E to be fed into this system .

Is the improvement sustainable?

System has been sustained so far.

Case Study 2: Feedback to GP's regarding delays due to inappropriate referrals reduces delays.
Birmingham Women's Health Care NHS Trust, Pan Birmingham Cancer Network.

What was the reason for the change?

There was significant delay between the General Practitioner (GP) urgent referral being sent to the gynaecology clinic and receipt of the referral request in the Rapid Access Centre (up to 8 days or more during bank holiday periods). This meant the Trust was sometimes unable to offer women an urgent appointment within two weeks of the GP decision to refer date.

How was the need for the change identified?

Some GP's were sending urgent requests for gynaecology opinion through inappropriate routes e.g. letters to individual consultants through external postal system. Consultant secretaries then re-routed the referral to the Rapid Access Centre via the internal postal system.

What changes were made?

- A letter was drawn up in collaboration with the consultant Gynae-Oncologists and the cancer team which would be faxed to GP's. This letter advised the GPs that their referral had been received via a different route to the agreed one. The Lead Cancer Nurse signed off the letter on behalf of the Trust.
- Cancer Data Manager identifies any urgent requests that have been inappropriately referred.
- A letter is then faxed to the GP's with the appropriate referral proforma to ensure that they have it for any future referrals.
- The MDT co-ordinator ensures an up-to-date secure fax number for all GP's.

What were the implemented improvements?

A letter was designed to fax to GPs. The letter informs GPs of the significant delay prior to receipt of their referral request by the Rapid Access Centre. The letter also confirms the appropriate referral route and provides the correct fax number. A copy of the rapid referral form is faxed in addition to the letter. The Cancer Data Manager or MDT co-ordinator will fax a copy of the letter and referral proforma to GPs.

What was the impact ?

There was a reduction of referrals made through the post and the system is continuously monitored to ensure referrals are received as quickly as possible.

What is the situation now?

There is a faxed feedback strategy, which has been developed to ensure appropriateness/timeliness of urgent gynaecological referrals communicated to GPs.

Is the improvement sustainable?

When the system was audited in 2002, there were still instances of referrals being received through the wrong route and letters and referral forms continue to be sent out. A record is kept of all letters sent out to GP's. This information can then be fed back to the PCT's in order to identify any practices that repeatedly refer outside of the agreed pathway.

Case Study 3: Referral protocols for colorectal patients
University Hospitals of Leicester – Colorectal Leicestershire, Northants & Rutland Cancer Network.

What was the reason for the change?

Before the new "Straight to Test" protocol was introduced only 30% of electively-referred colorectal cancer patients came through the 2 ww route, of these fast tracked cancer patients only 70% were diagnosed within a month of referral.

How was the need for the change identified?

Recognition of increasing waiting times and a number of different types referral protocols.

Which change ideas were tested and implemented?

First the colorectal team developed their colorectal test protocol and agreed on the new "Straight to Test" sequence (primary care, gastroenterology, radiology, surgery). They developed a new primary care referral proforma and administration processes before they tested the new "Straight to Test" initiative. Through carrying out a dry run they could help predict demand and assess and realign capacity.

What was the impact?

Over 85% of colorectal diagnoses (benign or malignant) are now being made within 1 month through replacing the standard referral route of GP to outpatient clinic with the "Straight to Test" protocol.

What is the situation now?

Due to the success, the new initiative is currently being rolled out across the city.

Is the improvement sustainable?

Yes.

Case Study 4: Electronic "end-to-end" booking speeds up the process for breast patients.
Newcastle upon Tyne Hospitals NHS Trust, Northern Cancer Network.

What was the reason for the change?

There was a growing number of fax referral forms that GPs were using. Many of these faxes were not arriving in time, going astray, incorrectly filled or with vital information missing.

How was the need for the change identified?

Identified through a local CSC'IP'' meeting and a process mapping exercise.

Which change ideas were tested and worked?

- Direct electronic referral from GP surgery to the electronic breast clinic slot - i.e. end-to-end booking of suspected breast cancer patients.
- The time from GP referral to the patients appointment time being confirmed back to the GP was established as 7 minutes.
- Time span allows the GP to confirm the appointment time to the patient while she is still in the surgery.

What were the implemented improvements?

GP is able to identify an agreed appointment time with the patient in the surgery. The patient now leaves the surgery with a "cast iron" appointment time thus improving patient satisfaction by being aware of time scale.

At present this has impacted on over 100 patients.

What is the situation now?

There are at present 14 GP practices involved in this pilot in Newcastle upon Tyne, with plans to roll out to the remaining 30 over the next year.

Is the improvement sustainable?

This scheme acts as a precursor to change the referral culture prior to a national solution.

References

Useful MDT Co-ordinators' induction pack (Pan Birmingham) available at www.modern.nhs.uk/mdt

The Belfry Plan, available at www.modern.nhs.uk/cancer/uppergi

Section 6

Diagnostics

It is widely recognised that access to diagnostic services is one of the key issues that needs to be resolved both for the achievement of the cancer waiting times targets and the recently announced 18 week referral to treatment target for 2008 which applies to all patients, irrespective of condition.

Diagnostics represent a key component of many patient pathways and is therefore fundamental to early diagnosis. This section covers endoscopy, radiology and pathology.

Endoscopy

Endoscopy general issues

- There is significant variation between trusts in managing endoscopy services. Units are often managed by more than one directorate.
- Endoscopy is sited in a variety of places including theatres, radiology or may be self contained.
- Historically there has been no formal training programmes in endoscopy.

These issues contribute to a wide variation in waiting times.

Understanding the current situation

- Many departments have undertaken a self-assessment; **'Endoscopy Unit Global Rating Scale' (see Section 2)** which helps identify areas for improvement
- Process mapping and capacity and demand studies are also key to understanding current processes. Ensure good data - See the service through the patients eyes.

What are the changes that will make the biggest difference?

- Use the Endoscopy Toolkit. This is a customised toolkit developed by the NHS Modernisation Agency for improving endoscopy services.
- Aim for whole endoscopy service modernisation
- **Manage the waiting lists**
  - **Document** active and planned waiting lists separately.
  - **Validate** active and planned lists. There are two types of list validation: Clerical and clinical. Clerical ensures that there are no duplicate requests and clinical list validation ensures that the procedure is still appropriate.
  - Use **Primary targeted lists (PTL)** (See page 67)
  - Use **Clinically Prioritise and Treat (CPaT)** (See page 67)
- Use capacity and demand data to identify and reduce 'did not attends' (DNAs), cancellations, late starts.
- Enforce six week annual leave policy.
- Introduce pooling of lists, 'choose and book' and scheduling systems.

Benefits of implementing High Impact Changes for endoscopy.

Service delivery

- Appropriate demand management.
- Booked appointments with a choice of date.
- Shorter waiting times through eliminating the number of queues and effective scheduling.
- Fewer cancellations and DNAs.
- Understanding of true capacity and resource implications.
- Increased utilisation of existing capacity.

Patient experience

- Patient choice of date and time.
- Shorter waiting times, equity of waiting times.
- Reduced visits.
- Reduced anxiety.
- Increased patient satisfaction.
- Respect for privacy and dignity.
- Clear and concise patient information.

Clinical outcomes

- Likelihood of earlier diagnosis and improved outcomes through protocol delivered care.
- Reduced risk of error due to fewer handoffs.
- Increase the potential for better prognosis or improved outcomes.

Benefits for staff

- reduction in time staff spend managing waiting lists and queues.
- Reduced pressure on staff, increasing staff morale.
- Appropriate use of skilled staff.
- Greater MDT working.
- Improved staff skill and knowledge.

The following case studies illustrate the impact of implementing key changes in endoscopy.

Case Study 1: The introduction of a scheduling tool

St James's Hospital, Leeds Teaching Hospitals NHS Trust.

Issue

Scheduling was being coordinated by allocating either 15 minute or 30 minute appointment slots based on the procedure to be performed. Learning events hosted by the NHS Modernisation Agency's National Endoscopy Team promoted the use of a 'scheduling tool' to plan lists and increase utilisation.

Changes made

It was decided to start using a 'scheduling tool' at St James's Hospital. To do this each endoscopists list had to undergo a timings study. Once this was complete template strips were developed for each procedure and each endoscopist.

An outside printing firm was used to make the board for the tool and ten boards were bought so other departments could use them as well. The sister in endoscopy used the strips and the board to plan initially one list (as a pilot).

Impact of changes

Better scheduling meant that one extra procedure could be added to the list which meant the waiting time for patients in the department was reduced.

Better utilisation was shown in the monthly reports (increased from 57% at worst to 75% at best). Patients were happier as they were not waiting around in the department for their procedure.

Challenges

Most of the challenges around implementing this scheduling tool were around the practical issues such as designing the board and the strips for each endoscopist.

Lessons learnt

Even though it was extremely time consuming to develop the practical side of the scheduling tool, it was worth it as the benefits out weighed the hassle of setting it up. Once you have the basic template in place you can use this tool for any type of scheduling.

Next steps

Continue to use scheduling tool and make adjustments to strips in accordance with changes in department which affect timings. Use this tool at other endoscopy sites within the trust.

Case Study 2: The introduction of a Nurse Led rectal bleed clinic

Northwest London NHS Trust (St Marks)

The clinic offers clinical assessment, health promotion, advice and treatment to patients with rectal bleeding.

Starting point

- Long waiting times for outpatients clinics.
- Multiple hospital visits for patients (outpatient and endoscopy).
- Poor access to health promotion and other advice.

Process

- Patients who were previously referred to consultants in the outpatients department are now transferred to the nurse led rectal bleed clinic for a flexible sigmoidoscopy.
- This was initially piloted for one consultant.
- Patients are booked directly into the rectal bleed clinic.
- Patients are sent information about the procedure, what to expect when they attended the unit and a copy of the consent form.
- General Practitioners were sent letters giving the results of the procedure within 24 hours of the procedure.

Outcomes

- Outpatient appointments slots are freed up.
- All patients who need to be seen urgently are offered a booked appointment.
- All patients with positive findings had further investigations ordered and booked on the same day.
- 60% - 70% of patients are seen only once.
- The maximum wait for non-urgent patients reduced to ten weeks.
- All two week cancer referrals are seen within 14 days.
- Outpatient waiting times have decreased because of available clinic slots.
- Decreased number of hospital visits for the patients.
- Better management of the flexible sigmoidoscopy clinics.

Case Study 3: Reducing the access waiting times for endoscopy

East Lancashire Hospitals NHS Trust

Issue

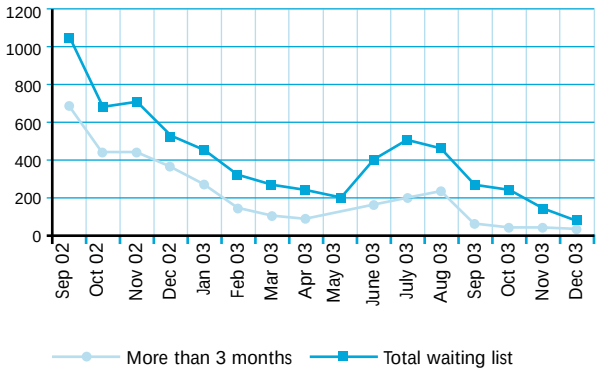
- In September 2002 waiting times were 12 months for a routine gastroscopy and 17 months for a colonoscopy.
- Target was for all first scoped patients to be seen within 13 weeks by January 2004.

Action

- Partial booking was implemented.
- Waiting lists were validated.
- Referrals were partially pooled.
- The patient journey was process mapped and timed which led to two extra slots being added to every list.
- A third consultant gastroenterologist was appointed which meant activity was increased by two session a week.

Impact

- Active waiting list is now eight weeks for colonoscopy procedures and four weeks for gastroscopy procedures.



Radiology

Radiology general issues

- 500,000 patients are waiting for imaging at any one time nationally.
- Demand for radiological examinations is increasing (40% rise in CT, 60% for MRI).
- National shortage of radiologists and radiographers, with a changing scope of work
- Historical under-funding for the replacement of new equipment.
- Commonly held perception that demand exceeds capacity.
- Other pressures include the working time directive, Agenda for Change, NICE Improvement Outcomes Guidance for head and neck cancers, booking and choice and increased screening programmes.

Despite these issues there are key changes we can make to reduce radiology waiting times.

Understanding the current situation

- Process mapping and demand and capacity studies are crucial in understanding the issues within radiology.
- Process mapping should be undertaken from the decision to request an imaging test to the result being available.
- Demand and capacity should include all modalities. Use of process templates to ensure effective scheduling of appointments within each modality is recommended.
- As well as the self assessment summary included in section 2 of this guide, a detailed self assessment questionnaire has been developed that helps clarify understanding of the current position and service improvement opportunities within radiology. This is available at www.modern.nhs.uk/radiology.

What are the changes that will make the biggest difference?

- The NHS Modernisation Agency has developed a National Framework for Radiology Service Improvement which provides support for clinical teams.
- Learning from pilot sites has shown that with proactive clinical leadership and executive support, significant improvements for patients with subsequent benefits for staff can be achieved and sustained.

The key principles of the framework are:

- Clinically led process, identifies its own priorities.
- Patient is at the heart of the process.
- Modality approach to whole systems of care.
- Works across primary and secondary care.
- Ensure that workforce issues are recognised.
- No one group of patients disadvantages another.
- Ensure legislation - IRMER - is not compromised.
- Service improvement is linked to all radiology modernisation strategies.

- Look at the way the diagnostic phase of the patient pathway is organised. Can this be organised differently? One approach proven to be particularly effective is ensuring patients have all tests prior to first consultant appointment.
- For example: The 'straight to test' approach for suspected colorectal cancer requires that patients who are referred for a specialist opinion regarding lower GI symptoms be directed to a diagnostic test in the first instance. This requires a clear history to be obtained from the patient either by the referring doctor, or by telephone or by post by the hospital in order to direct the patient to the most appropriate test.
- Shared resources across primary and secondary care centres and units.
- Extended roles in all staff disciplines. Implementation of the 4 Tier structure.
- Maximise technology ie. integrated HIS and RIS systems, use of voice recognition dictation, teleradiology and video conferencing. Maximised opportunity for Computed Radiography and Direct Radiography equipment PET scanning.
- Timely reporting and improved access to results should be available prior to first outpatients visit.
- Standardised requesting, scanning and reporting protocols should be agreed and implemented.
- Radiology should support and implement where possible one-stop clinics such as haematuria clinics, TRUS and Biopsy one-stop clinics, one stop breast clinics, ultrasound and cystoscopy clinics.
- Pooled referrals and single queues. Segmentation should be implemented where appropriate and avoid carve out of slots or specialisation. Cross cover and skill mix will help.
- Booking scheduling systems (including waiting list validation and DNA policy and annual leave policy).
- User and patient involvement is key to ensuring that diagnostic services support the needs of primary and secondary care clinicians.

Benefits of implementing changes for radiology

Service Delivery

- Appropriate demand management.
- Booked appointments with a choice of date.
- Shorter waiting times through eliminating the number of queues and effective scheduling.
- Fewer cancellations and DNAs.
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Patient Experience

- Patient choice of date and time.
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- reduction in time staff spend managing waiting lists and queues.
- Reduced pressure on staff, increasing staff morale.
- Appropriate use of skilled staff.
- Greater MDT working.
- Improved staff skill and knowledge.

The following case studies illustrate the impact of implementing key changes

Case Study 1: Reduced waiting times for diagnostic tests; patients receiving ultrasound scans on same day as 1st OPA - Stockport NHS Trust.

Case Study 2: Improvement to fluoroscopy service and reduced waiting times for barium examinations - James Cook University Hospitals, South Tees.

Case Study 3: The redesign of the barium enema service - Taunton and Somerset NHS Trust.

Case Study 4: Improving access to general ultrasound - East Sussex Hospitals NHS Trust.

Case Study 5: Using data to support a business case for additional MR scanner - Royal Liverpool and Broad Green Hospital.

Case Study 1: Reduce the waiting times for diagnostic tests - patients receive ultrasound scan on the same day of first appointment with the specialist team.

Stockport NHS Trust
Greater Manchester and Cheshire Cancer Network

Why was the change undertaken?

Before the redesign urology patient's were given separate appointments for their ultrasound scan which meant patients had to attend the hospital at least twice adding another step into their journey.

How was the need for the change identified?

Patient questionnaires.

Which change ideas were tested and implemented?

A nurse led haematuria clinic was set up to perform same day Flexible Cystoscopy and Ultrasound Scan for patients thus freeing up consultant time.
This improvement was largely achieved by the improved communication between the Radiology and Urology departments.

What was the impact?

- Patients attending the Nurse Led Haematuria clinics now receive ultrasound scan on day of their first appointment with the specialist team.
- By reducing the number of steps and visits the patient has to make to the hospital by implementing same day investigations the trust has reduced their waiting times in this area from five weeks to one day.
- This change has meant that it's more convenient for a patient as all the tests can be done on the same day and they then can see the consultant with their diagnostics report as well on the same day.
- If a patient needs an IVU that also can be booked if need be at the clinic.

Case study 2: Improvement to the fluoroscopy service and reduced waits for barium Examinations.

James Cook University Hospital – South Tees

What was the reason for the change?

- There were waits of up to 11 weeks for urgent barium swallows, 5 weeks for urgent barium enemas and long waits of up to 40 weeks in some cases for other non-urgent examinations.
- Poor scheduling.

How was the need for the change identified?

A review of the service processes for fluoroscopy examinations identified that there were bottlenecks and constraints in the system due to:

- Lack of access to lists.
- Poor of use of skill resources.
- Poor scheduling.

Which change ideas were tested and implemented?

- Clinical Lead for Fluoroscopy was given responsibility for monitoring waiting lists and taking appropriate action to address backlogs.
- Introduction of the four tier structure – assistant practitioners in fluoroscopy and advanced practitioners.
- Independent reporting of barium enema examinations by two Advanced Radiographer Practitioners.
- Additional training of Radiographer Practitioners both to perform and report barium enema examinations.
- Radiographer vetting of barium enema / barium swallow & meal requests.
- Independent performing / reporting barium swallows / meals.
- Additional radiographer sessions to clear the backlog of referrals, utilising empty lists due to Consultant Radiologists on leave.
- Dedicated VFL (Video Fluoroscopy) swallowing clinics, with dual reporting, provided for patients with swallowing disorders now provided by Lead Advanced Radiographer Practitioner and Speech & Language Therapists.

What was the impact?

- Backlog of barium enema referrals cleared, resulting in increased capacity and enabling provision of slots for same day barium enema examinations following failed colonoscopy.
- Increased capacity has allowed the backlog of other examinations, such as small bowel meals, to be cleared thus reducing waiting times for barium procedures.
- Delays in vetting process eliminated for barium enemas/ barium swallows.
- Overall capacity increased which allows urgent / emergency inpatients and outpatients to be examined promptly.
- Improved access for VFL (Video Fluoroscopy) examinations, for patients with swallowing disorders.

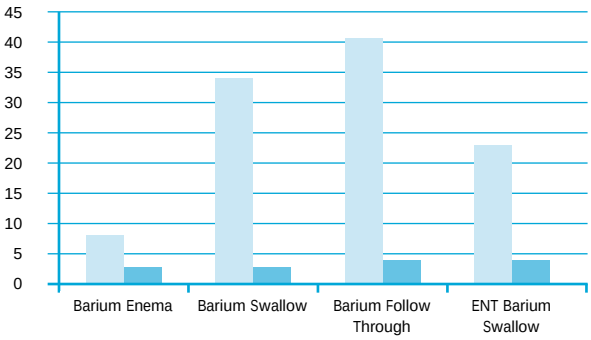
What is the situation now?

Patient Satisfaction survey highlighted the improved access and patient friendly service.

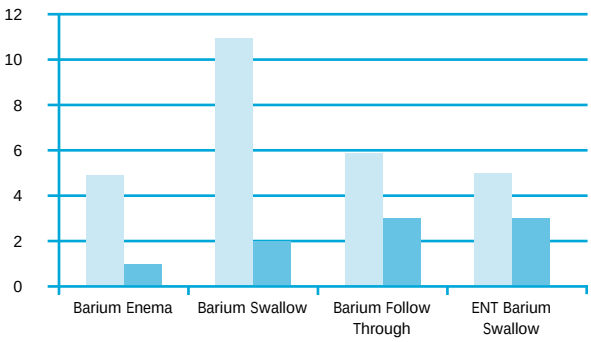
Is the improvement sustainable?

Yes.

Number of weeks waiting for non-urgent Barium Studies



Number of weeks waiting for urgent Barium Studies



April 2003 October 2004

Source: Radiology Service – Improvement Case studies & Learning from phase 2 & 3 pilot sites – document June 2004.

Case Study 3: Radiology service improvement - The redesign of the barium enema service

Taunton & Somerset NHS Trust - Musgrove Park Hospital Taunton

- Barium Enemas.
- 1000 examinations per year across 2 sites.

Details of improvement

What was the problem?

- The waiting lists were 17 weeks on the main site and 18 weeks at one of the peripheral sites. No booked admissions.
- Carve out slots for fast track patients which were often unfilled and in breach of the 2 week wait.
- Radiologists vetted all requests but there were delays of up to two weeks when they were on annual leave.
- Radiographers (3 trained) performed examinations but only on the main site. Lists were closed when Radiologists were unavailable.
- There were reporting delays of up to five days for urgent findings and two weeks for other examinations as no specific time was allocated to radiologists for reporting.
- There were different patient information sheets on the two sites and poor diet instructions. Patients often arrived poorly prepared and unfit for the procedure.

How was it identified?

- Staff (clerical and radiographers) reported problems to management using the incident reporting system used for delays in treatment and poor preparation.
- The cancer network fed back information on two week waits.
- Waiting lists were reviewed monthly at the department's directorate meeting.
- Patients were asked for feedback.

How was it identified?

- Process mapping was carried out with input from all staff groups and a local GP and a system of bookings was implemented.
- The job role of one of the experienced senior radiographers was altered to give her the responsibility for the service. She designed a new patient referral sheet with criteria for suitability which is sent to all referrers. An adapted one for patients was also created which forms part of the pre appointment patient information. She produced a more patient friendly diet sheet with input from patients and dieticians and an after care leaflet which patients take away with them.
- The department introduced a protocol for vetting by radiographers and following a three month audit and review this is now in place. Two experienced radiographers vet all requests which has reduced the delays.
- The two departments agreed to transfer urgent requests across sites so patients on one site are not disadvantaged by lack of resources or long waiting lists.
- The appointment's staff and a nurse practitioner in endoscopy observed patients undergoing the procedure and can now answer far more patient queries.
- The department increased the capacity by adopting a flexible consultant programme matching staff availability with room capacity. Lists are opened or closed by the senior in charge of the service as the demand fluctuates. She also allocates the staff to ensure correct skill mix. Two more radiographers started training and there are no carve out slots.
- Dedicated reporting time was also introduced for radiologists.

What is the situation now?

- The system is working well and there is excellent communication between the appointment's staff, radiographers and endoscopy.
- All requests are vetted by two radiographers and the radiologists cover when they are on annual leave.
- Two more radiographers are now trained (total 5) and the radiographers at the peripheral site are going to start training at the end of the year.

How is it sustainable?

- The system is working well and the responsibility for the service is incorporated into the job descriptions of the staff. Sustainability will only be a problem if there are insufficient radiographers.

Measurable outcomes. What impact has this had on waiting times?

- Waiting times are now between 2 and 5 weeks at both sites.
- Urgent referrals are seen within 2 weeks and there is enough flexibility for other in-patient requests.
- There has been a reduced number of reported incidents of poor referrals.
- Urgent findings are reported within 24 hours and the rest of the reporting is carried out within 3 or 4 days.

Booking and choice

- All appointments are fully booked.

Capacity and demand

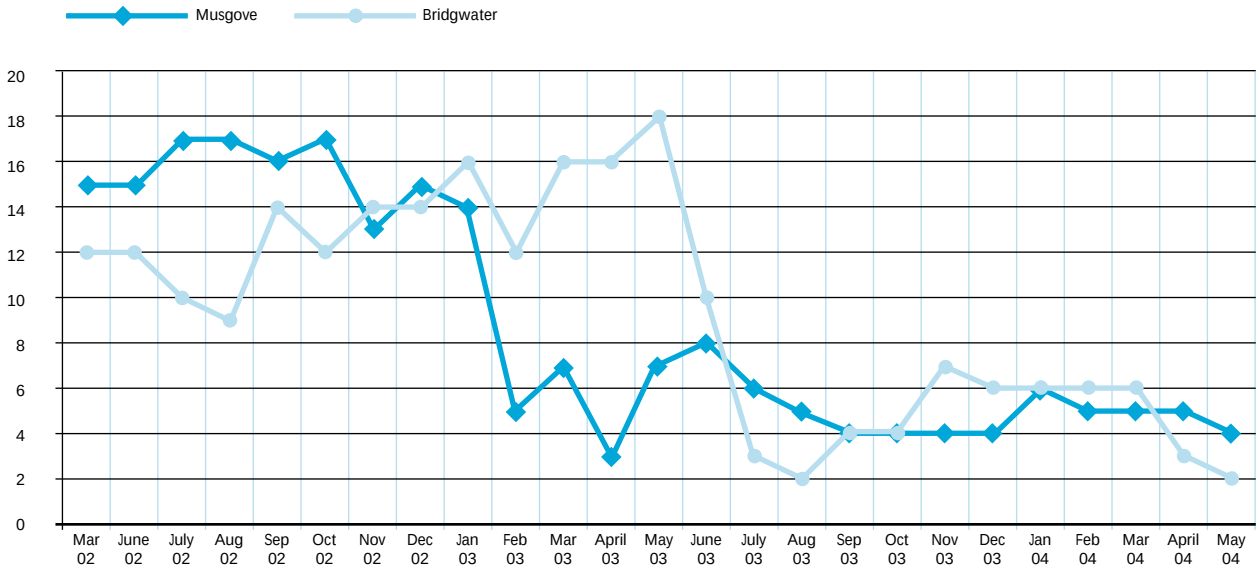
- Activity and demand is looked at in terms of 30 minute slots as there is only one type of examination to consider. Slots are not wasted as there are almost no DNA's and staff are deployed elsewhere in the department as they are multi-skilled.

Staff benefits

- Staff development and satisfaction has improved. Appointment staff have more control over the bookings and can move appointments to suit the patient without having to find a radiographer. They also have a better understanding of the examination and can advise patients.
- Radiographers have increased their knowledge and skills and now attend the MTD meetings providing valuable input.

Patient benefits

- Better information around meal options for patients especially for those with diabetes and for vegetarians.
- Input from radiographers at MDT meetings has improved communication and patient care.
- Patients have the choice of their appointment times and clearer information. Patients are now given the opportunity to inform staff of disability or mobility problems prior to arriving in the department. Staff available are then tailored to their needs.



Case Study 4: Improving access to general ultrasound

East Sussex Hospitals NHS Trust – Eastbourne DGH

Background

- Long waiting times of 22 weeks for general ultrasound.
- Shortage of sonographers due to long term sickness and 1 sonographer on a career break.
- Limitations of current equipment.
- Complex method of validating requests.

The problems were identified through applying service improvement approaches

- Process mapping identified problems with validating requests and booking procedures.
- Capacity and demand analysis demonstrated that in order for capacity to meet demand, changes in working practices needed to be considered.
- Guidelines were also updated for validating requests.

Implemented improvements

- All outstanding requests were revalidated and prioritised.
- Additional sessions introduced on both Saturday and Sunday over 3 weekends with 2 sonographers working each session to clear the backlog. This was paid for using waiting list initiative monies.
- Adjustments were made to sonographer working hours by extending the working day to 8 hours with a half day off a week. Evening sessions were also rostered. This was to make more efficient use of the better equipment.
- New appointment schedules were developed using data collected from the analysis
- Examinations grouped together of similar time length thereby making better use of each hour of scanning time i.e. 6x10mins, 4x15mins, 3x20mins, 2x30mins.
- Named sonographer lists introduced including dedicated sessions for ward patients.
- Timetable developed of radiologist availability to discuss complex cases with set times for discussion in order to reduce radiologist interruptions and sonographer time searching them out.
- Strict validation of requests with inappropriate requests returned with an explanatory letter.
- DNA policy reviewed to reduce repeat appointments.

What is the situation now?

- Appointment schedules remain in place.
- 2 evening sessions a week remain on-going.
- Sonographers have named lists.
- Waiting lists remain constant at 3 weeks.
- Less inappropriate requests.
- Constant review of waiting times.

Sustainable change and improvement has been achieved

Waiting times have reduced from 22 weeks to 3 weeks for routine cases with urgent outpatient cases seen within 5 days.

Booking and choice - Improving the patient

This has been fully implemented for obstetric cases and some outpatient gynaecological referrals. We hope to roll this out fully when a new RIS system is in place.

Capacity and demand

Now remains in balance however, there are some pressures on certain equipment as there are 2 machines on which limited examinations can be performed.

Staff benefits

- Sonographers have flexible varied sessions.
- Morale and job satisfaction has generally improved.
- Role development and responsibility for sonographers.
- Improved working conditions for sonographers by evening out workload.
- Reduced pressure on staff.

Case Study 5: Using data to support a business case for an additional MR scanner

Royal Liverpool & Broad Green Hospital NHS Trust

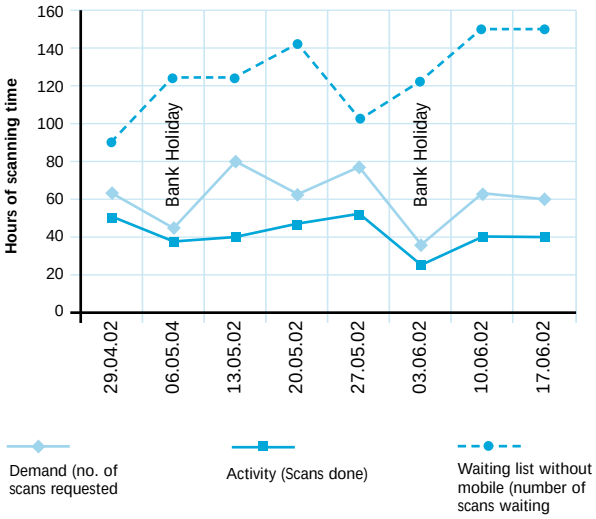
What was the problem?

- Long waiting time for routine scans - 26 weeks.
- 523 patients on the waiting list.
- Non-attender rate of 14%.
- Appointments sent out in post with no patient choice.

How was it identified?

- Demand, Capacity and activity data collection
- Analysis of waiting list.
- Analysis of non-attender rates.
- Process mapping.

MRI data in minutes without mobile scanner



What were the implemented improvements?

- Redesigned the appointment schedule, to improve effective use of scanning time.
- Examinations were block booked to alleviate delays caused by coil changes.
- Implemented partial booking for Out-Patients via the Call Centre and full booking of In-Patient requests.

What is the situation now?

- Data collected clearly showed that in spite of the redesign work undertaken, the demand far outweighed the capacity and the waiting lists could never be reduced without additional resources.
- In an effort to reduce waiting lists the Trust resourced, from Radiology vacancies, the services of a mobile MRI van on a weekly basis. This had the following impact:
  – 24 patients scanned per week.
  – Waiting list reduced to 17 weeks.
- The use of the van was subsequently reduced to 1 day per month as the Trust was in excess of budget and the waiting list started to rise again. Patients were sent as far away as Macclesfield to obtain MR on state of the art systems.
- The project team felt that the MRI scanner was working at full capacity and the only solution would be to have an additional scanner, we needed evidence for a case of need to improve the service for patients.
- Data collection was used in support of a business case for the provision of a second scanner for the Trust. The Trust was successful with this bid and building work has now commenced to accommodate a new scanner which will become operational in 2004.

Measurable outcome

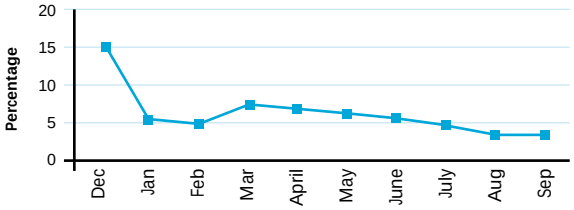
What impact has this had on waiting times?

- With extra capacity provided by the mobile scanner, in addition to the redesign work, waiting times dropped to 17 weeks, but this has risen to 25 weeks since the capacity has been reduced.

Booking and choice

- All patients are offered choice in the timing of their appointment.
- Non-attendance rate has dropped to approx. 4%.

MRI - Non-attender Percentages



Capacity and demand

- Data clearly demonstrates a mismatch between capacity and demand. This is substantiated by the increase in the waiting list since the additional capacity provided by the mobile scanner has been reduced to one day per month.

Pathology

Pathology general issues

- Pathology services are essential in ensuring prompt and correct diagnosis of patients.
- Demand for pathology services is increasing annually.
- In common with other diagnostic services, there are recruitment and retention issues.
- Pathology is often seen as a remote service and not routinely considered in many trusts.
- It is estimated that a significant number of tests are actually duplicate tests.

The pathology service improvement programme began in June 2004. A number of pathology "discovery days" have highlighted pockets of service improvements taking place in pathology services. A number of pathology service improvement pilot sites will be established in April 2005. These will act as exemplars to pathology services across the country.

Understanding the current situation

- Process map from the point that the decision is made to request a test until the result is communicated to the patient.
- Particular problems tend to occur at the interfaces of pathology with the users. Assess whether tests are appropriate, turn around times are acceptable and whether results are communicated to relevant healthcare professionals.
- Capacity and Demand analysis at key points in the pathology pathway. Use of process templates to ensure effective scheduling of tests within departments.

What are the changes that will make the biggest difference?

- Work to date has shown that effective demand management and scheduling can have a significant impact on improving pathology services. A key challenge for pathology services is to ensure effective user and patient involvement.
- An effective service improvement initiative within a pathology service in conjunction with users can lead to the development of fast and efficient services that can benefit the healthcare system as a whole.
- Extended roles in all pathology disciplines.
- Maximise technology to ensure effective use of the workforce.
- Pathology test results should be available prior to first outpatients visit.
- Standardised requesting protocols should be established to reflect the evidence base and the needs of users.
- Pathology services should support the use of single visit clinics throughout the health community.
- Diagnosis followed by immediate staging & intervention where appropriate.
- Booking and scheduling systems (including waiting list validation and DNA policy).
- Timely reporting and access to results.

Potential benefits of adopting a systematic approach to service improvement in pathology

Service delivery

- Reduced turnaround of results supporting rapid diagnosis and treatment.
- Reduced variability in turnaround times.
- Greater cooperation between pathology disciplines ensuring improved use of staff and technology.
- Improved layout and flow within pathology departments.

Patient experience

- Increased patient and user involvement.
- Services planned around the needs of the patient.
- Improved scheduling of tests to coincide with user requirements.
- Choice of booked appointments.

Clinical outcomes

- Standardised turnaround times preventing delays in diagnosis
- Effective demand management thus maximising the role of pathology in ensuring effective patient care.
- Reduced duplication of tests.

Benefits for staff

- Clinical certainty as to availability of results.
- Increased staff participation in service improvement.
- Improved staff morale.

Next steps and the development of case studies

Case studies are currently being developed and can be accessed via the website www.modern.nhs.uk/pathology

Useful Documents and Websites.

- National Framework for Service Improvement – July 2003.
- Radiology Toolkit- a Practical Guide to Redesign – June 2003.
- Case Studies and Learning from Phase 11 and 111 Pilot Sites – June2004.
- Radiology Service Improvement , Challenges and Top Tips – May 2004.
- Ultrasound Service Improvement , a collection of local case studies – Dec 2004.
- Radiology: Supporting the delivery of Emergency Care- Dec 2004.
- Role of the Service Improvement Facilitator - 2003

All these can be accessible through the NHS Modernisation Agency website.

www.modern.nhs.uk/radiology

Other useful websites:

www.modern.nhs.uk/pathology

www.modern.nhs/uk/endoscopy

Section 6

Additions

Diagnostics

Success Factors for Reducing Radiology Waiting Times and Improving Services for Patients

Introduction

Challenging targets have been set for the timely delivery of NHS Cancer Plan Targets 2005 and Access Target 2008. It is important that we do not 'carve out' access for any one category of patient, thereby extending waiting times for others.

We know what works

Service improvement in radiology is not new.
All imaging modalities share common problems and can share solutions. From working with clinical teams we understand the key success factors which, when applied under the principles of service redesign will make the most significant measurable improvements. For improvements to be successful the fundamental principles of service redesign must be applied:

- Clinical Leadership and ownership with Executive support
- Ensure the patient is at the heart of the service provision and service redesign
- Comprehensive process mapping to identify the bottlenecks, rate limiting steps and inform redesign action plans
- Ongoing capacity and demand data collection, to demonstrate the:
  - Current capacity of the service and its ability to meet the demand
  - Impact of changes in service provision and working practices
  - Adverse impact variation has on the service and the need to reduce it.
- Maximise use of existing and future technology
- Develop the workforce to meet service needs

Where demand can be shown to be greater than capacity, service improvement and redesign will not deliver reduced waiting times. However, the data will provide robust evidence to support a business case for additional resources including staff and equipment.

Common Success Factors

- Waiting list validation
- Booking and choice - by admin staff, using diary or call centre system
  - Simple schedule rules based on capacity & demand data
  - Supported by robust DNA and annual leave policies for all staff
  - Reduce variation in demand by booking appropriate patient's at low peak times
- Quality patient information
  - Clear instructions, contra indications, directions, contact numbers
  - Oral contrast preparation sent to patients home
  - Trust website with access to information
- Flexible / extended working day/ week:
  - Efficient use of lunch hours, three session days, off peak appointments
- Health care assistants / radiology helpers in post to improve throughput

Skill mix – Implementing skills escalator

Radiographers / Sonographers (including Consultant & Advanced Practitioners)

- Vetting requests to protocol
- Performing: barium studies, general ultrasound - TRUS and biopsy, musculoskeletal, cardiac, Vascular etc
- Reporting: plain films, CT, MRI , nuclear medicine, sialograms, hysterosalpingograms, venograms, fluoroscopy procedures
- Performing injections
- Requesting additional plain films (MRI, nuclear medicine)

Assistant Practitioners

- Performing plain films, mammography
- Supporting health promotion - breast

Radiographer Assistants

- Inserting venflons
- Performing warm up procedure under protocol (CT, MRI)
- Preparing patients, assisting with completion of safety assessment (MRI),
- Undertaking simple nursing duties

Nurses/AHP practitioners requesting imaging to protocols

- Avoid carve out, implement single queue
  - Use segmentation based on capacity & demand data
  - Eliminate large batching of examination types
  - Assess clinic flows, especially Orthopaedics, based on mapping and C & D
- One-stop clinics and straight to test pathways eg breast, urology
- Standardised scan protocols to reduce radiologist supervision
- Appropriate demand management - standardised referral, scanning and reporting protocols agreed by all primary, secondary and tertiary centres across the network
- Flexible radiologist rota to cover sessions
- Dedicated protected radiologist reporting time:
  - Avoiding interruptions
  - Good ambient conditions – especially for PACS
  - Additional work stations for reporting
  - Pooled reporting – to avoid carve out
  - Data collection to establish reporting capacity
- Digital dictation , voice activated dictation
- Hot reporting
  - Radiologists / Radiographers available in A & E for reporting and advice
  - Extended Red Dot system
- Proactive pathway management - streamlined processes eg
  - Referral to Lung MDT following suspicious CXR
  - CT following bronchoscopy for lung cancer
  - Flexible sigmoidoscopy followed by barium enema
  - GI pathway agreed with endoscopy
- Inpatient ward coordinator
- 'Fit for discharge' policy –
  - Allow IP to go home and return with early appointment - reduce bed blocking
- Sufficient portering within Radiology
- Quantify backlog:
  - Use evening/Saturday session or alternative providers to clear backlog (needs to be done as part of redesign process)
  - Reduce waiting list in chronological date order, longest waiters first
- Use of IS (Independent sector)
  - High volume studies to reduce backlog, ensure redesign of existing services
  - Ensure linkages with other NHS systems
- MDT Coordinator and video conferencing for cancer staging scans
- PACS / Teleradiology / remote reporting
- Room layout – separate area for inserting venflons, sufficient changing cubicles
- Point of Care testing
  - Ultrasound OP – eg Urology clinics
  - Ultrasound in A&E to reduce number of admissions
- New Technology – CR for complex low volume work, DR for simple high volume
- Maximise use of capacity across sites,
  - Use of peripheral or community units
- Utilise/develop capacity in primary care (U/S, plain films)
  - Provide patient choice, reduce travelling times and parking expense
  - Maintain quality, CPD, access to wide case mix, by employing staff across health care community
  - Good IT links to support single patient record and avoid duplication of scans
  - Allow time to access specialist / second opinion

Specific to certain modalities

Ultrasound

- Flexible scanning sessions to avoid repetitive strain injury
- Sonographer Led Service – U/S
- Co-ordinated use of spare machine capacity elsewhere in Trust eg equipment in Op clinics
- Extend the workforce – scanning to agreed competencies
  - Nurses and midwives
  - Urologist/other hospital clinicians
  - GPwSPI community
  - Anaesthetists – Theatre/ICU
  - Physiotherapy – Musculoskeletal

Endoscopy

- Radiographer led service
- Radiographers trained in bariums and endoscopy procedures

Angio

- Treat Day Case as norm
- Use alternative non invasive imaging eg MRI
- Nurse Led pre assessment

Nuclear Medicine

- Timely Radio-pharmaceutical services with service level agreement

CASE STUDIES

Case Study 1: Ultrasound

Epsom and St Helier NHS Trust

Proactive Patient Management - Radiologists booking investigations further along the urology cancer patient pathway

Details of improvement

What was the problem?

- Patients experienced unnecessary delays in their pathway up to 4 weeks on average
- Patients had to wait for further outpatient appointments before the next stage in diagnostic investigations.

How was it identified?

- Mapping the urology patient pathway identified delays along the journey

What were the implemented improvements?

- A radiology team meeting was held to discuss problem.
- A number of radiologists were keen advocates for change and encouraged their colleagues.
- A protocol was written outlining the need for radiologists to use their discretion and book the next step in investigations as indicated by results.

What is the situation now?

- Ongoing in early stages with monitoring of use of protocol

How is this sustainable?

- Encouragement for continued use from advocates of process.

Case study 2: Streamlining chest x-ray reporting to lung MDT

The Great Western Hospital, Swindon and Marlborough NHS Trust

Details of improvement

What was the problem?

How to meet and facilitate the NHS Cancer Plan initiative to reduce the time between GP referral and treatment for lung cancer patients.

There seemed to be difficulty in streamlining the process from reporting of X-rays to MDT meeting and subsequent treatment. We have in the last 2 years been fortunate to have both a PACS and EPR (electronic patient record) system introduced within our department. We hoped to be able to use the inherent advantages of this technology to speed the process that patients go through from X-ray to Treatment.

How was it identified?

- Cancer Audit of waiting time
- Problems highlighted at MDT meetings

What improvements were made?

The following improvements were implemented as a result:

- Chest X-rays with changes suspicious of lung cancer are urgently reported and the report is immediately phoned through to the GP's surgery.
- The Radiologist directly refers the patient to the chest physician by including the patient's images at the next weekly Chest meeting
- This reduces the waiting time as there is no wait for the GP to act on the report and then to refer the patient to the chest Physician.
- At the MDT meeting, through the EPR, the patient's record can be checked to see if an outpatient appointment has already been arranged. Likewise Blood and past pathology results can also be reviewed and where relevant further tests (eg CT scans) can be immediately booked.

This again facilitates the patient pathway.

Waiting times

The whole process has reduced the time from initial investigation to diagnosis and treatment. In addition by using both PACS and EPR effectively we are able to streamline this further and we now easily meet the government guidelines for a time of less than one month between referral and treatment.

What is the situation now?

- A recent audit confirmed that the Cancer Waiting Times Targets are being achieved.
- The MDT meeting now runs more effectively with the aid of PACS and EPR as there is immediate access to all of the patient records and a joint decision and a patient care plan can be made at the time of the meeting

Measurable Outcome

GP patient's referral Audit

- Last 3 months: 17 new patients
- Time from chest x-ray to chest MDT meeting 0-13 days, mean 4 days
- First CXR to CT: 16 patients 1-24 days, mean 11 days

Case study 3: Reducing The Breast Cancer Pathway by Combining Diagnostic Radiological Studies, **The Great Western Hospital, Swindon & Marlborough NHS Trust**

Details of Improvement

What was the problem?

- Breast cancer patients requiring ultrasound (u/s) and nuclear medicine scans for staging were given appointments on separate days
- Patients had to make multiple journeys to the hospital adding to their anxiety

How was this identified?

- A review of patient pathway from request to result showed that delays were greater when more than one diagnostic test was requested
- Regular meetings with radiographers in both modalities

What were the implemented improvements?

- Clinicians were asked to complete one request form for all examinations (i.e. bone scan, liver u/s and CXR) on one form
- The clinician writes the follow-up clinic appointment on the form so that the results are available for that date
- Additional training was given to the clinic clerical staff to enable them to book appointments on the same day and in the right order
- The u/s is performed first before the patient is injected with radioisotope for the bone scan
- The patient pathway from referral to follow-up has been streamlined ensuring that diagnostic testing is completed without compromise to cancer target times

What is the situation now?

- Breast cancer patients requiring u/s and bone scans have the studies booked on the same day
- There are fewer phone calls from the patient to the booking office with queries or to request appointment changes
- Patients only have to attend the hospital for one day for their diagnostic tests

How is this sustainable?

- Continued support and close working of all diagnostic and clinic team staff

Measurable outcome

Audit

- There is a decrease in the number of DNA's

Waiting times

- All urgent scans are carried out within 1-2 weeks

Booking and choice

- Patients bring the request form to Radiology and their appointment for their scans is arranged
- This allows a mutually convenient appointment to be made, which reduces the risk of DNA's
- All patients are fully booked (i.e. within 24 hours from referral)

Patient Benefits

- Combined tests means that patients do not have multiple hospital appointments to diary and attend
- Streamlined process reduces overall pathway
- Treatment can be discussed earlier and options considered

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Case study 4: Reducing The Colorectal Cancer Pathway by Proactive Management of the Patient by Consultant Radiologists,

The Great Western Hospital, Swindon & Marlborough NHS Trust.

Details of Improvement

What was the problem?

- Unnecessary imaging delays of 42 days on average (range 13 to 101, median = 15) in the colorectal cancer pathway
- Patients suspected of colorectal cancer undergo barium enema three times more commonly than colonoscopy
- This is followed by CT staging scan if found to be positive
- Usual practice was for the clinician to see the patient at a second visit to discuss the result and request the CT as appropriate
- Ability to meet cancer target rendered unachievable

How was this identified?

- Inspection of the breach analysis identified common bottlenecks
- Audit of calculated time intervals between barium enema diagnosis of cancer and CT staging study for all patients over a six month period

What were the implemented improvements?

- To streamline the patient process through radiology and diagnostic studies, a new strategy was implemented by which the radiologist (rather than the referring clinician) organised the CT appointment when they found a cancer on barium enema
- As the patient is unaware of the diagnosis, the referring clinician (GP or hospital specialist) is telephoned, told the barium enema result and informed that the CT has been arranged
- The clinician then contacts the patient and explains the situation prior to CT staging scan

What is the situation now?

- Reduction in patient pathway of 26 days on average (see audit results)
- Radiologists controlling imaging waiting lists (via vetting protocols) are taking greater responsibility for meeting cancer plan targets
- Additional tests (e.g. MRI for rectal cancer staging) can more readily be organised
- The same radiologists tends to interpret all imaging relating to the individual patient enabling greater continuity of care
- The need for an additional outpatient visit is avoided, freeing clinics and increasing their capacity without cost!
- The waiting times for CT staging post barium enema is just over 2 weeks.
- The desire to reduce this time further is open to wider debate because residual colonic barium (present for up to one week post barium enema) degrades the CT images and reduces their diagnostic value

How is this sustainable?

- Ongoing cooperation of radiologists

Measurable outcome

Audit

- Re-audit of time intervals for a further six months following implementation of the new strategy found a reduction in average waiting times to 16 days (range 5 to 40, median = 35)

Waiting times

- Pathway reduced by over 3 working weeks for the patient

Patient Benefits

- Reduction in delays across diagnostic part of cancer pathway ensure treatment plan can be negotiated more quickly with all relevant information to hand
- Less anxiety waiting for all studies to be completed
- Reduced outpatient visits

Staff benefits

- Streamlined process is more efficient which leads to reduction in duplicated administrative processes and reduction in futile tasks (e.g. transporting clinical records and image files between departments, sending out appointments etc)
- Improved MDT relationships

Future

- Alternative technique of CT colonography may be a solution to residual barium post enema and inherent delay before CT staging scan can be executed

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Case study 5: Proactive Management of Patient Pathway following abnormal CXR, Worcestershire Acute Hospitals Trust

Details of improvement

What was the problem?

- Significant delays for patients found to have abnormal x rays when requested by GPs
- It was up to 3 weeks for the results to get back to the GPs following reporting, typing, verifying and post.
- Results would be sent back to GP who would then refer patient back to the hospital.
- This could incur a further delay of about 2-3 weeks, as the GPs referred the patient by a letter.

How was it identified?

- The issue was raised by the Multi Disciplinary Team (MDT)
- MDT identified patients slipping through the net and appearing as emergencies later on, or in two months time as a routine referral.

What were the implemented improvements?

- GPs refer patient for x ray
- If x ray is abnormal radiology team suggest a 2 week wait referral on bottom of report.
- A copy of report goes to GP and to 2 week appointment office.
- If GP does not make a referral within 48 hours clerical staff in 2ww office will follow up to ensure patient receives an appropriate appointment.

What is the situation now?

- System is ongoing

How is this sustainable?

- Ongoing cooperation between GPs, radiology department and chest physicians
- System is sustainable as long as the clerical staff, follow up the appointment.
- Radiology staff are happy to make the recommendation but not to spend the time making the appointment

Measurable outcome

Waiting times

- There has been a reduction in waiting time for patients referred for chest x ray which is found to be abnormal
- No direct access to plain film imaging for GPs at present. There has never been a specific wait for CXRs. The problem was that patients with abnormal CXRs were being lost in the system.
- The waiting time reduction refers to post examination (CXR) where the wait has dropped from up to 6 weeks to 2 weeks.

Capacity and demand

- There was been an initial increase in demand for two week urgent appointments but this has now levelled out again.
- This is an indication that patients were failing to meet target times
- The current demand is manageable

Booking and choice

- Patient is provided with an appointment with a lung physician as soon as the urgent referral is identified

Patient benefits

- Treatment plans can be negotiated earlier – with chance of better clinical outcome
- Up to 3 weeks delay in pathway has been eradicated

Staff benefits

- MDT happy that they now have timely referrals and the risks of patients being 'lost in the system' is eliminated

Future

- Plans underway to introduce a one stop system. A protocol is being established for patients to have CXR and proceed to CT +/- Bronch on one day with appointment made for the following week to issue results.

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Case study 6: Proactive management of Patient Pathway with Bronchial Lesions,

Doncaster and Bassetlaw Hospitals NHS Trust

Details of improvement

What was the problem?

- Patients presented by multiple routes for CXR
- No system was in place to fast track suspicious chest X rays

How was it identified?

- Process mapping the patient pathway indicated a need to speed up the 'front end' processes
- The clinical governance dept raised the issues of all patient complaints and all routes needing to be fast tracked (not just cancer referrals)

What were the implemented improvements?

- Discussions took place between the Clinical Director of Radiology, Radiologists and Respiratory Physicians
- A system was agreed that any suspicious X ray would be referred directly to a named Physician- one on each hospital site.
- If necessary the patient would then be telephoned with a CT and Bronchoscopy appointment to be carried out on the same day.
- All patient investigation results would then be discussed at the next available weekly Multi Disciplinary Team (MDT) meeting
- Considerable work with IT team to establish a bespoke electronic 'Tracker system'

What is the situation now?

- All patient groups are included in this system i.e. GP referrals, A&E, Pre-clerking, in-patients etc.
- The same system approach has been rolled out to colorectal.
- Any suspicious finding from CT or U/S is referred directly to the MDT co-ordinator and presented at the next MDT meeting
- All stages of patient pathway are entered onto 'patients tracker' system via MDT coordinator

How is this sustainable?

- This system has now been successfully embedded for six months

Measurable outcome

Audit

- 300 patients have been fast tracked through the system

Waiting times

- Patient care plans are discussed at the next available MDT- shortening the patient journey

Booking and choice

- Patients have telephone booking of further investigations such as CT or bronchoscopy

Staff benefits

- There is a route for staff from all departments to make urgent referrals rather than loose patients in the system.

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Case study 7: Improving mechanism for potential cancer cases referrals

University Hospitals of Leicester NHS Trust and Community Hospitals

Details of Improvement

What was the problem?

- No formal mechanism for Radiology to flag potential cancers to MDT meetings
- Problem identified by the Lung Cancer MDT in 2000

What were the implemented improvements?

- Lung cancer code created for Radiologists to insert into reports
- Enabled clerical staff to fax copies of report to the
- System worked so well it was rolled out throughout the Trust

What is the situation now?

- All suspected cancer and tuberculosis (TB) examinations have a radiology report code and are referred to MDT
- Code used whenever suspect disease is found
- Codes widely publicised and used across all modalities
- Hospitals which share RIS can also use system
- Weekly database search for each code sent to all MDTS to ensure that no-one is missed

How is this sustainable?

- System sustained at current level since August 2003
- Use of the 15 codes has increased since its original conception and is now embedded in normal practice

Measurable outcome

- MDTs now notified of suspect cancers via Radiology
- Patient journey reduced by 1 – 3 days
- Radiology staff have a clear and consistent method for notifying suspect cancers and TB
- 1500 plus codes have been used since August 2003 befittting potential cancer and TB cases
- Weekly database search helps identify patients who may have been missed
- Model is now part of the NICE Lung Cancer guidelines (NICE Clinical Guideline 24, February 2005

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Being clear towards reduced waiting times

Radiology - What Works

Do Now

- Ensure Clinical Team Engagement
- Validate Waiting List
- Instigate max 2 queue approach immediately
- Implement Booking with linked appointments (inc DNA & A/L policies)
- Proactive Patient Management
  - link staging to diagnostic study
  - direct referral to MDT
- Implement Straight to Test where appropriate

Do Next

- Establish protocol driven procedures
- Skill mix (streamlined process to appropriate roles)
- Pool lists
- One-stop straight to test before outpatient
- Collect Capacity & Demand data

Do Later

- Appropriate demand management
- Standardise referral protocols
- Redesign Roles (– workforce skill planning & assess training needs)
- Maximise use of technology
- Involve users & patients
- Reduce variation in capacity (flexible working)

Section 7

Multi-disciplinary teamworking

Introduction

Multi-disciplinary teams play a key role in ensuring that all aspects of a patients condition (history, clinical examination and investigations) are properly considered so that appropriate advice on treatment can be given.

The MDT meeting provides an excellent opportunity to review the timelines of each patient's progress through the care pathway and to review progress on performance against 31 and 62 day targets.

Understanding the current situation

The following questions can usefully be asked about MDT functioning in general:

Team decision-making

- Does this MDT have the required membership (as set out in the manual for cancer services)?
- Are MDT meetings held regularly? How frequently?
- Do members of the MDT attend regularly?
- How good is the MDT decision making?
- Is a record kept of patients who have been discussed and decisions that have been made?
- How well are decisions communicated beyond the MDT (e.g. to primary care)?

The following questions can be asked about MDT working and cancer waiting times:

- Is there a designated team member responsible for navigating patients through the care pathway and ensuring each step is taken in a timely fashion?
- How good is communication between secondary and tertiary care? Is the tertiary centre notified of new patients as soon as is reasonably possible following clinical diagnosis?
- Does the MDT have robust data capture systems in place?
- Do you use your MDT's to discuss and investigate waiting times' breaches? Are action plans drawn up to prevent further breaches of that particular nature?
- Do you check that all "new" cancer patients are identified -cross-referencing with pathology and hospital information systems?
- Is each patient's position relating to the 31 and/or 62 day targets discussed at the MDT meeting?
- Are cancer information staff involved in your MDT meetings?

See also section 3: Data: Quality and Completeness.

Changes that will have an impact

- Mechanisms to ensure full team presence meetings at a time of day suitable for core team members (either physical or virtual e.g. via video-conferencing).
- Full sets of patient-level information available to support decision making (investigations results etc).
- Processes to record decisions made as well as other patient data such as cancer waiting times.
- Ensure decision are communicated to all relevant team members including primary care.
- Ensure the patient's onward journey is planned, booked and coordinated. Consider appointing pathway managers, co-ordinators, trackers or navigators to support this function.
- Introduce protocols to ensure that onward referral happens within a specified period of time (e.g. within 5 working days of a clinical diagnosis).
- Ensure systems in place for teams to monitor individual patient's waiting times and breaches.

The benefits of a well-functioning MDT for appropriate and timely decision making

Service delivery
- Enables clarity of care pathway to be agreed with appropriate treatment referral.
- Reduce delays.
- Enables patient level data to be captured to evaluate effectiveness of the service.

Patient experience
- Supports booked care.
- Patient involved in decision making.
- Patient pathway the core process.
- Reduce delays.

Clinical outcomes
- Ensures effective decision making re best treatment for the patient with all key staff present.

Benefits for staff
- Value of team decision making processes.

The following case study illustrates the benefits of introducing a "tracker" for lung cancer papers and their work with the MDTs.

University Hospitals of Leicester – Lung 'Tracker'

Leicestershire, Northants & Rutland Cancer Network

What was the reason for the change?

The problem was that in order to try and meet targets for patient booking and to monitor patient progress, the clinical nurse specialist was using up a great deal of her time and required support.

How was the need for the change identified?

This was identified by the lung team who were trying to review and improve the service they provided.

Which change ideas were tested and worked?

A preliminary job description was drawn up for the appointment of a lung tracker. This was to be a person responsible for following the patient through their journey and ensuring all relevant booking took place and documentation etc was always available when necessary.

A spread sheet was prepared onto which all diagnosed patients would be entered and subsequently monitored and checked.

What were the implemented improvements?

- The tracker is notified of a patient at the point of a two week referral.
- The tracker pre books investigations prior to consultation and the consultation appointment.
- All investigation results are made available for the MDT 2 weeks after consultation.
- The tracker attends and supports the MDT.
- The patient has certainty and choice throughout their journey.
- The patient has someone they can contact to clarify or change appointments.
- Documentation follows the patient through their journey.
- The tracker supports all patients coming through the system with diagnosed cancer. The system continues to be successful and has been rolled out to the other trusts within the cancer network. Similar posts have now been appointed in other specialities.

What is the situation now?

This continues to be a successful system and a similar posts is being appointed in another specialty.

Useful web links

www.modern.nhs.uk/cancer
For MDT Resource Guide and Service Improvement.

www.dh.gov.uk
For Peer Review and Manual of Cancer Standards.

www.modern.nhs.uk/cancer/bowel
40 point Action Plan for Colorectal MDTs.

Section 8

Treatment

Treatment – Key Issues

Following the multi-disciplinary decision for treatment, healthcare professionals should meet with the patient, preferably in a parallel clinic to discuss and support the patient in reaching a treatment decision. This process usually involves a surgeon, an oncologist and a specialist nurse as appropriate. Patients may require additional time to reach a decision, and this should be taken into account.

Once the treatment option has been agreed with the patient, systems should rapidly ensure treatment is carried out within an acceptable timescale.

Treatment, as detailed in this section, will usually consist of one of 4 options:

- Surgical Management.
- Chemotherapy.
- Radiotherapy.
- Supportive and/or palliative care.

Treatment may take place in the hospital where the diagnosis is made, or commonly the patient will be referred to a specialist (tertiary) centre. Delays often occur during the onward referral process. This may because of the waiting times for particular treatments, or because of the referral process itself.

Understanding the current situation

The following questions are generic and relevant to all four treatment modalities, and will help you understand the current situation in your Trust:

- Has the patient journey been process mapped?
- Do you understand the demand and capacity for your service, and where are your backlogs?
- Have you reviewed the NICE Improving Outcomes Guidance with reference to treatment?
- Do you comply with Cancer Network guidelines on treatment?
- Do you have robust communication systems between disciplines and secondary and tertiary sectors?
- Do you have patients being managed by the right practitioner in the right place and the right time with the right skills?
- Have you streamlined your service?
- Do you proactively track your patients through the pathway to avoid unnecessary delays?

If you have answered 'no' to any of these questions, the following material and signposting to relevant toolkits will be of use to you.

Referral between secondary and tertiary care

There are two key factors in ensuring the timely onward referral of patients between sectors, as identified in section 7 on multi-disciplinary teams. These are:

- That patients are **proactively** managed through to treatment.
- That there are clear protocols for referral and good communication between secondary and tertiary care.

The changes outlined below are referenced in Section 7. They are re-emphasised here because of their potential impact on this part of the pathway:

- The introduction of a 'navigator' role as part of the MDT (otherwise known as a 'tracker' or 'pathway manager') to ensure patients onward journeys are coordinated, with tests and treatments booked, results gathered, the patient fully informed.
- Agreed mechanisms and timescales for tertiary referral, with sign-up by the referring and tertiary trust staff.
- Mechanisms within a DGH to alert the tertiary centre within the agreed timescales.
- Ensure systems in place for multi-disciplinary teams to monitor individual patient's waiting times on the 31 and 62 day timelines.

Specific treatment modalities

Surgery

As well as tackling delays in the referral process, improving the performance of operating theatres is a key to achieving shorter waiting times. A number of NHS Modernisation Agency (MA) Programmes have addressed some of the issues, and some organisations have made significant progress in reducing their waiting times.

Surgical management: Understanding the current situation

Key questions include:

- Has capacity and demand been properly assessed for:
  - Theatres.
  - In-patient beds.
  - Day case facilities.
  - High dependency beds.
- Is day surgery capacity used effectively (for cancer and non-cancer patients)?
- Is theatre capacity used effectively (e.g. by pooling lists and covering annual leave)?
- Do you use pre-assessment clinics to ensure patients are fit for surgery?
- Is discharge planning as effective as it could be?

Which changes will make the biggest difference to improving cancer treatment?

Cancer can not be considered in isolation, a whole systems approach is required.

The following generic changes should be considered:

- Importance of pre-assessment in reducing DNAs and cancellations; and efficient scheduling of theatres. A number of toolkits are available to support assessment and management of issues here. www.modern.nhs.uk/theatres
- Treating day surgery as the norm/scheduling surgery in the most appropriate environment. There is a wealth of information and contacts at www.modern.nhs.uk/daysurgery
- Ensure capacity and demand are measured in terms of time needed rather than number of patients. This has been a fundamental aspect of the Clinical Prioritisation and Treat (CPaT) work. www.modern.nhs.uk/cpat

Benefits of implementing changes around surgical treatment

Service delivery

- Utilising available capacity efficiently.
- Booked appointments with a choice of date.
- Shorter waiting times through streamlined treatment processes.
- Reduction in DNAs through robust pre-assessment processes.

Patient experience

- Booked appointments with a choice of date.
- Shorter waiting times, equity of waiting times.
- Reduced anxiety.
- Day surgery preferable for patients than treatment as an in-patient.

Clinical outcomes

day surgery as opposed to in-patient surgery:

- Avoidance of risks associated with being hospital (e.g. hospital-acquired infections).
- Avoidance of a general anaesthetic.

Benefits for staff

- Reduction in time staff spend managing waiting lists and queues.
- Increased staff morale.

General case-studies on reducing surgical waiting times can be found at:

www.modern.nhs.uk/theatres

www.modern.nhs.uk/daysurgery

www.modern.nhs.uk/cpat

Chemotherapy

Chemotherapy is the first definitive treatment for a small number of patients.

Key questions:

- Do you schedule and book patients chemotherapy throughout the day?
- Do you have electronic prescribing to reduce error?
- Do you understand how chemotherapy services function across the cancer network?
- Do you involve the local/network Pharmacist in streamlining chemotherapy services?
- Do you receive blood results in time for patient's treatment to be prescribed to avoid unnecessary delays?
- Do you use your skill mix effectively to release consultant and qualified nurse time?

Process Mapping - undertake a comprehensive process mapping exercise that reflects accurately the current service. Look at your service through the patients eyes.

Changes that make the biggest difference

The CSC'IP' chemotherapy team is developing a toolkit that will enable Networks and Trusts to plan their capacity and to forecast future trends and workloads. The toolkit will be available by early spring 2005 via website www.modern.nhs.uk/chemotherapy. Further work is planned to support chemotherapy clinical risk management.

We do know however some of the changes that make the biggest difference around the chemotherapy part of the patient journey are;

- Streamline the service through working across departments and specialities (including phlebotomy, pathology, pharmacy).
- Improve communication systems between disciplines and between the secondary and tertiary sectors to minimise delays and reduce clinical risk.
- Matching the capacity with the demand for the service.
- Schedule chemotherapy throughout the day.
- Development of work force (for example development of health care assistant roles to act as 'coordinators', reducing CNS time spent on administrative tasks).
- Electronic prescribing to reduce error and standardise protocols.

The main benefits of implementing High Impact Changes for chemotherapy

Service delivery

- Utilising available capacity efficiently.
- Booked appointments with a choice of date.
- Shorter waiting times through scheduling patients across the day.

Patient experience

- Booked appointments with a choice of date and time provides certainty.
- Shorter waiting times during each visit.
- Reduced anxiety.

Clinical outcomes

- Day surgery as opposed to in-patient surgery:
  - Reduced risks of error with electronic prescribing.
  - Improved outcomes by reducing delays.

Benefits for staff

- More manageable and organised work environment.
- Improved communication and shared understanding of roles.

The following case-study illustrates the impact of changes in chemotherapy

View the service improvement guide www.modern.nhs.uk/chemotherapy for additional information

Case Study:
Gloucestershire Hospitals NHS Trust, Three Counties Cancer Network

What was the reason for the change?

Large numbers of patients attending chemotherapy clinics and the complexity of the total process resulted in some patients being in the department in excess of 8 hours.

How was the need for change identified?

Process mapping

Which Changes were tested and worked?

- The number of nurse-led pre-chemotherapy regimes were identified as being appropriate for pre-prescribing, allowing the cytoxics laboratory to plan for their incoming work.
- The use banded-strength chemotherapy has been introduced saving significant amounts of time for the laboratory staff in drawing up and preparing the chemotherapy.
- A separate project to examine the operational arrangements that occur within the cytotoxics laboratory (and communication arrangements between the pharmacy and the chemotherapy clinic) has been commissioned, completed and reported on and is being considered for action by the pharmacy management.

What were the implemented improvements and how did they benefit patients?

All the above changes have been implemented. Individually and collectively they benefit patients by providing patients and staff with a structured approach to the provision of chemotherapy treatment.

Initially these improvements were applied to one oncologist's clinic, where more than 300 new (or new episode) patients are seen each year.
This work is now being cascaded out to the other 7 oncologists' chemotherapy clinics, so that approximately 2000 new (or new episode) patients will benefit from this approach each year

What is the situation now?

At the end of Phase 2 of the CSC'IP' Programme, 3 oncologists' chemotherapy patients have been applied to the scheduled approach for chemotherapy clinic redesign and the approach is in the process of being rolled out across all clinics.

This project has been subject to continuous change and validation.

Radiotherapy

There are currently delays in many cases for radiotherapy treatment through shortages of key staff and lack of co-ordination of the complex pre-treatment preparation pathway.

Understanding the current position

As with other elements of the patient pathway, process mapping, and capacity and demand studies are crucial in understanding where to target improvement efforts.

- **Focus on whole systems** and across a pathway of care. Work across secondary and tertiary care and ensure an integrated care approach in understanding the issues.
- **Assess skill mix** - assess the duties of each staff group involved in the process. Implement flexible working to maximise capacity and look for potential to eliminate variation. Look for opportunities to expand roles.

The RES (Radiotherapy Episode Statistics) project was developed in response to the difficulties teams had in collecting / analysing radiotherapy capacity, demand and wait times data. It will provide teams with a mechanism for capturing real-time data and form the basis of the first ever national radiotherapy database, as well as giving teams access to high quality local data for use in service improvement. The project was launched in June 2003 and we now have electronic data extracts The project background and datasets are available at www.modern.nhs.uk/cancer/radiotherapy

Changes that make the biggest difference

The CSC'IP'' radiotherapy team has developed a Service Improvement Toolkit which is a step-by-step guide to building process templates, streamlining care and collecting capacity and demand data for planning and modelling use. There is also a radiotherapy Service Improvement Guide which details examples of improvements along the pathway implemented and verified to date.

Current examples of elements teams are working on are available on our reporting system.

The changes that make the biggest difference to the radiotherapy treatment part of the patient journey are:

- Streamlining the registration and referral process - MDT meeting or electronic peripheral clinic referral can cut 2 weeks from the process and allow patients to leave with an appointment (Portsmouth and Coventry).
- Appropriate skill-mix - the introduction of booking clerks / support staff releases radiographer time. This can allow extended roles in patient planning and fast-track services alleviating the "doctor bottleneck" (Newcastle and Southampton).
- Appropriately scheduling staff and workload to allow for variability. Reduces staff overtime, increases throughput and allows urgent patient workload to be accommodated more easily without overbooking (Bristol).
- Getting the underpinning protocols in place (Newcastle, Bristol and Mount Vernon).

The main benefits of implementing High Impact Changes for radiotherapy

Service delivery

- Enables clarity of care pathway to be agreed with appropriate treatment referral.
- Enables patient level data to be captured to evaluate effectiveness of the service.

Patient experience

- Information pathway appropriately dovetailed.
- Booked appointments with a choice.
- Patient involved in decision making.
- Patient pathway the core process.

Clinical outcomes

- Allows monitoring against key peer review and cancer plan indicators.
- Ensures timely pathway of best treatment for the patient is implemented.

Benefits for staff

- Value of team in implementing, monitoring and maintaining patient pathway standards.

Case Studies

The following case studies illustrate the benefits of improving radiotherapy services:

Case Study 1: Radiotherapy Fast Track, Southampton NHS Trust, Central South Coast Cancer Network

Case Study 2: Improving Oncology Services - Creating Capacity from Nowhere, United Bristol Healthcare Trust

Case Study 1: Radiotherapy Fast Track Southampton NHS Trust, Central South Coast Cancer Network

What was the reason for the change?

Due to our long waiting list, patients with painful boney metastases were not receiving timely treatment for relief of symptoms.

What was the reason for the change?

Through data collection we were able to determine how long each category of patient was waiting for treatment. We also were aware from our consultants that they were experiencing problems. CNSs were reporting a high level of contact from anxious patients and we were aware though our own experience that patients were waiting too long.

Which change ideas were tested and worked?

- Radiographer led planning of patients, who required 5 fractions of treatment or less, who were referred from clinic with their treatment already consented and prescribed.
- Extending the working day by two hours on the one treatment unit that worked a 9-5 day, using radiographers who were willing to work overtime.
- Radiographer booking and arrangement of appointments.

What were the implemented improvements?

- Radiographer-led planning.
- Radiographer booking.
- New fast track booking forms.
- Quality documentation to support the project.
- Patients are seen in clinic by their clinician who completes a fast track booking form, obtains consent and completes a treatment sheet complete with signed prescription. This is then delivered directly to the Simulator where the radiographers involved in the project identify suitable planning and treatment slots and contact the patients by phone. The patient receives planning and treatment within 14 days of the clinic appointment and often within 5 days. Patients have been extremely pleased with the service and are receiving prompt treatment for the relief of symptoms from boney metastases. This has reduced the overall waiting time for palliative patients from six down to four weeks.

What was the impact ?

Fast track and our palliative wait has been reduced overall from 31 to 19 days and a reduction of all patient waits from 48 days to 29 days.

Is the improvement sustainable?

It is envisaged that when we are fully equipped in our new centre this service will be provided within normal working hours.

Case Study 2: Improving Oncology Services - Creating Capacity from Nowhere
United Bristol Healthcare Trust

What was the reason for the change?

Despite a belief to the contrary a capacity and demand study revealed radiographers made very poor use of time and resources. This resulted in regularly running late, generating vast amounts of overtime and additional costs. Further investigation revealed that there was no real structure to the day, with radiographers taking on tasks in a haphazard manner. Further radiographers would take on easy or popular tasks first, leaving the others until last.
Regular interruptions meant that few tasks were completed expediently and increased clinical risk. Further these interruptions delayed completion of tasks extending the working day unnecessarily. The knock-on effect of this being increased waiting times for patients in the unit. In addition it meant that fewer patients were treated daily than the theoretical capacity indicated.

Which change ideas were tested and worked?

A daily schedule was put in place. This identified three "roles" which were split between the four members of the radiography team.

These three roles are:

- Runner.
- Paperwork.
- Substitute.

Runner

This is two staff. They deal exclusively with the patient, getting them into the room, settled and deliver treatment. They are also responsible for the paperwork linked to delivery of treatment.

Paperwork

A member of the team exclusively dedicated to calculating plans, writing letters and other administrative tasks. Where necessary they do this away from the treatment set in order to avoid disruption.

Substitute

Although the most disliked role, this has also been recognised as the most beneficial role in the new scheme and has the greatest impact. The substitute fulfils several functions. Firstly, as their name suggests they substitute in for any running radiographer that for some reason needs to spend time with a patient in treatment. Where possible the patient and the radiographer move to a private room to continue the conversation. The substitute then steps in and the set continues running without interruption. This also ensures that the patient has continuity with the same radiographer instead of being passed on to someone else if they have a problem. The other part of the role is to pick up all the odds and ends tasks that need to be done. They answer the telephone, deal with visitors, run errands, locate staff and/or patients, track down notes, complete miscellaneous tasks listed in the diary etc. It is a busy role but it allows the remaining three to dedicatedly work on their roles without interruption. This reduces the chance of errors and ensures little time is lost to disruption.

When initially imposed the schedule was viewed by the radiographers as very rigid and taking away freedom. Once it had been adjusted to fit their way of working, they found it a valuable tool. It helps them plan their day effectively and gives structure to what is happening. The day runs far more efficiently and smoothly with tasks getting completed faster and with no extra effort.

The Lead Radiographer is responsible for ensuring that the schedule is prepared (this is done at the end of each week for the following week) and for making ad hoc adjustments for meetings, sickness or other absence. Any new radiographer on the set is expected to take on the daily tasks for the radiographer they are replacing.

Breaks are scheduled so that wherever possible the maximum number of radiographers remain on the treatment set, unlike the previous method where the number on set went down to 2 at any break time. It was also evident that that the impact on the set was large if all the staff had breaks in the morning, then lunch and no breaks in the afternoon. This was changed so that those staff on early lunches had afternoon breaks instead.

One difficulty with this process was educating radiographers to be able to say "No". Many of them were involved with additional tasks, particularly when on errands round the building or en route to breaks. This resulted in a lot of time being wasted, radiographers performing inappropriate tasks and disruption on set due to radiographer absence. Radiographers now refer requests for assistance to their set lead who will make a decision who is the best resource to use for the job, or if necessary point the request in the direction of a more appropriate resource.

What was the impact?

As above - the patient improvements are an immediate improvement in waiting times in the waiting room. The working day rarely over ran. As the project implementation progressed it became clear that there was spare, unused capacity in the system. Radiographers complained of boredom during the working day as they had completed all peripheral tasks like paperwork yet and were ahead of the appointment list.

To rectify this approximately 8% more appointment slots were added to the working day. These resulted in a comfortably achievable daily workload with no overtime generated.

In addition, clinical risk due to interruption has been eliminated.

Is the improvement sustainable?

These changes are easily sustainable so long as there is the will of the radiographers to continue to do so. As these changes were of significant importance to the radiographers the changes have been well maintained through peer pressure.

Supportive and palliative Care

A significant proportion of patients with an immediate diagnosis of cancer will need to move rapidly into an integrated care pathway for palliative care. It is crucial that an appropriate assessment is made as quickly as possible. This can be through primary, acute or hospice care setting.

In order to ensure that patients get the right care delivered in the appropriate care setting it is key that the correct care pathway is selected. The following pathways form part of the Department of Health 'End of Life Care Initiative':

- The Gold Standards Framework - Programme for Community Palliative Care.
- The Liverpool Care Pathway for improving care in the last 48 hours of life within primary, acute or a care home setting.
- The Preferred Place of Care: A process of identifying services being accessed by palliative care patients, changes that occur in care planning and the reasons why the changes occurred.

For more information, see contact details in the Signposting Section at the end of this guide.

References:

Improvement Leaders' Guide to Matching Capacity & Demand (Series 1) NHS Modernisation Agency, 2002. www.modern.nhs.uk/improvementguides.

Radiotherapy Toolkit, NHS Modernisation Agency, 2003. Available from www.modern.nhs.uk/cancer/radiotherapy.

Radiotherapy Service Improvement Guide, NHS Modernisation Agency, 2003. Available from www.modern.nhs.uk/cancer/radiotherapy. Visit website: nww.wils.nhs.uk. To register, please e-mail cancer.collaborative@npat.nhs.uk.

Gold Standards Framework – Programmed for Community Palliative Care, Macmillan Cancer Relief, Dr Keri Thomas. Available from www.goldstandardsframework.nhs.uk

The Liverpool Care Pathway – Promoting Best Practice For Care Of The Dying. Dr John Ellershaw. Available from www.lep-mariecurie.org.uk

The Preferred Place of Care, Lancashire and South Cumbria Cancer Services Network. Available from www.cancerlancashire.org.uk or www.cancercumbria.org.uk

Section 8

Additions

Treatment

Radiotherapy: recommendations for reducing waiting times

Currently, many radiotherapy services have delays for their patients in excess of the NHS Cancer Plan and Cancer Standards / Royal College of Radiologists targets. This can be due to lack of key staff, equipment or due to the appropriate coordination of the tertiary and complex patient care pathways.

Understanding the current position

Teams need to be able to locate where their actual problems lie through a combination of:

- Process mapping

  Map every step of the process, the time it takes and the time in between each step. Look for steps that are duplicated, unnecessary or multiple tasks that could be completed at one point. See if you can schedule work around key bottlenecks, ie doctor availability in the planning process.

- Capacity and demand

  Do you have a waiting list? What is causing it? Can you get rid of it? Detailed capacity and demand studies around the key bottleneck point, eg treatment unit, simulation, planning or doctor availability will allow you to see if you have your capacity, demand and activity are in balance and if not, can help you plan to address it, by quantifying the amount of work (demand) waiting (waiting list / time).

The RES (Radiotherapy Episode Statistics) project has been developed in response to the difficulties teams have had in collecting and analysing radiotherapy capacity, activity, demand and waiting time data. It is providing teams with real-time mechanisms for capturing their data, feedback analysis and forms the basis of the first ever national radiotherapy database that they can then use to benchmark themselves against. This local data will also be an excellent resource for use in service improvement.

Full details of the RES project and help from the national team regarding radiotherapy capacity and demand and service improvement are available at www.mocern.nhs/cancer/radiotherapy.

Changes that make the biggest difference

The CSC'IP' team has developed a Service Improvement Toolkit which is a step by step guide to building process templates, streamlining care and collecting capacity and demand data for service improvement, planning and modelling use.
There is also a Radiotherapy Service Improvement Guide which has examples of improvements teams have implemented along the radiotherapy pathway, with further examples available via the WILS on-line reporting system.

Some key service improvement questions:

1. Do you have referral guidelines and clinical protocols for treatment?
   These can help prioritise the right patients and make sure preparation for radiotherapy is booked and in the right order

2. Do you have systems links to the MDT meeting?
   This can mean patient appointments to see the Oncologist are booked from the MDT and so reduce administration delay. It can also help flagging appropriate 31 and 62 day patients for monitoring.

3. How far in advance to you book patients?
   If patients are scheduled in months in advance this will increase DNAs (due to patients forgetting, being on holiday, moving house, death), and short notice cancellations (due to changes in condition and disease status and treatment plan). This can lead to the loss of valuable simulation and treatment slots, which will increase overall waiting times. It also reduces flexibility to accommodate acute / urgent patients and swings in type of workload.

   The solution – book only as far ahead as your longest patient pathway and "pend" the patients until that time (as most OP waiting systems). IF you have electronic systems the patients can be logged and tracked by their referral date to ensure they are not lost.

4. How many times does the patient visit?
   Can the steps / visits be reduced? Ideally a patient should visit to see the Oncologist to discuss treatment, to be simulated (can include construction of 5 point restraint on the same day for Head and Neck patients), and then to be verified and start treatment.

5. Have you got the doctor / skills in the right part of the process?

If the patient is simulated when the doctor is present, then the doctor will need to define and prescribe treatment following that visit. This can take a further 2 weeks if the doctor is only on site once per week.

Scan / simulate the patient prior to the scheduled doctor slot, schedule time for them to define, check and prescribe treatment and the process can be reduced to days. If the Oncologists also work in teams, this helps to further reduce delays due to weekly availability, holidays, study leave, etc.

6. What fractionation regimes do you use?

During times of acute waiting time problems due to linear accelerator capacity it would be worth reviewing the fractionation regimes in use by your Oncologists. Evidence-based reductions can be made to palliative patient (single fractions, reducing short course from more than 10 to 4-5), breast patient (15 rather than 25) and prostate (20 rather than 34) regimes.

7. Are you utilising your workforce appropriately?

Appropriate support (admin, booking, helper) can release radiographers to increase capacity. Assistant Practitioners can release staff to take on advance roles to alleviate doctors of routine bits of the planning process, including radiographer led palliative and breast fast track services. Planning dosimetrists can release Physicists to optimise their roles.

8. Have you involved your patients?

There is not much point in planning to work 12 hour days on linear accelerators to create more capacity if most of your patients come by hospital transport or don't like coming after 4.30pm.

Treatment as a day case

Case Study: Urology,
Ipswich Hospital and Suffolk East PCTs

Service Improvement

Superficial bladder tumour laser treatment as day case

Date service change was implemented

September 2003

Is the change still in place?

Yes

Summary of change

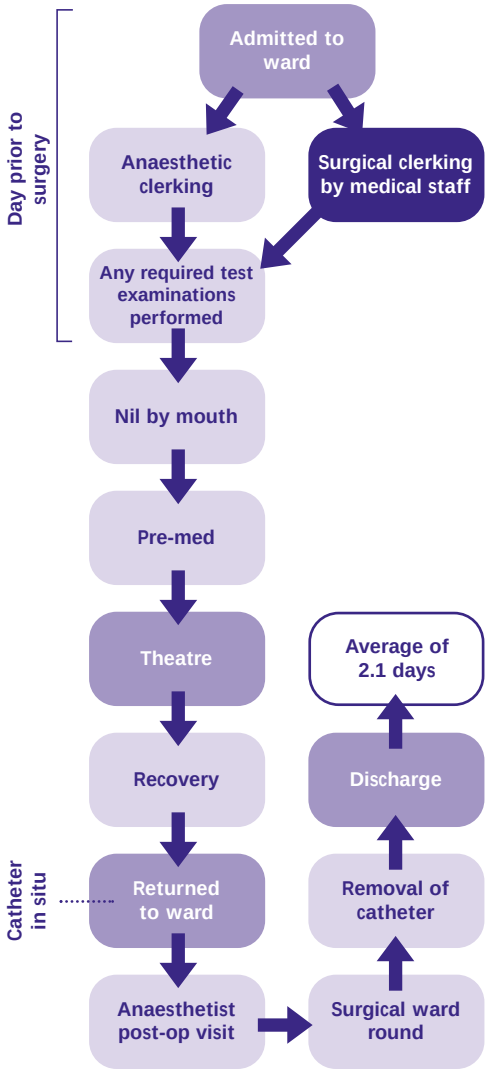
Patients requiring ablation of recurrent superficial bladder tumours are now treated under topical anaesthesia with laser as a day case. A consultant urologist performs this procedure in the urology operating theatre. At present, one session is conducted each month.

Why the change was undertaken?

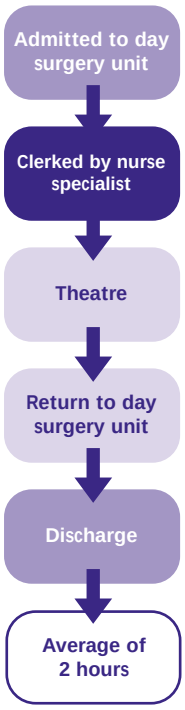
There are a significant number of patients who have superficial bladder tumours that need to be treated. These were previously admitted and usually stayed in hospital for one or two days. By using a Holmiun YAG laser, these patients can now be treated by means of a flexible cystoscope, as day cases.

Impact of change on the patient pathway.

Non laser bladder tumour treatment



Laser treatment of bladder tumour



How was the change achieved?

One urologist had sufficient experience of laser surgery to undertake this work.
A laser was leased on a sessional basis.
One operating list per month was earmarked for laser surgery.
Due to legal and safety requirements associated with laser usage and the de-contamination of the flexible cystoscopes, it was decided to perform the treatment in the urology operating theatre.
In order to prevent the use of an inpatient bed and the use of the theatre recovery facilities, patients are admitted to the day surgery unit where a urology nurse specialist admits them. From here, the patient is taken to theatre in a wheelchair where the procedure is performed and then returned to the day surgery unit where postoperative advice is given followed by discharge.

Workforce changes related to the service change.

This innovation has not required any significant workforce changes.
As only one urologist is currently performing this procedure, he has reached an arrangement with his colleagues for undertaking this work for their patients.
This procedure requires no additional staff but dispenses with the need for an anaesthetist and recovery staff.
In order to address sustainability requirements and ensure a robust service, the training of other urology surgeons in laser techniques needs to be implemented.

Challenges and lessons learnt in implementing the change

Ideally, we would have purchased a laser for this purpose but due to financial constraints, this has not been possible to date. As a result, the training of personnel in these techniques is compromised, as is the ability to extend the service to lasering of patients requiring TURP.

We have been unable to transfer this work to outpatient treatment facilities and free up theatre facilities due to health and safety regulation

What was the impact on other services?

All the impacts have been positive:

- anaesthetic time released for other surgery
- ward beds released creating capacity
- day surgery unit better utilised
- improved throughput on lists
- shorter waiting time for patients

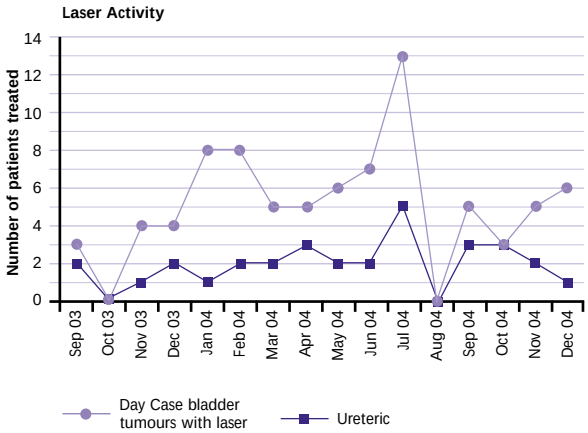
Cost of the service change

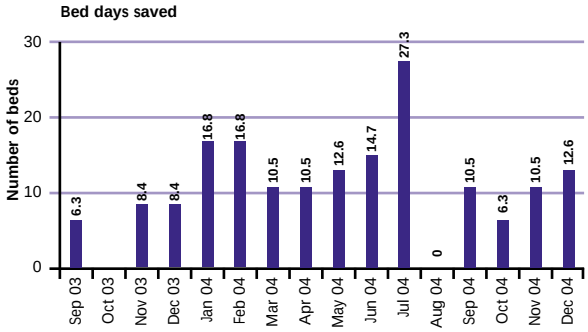
Leasing of the laser is £1000 per session (purchase price £120,000). The cystoscopes need to be laser compatible, which ours fortunately were. The wear and tear on the cystoscopes is negligible, however there is potential for the laser beam to cause extensive damage to the scope if a mistake is made.

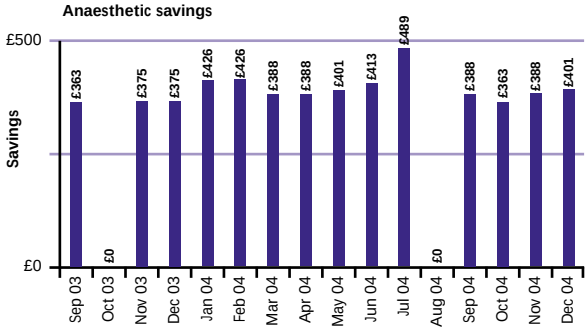
Overall significant savings were made as constrained capacity in terms of beds and anaesthetic time could be utilised for other work.

Measurements of success

Quantitative data was measured in terms of throughput and cost savings as demonstrated in the following charts.







Patient views

Qualitative data was obtained through retrospective patient questionnaires	
Satisfaction with written information given	100%
Satisfaction with verbal information	95.60%
Percentage of patients who found procedure differed from what they expected	42.80%
Average discomfort experienced during procedure on scale of 0-5	<2
Mean duration of discomfort following procedure	0.5 days
GP or hospital contacts following procedure	4.3% (1 pt)
Percentage of patients who found procedure less favourable than routine flexible cystoscopy	28.60%
Percentage of patients who would opt for this procedure in favour of procedure as inpatient under GA	100%

Impact to staff

Description of impact	Measurement method
Ability to plan workload reliably, as day case patients are not affected by variability in bed capacity, thus preventing rework cancelling and rebooking which upsets patients and consequently staff	Day case rate
Enhanced surgeon and operating team use of laser technology.	Amount of laser surgery performed
Faster turnaround of patients in theatre, which improves staff morale as there is less waiting around	Staff questionnaire

Impact to patients

Description of impact	Measurement method
Reduced likelihood of short notice cancellation compared to previous process	Count of number of cancellations
Topical anaesthetic has less risk of morbidity and mortality. Patients who would not be fit for general anaesthetic can now have the operation.	Count of number of cancellations compared to previous process
Recovery time post procedure is greatly reduced	Change in process and patient questionnaire
Shorter waiting times	Waiting list reports
Bed and anaesthetic capacity available for other patient groups	Analysis of savings

Impact to service delivery

Description of impact	Measurement method
Please see section 12	

Impact to clinical outcome

Description of impact	Measurement method
Reduced risk of anaesthetic Treating more quicker	Number of topical anaesthetic complications
reduces the risk of clinical complications	Waiting list reduction

Radiotherapy:

Do Now, Do Next, Do Later

A guide towards achieving Service Improvement, Cancer Targets and longer term sustainability for Radiotherapy services

Achieving service improvement and streamlining of care pathways has and continues to be a challenge fro those involved in delivering radiotherapy services.
Radiotherapy for most patients is only one part of a multi-faceted care package requiring coordination between many groups of staff, which can be laborious and tortuous in the absence of adequate IT systems and good robust processes.
Delivery of radiotherapy itself is a complex multi-step process involving three main professional groups – Radiographers, Physics staff and Oncologists and their teams.

Achieving the current 31 and 62 day Cancer Waiting Times targets for patients receiving radiotherapy as a first definitive treatment will be a major challenge. Monitoring for achievement for these targets will begin on the 31st December 2005 – that means patients referred urgently from early November (62 day patients) and early December (31 day patients) will count towards your achievement of these targets.

The issue for radiotherapy is complicated further by the type of patients they are likely to be – head and neck, radical lung, pre-operative rectum patients, etc. – those requiring multi-stranded preparation for treatment and complex radiotherapy planning. However, these patients are also likely to be the ones that are clinically prioritized for treatment when waiting times are long.

The problem for many radiotherapy departments is how they identify these patients and the proportion of their workload they are likely to be. There has been a national figure quoted of 6%, but this refers to the number of patients nationally who will have radiotherapy as a first definitive treatment, not the average proportion of 31 and 62 patients in relation to the total radiotherapy workload.

The proportion of target patients will depend on many factors and will vary from centre to centre depending on:

- **Clinical practice**
  The amount of radiotherapy given as first definitive treatment will depend on the extent of trials work, availability and integrated multi-disciplinary working.

- **Size of radiotherapy facility to host hospital**
  If the radiotherapy facility is large and attached to a smaller acute hospital, the proportion of reported radiotherapy first definitive treatments for that Trust will be higher.

- **Correct recording of first definitive treatment (FDT)**
  There is still confusion in this area. Any treatment (as defined in the current CWT guide www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Cancer/CancerArticles/fs/) given prior to radiotherapy, regardless of reason (e.g. long waiting times) is counted as the first definitive treatment, e.g. pre-radiotherapy hormone or chemotherapy not normally given.

There are many excellent examples of service redesign that clinical teams have undertaken which can produce great gains in efficiency and best use of capacity – really working smarter, not harder.

This document hopes to help teams in their aims to improve their services for their patients by highlighting the quick wins and longer term actions that will help them in their service redesign and future planning efforts.

Do Now

Know what your problems are

You can do this by:

- **Benchmarking your performance against:**

– The ideal radiotherapy journey (view at www.cancerimprovement.nhs.uk/radiotherapy)

– 8,000 fractions per linac per annum

– 3-4 radiographers per unit

– 11-12 minute appointment slots / 4 – 5 patients or fractions per hour

– Royal College of Radiologists waiting times audit

– Number of linacs per million population (current recommendations 4, likely to rise when the National Radiotherapy Advisory Group reports)

– Access rate for your diagnosed cancer population (should be in the order of 50%)

– Current Cancer Waiting times performance (available from your Trust / Cancer Network)

– Coming soon
- RCR evidence based fractionation document
- Radiotherapy Episodes Statistics data

- **Having accurate, all patient based waiting times** (view example at www.cancerimprovement.nhs.uk/radiotherapy)
- **Being able to plot and monitor capacity and activity** (view example at www.cancerimprovement.nhs.uk/radiotherapy)
- **Have quantified any backlog or be able to display demand against capacity and activity** (view example at www.cancerimprovement.nhs.uk/radiotherapy)

This exercise should help to identify your bottleneck area(s) and give a focus for the place to start your redesign.

Identify your 31 and 62 day target patients

Your Trust will have a system, an IT one if you are lucky, for capturing urgently referred (62 day patients) and newly diagnosed cancer patients who have decided to have treatment (31 day patients).The problem for many radiotherapy services is that they are a tertiary referral centre for many other Trusts in their network and identifying these patients can be more difficult but they will be recorded by the individual Trusts.

Communication links need to be made to allow timely flagging of these patients to you. MDT coordinators and Trust and Network Cancer and Data Managers are a good starting point if there is no Trust or Network wide CWT IT system in place.

There are then a number of actions you can take:

- Validate the 31 and 62 day lists – remove dead, not for treatment and not radiotherapy first definitive treatment patients.
  This can often halve the number of patients.
- Identify the volume and type of 31 and 62 day patients and when they are flagged to you.

– The 31 day patients should be completely under your control – date of decision to treat is decided with your Oncologists, and depending on clinical priority it may be possible to pro-actively manage / book these patients to achieve the targets

– The 62 day patients tend to be a much smaller volume, but are worth investigating to identify the reasons for their delays (often in diagnosis)

Do Next

Once you have undertaken the "do now" steps, you should be aware of your services particular problems. The following suggestions are all areas that teams have used to streamline their service and reduce waits for patients.

Streamline your booking process

If you have waiting times longer than 3-4 weeks, how far in advance to book your patients becomes an issue. Traditionally, departments have operated by booking the patient as soon as the referral arrives. This creates problems with increased workload / waiting time, due to rebooking and rescheduling because:

- **Patients condition changes in the interim**
- **Delays occur before patient is due to you, e.g. in surgery and chemotherapy, which are not communicated**
- **Patient DNAs due to long lead time due to forgetting / death / holidays, etc.**

In moving to a system of pending patients until 3-4 weeks before their due to start treatment, the rebooking / rescheduling workload is removed and lost slots are reduced. If this is accompanied by the immediate issue of a letter to patients on receipt of referral, telephone contact can be offered and dates of other treatments, holidays, etc., can be noted which also reduces lost slots. Full patient booking can also be complied with if patients are then asked to phone in and arrange their planning and treatment appointments.

In some systems it can take up to 2 weeks for the booking form / referral to reach radiotherapy. Electronic or same day fax systems can reduce this, as can MDT systems where Oncologist appointments can be made by the MDT co-ordinator.

Maximize capacity at bottleneck(s)

This will depend very much on where your capacity problem is:

- **Staffing**

– Can you extend hours by either staff shifts or overtime?

– Do you have an assistant, helper, booking clerk and admin roles to release radiographers / physics staff / doctors?

– Can staff be trained to take on more flexible / advanced practice roles in key areas, e.g. patient review and outlining in planning?

– Have you addressed morale and sickness issues?

- **Linear accelerator**

– Have you streamlined the workflow on the linac?

– Are you using auto sequencing, DICOM transfer and patient management systems?

– Do you have matched beams / equipment to enable more flexible transfer of patients when required?

– Do all patients get changed outside the room?

- **Simulation / Planning**

– Can you increase throughput by removing the doctor bottleneck and scanning patients in advance of their sessions?

– Can you introduce one-stop or fast track radiographer led services to reduce waits for palliative patients?

– Can you change doctor sessions to those dedicated to voluming and prescribing rather than simulation to increase throughput?

– Can you introduce team-working for clinicians to reduce cancelled sessions due to annual leave and other commitments?

– Can you reduce the planning burden by simplifying some techniques?

– Are your patients attending more times than they need to, e.g.

- For verification which should be carried out as part of first treatment using EPIDs?
- For consent - completion can be carried out by sim radiographers if started in peripheral clinic?

- **Equipment**

– Can you move servicing out of hours to release capacity?

– Do you have the facility for continuing treatment in advent of breakdown (spare linac / staff flexibility)?

Agree patient groups for treatment and fractionation schedules

- Have you an agreed list, including trials, of those patients who you will treat?
- Have you a list of fractionation regimes that your Consultants have agreed to use?
- Is practice against these lists audited regularly and fed back into service performance monitoring?

Establish clinical protocols and pathways

Cancer Waiting Time Targets are designed to improve the journey from diagnosis to treatment for all cancer patients, but it is acknowledged that, at present, the targets only apply to a proportion of patients. It is hoped that streamlining processes and pathways will result in benefits for all patients, but in some circumstances, such as when capacity cannot meet demand despite maximal service improvement, this may not be possible. In theory, this might lead to target-eligible patients being prioritised over other patients, but this should not be done if it could jeorpardise the care being given to some individuals. Therefore clinical priorities must not be distorted, and local groups should work towards ensuring that delays are kept to a minimum for both target-eligible and clinically necessary cases.

Establishing clinical protocols and pathways for all patients may enable this to happen. These can provide booking templates and streamline processes as all involved know what should happen to each patient at each stage.

There needs to be a mechanism for review of the protocols so that any major changes to practice that would impact on capacity can be quantified, discussed and planned for before introduction.

Do Later

By this stage, teams should be looking at longer term planning and how they can use the data and service improvement techniques they have learnt to predict and manage patterns in radiotherapy utilization.

Traditional models used existing activity with yearly % increase, but this is not nearly sensitive enough. Predictions and plans for future facilities, equipment and workforce needs should be based on current demand, any benchmarked underutilization, predicted areas of growth (fractionation extensions, trials, new diseases / applications for radiotherapy, future population / catchment) and horizon scanning for new technologies.

Plans should marry equipment expansion plans with appropriate and timely workforce planning requirements, taking into account the move to 4 tier practice, role extension, and flexible ways of working. They should also include planned equipment upgrade and replacement timetables and be in line with the outcomes of the National Radiotherapy Advisory Group report (due Spring 2006).

And finally

For further information on any of the aspects of service improvement and for practical examples, please visit our website:
www.cancerimprovement.nhs.uk/radiotherapy

Current teams' activity is reported via our on-line reporting system. You can register for read-only access by visiting:
nww.wils.nhs.uk

Section 9

Follow-up

Follow-up: General issues

- 37 million follow up appointments within the NHS each year.
- A proportion of these are clinically unnecessary and cause unnecessary anxiety for patients.
- 75% of all outpatient DNAs are for follow up appointments.
- We need to ensure that follow up procedures for cancer patients are clinically appropriate, make the best use of resources and enhance the experience for patients.

Clinical and managerial buy-in are essential if follow-up practice is to be changed. The views of patients and carers should also be sought. Recommendations in NICE Improving Outcomes Guidance related to individual cancer types should be used as the basis for planning.

Understanding the current situation

The following will be helpful in assessing the current position:

- Review the follow up section of the local and Cancer Network Clinical Guidelines for the relevant cancer type.
- Review relevant national guidance, e.g. NICE Improving Outcomes Guidance for recommended follow up protocols.
- Understand the current clinic mix to find out where the follow up patients are being seen and by whom.
- Undertake a capacity and demand analysis.
- Review DNA rates relating to follow up appointments.
- Seek patients and carers views.

Changes that can make the biggest difference

Reducing consultant led follow up to release capacity by:

- Gaining clinical and managerial buy-in to redesign the service.
- Initiating cross boundary and cross professional working - possibly seeking consensus within the network tumour site-specific groups.
- Designing and implementing standardised follow up protocols.
- Designing and implementing new/extended roles (e.g. for nurses) with appropriate training and supervision.
- Providing patients with information about follow up processes and contact details of key staff who can be contacted when necessary.
- Measuring progress continuously.
- Communicating benefits to staff and patients.

Benefits that can be obtained by reducing Consultant led follow up to increase capacity

Service delivery.

- Potential reduction in DNA rates.
- Redirected Consultant time for other clinical priorities.
- Manage capacity and demand more effectively.
- Improved clinic scheduling to see new patients.
- Active discharge of (breast) cancer patients after regular follow up for five years.

Patient experience

- Follow up in the community near to home.
- Increased patient choice.
- Reduction in the number of visits.
- Reduced waits.
- Nurse led clinics offering patients more time.
- Enhanced continuity of care in nurse led clinics.
- Positive patient satisfaction surveys.

Clinical outcomes

- Increased capacity to see new patients sooner.
- Provision of rapid access to service for diagnosed cancer patients.
- Compliance to follow up protocols can be audited.

Benefits for staff

- Enhanced nurses / therapists roles.
- Training opportunities.
- Follow up protocols aid instruction of junior doctors.
- Reduced duplication and non value added time
- Enhances timely decision making.

Case Studies illustrating improvements to follow-up care:

Case study 1: Reduced breast follow-up at 5 years, Royal United Hospital, Bath.

Case study 2: Nurse-led follow-up, for prostate cancer Northern Cancer Network.

Case Study 3: Nurse-led follow-up for colorectal cancer, East Somerset NHS Trust.

Case study 4: Patient triggered follow up, South Tees.

Case study 1: Reduced breast follow up at 5 years

Royal United Hospital, Bath
Avon, Somerset & Wiltshire Cancer Network

What was the reason for the change?

At the Royal United Hospital it was felt that a review of the protocols for Family History and Breast Cancer Follow Ups would lead to an improved use of clinic capacity. It was estimated that a minimum of 2000 outpatient appointments could be re utilised in the surgical and oncology breast clinics.

How was the need for the change identified?

Identified through discussion by the Breast Team, Cancer Steering Group and CSC'IP'.

Which change ideas were tested and worked?

Draft protocols were discussed with the cancer steering group and the primary care cancer representatives. Letters and questionnaires were sent to the relevant parties for ratification.
An audit was made of medical records for patients on existing follow up (both family history and breast cancer patients) to determine eligibility.

What were the implemented improvements?

- For the Family History Service
  - a self-assessment questionnaire is sent to the patient for completion, following referral.
  - Questionnaires are vetted by the family history clinical lead and risk assigned.
  - Patients are then seen in the clinic for further assessment and discussion and entered onto the mammographic screening programme – not seen again in the clinic unless a clinical or radiological problem.
  - Patients not accepted are sent a letter of explanation and reassurance.

- For the Breast Cancer Follow ups
  - Patients discharged from clinical follow up at 5 years post treatment (was 10yrs) and entered onto mammographic screening programme.
  - To prevent duplication on follow up by oncology and surgical follow up, patients seen in either clinic on an alternating basis.
  - Post discharge patients continue on mammographic surveillance for another 5 years (until 10 years post treatment).
  - Radiographers trained to go through a questionnaire with each patient at visit for mammography (following discharge from the clinic).
  - Patients can self refer at any time – by contacting breast care nurse.

What was the impact ?

To date 1,000 breast cancer patients have been discharged from clinical follow up at 5 years post treatment (was 10 years) and entered onto the mammographic screening programme. Overall there has been an increase in clinic capacity of 1000 slots per annum.
There were 560 family history patients already in the system, of this number, following the new guidelines 209 were discharged after notes review, and the remaining 353 were entered onto the mammographic screening programme. Of the 331 new referrals, 153 were declined as Low risk, and 161 were accepted, seen once in clinic and entered onto the mammographic screening programme. An overall increase in clinic capacity of 730 slots.

What is the situation now?

Gradual improvement as each patient on a follow up programme is reviewed and clinical capacity will gradually increase.

Is the improvement sustainable?

New clerical post has now been set up within the unit. This person manages the screening programmes for the family history and breast cancer follow up database and dictates patients to be called for mammography.

Case Study 2: Nurse led follow-up

Northern Cancer Network

Nurse-led clinic standardises referral process and frees consultant appointments.

What was the problem?

Originally all prostate patients were first seen and followed up by different consultants in general urology clinics.

How was it identified?

As a result of the implementation of the 2 week rule a nurse led prostate screening clinic was introduced. This led to an increased pathway time but patients still had to wait until they could be fitted into consultant clinics for follow up. It was therefore necessary to review the timing of the whole pathway.

Which change ideas were tested and worked?

- Nurse led prostate screening clinic was piloted and implemented.
- Pre booking of appointments along the prostate patient pathway was piloted and implemented.
- Protocols were written for nurse led follow up and approved by the consultant.
- Nurse led follow up was introduced, with the patients being reviewed by the consultant once a year.

What were the implemented improvements and how do they benefit patients?

- Patients are booked into a nurse led screening clinic within 24 hours of receipt of referral.
- The first appointment and all subsequent investigation and follow up appointments are agreed and booked with the patient in advance.
- Patients are supported by the same nurse throughout their care, either through direct contact or in support of consultant appointments.
- Follow up is carried out to an agreed protocol which allows for patients to be referred back to the consultant if deemed necessary.

How many patients has this impacted on?

70 patients have taken part in the nurse led follow up in the past nine months.

What is the situation now?

The system is working well and ongoing.

Is the improvement sustainable?

Yes - the system is now well established.

How are patients involved in identifying the problems or solutions and evaluation?

The initial change in service to a nurse led clinic was evaluated positively. This was carried out through a patient semi structured questionnaire. Patients were not specifically asked about follow up as a separate issue.

Date that change was implemented

Case study was last validated in February 2002.

Case Study 3: Nurse Led follow-up
East Somerset NHS Trust, Yeovil District Hospital, Higher Kingston

The development of a nurse led follow-up clinic for patients who have had surgery for colorectal cancer.

What was the problem?

Following surgery for colorectal cancer, patients require ongoing advice and support throughout their recovery period especially if they have a colostomy. The current pressure on capacity for clinics results in patients being given clinic slots that do not provide the necessary amount of time for in depth discussion and provision of advice and support by the clinical team.

How was the problem identified?

The need for this facility was identified at the start of the Enhanced Recovery Trial, a clinical trial which concentrates on the recovery period following surgery for colorectal cancer. More time was required to fulfil the assessment process required, and it was felt that a nurse led clinic could provide the appropriate environment for the needs of these patients.

Which change ideas were tested and worked?

A pilot programme was funded by the Enhanced Recovery Trial for the trial patients, with the intention that if successful, it would be rolled out to include other cancer and non-cancer patients following surgery. This clinic was immediately successful with all patients benefiting from the time spent with the Nurse Specialist.

What were the implemented improvements and how do they benefit patients?

- The intention is that this clinic is ‘patient focused’, rather than ‘disease focused’, achieving the aims of the NHS Cancer plan to put the patient at the centre of the service.
- The clinic was implemented on one day each week with twenty minute slots allocated to discuss quality of life issues as well as health education, dietary and bowel function advice in an individualised session, with further time available if required.
- Patients become involved in their care by discussion of what will be discussed at each session and what surveillance they should expect. They are also given information regarding signs and symptoms to look out for and a direct contact number for the nurse specialist. If at all concerned they are advised to contact the Nurse Specialist who will advise them and if necessary bring their appointment forward.
- Continuity of care is improved by the patient always seeing the same Nurse, who as an experienced Colorectal and Stoma Care Nurse has a wealth of knowledge and expertise.

How many patients has this impacted on?

- There are approximately 110 colorectal cancer patients per year, and all uncomplicated cases could be referred to the Nurse led clinic for post operative care and follow up.
- The Consultant clinic slots that these patients would have taken are now released for new patients to be seen.

What is the situation now?

- The Enhanced Recovery Trial will be completed in November 2004, and the Consultant Physician has requested that the Nurse Led clinics continue for all the colorectal patients as they are proving so successful.
- A further nurse led clinic has been commenced for another consultant in the same way.

Is the improvement sustainable?

The nurse led clinic receives back up from the whole clinical team and is deemed cost effective through efficient use of resources. It has now been rolled out to include other colorectal cancer patients outside the trial.

How are patients involved in identifying the problems or solutions and evaluation?

- Patients are consulted during the bi-annual colorectal and stoma care open days, and also through patient questionnaires.
- The CSC'IP'' has commenced a User Involvement project that will seek patient's views about these services through cancer patient focus groups. The clinical teams will be able to ask the members of the focus groups specific questions about the nurse led clinics in order to help inform and plan future changes.

Date that change was implemented

November 2002

Case Study 4: Patient triggered follow-up

South Tees NHS Trust
Cancer Care Alliance, South Durham and North Yorkshire

Respiratory nurse specialists set up an open access clinic allowing patients to self refer to the service

What was the problem?

The problem was that there was a capacity issue for the Chest Physicians. Lung nurses were concerned about the quality of follow up for patients.

How was the problem identified?

The Lung Multi Disciplinary Team raised the issue.

Which change ideas were tested and worked?

The respiratory nurses agreed to set up an open access clinic once a week to which patients, relatives, and GPs can refer by telephone.

What were the implemented improvements and how do they benefit patients?

- The clinic is advertised/promoted in GP surgeries, through community staff and on a patient information leaflet.
- The clinic is used to monitor side effects of treatment, symptom management and coping skills.
- There is also an opportunity for patient education and information provision.
- The clinic ensures continuity of support and onward referral to other agencies as appropriate.
- There is an opportunity for holistic care.
- There is a reduced need for unnecessary appointments.
- When necessary letters are dictated and sent out the next day.

How many patients has this impacted on?

To date 64 patients have benefited from this service, of which 42% were self-referrals.

What is the situation now?

The clinic is running well. Plans for nurse-led prescribing.

Is the improvement sustainable?

Yes, as confirmed by a recent audit.

How are patients involved in identifying the problems or solutions and evaluation?

Patients have participated in lung group questionnaire.

Date that change was implemented

February 2002 and last validated in December 2003.

Contact:

South Tees NHS Trust
Cancer Care Alliance
South Durham and North Yorkshire

References:

High Impact Changes for Service Improvement and Delivery. NHS Modernisation Agency, Sept 2004

Improving Outcomes Guidance, National Institute of Clinical Excellence. Available from www.nice.org.uk

Section 9

Additions

Reducing consultant-led follow-up

Case studies from Urology

Case study 1: PSA tracker software and nurse-led telephone follow-up, Royal United Hospital, Bath.

Case study 2: Nurse-led telephone follow-up, Ipswich Hospital, Suffolk East PCT Trust.

Case Study 3: Nurse-led telephone follow-up - prostrate cancer, Lancashire Teaching Hospitals NHS Trust.

Case study 1: PSA tracker software and nurse-led telephone follow-up
Royal United Hospital, Bath.

Background

The Urology Department at the RUH saw a 100% increase in the rate of patients diagnosed with prostate cancer between 1999 and 2002. Once their disease has been stabilised, most of these patients will be followed-up every 6 months in consultant outpatient clinics over many years, with little change in disease status and only occasional need for intervention.

Our department (of 4 consultants) currently sees around 30 follow-up prostate cancer patients every week. We were seeking a new model of patient care that would relieve the burden on patients of attending a hospital appointment, and free-up a significant number of consultant slots.

Objective

- To reduce the burden of long-term follow-up in secondary care for patients with prostate cancer by developing an automated system to monitor patient well-being and PSA.

Overview of the change

Rather than seeing a consultant for every follow-up visit, routine follow-ups are overseen by a specialist nurse, assisted by a new piece of software. Patients receive a postal questionnaire asking about their general state of health, and have bloods taken for PSA testing in primary care. PSA levels and treatment history are captured on a new computer system, "PSA Tracker", which automatically triggers routine postal follow-up or recall to an outpatient clinic, based on clinically established algorithms for PSA.

Outcomes

Prior to the change, a survey of new follow-up patients found that 80% would prefer postal follow-up.

After the change, which occurred in September 2004, participating patients have fewer visits to hospital for routine checks (ie. potentially 2 visits per year saved for 500 patients).

A patient survey will be performed after 18 months, by which time the change should have had an impact on patients' views as they will have been through 2 or 3 routine follow-ups.

There should be no impact on clinical outcome for patients under review for Prostate Cancer. All patients on the new system will be recalled to an outpatient clinic at 2 years to ensure there are no problems.

Case study 2: Nurse-led telephone follow-up
Ipswich Hospital, Suffolk East PCT Trust.

When was the service change implemented?

March 2004

Is the change still in place?

Yes

Summary of change

Since 5 January 2004, patients who have undergone surgery for TURP have been followed-up through Urology Nurse Specialist telephone service.

Why was the change undertaken?

Increasing phone follow ups

Having introduced the concept of phone follow-up clinics on our patients with prostate cancer who have stable PSAs. We decided to expand this service and also offer phone follow-up clinics for patients post-TURP and for treatment planning for diagnosed bladder tumour patients, substantially reducing the number of patients needing to be seen in clinic.

The benefits will be to reduce the number of follow-up attendances, minimise inconvenience to patients and frees up consultant time.

Impact of change on the patient pathway.

Patients no longer attend the clinic for follow up appointment following TURP unless specifically requested by the urologist or indicated by protocol following the telephone conversation with the nurse specialist.

How was the change achieved?

- A nurse specialist was trained to follow up patients in the clinic.
- A training programme was developed by the urologists
- A telephone follow up protocol was developed.
- A telephone audit tool was set up by the IT department
- The training programme was implemented.

Workforce changes related to the service change.

Extended new role for nurse specialist

Challenges and Lesson learnt to implementing the change

It was relatively easy to implement as it replicated a similar service already introduced within cancer services.

What was the impact on other services

During the first 12 months of this service 106 consultant outpatient slots have been freed up to see other patients.

Case study 3: Nurse-led telephone follow-up, prostrate cancer
Lancashire Teaching Hospitals NHS Trust.

When was the service change implemented?

November 2004

Is the change still in place?

Yes

Summary of change

Patients with stable prostate cancer who previously attended hospital for their follow up consultation are now telephoned at home by a specialist nurse

Why the change was undertaken?

There was a great deal of pressure on clinic time and staff. In order to achieve the out patient waiting time target for new referrals, the Trust had to look at how clinic capacity could be best utilised to allow better access for new patients. It was agreed that telephone follow-ups would not only assist with the above but would also benefit the patient.

Impact of change on the patient pathway.

Prior to this change patients had no alternative other than to attend hospital for their prostate cancer follow up. With this came the anxiety of how they would get to the hospital, costs involved and, if in a car, how soon prior to their appointment time would they have to arrive to find a parking spot. This was in addition to the time spent in clinic waiting to see the doctor.
Patients are now able to have a full consultation without leaving their home at a time agreed by them.

How was the change achieved?

As the telephone clinics were being run by highly experienced specialist urology nurses very little training was required. Guidelines were produced to enable the nurses to make very clear decisions when speaking to the patients.
The following information was produced prior to the clinics commencing:

- Protocol to assess suitability for telephone follow up
- Format of the telephone follow up for
  - Radical Prostatectomy
  - Radiotherapy
  - Hormone Therapy
  - Active Surveillance
- Criteria for referral to or discussion with consultant

Negotiations were undertaken with Medical Records to allow provision of notes to the nurses.

Workforce changes related to the service change.

As the specialist nurses already held nurse-led clinics, this was simply an extension to their role.

Challenges and Lesson learnt to implementing the change

Time – as the two specialist nurses already work full time these clinics have been incorporated into their weekly duties. This has proved very demanding for them. An agreement was reached whereby any additional hours required to ensure they continue to provide a quality service within urology should be funded from project monies. Should the telephone clinics continue after the project end additional nursing hours would have to be funded to backfill the specialist nurses.

Delayed implementation of EPR – we encountered major problems at the beginning of the project in getting the nurse led clinic templates set up. This was due to a freeze on PAS changes prior to 'go live' with EPR. Unfortunately the 'go live' date was delayed several times and eventually the freeze on PAS was removed. The alternative would have been to use a manual diary.

Patient notes – As the telephone clinics were classed as an additional clinic, medical records refused to pull the notes for the nurses unless further resources were identified. Following negotiations, an agreement was reached whereby, for a substantial fee, the notes would be pulled for the duration of the project. As before, should the clinic continue long term recurrent funding would have to be agreed .

Funding for nurse led clinics – This is an issue generally within the Trust regarding non-consultant led activity. Although this service has benefits to both the patient and the Trust, national guidelines state that nurse led clinics cannot be counted against activity. Upon discussions with the PCT's regarding this issue, we are informed that a new document is due soon, which will address this issue.

What was the impact on other services

We are currently auditing the impact on other services but we project the following

Negative impact

- Additional pathology – as more patients are being seen in total there may be a rise in pathology costs

Positive impact

- Transport costs – as fewer patients require attendance at hospital there should be less need for transport
- Additional clinic capacity – the time previously allocated to the telephone follow up patients is now available for seeing new patients

Cost of the service change

As the nurse specialists are leading the service throughout the length of the project the set up costs were minimal. The funding to medical records for the pulling of casenotes was the only outlay prior to the clinic commencing.

Annual costs of running the service long term would be

- 2 sessions per week of a H grade Nurse Specialist: £6,627 PA (10 patients per session
- Patient Information: £500 leaflets
- Casenotes: £3,350
- Secretarial support: £1,950

However there would be savings associated with these patients not attending hospital-based clinics

9 Follow-up

Measurements of Success

An ongoing audit is being carried out for all follow up prostate cancer patients to determine:

- Whether patient is suitable for telephone follow up
- If not, why not
- If suitable, does the patient wish to have telephone follow up
- If not, why not
- What form of transport the patient required to get to the hospital
- Length of patient's journey, door to door
- Total cost of journey

As the clinics only commenced in November much of this information is not yet available.

Impact to patients

Description of impact	Measurement method & Outcomes
Prior to being asked if they would like a telephone follow up appointment the nurses sit with the patient and explain in full what it involves. Should they choose to accept they also leave with a leaflet that they can read at their leisure. Patient feedback has been very positive although a formal patient survey has not yet been undertaken. See attachment 5 – Patient information leaflet Telephone follow up automatically reduces the number of visits a patient has to make to the hospital and consequently reduces the time spent waiting in clinic and trying to find a parking space.	To date 98 out of 289 patients with prostate cancer have been eligible for this clinic. Of these, 86 have chosen to date part in the project.

Impact on staff

Description of impact	Measurement method & Outcomes
This was an extension to the existing role of the nurses involved. As described in Section 8, it has ed to some time pressures, which ae yet to be resolved. technology.	

Impact to service delivery

Description of impact	Measurement method & Outcomes
All patients receive a fully booked date for their follow up appointment. Once the outcome from the telephone assessment has been agreed, the specialist nurse will book the patient into the most appropriate clinic.	As the clinics are in the very early stage it is too soon to see the impact on clinic capacity/waiting times but these will continue to be monitored

Impact to clinical outcome

Description of impact	Measurement method & Outcomes
As the service has only just commenced, no information is available as yet. As appointments are more convenient for the patient, the number of patients lost to follow up may be reduced.	

Contact Details

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Organisation involved
Lancashire Teaching Hospitals NHS Trust

Strategic Health Authority Area
Cumbria & Lancashire Strategic HA

Follow-up Checklist

Avoid unnecessary follow-ups for patients and provide necessary follow-up in the right care setting

The aim of this checklist is to help MDT and NSSG chairs/local lead clinicians to establish a baseline position from which they can assess the actions needed to be taken to enable the delivery of the cancer waiting times.

Important Points to consider:

1. Follow-up should have a clear clinical purpose

2. The first aspect of this high impact change is to streamline the patient's journey to create a 'one stop' or straight to test approach"- to reduce unnecessary patient visits to promote the efficient use of capacity.

3. The second aspect to this high impact change is that follow-up appointments after treatment should take place in the right healthcare setting and be delivered by the appropriate healthcare professional.

4. The third aspect is to stop and question your own thinking – "is a follow-up visit really necessary?" Is the Trust/Clinical teams calling things "routine" and falling into the trap of making appointments and using an unquestioning hospital process?

5. For the purpose of this checklist the following definitions of "follow-up" can be applied.
a) "Any visit other than the first visit where there is a clear clinical purpose".
b) Follow-up during the primary diagnosis-treatment sequence
c) Selective follow-up where a considered approach to follow-up is applied based on evidence.

6. Since commissioners pay for follow-up, they are asking:

- Why patients need hospital base follow-up?
- Why patients need consultant led follow-up?
- Why follow-up and associated diagnostic procedures need to take place in hospital?
- Why such procedures might not be commissioned in the non-NHS sector?
- Why oncologists, chest physicians and surgeons specifically need to follow-up patients?

9 Follow-up

This checklist aims to help clinical teams assess the current situation

Checklist	Nothing planned	In Progress	Implemented
Leadership			
Leadership of the follow-up process is owned and managed by the Clinical Team.	☐	☐	☐
Demand Management			
The clinical team validates the outpatient waiting lists . e.g. at every clinic there is an accumulative validation sheet for the clinic in which there is a simple yes/no question as to whether follow-up was necessary	☐	☐	☐
The clinical team has an agreed follow-up protocol. e.g this is part of the above validation process was the protocol adhered to Y/N	☐	☐	☐
The clinical team receives information on the ratio of new outpatient appointments to follow up within the speciality?	☐	☐	☐
The clinical team has a policy on how to handle DNAs?	☐	☐	☐
The clinical team receives information on its outpatient DNA rates.	☐	☐	☐
The clinical team receives information on how many DNAs are follow-up patients.	☐	☐	☐
The clinical team is aware how many times DNA patients are offered follow-up appointments.	☐	☐	☐
The clinical team is aware how long the waits are for follow-ups Minimum & Max wait	☐	☐	☐
The Clinical Team is aware of the number of patients who will not be accommodated within the requested follow-up timescale	☐	☐	☐
The Clinical team is aware of the categories of follow-up waiting (see definitions above)	☐	☐	☐
Capacity			
The Clinical team has an agreed policy as to which types of patients are seen at follow-up visits by specific grades of staff.	☐	☐	☐
Consultants see follow-up patients only when clinically necessary.	☐	☐	☐
Nurse/Therapist led follow- up is in place. (where appropriate)	☐	☐	☐
The distribution of patients for the clinic is determined by the Consultant on the day of the clinic.	☐	☐	☐
The follow-up process has been process mapped.	☐	☐	☐

Checklist	Nothing planned	In Progress	Implemented
Appropriateness			
Follow up protocols have been agreed with Multi-disciplinary Teams. Network Boards. Primary Care Trusts. Tumour Site Specific Group.	☐	☐	☐
Regulation of ongoing therapy There is an agreement that this can be done in primary care e.g. blood tests	☐	☐	☐
There are support systems for local GPs in place e.g. educational protocols for cancer follow-up?	☐	☐	☐
The clinical team has reviewed the available literature (published evidence) supporting different models of follow-up for their tumour site/	☐	☐	☐
Patient Choice			
Patients have the opportunity to access follow-up outside scheduled clinics e.g. direct access, patient triggered follow-ups.	☐	☐	☐
Patients know how to access the above	☐	☐	☐
Follow-up of patients is active in Primary Care	☐	☐	☐
Patients are given oral and written information about their condition and given instructions about self -surveillance	☐	☐	☐
Booking and Choice: patients have the opportunity to agree follow-up dates and times	☐	☐	☐
Non – face to face follow-up methods are offered e.g telephone follow-up.	☐	☐	☐
Patients are asked where they would prefer to go for their follow-up appointment.	☐	☐	☐
Diagnostic/Surveillance			
There are locally agreed follow-up referral protocols for surveillance diagnostics in place for: Endoscopy Imaging Physical measurements Pathology	☐	☐	☐
Endoscopy: An audit of each follow-up guideline is performed at least every 2 years for procedures performed <50 x/year	☐	☐	☐
Diagnostics: Regular clinical validation of recall procedures and protocols are conducted on an annual basis. To ensure that the recall procedure was necessary and protocols are still valid	☐	☐	☐

Follow-up
What's Working In Practice

The following are working practices that demonstrate the benefits that can be obtained from reviewing and redesigning current follow-up practices.

Colorectal

Managing demand re-directing Capacity

For every patient who requires more than one visit to an outpatient follow-up clinic it is good practice for a Consultant to see them at least 1 in 3 of the visits. This will increase the proportion of patients discharged.
Mrs C Ingham Clark Consultant Colorectal Surgeon, Whittington Hospital

Nurse Led Follow-up: re-directing Consultant time

For common cancer follow-ups, it is usually possible to organise a postal/telephone follow-up which is nurse led enabling the Consultants time to be re-directed effectively.
Ms McCue, Consultant Colorectal Surgeon, North East Herts

Reducing Patient Visits

If a well-organised system is set up to bring results of investigations together with notes for consultant review in clinics then paper clinics can be done without bringing the patient back.
Mr Lunniss Colorectal Surgeon, Homerton Hospital

Lung

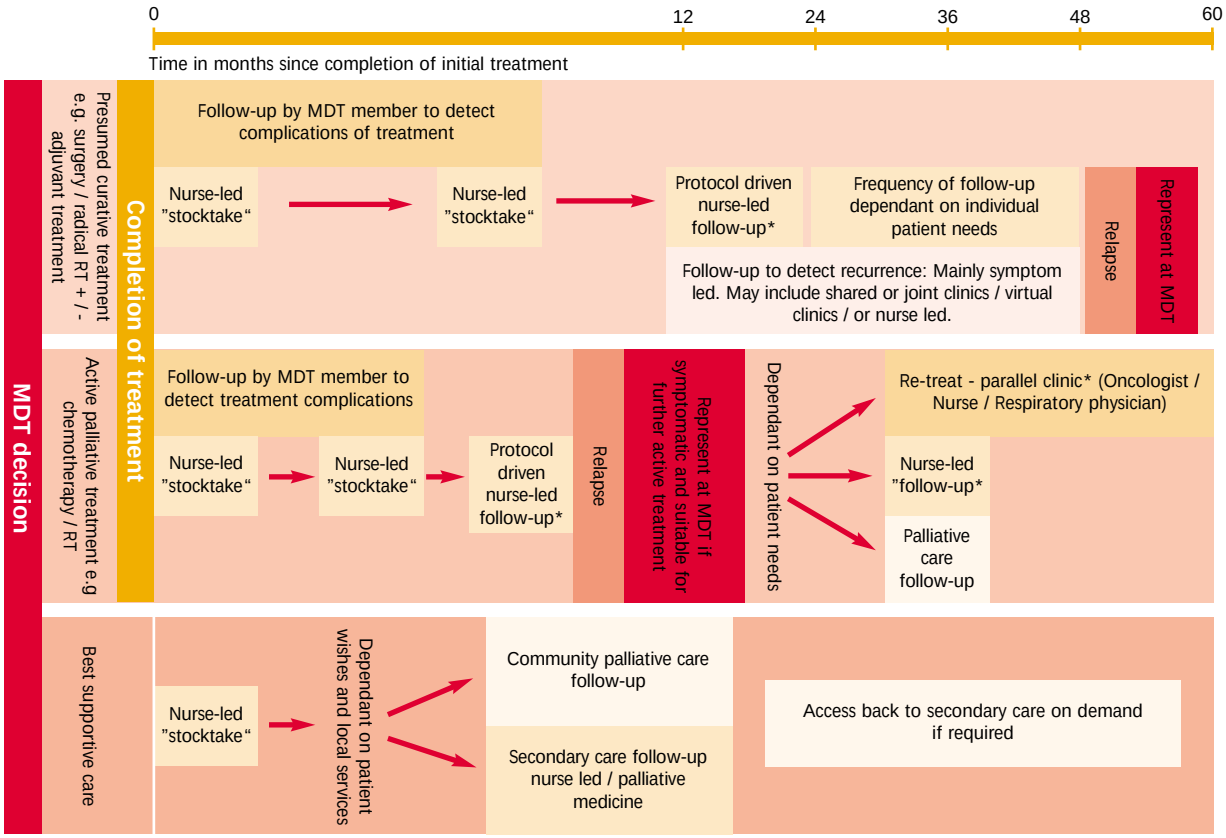
Nurse-led follow-up Lung clinic

Nurse-led follow-up clinic for patients who have completed treatment. Based on agreed protocols. Patients will be seen 12 weeks from their diagnosis to reassess them physically, psychologically and socially in order to link them with the appropriate support services. (This Nurse led follow-up service is a new development)
Dr Mick Peake Lung Physician University Hospitals of Leicester and Jane Brunskill Lung CNS

Patient led Follow-up for Lung Patients

Patients are allowed to attend as frequently or infrequently as they like. Some patients are advised to have an annual X ray (e.g post Lung cancer patients) and they can either organise through our clinic or via their GP or any other clinic they attend. This works for diseases that do not have asymptomatic development that can be positively benefited by earlier detection or treatment. Most of our cancer patients do not benefit from detection or recurrence prior to symptom development.
Mr Richard Steyn Consultant Lung Surgeon Heartlands Hospital

Lung Cancer follow-ups: British Thoracic Society Recommendations for MDTs and Nurse Led clinics



* Copy letters should be sent to all members of the MDT who have been involved in the patient's management
Nurse-led stocktake refers to a consultation designed to address holistic needs of the patient. Social and psychological issues should be explored in addition to physical symptoms.

The follow up model on the previous page draws on the following key service improvement changes:

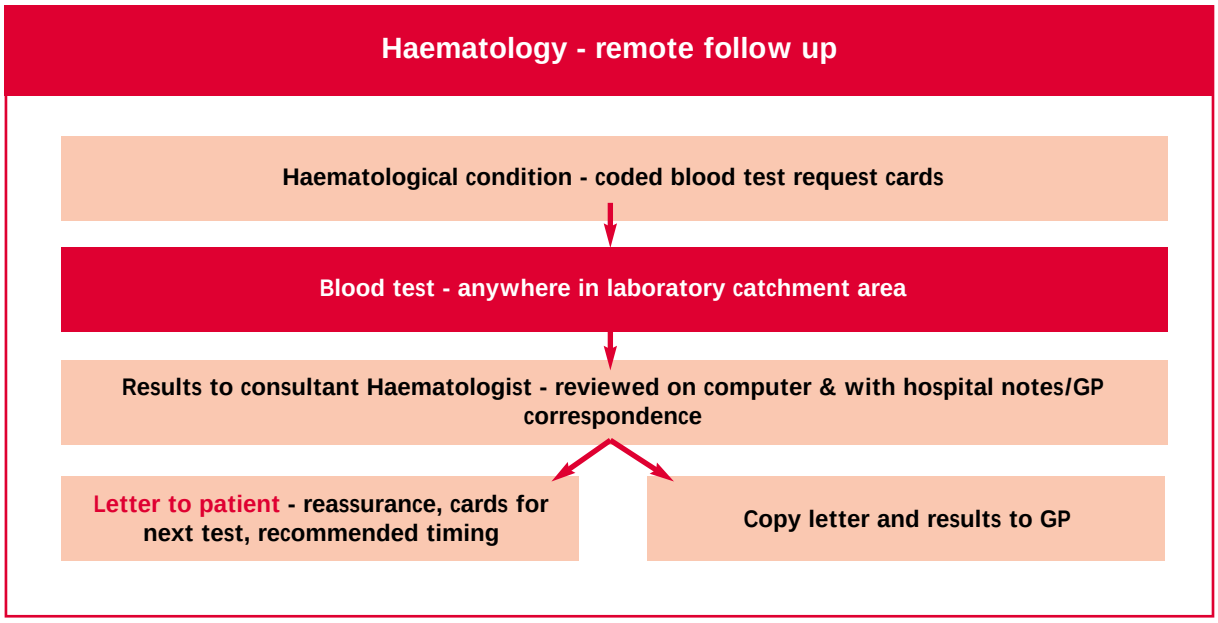
- Agreeing the follow-up pathway for defined patient groups with a clear clinical need
- Protocol driven, nurse-led pathways
- Teamwork, clear decision making and communication at MDT

Dr Mick Peak Lung Physician University Hospitals of Leicester

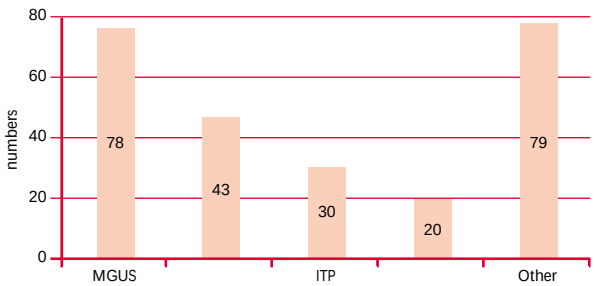
Haematology

"Remote Follow-up"

"Remote" follow-up. Patients with low -grade conditions with low likelihood of change / progression / relapse (includes longer term acute leukaemia follow-ups) have an annual or 6 monthly blood test results are coded back to the consultant. A letter is sent from the consultant to the patient about the results with cards and instructions on the timing of the next blood test. Copies of the letter and results are sent to the GP.



Haematology - remote monitoring



Saving of approximately 300 attendances p.a

Alastair Smith Consultant Haematologist Southampton General Hospital.

9 Follow-up

Breast & Colorectal

Only Follow-up if its of proven benefit.
Where possible follow-up should be done by phone, letter or e-mail/text!

If the patient requires an examination, then it should be suitability trained practitioner (nurse, radiographer) and only a Doctor when required for governance reasons i.e. prescribing chemotherapy.

An example of the above is the Breast Clinic Weston Super Mare NHS Trust.
Colorectal Clinics at North Bristol
Mr Simon Cawthorn, Consultant Surgeon, North Bristol NHS Trust.

Breast

Breast Follow-up – 2 years

Patients are seen for follow-up for 2 years (alternating with Oncology). If all is well patient's are discharged to mammographic follow-up. Annual for a conserved breast for 5 years, at 1,3,& 5 years for the contralat breast after mastectomy. After this patients would go to NHS BSP 3 yearly unless they are still <50 when they continue with mammogrammes every 2 years until they reach NHSBSP screening. There is a rapid access clinic available if needed.
Mr Tim Archer Ipswich Hospital

Good examples of Nurse led Clinics for follow-up can be found
Northumberland (Wansbeck and North Tyneside) and Gateshead.
Clive Griffiths Breast Surgeon Newcastle.

Patient Triggered Follow-up for Breast Patients

Hillingdon Breast Unit has piloted the acceptability of "patient triggered follow up" since June 2000
More than 400 patients have now undergone a "sign off interview"
Self triggered follow up is acceptable to patients & hospital & primary care staff in DGH breast unit
Access through Breast Care Nurse appears feasible & safe without undue increased work.
Breast cancer patients completing intial treatment are offered self-managed follow-up with early mammography for five years and direct access to the clinic via the Breast care nurse. Follow-up appointments have dropped by 30% and clinics which used to use two Doctors can be covered by one, re-directing valuable resources. Evaluation of of the new process shows 89% of GPs were happy with the new arrangement, 83% of Patients were happy with the contact they received after completion of treatment, 92% of patients felt secure with the new system.
Dr Jane Maher & Lynda Jackson Hillingdon Breast Unit Mount Vernon Cancer Centre

Follow-up and Commissioning

Follow-up and The Commissioning. Financial Framework

Developing a policy of selective follow-up of Cancer Patients outside clinical trails is a proposed way forward. This has been developed by Professor Roger James of the Kent Oncology Centre. The policy has been developed to reflect site specific proposals following chemotherapy and radiotherapy.
Professor Roger James Kent Oncology Centre.

Urology

PSA Tracker Software & Nurse-led telephone follow-up

The Urology Department at the Royal United Hospital Bath (4 Consultants)
Rather than seeing a consultant for every follow-up visit, routine follow-ups are overseen by a Specialist nurses, assisted by a new piece of software.
Patients receive a postal questionnaire asking them about their general state of health.
Bloods for PSA testing are taken in primary care
The PSA levels and treatment history are captured on the computer software, "PSA Tracker", which will automatically trigger routine postal follow-up or recall to an outpatient clinic, based on clinically established alogorithms for PSA.
The new care pathway is suitable for the majority of patients with slow-growing tumours who are willing and able to complete the health questionnaire.

Outcomes

- 100 Consultant slots saved per annum (estimated around 80% of eligible patients will take up the questionnaire service)
- Cost of patient pathway reduces from £88,200 pa to £30.063pa
- Patient satisfaction will be surveyed after service running for 18 months.

Mr Jonathan McFarlane Consultant Urologist Royal United Hospital Bath.

Gynaecology

Patient Initiated Follow-up

Several local clinical trials are presently being run within the United Kingdom to assess innovative forms of follow-up but in the absence of the power required to identify benefit of one form or the other in terms of survival, detection of recurrence or quality of life, these studies perhaps should best be viewed as feasibility and acceptability studies for alternative forms of follow-up.

The alternative model of follow-up proposed in these studies is a patient initiated follow-up:

- Detailed patient information is provided at an "exit" interview at the end of the episode of care (ie the clinic visit shortly following the completion of surgery, chemotherapy or radiotherapy). This consultation and the accompanying written information aims to educate the patient regarding symptoms suggestive of possible disease recurrence.
- A minimum standard follow-up regime is agreed
- Each patient is given a care diary in which the Nurse Specialist documents the proposed follow-up protocol for the individual patient.
- The patient is given contact details to a nurse specialist and is encouraged to telephone at any time to discuss any concerns she may have regarding symptoms suggestive of recurrent disease or potential treatment related side effects.
- In response to a call from the patient, the nurse specialist triages the patient appropriately, for urgent review by clinicians in a follow-up clinic, to the general practitioner, to a specialist service such as a lymphoedema clinic, or perhaps initially lists the patient for discussion in the multi disciplinary team meeting.

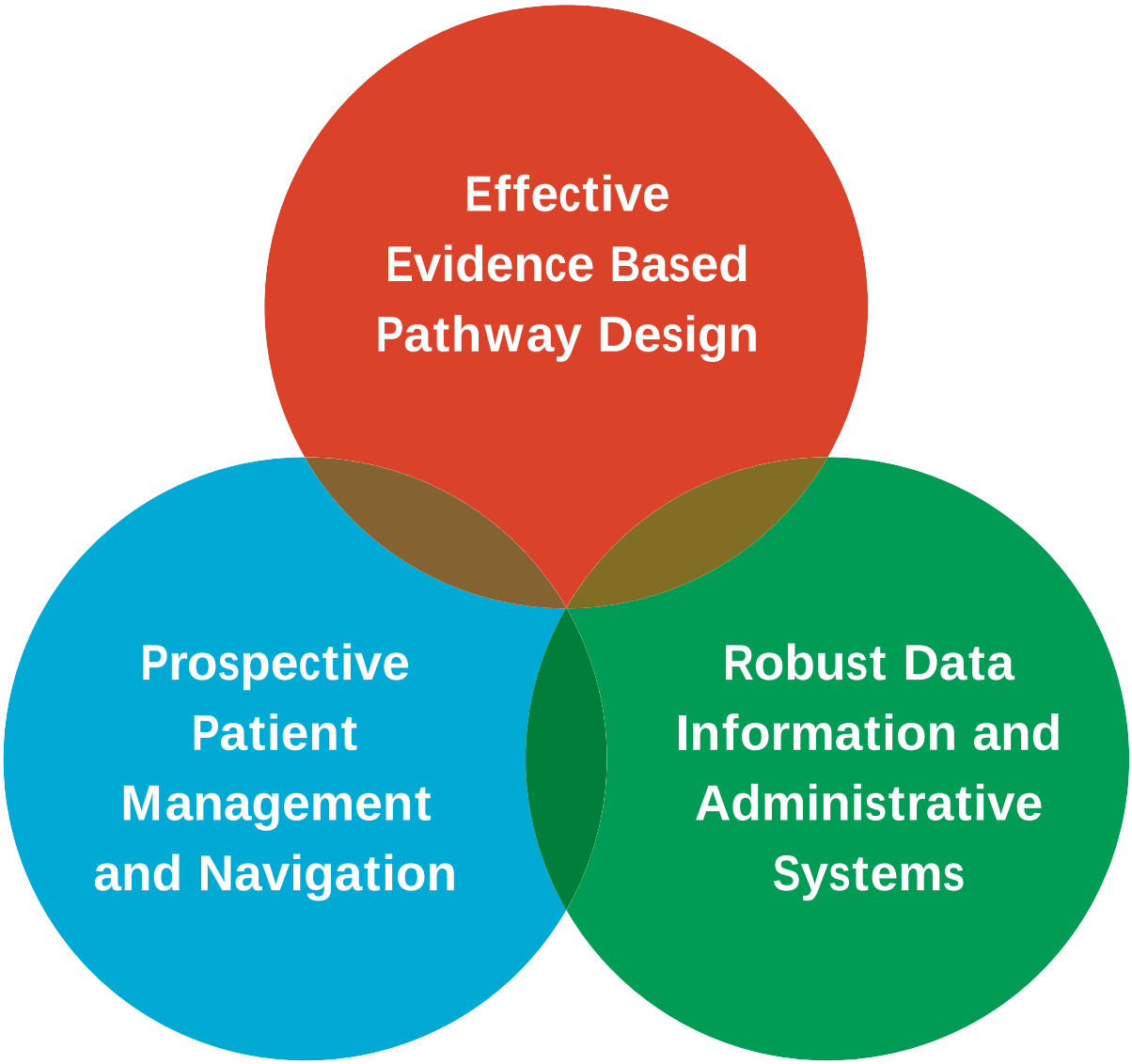
This model of care appears very attractive as it empowers patients and enables them to access care at short notice when required. The effectiveness of this model is currently being evaluated.

Mr Andy Nordin Consultant Gynaecologist, East Kent Hospitals

Section 10

Sustaining Cancer Waiting Times through Effective Pathway Management

Sustaining Cancer Waiting Times through Effective Pathway Management.



Produced in association with The National Cancer Waits Project

Executive Summary

The work of the Cancer Services Collaborative 'Improvement Partnership' and the Intensive Support Team over the past year, has led to a greater understanding of what is required in terms of performance management and service redesign in order to achieve the cancer waiting times. Over the past months, as many trusts begin to show a consistency of achievement, it has been possible to identify common themes of why some trusts achieve in a sustainable way and others do not.

Leadership at all levels in the organisation is crucial for achieving and maintaining the cancer waiting times and this should not be underestimated. Trusts should ensure effective leadership is in place from board level through to clinical teams.

Hitting the target in itself is no measure of sustainability as this has been achieved in a variety of ways over the past year. Trusts generally fall into three main categories:

- **Those achieving at or above 95% through having effective pathways,** and high quality, streamlined services combined with robust tracking navigation and escalation systems
- **Those achieving at or above 95% through short-term methods** (pushing patients through poor systems; carving out; reliance on single-handed staff etc).
- **Those without effective systems who have yet to achieve.**

From the experience gained over the past year, key factors have been identified as crucial to achieving the standards in a sustainable way. Without a clear action plan for the next year, achievement of the standards will not itself guarantee sustainability. The sections in this document highlight these factors and outline what needs to be in place for continuous achievement.

Key areas for focus

- Effective Pathways (Section B)
- Inter-Trust Transfers (Section C)
- Data Information & Administrative Systems (Section D)
- Prospective Patient Pathway Management (Section E)
- Self-assessment for Hospital Trusts, Primary Care Trusts (PCTs), Cancer Networks and Strategic Health Authorities (SHAs) (Section F).

It is acknowledged that sustainability is a major challenge and is complex in that it is dependent on a number of organisational and patient pathway factors (Effective Evidence Based Pathway Design, Prospective Patient Management and Navigation, and Robust Data Information and Administrative Systems), which are inter linked. Sustainability will require trusts to revisit how they have achieved to date and ensure they have effective pathway design and management in place.

Organisational and Patient Pathway Factors

The following key recommendations and actions will make a difference to sustainability if implemented:

Key recommendations for Trusts

- Develop a plan for sustainability
- Maintain focus on performance systems with robust tracking and navigation in place
- Continue to develop and implement good evidence based practice, focused on cancer High Impact Changes from referral to treatment within your Trust (see The High Impact Change document at www.cancerimprovement.nhs.uk)
  - One route into the system
  - Straight to test
  - Pooling of patients within specialties
  - Decision making through effective Multidisciplinary Team (MDT)
  - Reduced follow up
- Learning from others.

Key actions for implementation

All cancers

- Establish timelines for the urgent pathway for each tumour, designed to deliver first definitive treatment well within the 62 day target, identifying key events and escalation points including inter-Trust transfers
- Ensure that clinical information, including cancer waits data, is shared rapidly and accurately, ideally in one referral communication
- Implement pooling of patients, where clinically appropriate, at all stages of the pathway
- Develop, implement and evaluate protocols that support pre booking of diagnostic and staging tests, and treatments
- Ensure that communication between trusts is highly effective at every level
- Make use of pre-booking and "early warning" systems between trusts.
- Assess and monitor services to ensure they are delivered by the most appropriate healthcare practitioner at the right time in the right place.

Risks to sustainability

A number of key risk factors have been identified. If any of these apply to you it is unlikely that your current performance is sustainable, read on now.

- Tracking patients on top of ineffective pathways that have not been reviewed or redesigned
- A focus on reactive counting of numbers rather than proactive patient management
- Carve-out rather than planned capacity for the appropriate demand on a service
- Waiting list initiatives to clear backlogs without redesign of the process
- High Impact Changes not in place or not embedded
- Lack of consistency in systems
- Organisational focus moving to other priorities with the risk of cancer being left unfinished and unsustainable
- Elements of the pathway dependent on a single person with no cross cover or contingencies for absence
- Wrong person undertaking wrong task: e.g. Cancer Nurse Specialist's (CNS') or cancer managers undertaking clerical processing tasks.

It is now evident that delivery of the cancer waiting times standards are possible but to achieve and sustain the gains made requires time, determination, focus and combined organisational effort and leadership. The reward for investing in making your services sustainable is that you will reduce the workload on your clinical and managerial teams.

Contents

Section A

Introduction

Welcome to the Sustainability Guide which has been compiled to support Trusts, PCT's, Cancer Networks, and SHA's to maintain the achievement of the waiting times standards as set out in the NHS Cancer Plan 2000, by improving cancer services to patients across the entire pathway of care.

The guide sets out the key areas of focus which we know are the most difficult to get right, but also reap the greatest rewards in terms of sustainable delivery of the Cancer Waiting Times.

The guide draws on evidence generated by the Cancer Services Collaborative 'Improvement Partnership' (CSC'IP') and the National Cancer Waits Project, specifically from the CSC'IP' demonstration sites, DH intensive support sites and the DH/Prime Ministers Delivery Unit (PMDU) Cancer 62 day Waiting Time Priority Review (May 2006).

The aims of the guide are to:

- Enable NHS organisations to assess their overall position and risks in sustaining the cancer waiting times, specifically the 62 day standard
- Support health communities in sustaining waiting times through the implementation and management of effective pathways
- Provide learning and advice to organisations about the critical factors for sustaining pathways and laying the foundations for future service development including other programmes.

The Recovery Support Unit has developed self-assessment questionnaires to aid all organisations in assessing their ability to sustain the cancer waiting times. These can be found in Section F (Self-assessment).

This guide is an evolving document which will be built on through the website www.cancerimprovement.nhs.uk/sustainability as we increase our knowledge of the key factors to achieve long term sustainability.

Section B

Designing Effective Pathways

(To be read in conjuction with Section C Inter-Trust Transfers)

Why does an effective pathway matter?

- Effective pathways deliver quality and timely care to patients throughout their cancer journey
- Implementation and embedding of the cancer high impact changes within a pathway helps sustain cancer waiting times see graph 2 and 3 later in this section
- Effective pathway development implementation and evaluation across organisational boundaries will support the delivery of sustainable cancer waiting times
- Development of effective pathways that 'automatically' pull patients through require minimum intervention and support in terms of tracking and navigation
- Sustainability is unlikely to be guaranteed where pathways are designed to fit the maximum waiting time of 62 days for urgently referred patients. Trusts that have achieved consistent delivery and sustained performance have pathways that deliver well within this timescale.

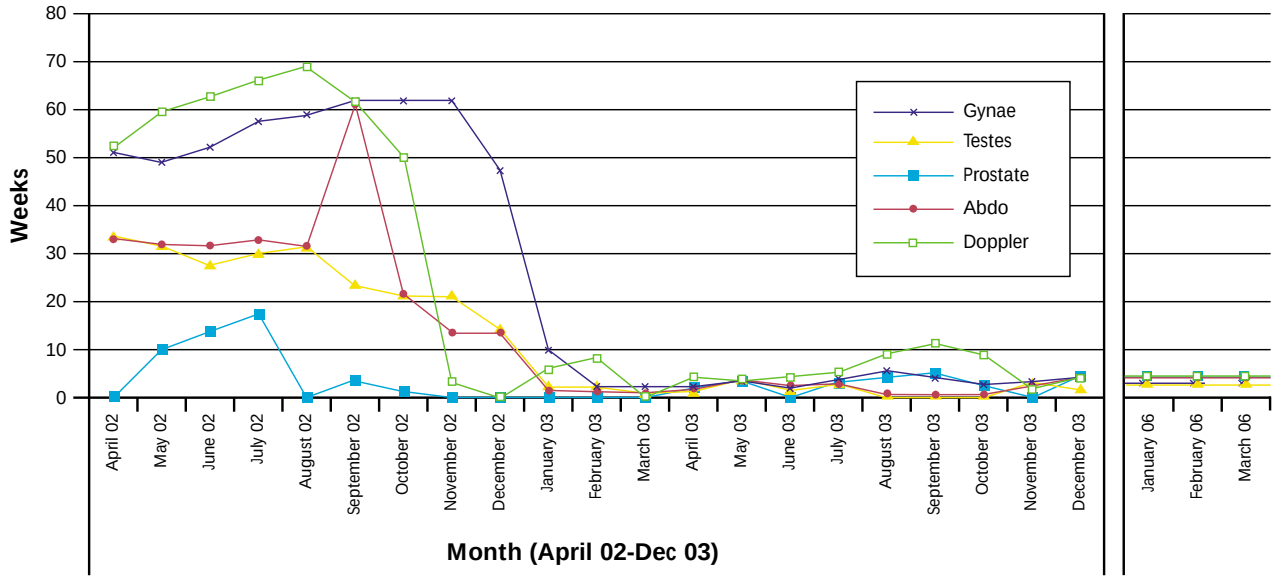
What are its characteristics?

- Agreed by all providers/stakeholders across the pathway
- Clear timings for each step in the pathway with identified escalation points
- Achievable well within the 31/62 day target
- Cancer High Impact Changes applied across the pathway
- Strong teamwork/a well functioning MDT with clarity of role in pathway coordination
- The sort of pathway we would want for ourselves and our families.

The Diagnostic Pathway

The Diagnostic Pathway is a key component of the effective pathway. Sustainability will rely on timely access to diagnostics with radiology departments operating two queues with no backlogs. The graph below illustrates how the waiting times should look, using the illustration of Ultrasound for all specialities.

Graph 1 - Example of sustainable change: Plymouth Hospitals NHS Trust, Reduced waiting times in Ultrasound



These waiting times have been sustained to date (April 2006) and impact on 25,500 patients per annum.

Key actions to achieve sustainable services for radiology and pathology can be found in the diagnostic section of The 'how to' guide. Key actions to achieve a sustainable endoscopy service can be found at www.endoscopy.nhs.uk

Showing National Distribution versus a Trust who has sustained their performance for more than a year

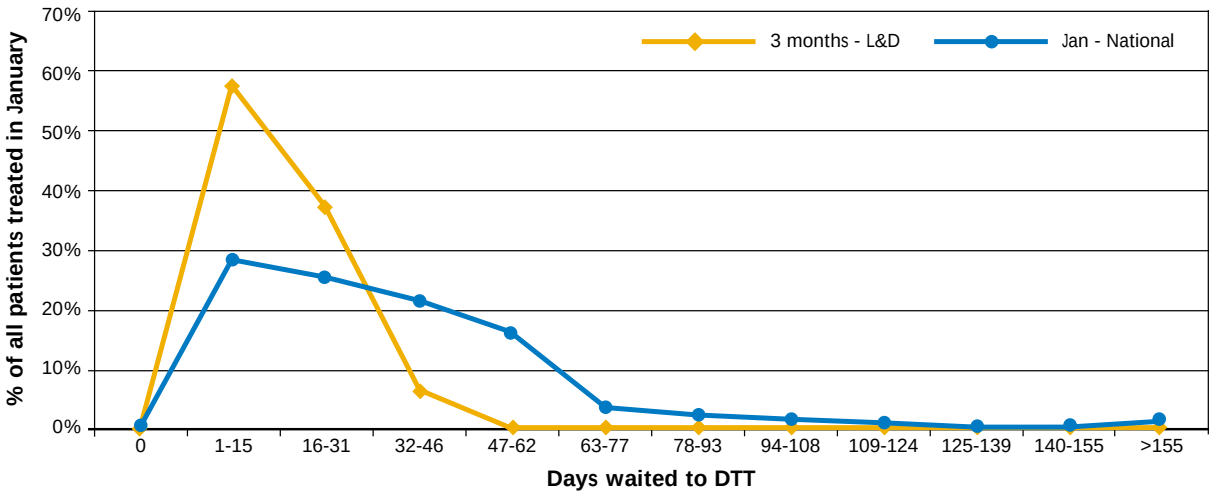
One way of understanding whether your referral to treatment pathway is likely to be sustainable is to review the distribution of waits experienced by patients in your trust.

If a patient reaches their decision to treat late in the 62 day pathway, only a few days will be left to start treatment. This is likely to be an unsustainable system as continual manual interventions and escalations will be required to achieve the standard.

We know from national data that almost all patients (99.6%) who reach their Decision to Treat (DTT) within 31 days go on to achieve the 62 day target. Hence it is important that trusts understand how long their patients take to reach this point in the pathway. Luton and Dunstable Hospitals NHS Trust has achieved the target consistently for more than a year. Although their numbers are small, their data demonstrates what sustainable performance looks like.

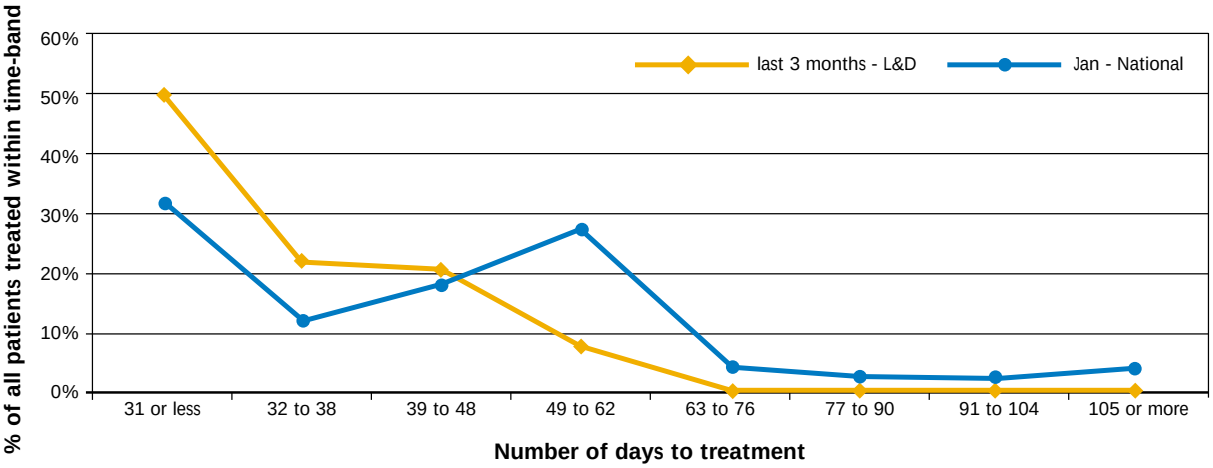
Graphs 2 and 3 show the national distribution of time from referral to decision to treat v Luton & Dunstable Hospitals NHS Trust.

Graph 2 - National distribution of time from referral to decision to treat versus Luton & Dunstable Hospitals NHS Trust (source date - April 2006)



73% of patients who breach have not reached their DTT by day 62.
94% of Luton and Dunstable Hospitals NHS Trust's patients have a DTT within 31 days. This ensures that there is sufficient time left in the pathway to deliver treatment within 62 days of the patient being referred. Nationally this figure is only 54%.

Graph 3 - National distribution of time from referral to treatment versus Luton & Dunstable Hospitals NHS Trust (source date - April 2006)



Graph 3 shows the distribution of the total patient wait from referral to treatment. With most patients reaching DTT by day 31 (Graph 2), Luton and Dunstable Hospitals NHS Trust manage to treat most patients well within the national target time. 92% of Luton and Dunstable Hospitals NHS Trust's patients are treated within 48 days, compared with 63% nationally.

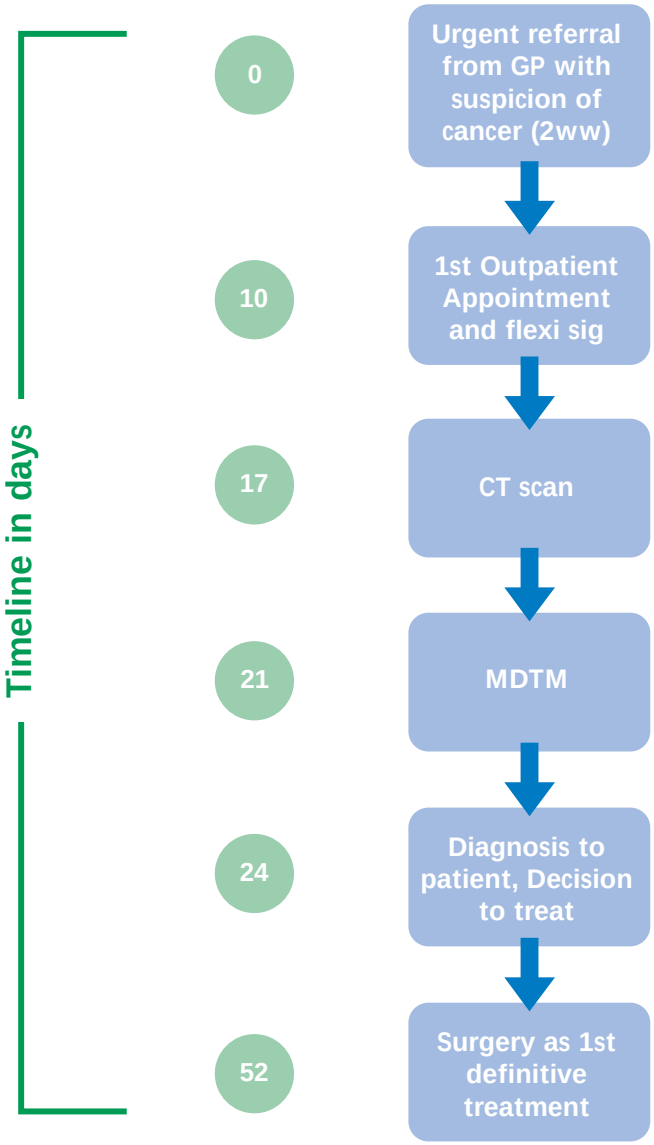
What does an effective pathway look like?

The following example flow charts show simple pathways (Diagram 1 - Colorectal Cancer, Diagram 2 - Bladder Cancer) and a complex pathway (Diagram 3 - Lung Cancer), all of which show delivery well within the 62 day target.

Queen Mary's Hospital, Sidcup

Example of Colorectal Pathway
(Source date - January 2006)

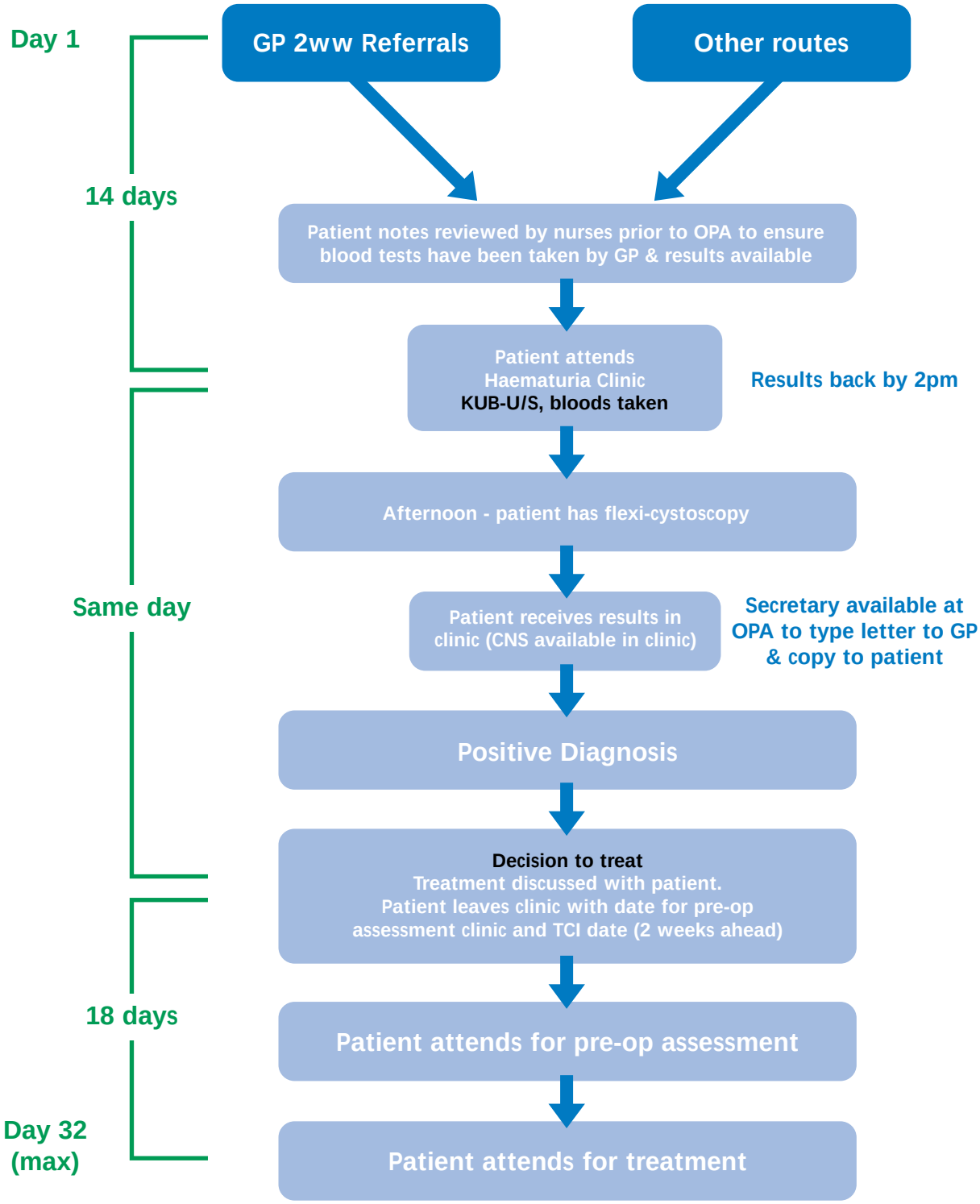
Diagram 1



Plymouth Hospitals NHS Trust

Example of a simple Bladder Pathway
(Source date - July 2002)

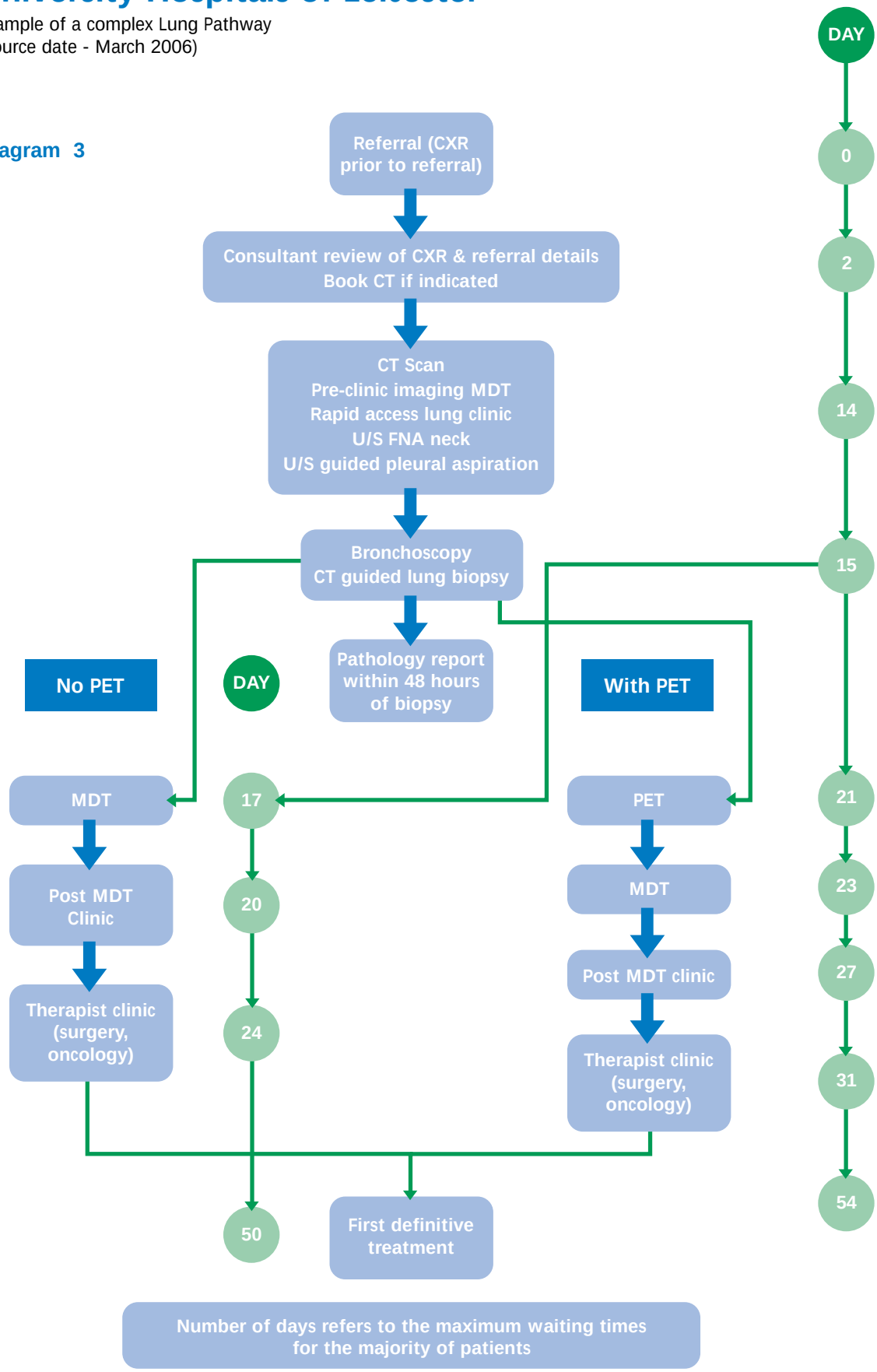
Diagram 2



University Hospitals of Leicester

Example of a complex Lung Pathway
(Source date - March 2006)

Diagram 3



Delivering the 31 day treatment target in Radiotherapy

Below is an example of a hospital Trust who is delivering the first radiotherapy treatment well within the 31 day treatment target.

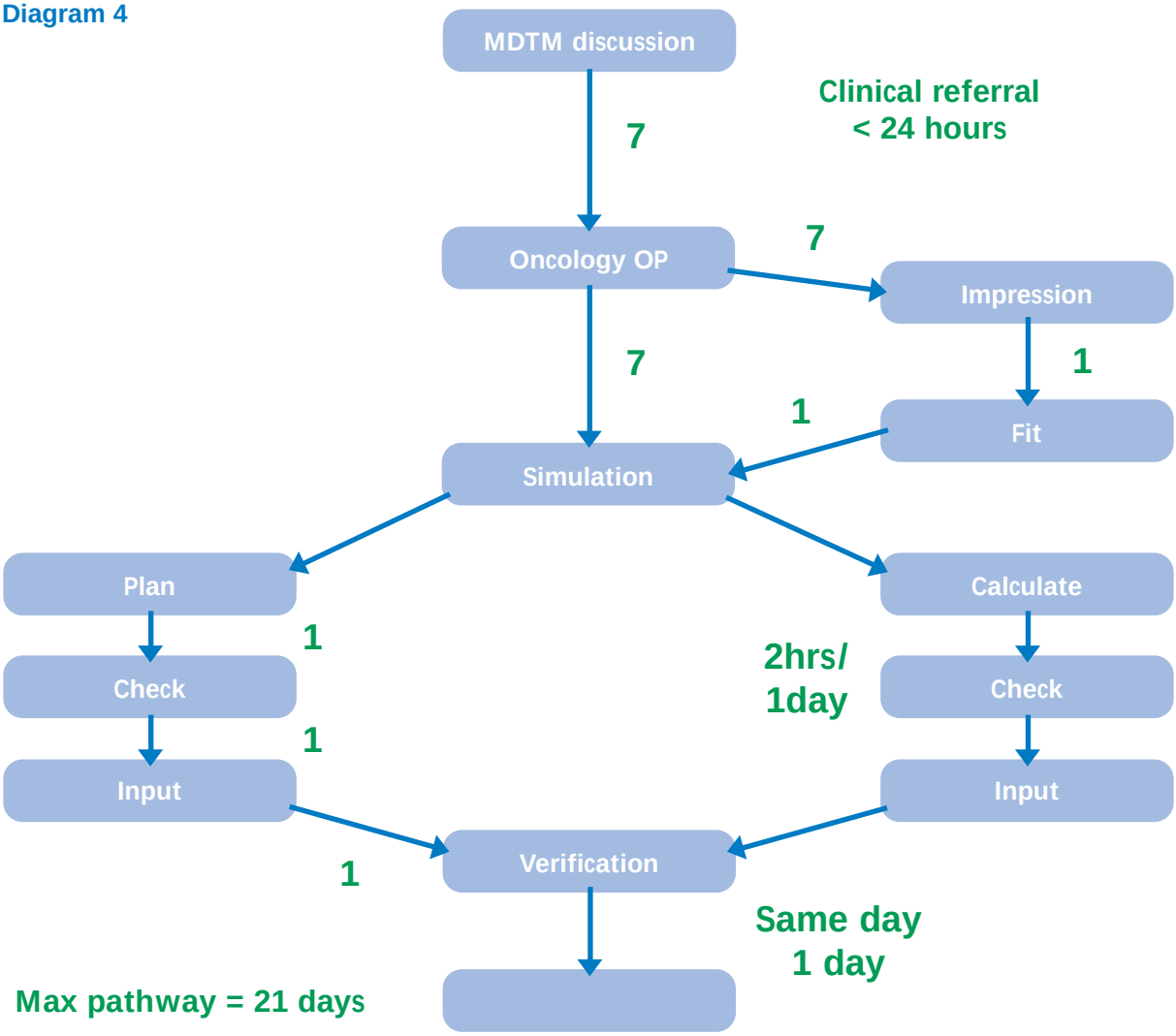
In order to ensure services are streamlined and organised to assist teams to meet relevant standards and patient needs, each process or service should have a simple, high level, timed pathway that allows the clinical process to progress smoothly and pull the work through. In order to do this there should be:

- Clear criteria for the information required to progress a patient through the pathway
- Timescales identified for the delivery of key actions
- Agreed trigger points and actions to be taken if information/time standards are not met.

The Newcastle upon Tyne Hospitals NHS Trust

Example of a Radiotherapy Pathway
(Source date - October 2005)

Diagram 4



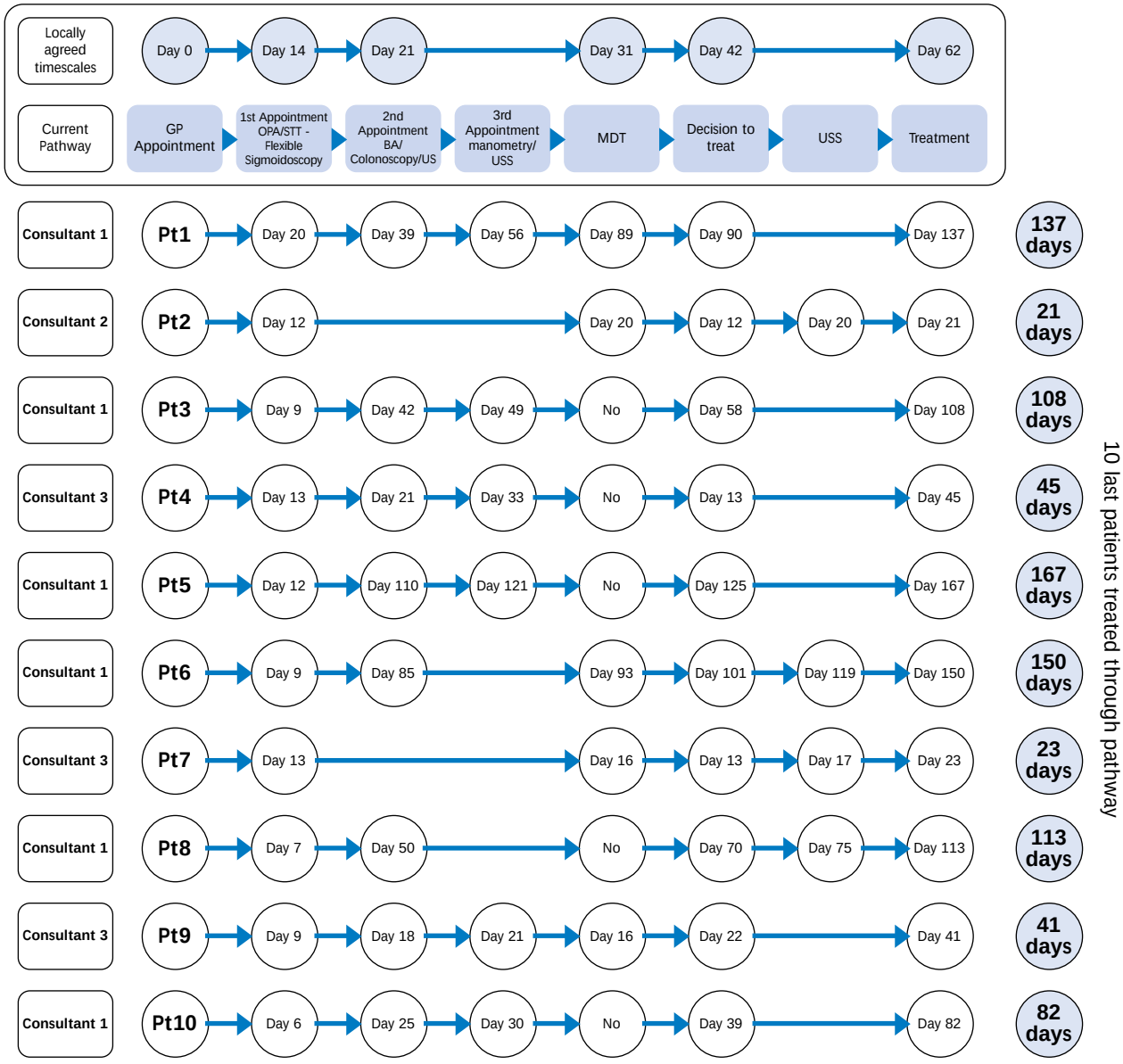
Using the last 10 patients to assess the effectiveness of your pathway

The following example illustrates the variability in practice and the risk this presents to delivering and sustaining the cancer waiting times 62 day target. This has given the Trust key information about the pathway and where their issues are so that they can action plan to deliver an effective pathway.

Colonic pathway - United Lincolnshire Hospitals NHS Trust

Diagram 5

(source date - March 2006)



Section C

Inter-Trust Transfers

(To be read in conjunction with Section B, Designing Effective Pathways.)

Inter-Trust Pathway Management

Pathways must be agreed, implemented and evaluated to:

- Ensure patients have a quality, timely and effective experience at all stages of their pathway
- Avoid delays and duplication of diagnostic and staging tests
- Ensure there are no gaps or conflicting pathways operating in organisations along the patient pathway
- Ensure effective navigation of patients through the system
- Minimise delays due to poor information and communication systems
- Ensure the provision of consistent information for patients

Key actions to achieve good inter-Trust pathway management are:

- Know your patients
  - Know how many patients and organisations are involved in transfers for individual tumours
  - Understand the pathway flow and the timelines for each part of the patient journey
- Agree a guideline or protocol for inter-Trust working which is aligned to an effective patient pathway
  - Develop the pathways through Tumour Site Specific Groups across Networks
  - Have a clear process for sign off with allocated responsibility for delivery
  - Agree responsibilities for anticipated costs
  - Agree the action plan for implementation with timed review points
- Identify key roles in the transfer process within and between organisations
  - Responsibility for monitoring compliance
  - Responsibility for delivering specific parts of the pathway
  - Ensure training needs addressed
  - Ensure communication regarding the process is disseminated at all levels
  - Ensure cross cover for absences
- Ensure an appropriate flow of patient level information between organisations
- Agree the communication flows back and forth between organisations (Diagram 6)
  - See example from Cancer Care Alliance
- Ensure appropriate tracking and navigation of patients across organisational boundaries
  - See Section E Prospective Patient Pathway Management
- Evaluation of inter-Trust transfer process to monitor its effectiveness
  - Networks should have a key role in monitoring the effectiveness of the process
- An effective escalation policy agreed and in place to manage potential/actual breaches wherever they occur.

Assessment of risks:

- Delivering an effective pathway should be role specific rather than person specific. The system should be robust enough to avoid breaches due to a named individual being absent from work
- Responsibility for individual tests/interventions along the pathway needs to be clear and accounted for in the timeline. This will ensure timely patient transfer
- Effective escalation procedures can work well to avoid breaches. Appropriate monitoring will indicate problems within a pathway which need tackling or delivery will not be sustainable
- Trusts that continue to manage patients retrospectively who don't move to effective prospective management will have difficulty sustaining their delivery.

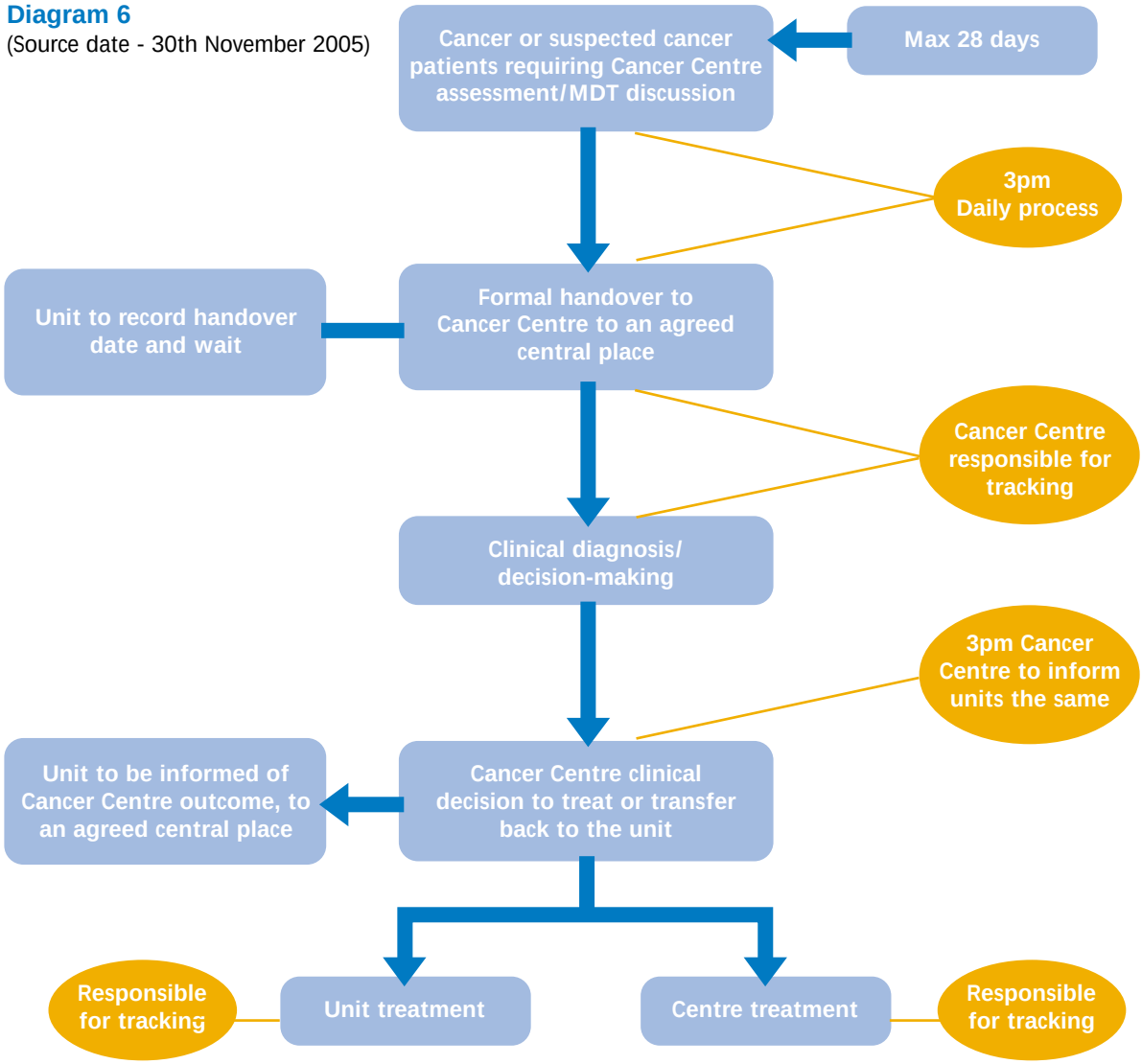
Example of a medium sized Cancer Network approach to the delivery of inter-Trust transfers: Cancer Care Alliance.

This has been implemented and sustained for at least 12 months and has combined the principles of tracking and navigating.

The following principles were developed:

- 24 hour turnaround from MDT decision to handover of care
- All patients will receive a definitive diagnosis (including appropriate MDT discussion) within 28 days of referral
- An aspiration to achieve a definitive diagnosis within 21 days
- Daily tracking & handover of patients across organisations.

Diagram 6
(Source date - 30th November 2005)



For further information please refer to the case study on the sustainabiity website at www.cancerimprovement.nhs.uk/sustainability

Section D

Data, Information & Administrative Systems

(To be read in conjunction with Section E, Prospective Patient Pathway Management.)

Information systems must be complete and robust to:

- Guarantee delivery of the standard for all patients
- Navigate your patients effectively through their pathways
- Ensure patients do not slip through the net and wait far too long for their diagnosis and/or treatment.

A good data capture system should:

- Be a consistent process, embedded in the organisational wide data capture systems and owned by the whole organisation not just the cancer team
- Link to other IT systems such as Patient Administration System (PAS), radiology and pathology systems
- Capture all patients who enter the trust via the two week wait system and be used to track patients to diagnosis and subsequent treatment for cancer
- Capture all patients receiving elderly care/palliative care and/or with no histological diagnosis, and patients with cancer found as an incidental finding
- Have clear protocols in place to support data capture with clarity about which individuals own and revise it
- Establish clear written processes that identify:
  - where and when data is captured i.e. two week referrals received
  - first out patient appointment, radiology appointments, weekly pathology reports, MDT meetings, etc.

An effective escalation policy has:

- Clear written robust protocols for action/further escalation at all levels of the organisation with identified roles for each level of escalation through to the executive lead
- Clear escalation timescales e.g. how long the service manager has to resolve an issue before it gets raised with the executive lead
- Links to individual tumour site pathway timescales identifying key actions by specific dates i.e. an effective lung pathway may require a patient to have a CT scan by day eight if not escalation is needed
- It has information about how the Patient Tracking List (PTL) will be monitored and used effectively to navigate patients through agreed pathways.

Removing patients who don't have cancer:

- National guidance states that "patients who have received a formal non-malignant diagnosis should be removed form the cancer PTL, even if they are being followed up for other reasons. Trusts should only track those patients where there is still a suspicion of, or confirmed cancer"
- Individual tumour specific pathways should highlight when on the pathway the diagnosis may be made and hence when a patient may be removed i.e. after a first outpatient appointment, after a certain negative diagnostic test etc.
- The diagnosis should be clearly documented in the clinical notes - Trusts that have introduced outcome forms after a patient's first outpatient appointment have found that they can be clear early on which patients have a benign diagnosis and remove them from the PTL. It is important that the patient is informed of their diagnosis.

Risks and solutions

- Good data systems must not rely on one individual with intimate knowledge of a bespoke system. Cancer data needs to sit within the organisations data structures and not operate within a separate silo
- Paper based systems which involve multiple hand offs of information are ones where patients are missed. Move from paper based systems to a centralised cancer database solution or a bespoke information system
- Trusts that continue to manage patients retrospectively and don't quickly move to effective prospective management. The PTL is a vital tool here and trusts that do not have a complete PTL are at risk of missing patients
- Escalation can work well to avoid breaches but too frequent escalation can indicate problems within a pathway and unless this is tackled delivery will not be sustainable
- Where information is not disseminated throughout the organisation this affects the ability of clinical teams to respond appropriately to the issues.

Section E

Prospective Patient Pathway Management

(To be read in conjunction with Section D, Data Information & Administrative Systems)

Prospective management of your patients allows you to:

- Know where your patients are in the system
- Navigate patients through the pathway and ensure they are in the right place at the right time receiving the right care
- Enhance the flow in the patient's journey between departments within and across organisations.

A good prospective patient pathway management system should:

- Use a central data collection system preferably electronic to provide immediate information on each patient's progress for clinical and managerial staff
- Monitor all patients entering the Trust via the two week wait route ensuring they are tracked and navigated until they achieve their First Definitive Treatment or are removed from tracking following a non cancer diagnosis being made
- Ensure key roles are identified for tracking and navigating with clear levels of responsibility and accountability
- Identify escalation trigger points that are agreed and communicated along the pathway
- Provide clear responsibility/accountability at an appropriate level in the organisation to resolve escalation issues.

Key actions to achieving a prospective pathway management system include:

- Use of agreed symptom/tumour specific timed pathways to navigate patients through the system
- Monitor all two week wait patients to ensure they are added to the tracking/navigation system
- Specifying who is responsible for delivery at key points along the patient pathway
- Effective communication and administrative processes within the organisation/across organisations
- Effective MDT's discussing where patients are along the pathway and promoting efficient flow along the pathway
- Support at a senior clinical and managerial level for those tracking and navigating patients through the system.

Trusts to date have implemented prospective pathway management in different ways. In some organisations tracking and navigation is looked at separately and stand alone roles have been established. The roles should work in parallel for proactive patient management to function. In others it is an extension of responsibility to an established role. In many organisations this will be a transitional role as pathways become embedded in the organisation.

All relevant staff must understand the purpose, impact and significance of the role as the post-holder needs to work with a variety of professional groups to be effective. Understand that tracking and navigation are different.

Definitions:

Tracking: Skilled in following the pathway - Knowing where the patients are in the pathway.

Navigation: Skilled in directing, guiding and "pulling" patients through the pathway. Actively positioning patients where they should be – right time, right place, right person, right skills.

Tracking & Navigating – New Skills and New Practice – the questions to ask

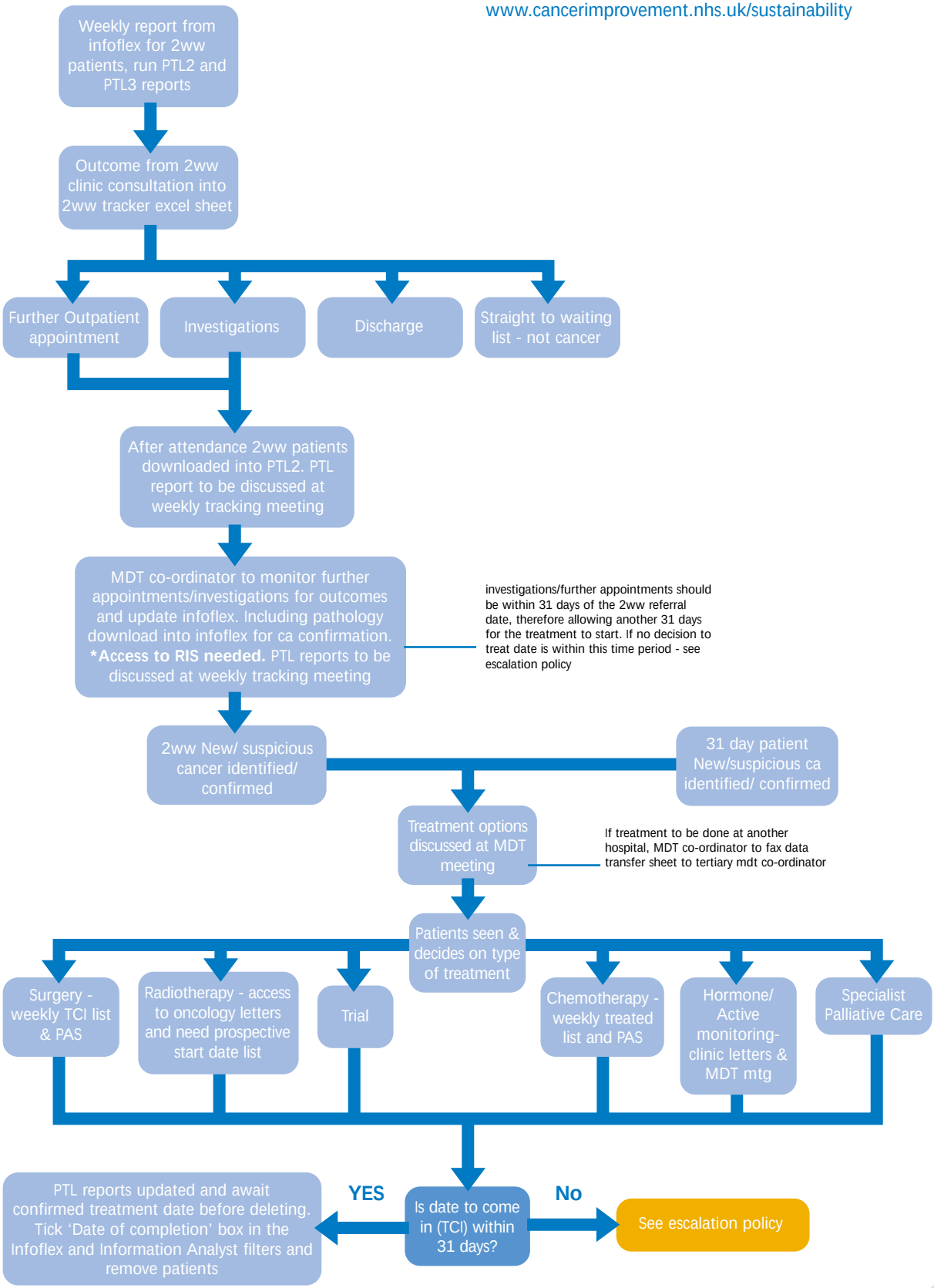
By asking the questions set out below, organisations can ensure they are working towards a robust job description and person specification for a tracking and navigation role

- Is there a clarity and agreement about the role re:
  - The purpose(s)?
  - Main function(s)?
  - Focus?
  - Position within the Trust?
  - Inter and intra-Trust relationships?
  - Authority to make decisions?
- How does the tracker/navigator role fit into proactive pathway management?
- Does the post have the support of key colleagues and clinical staff to make decisions?
- What are the mechanisms for ensuring that the role is understood by staff and patients?
- Have the factors that facilitate effective team relationships been addressed to ensure the role/postholder is effective and part of the multi-disciplinary team?
- Are arrangements in place for post-holders to have access and work across sites, departments and professional boundaries?
- Are there arrangements in place to cover sickness, study leave, annual leave and maternity leave?
- What arrangements have been put in place to ensure the post-holder is included and aware of service improvement changes in pathways?
- How can post-holders maintain an appropriate level of identity, authority and empowerment?
- How does the post-holder get access to information?
- Is the role/post sustainable?
- Is the tracker/navigator role required due to:
  - Lack of agreed, timed and implemented patient pathways?
  - Lack of information systems?
  - Lack of proactive patient management?
  - Lack of implementation of high impact changes?

The tracking process

Diagram 7

(Source date - 27th September 2005)



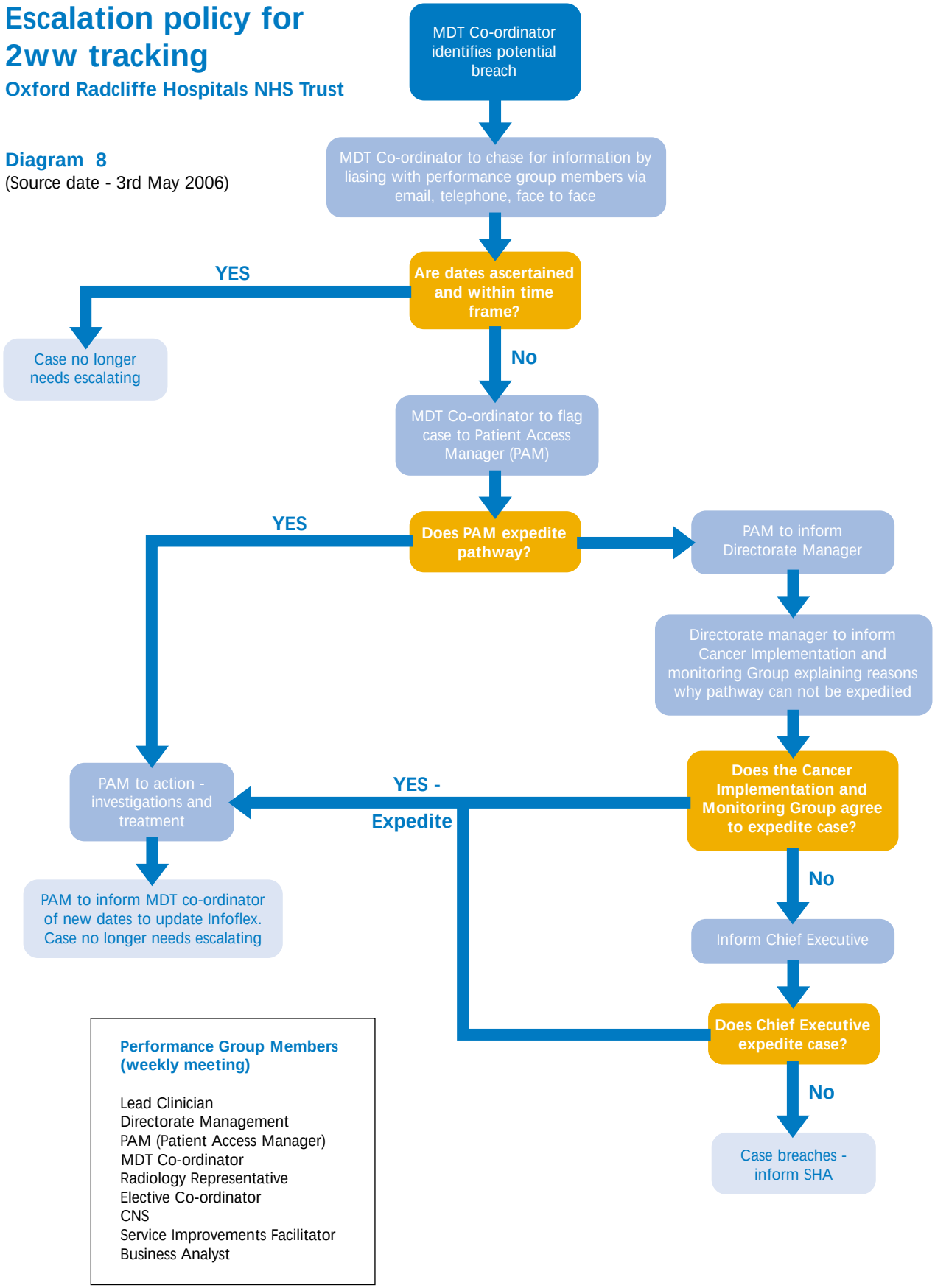
The following is an example tracking process from Oxford Radcliffe Hospitals NHS Trust

The impact of implementing this policy on data completeness and cancer target delivery can be found on the sustainability website
www.cancerimprovement.nhs.uk/sustainability

Escalation policy for 2ww tracking

Oxford Radcliffe Hospitals NHS Trust

Diagram 8
(Source date - 3rd May 2006)



Performance Group Members (weekly meeting)

Lead Clinician
Directorate Management
PAM (Patient Access Manager)
MDT Co-ordinator
Radiology Representative
Elective Co-ordinator
CNS
Service Improvements Facilitator
Business Analyst

Section F

Self-assessment - Sustaining delivery of the Cancer Waits Standards

All NHS organisations, including SHAs, PCTs, Cancer care providers, and Cancer Networks have a vital contribution to make in the planning, commissioning, monitoring and maintenance of timely cancer waiting times. Delivery is not solely the job of those organisations that diagnose and treat patients directly. This guide sets out good practice, and this section describes the self-assessment process that all NHS organisations will be expected to adopt.

All organisations need to:

- Understand what it takes to deliver the cancer waits standards in a sustainable way
- Assess whether local practice matches up to this
- Agree a plan to sustain delivery
- Implement any necessary improvements to make delivery truly sustainable.

The process of self-assessment outlined in this section is a first crucial step for all to take.

The self-assessment process adopted within an organisation must be realistic, evidence-based, and honest in order to achieve these aims. It should involve the collection of evidence and a systematic examination of that evidence to form an assessment about sustainability. The final assessment must be owned by the Chief Executive, Board and leaders of the organisation, be shared with partner organisations, and lead to improvement in sustainable delivery where needed.

SHAs, Cancer Networks, PCTs and Cancer Providers need to carry out an assessment of the sustainability of their delivery. Assessment templates for each type of organisation have been developed and can be copied from this guide or completed online at www.cancerimprovement.nhs.uk/sustainability

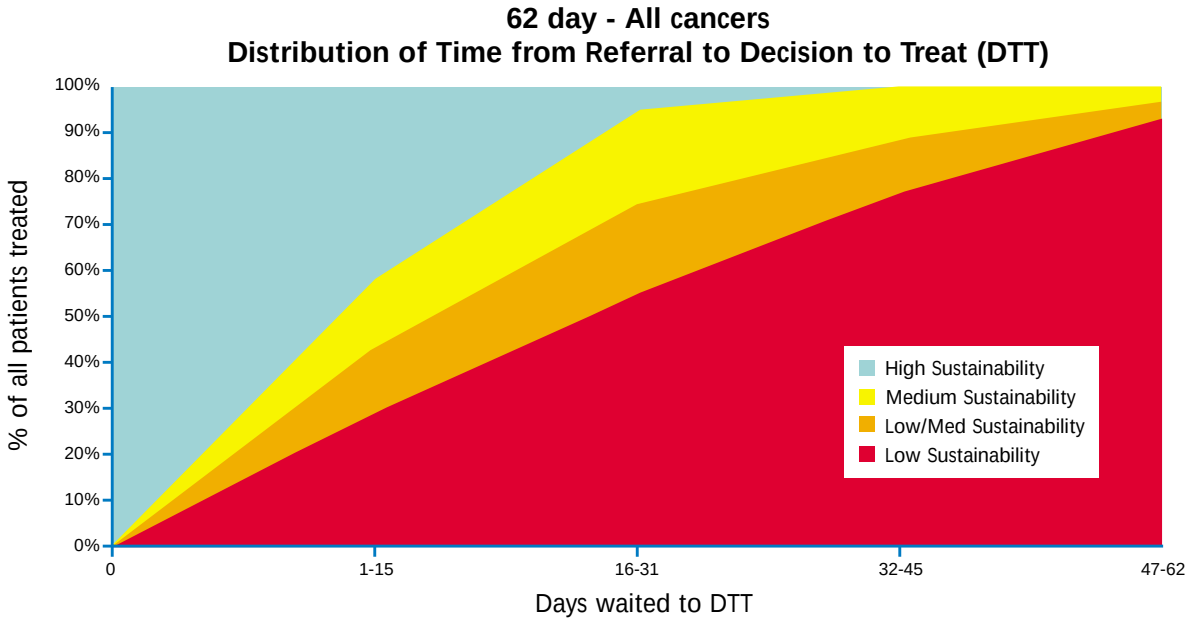
The self-assessment questionnaires provide a structure for both qualitative and quantitative aspects, designed to help organisations make an assessment as to whether there is a gap between their current practice and sustainable practice.

From a qualitative point of view:

- The hospital cancer services provider questions relate to the effective navigation of patients through redesigned pathways, effective leadership, data, information systems, inter-Trust transfer arrangements and whether delivery is maintained by short term "fixes".
- The PCT questions relate to the commissioning of effective pathways which provide sustainable delivery of the cancer waiting times
- The Cancer Network questions relate to its role in supporting effective pathways and the monitoring and benchmarking of organisations within the Network
- The SHA questions relate to its overall role in ensuring sustainable delivery.

From a quantitative point of view:

It is possible to obtain some clear measures of sustainability from the data collected for the Cancer Waits Database. The critical factor in delivery of the 62-day target is that the decision to treat is made at an early enough stage to enable the treatment to be planned and implemented in an orderly fashion. Whilst it is clearly possible to deliver care "just in time", experience from the sites that have been delivering the target for some time is that their profile of time to decision to treat shows a greater proportion of patients with a decision to treat within 31 days. This is shown on the next page:



Profiles for individual tumour types will legitimately vary from this aggregate picture.

All organisations must understand what the profile is for their own patients – including as appropriate inter-Trust transfer patients – and make assessments on sustainability based on what the data says.

Having assessed their current position organisations together with partner organisations will need to plan action to close any gaps.

All organisations will be expected to have undertaken an assessment of the sustainability of their own cancer waits delivery. This reflects the national priority attached to the sustained achievement of the standards.

The online assessment questionaires can be found at www.cancerimprovement.nhs.uk/sustainability

- Self-assessment for Hospital Cancer Service Providers
- Self-assessment for Cancer Networks
- Self-assessment for Primary Care Trusts
- Self-assessment for Strategic Health Authorities

For advice and information, please contact Nick Chapman, nick.chapman@dh.gsi.gov.uk

Sustaining Delivery of the Cancer Waits Standards

Self-assessment for Hospital Cancer Service Providers (1 of 4)

This is a practical assessment tool to help identify the likelihood of sustaining the delivery of the cancer waiting time standards.

The key questions are in bold and the bullet points are the criteria for sustainability.

1. Do we have an agreed plan to sustain delivery of the cancer waiting time standards? To include:

- Content of the plan includes: implementation of effective clinical pathways, effective management of inter-Trust transfers, active patient navigation arrangements, robust data and information systems
- The plan has been endorsed by the Trust Board with strong commitment to its implementation
- The plan is agreed by local PCTs , and Cancer Network, and is jointly owned
- There is strong clinical commitment to implement the plan

We do not meet any of the criteria ☐
We meet some criteria but our plan is very weak ☐
We meet some of the criteria but our plan is in need of some strengthening ☐
We meet most of the criteria but our plan needs minor strengthening ☐
We meet all of the criteria ☐

2. Is our leadership on cancer waits being effective? To include:

- A formally designated Executive Lead
- Strong Clinical Leadership for Cancer Waits
- Clear and robust management structure for cancer waits delivery
- Clear and robust managerial processes for sustained cancer waits delivery
- Arrangements in place to monitor and review delivery against the plan and take corrective action where necessary
- Escalation policies to prevent breaches
- Regular reports to the Trust Board

We do not meet any of the criteria ☐
We meet some criteria but our leadership is very weak ☐
We meet some of the criteria but our leadership is in need of some strengthening ☐
We meet most of the criteria but our leadership needs minor strengthening ☐
We meet all of the criteria ☐

Self-assessment for Hospital Cancer Service Providers (2 of 4)

3. Have we implemented effective redesigned tumour or symptom specific pathways for all patients with suspected or diagnosed cancer? To include:

- The high impact changes have been implemented and sustained in each tumour site i.e.
  - one route into system
  - straight to test in major tumour sites
  - consultants pooling referrals
  - reducing unnecessary follow-ups
- All patients managed through MDT
- All stages of the pathway are timed and designed well within the 62 day timescale
- Diagnostic services have capacity and provision to ensure cancer patients are treated urgently
- Pathways have been documented and shared with other trusts, PCTs and the cancer network
- Redesigned pathways have been tested against best practice nationally
- We have evidence that the pathways are actually being used and are being audited

We do not meet any of the criteria ☐
We meet some criteria but our pathways are very weak ☐
We meet some of the criteria but our pathways are in need of some strengthening ☐
We meet most of the criteria but our pathways need minor strengthening ☐
We meet all of the criteria ☐

4. Do we have clear systems in place for inter-Trust referrals which are agreed and implemented? To include:

- A standardised referral system is in place and agreed between all key stakeholders
- Referral timelines are agreed and monitored
- Clinical pathways are agreed and in place which support inter-Trust transfers and deliver treatment within 62 days
- Consistent information and communication strategy to support referrals
- The systems and pathways are understood and used by all MDTs
- There is no duplication or delay to test/investigations
- A named person is accountable for the referral systems in each Trust
- There are defined timescales for onward referrals
- There is an effective escalation policy in place

We do not meet any of the criteria ☐
We meet some criteria but our transfer systems are very weak ☐
We meet some of the criteria but our transfer systems are in need of some strengthening ☐
We meet most of the criteria but our transfer systems need minor strengthening ☐
We meet all of the criteria ☐

Self-assessment for Hospital Cancer Service Providers (3 of 4)

5. Do we have a robust patient specific database, information and administration system(s) that are an integral part of the Trust's procedures? To include:

- We have complete patient level data capturing all urgently referred cancer patients
- Data is of high quality and is used every day by staff involved with cancer patients
- The MDT reviews real time data and information
- Patients without cancer are rapidly removed from the database
- The cancer system is integrated into other hospital systems such as PAS, radiology/pathology rather than stand alone with manual input of all data
- We use our cancer information actively in the management of our service

We do not meet any of the criteria ☐
We meet some criteria but our systems are very weak ☐
We meet some of the criteria but our systems are in need of some strengthening ☐
We meet most of the criteria but our systems need minor strengthening ☐
We meet all of the criteria ☐

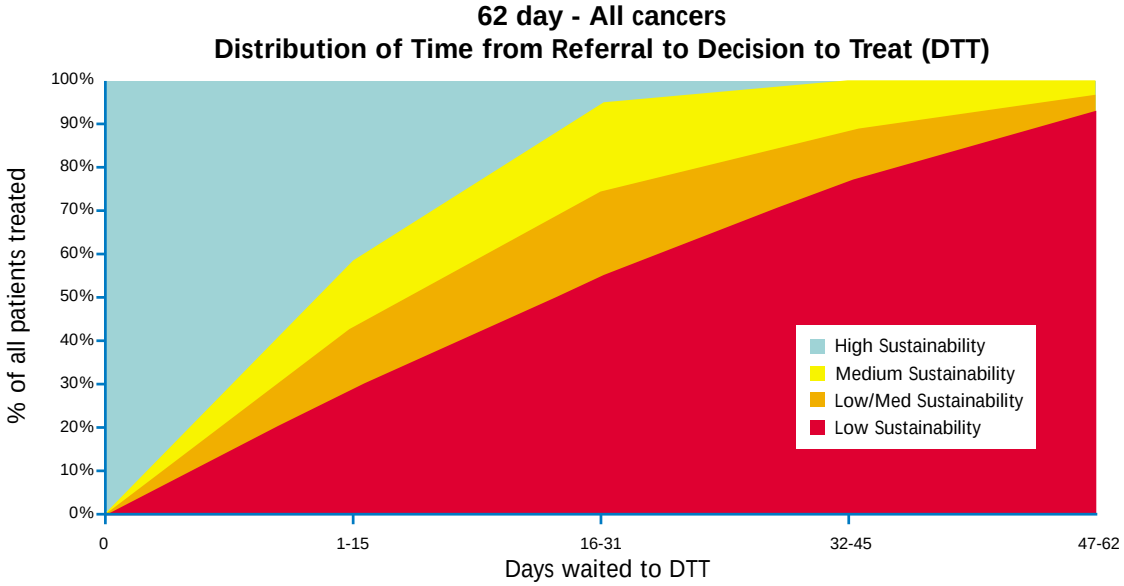
6. Have we implemented a system to navigate our patients through the diagnostic and treatment pathways? To include:

- We have a system in place to identify where all cancer patients are in their pathway
- Clear identification of any backlogs
- Active navigation systems integrated into the process of caring for patients
- Clearly defined navigation roles not reliant on one person
- Defined escalation processes
- Regular review of prolonged pathways and breaches

We do not meet any of the criteria ☐
We meet some criteria but our systems are very weak ☐
We meet some of the criteria but our systems are in need of some strengthening ☐
We meet most of the criteria but our systems need minor strengthening ☐
We meet all of the criteria ☐

7. Our data shows that we arrive at a decision to treat for patients diagnosed with cancer within national benchmarks of sustainable practice

Plot your trust's aggregate data (for all tumour sites together) onto the diagram



Self-assessment for Hospital Cancer Service Providers (4 of 4)

Our data is all in the low zone ☐
Our data is in the low and low to medium zones ☐
Our data is the low to medium and medium zones ☐
Our data is in the medium zone ☐
Our data is in the high zone ☐

8. Our delivery of cancer waiting times is based on long-term sustainable solutions and best practice rather than short-term (11th hour) solutions. To include:

- The targets are met without the use of waiting list initiatives
- Delivery is not dependant on temporary posts
- Cancer waiting times delivery is based on an MDT approach and not reliant on one person alone
- Capacity and demand for diagnostics has been assessed and plans to sustain waiting times are in place
- Our delivery can be sustained without de-prioritising other urgent patients

We meet none of the criteria ☐
We meet some criteria but our solutions are very weak ☐
We meet some of the criteria but our solutions are in need of some strengthening ☐
We meet most of the criteria but our solutions need minor strengthening ☐
We meet all of the criteria ☐

Self-assessment Summary

Based on our answers to the questionnaire, and our own judgment of other relevant local factors our assessment of the sustainability of the delivery of cancer waits in this trust is set out below:

We meet no confidence that we can deliver the standards sustainably ☐
We have some confidence but it is low ☐
We meet some confidence but it needs strengthening in some areas ☐
We have a good degree of confidence with only minor area of concern ☐
We are very confident ☐

Reasons for the above summary assessment

Signed _____

Dated _____

Sustaining Delivery of the Cancer Waits Standards

Self-assessment for Cancer Networks (1 of 4)

This is a practical assessment tool to help identify the likelihood of sustaining the delivery of the cancer waiting time standards.

The key questions are in bold and the bullet points are the criteria for sustainability.

1. Do we have an agreed plan to enable sustained delivery of the cancer waiting time standards? To include:

- Content of the plan includes: implementation of effective clinical pathways, effective management of inter-Trust transfers, active patient navigation arrangements, robust data and information systems
- The plan has been endorsed by the Network Board with strong commitment to its implementation
- The plan is agreed by local trusts ,PCTs , the SHA and the Cancer Network, and is jointly owned
- There is strong clinical commitment to implement the plan

We do not meet any of the criteria ☐
We meet some criteria but our plan is very weak ☐
We meet some of the criteria but our plan is in need of some strengthening ☐
We meet most of the criteria but our plan needs minor strengthening ☐
We meet all of the criteria ☐

2. Is our leadership on cancer waits being effective? To include:

- The Network has a clear and strong governance structure
- Strong representation from PCTs and cancer Service Providers on the Network Board
- The Network has a strong commitment to support sustainable Cancer Waits delivery
- There is a clear and agreed role for the Network's Service Improvement Lead
- Clear and robust arrangements to support cancer waits delivery
- Arrangements in place to monitor and review delivery against the plan and take corrective action where necessary
- Regular reports to the Network Board

We do not meet any of the criteria ☐
We meet some criteria but our leadership is very weak ☐
We meet some of the criteria but our leadership is in need of some strengthening ☐
We meet most of the criteria but our leadership needs minor strengthening ☐
We meet all of the criteria ☐

Self-assessment for Cancer Networks (2 of 4)

3. Is the Network supporting the development of redesigned tumour or symptom specific pathways all patients with suspected or diagnosed cancer? To include:

- The Network has a clear picture of whether pathways incorporate the high impact changes in each tumour site i.e.
  - one route into system
  - straight to test in major tumour sites
  - consultants pooling referrals
  - reducing unnecessary follow-ups
- The Network monitors whether these pathways have been implemented and are subject to audit
- The NICE referral guidelines for suspected cancer have been implemented (published June 2005 ref CG027) and this is subject to audit
- All patients managed through MDTs
- All stages of the pathway are timed and designed well within the 62 day timescale
- Diagnostic services have capacity and provision to ensure cancer patients are treated urgently
- Pathways have been documented and shared with other trusts, PCTs and the cancer network

We do not meet any of the criteria ☐
We meet some criteria but our pathways are very weak ☐
We meet some of the criteria but our pathways are in need of some strengthening ☐
We meet most of the criteria but our pathways need minor strengthening ☐
We meet all of the criteria ☐

4. Have clear systems been agreed and implemented for inter-Trust referrals? To include:

- A standardised referral system is in place and agreed between all key stakeholders
- Referral timelines are agreed and monitored
- Clinical pathways are agreed and in place which support inter-Trust transfers and deliver treatment within 62 days
- Consistent information and communication strategy to support referrals
- The systems and pathways are understood and used by all MDTs
- There is no duplication or delay to test/investigations
- A named person is accountable for the referral systems in each Trust
- There are defined timescales for onward referrals
- There are an effective escalation policies in place

We do not meet any of the criteria ☐
We meet some criteria but our transfer systems are very weak ☐
We meet some of the criteria but our transfer systems are in need of some strengthening ☐
We meet most of the criteria but our transfer systems need minor strengthening ☐
We meet all of the criteria ☐

Self-assessment for Cancer Networks (3 of 4)

5. Do we have robust cancer waits information Systems and support their development? To include:

- We have complete patient level data capturing all urgently referred cancer patients
- Data is of high quality
- Patients without cancer are rapidly removed from the database
- We have specific information to enable us to review performance by tumour site and with reference to inter-Trust transfers
- We have information to enable us to review the performance of all organisations in networks and to benchmark organisations against good practice
- The Network supports the development of high quality data systems in all PCTs and Cancer service providers

We do not meet any of the criteria ☐
We meet some criteria but our systems are very weak ☐
We meet some of the criteria but our systems are in need of some strengthening ☐
We meet most of the criteria but our systems need minor strengthening ☐
We meet all of the criteria ☐

6. Are there effective service level agreements and contracts in place between PCTs and providers that will deliver the 62 day standard on a sustainable basis?

- SLA's/contracts are agreed with all PCTs and cancer providers
- We are confident that the volumes of care required can be delivered
- SLAs/contract are regularly reviewed and action taken as appropriate
- We are confident that they will deliver the standard sustainably

We do not meet any of the criteria ☐
We meet some criteria but our SLAs are very weak ☐
We meet some of the criteria but our SLAs are in need of some strengthening ☐
We meet most of the criteria but our SLAs need minor strengthening ☐
We meet all of the criteria ☐

7. The delivery of cancer waiting times for our patients is based on long-term sustainable solutions and best practice rather than short-term (11th hour) solutions. To include:

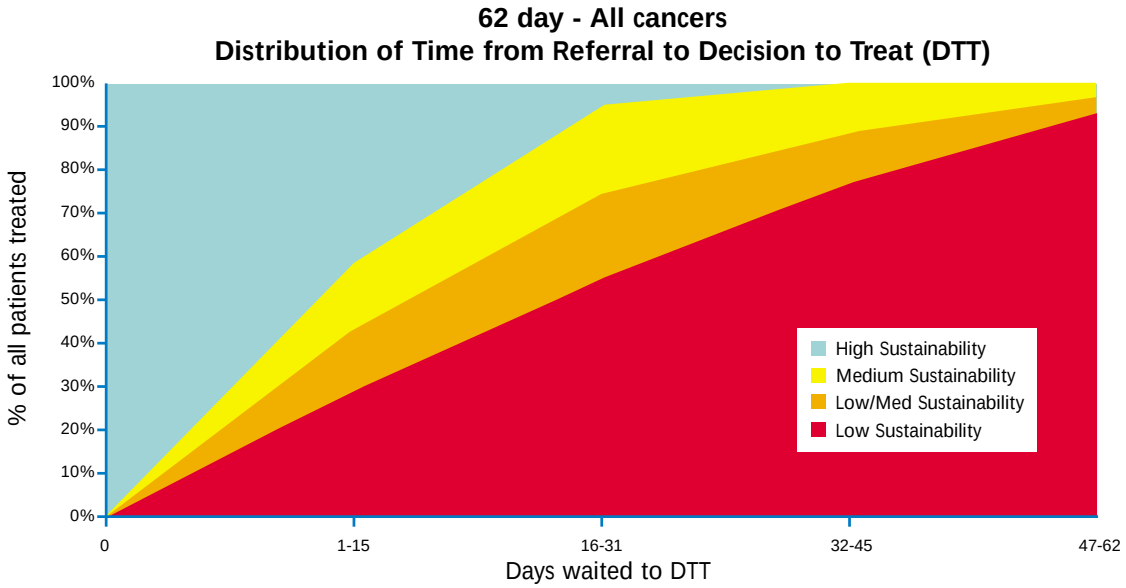
- The standards are met without the use of waiting list initiatives
- Delivery is not dependant on temporary posts
- Cancer waiting times delivery is based on an MDT approach and not reliant on one person alone
- Capacity and demand for diagnostics has been assessed and plans to sustain waiting times are in place
- Our delivery can be sustained without de-prioritising other urgent patients

We meet none of the criteria ☐
We meet some criteria but our solutions are very weak ☐
We meet some of the criteria but our solutions are in need of some strengthening ☐
We meet most of the criteria but our solutions need minor strengthening ☐
We meet all of the criteria ☐

Self-assessment for Cancer Networks (4 of 4)

8. Our data shows that our patients diagnosed with cancer arrive at a decision to treat for within national benchmarks of sustainable practice

Plot your Network's aggregate data (for all tumour sites together) onto the diagram



Our data is all in the low zone ☐

Our data is in the low and low to medium zones ☐

Our data is the low to medium and medium zones ☐

Our data is in the medium zone ☐

Our data is in the high zone ☐

Self-assessment Summary

Based on our answers to the questionnaire, and our own judgment of other relevant local factors our assessment of the sustainability of the delivery of cancer waits in this Network is set out below:

We meet no confidence that we can deliver the standards sustainably ☐

We have some confidence but it is low ☐

We meet some confidence but it needs strengthening in some areas ☐

We have a good degree of confidence with only minor areas of concern ☐

We are very confident ☐

Reasons for the above summary assessment

Signed _____

Dated _____

Sustaining Delivery of the Cancer Waits Standards

Self-assessment for Primary Care Trusts (1of 5)

This is a practical Assessment Tool to help identify the likelihood of sustaining the delivery of the cancer waiting time standards.

The key questions are in bold and the bullet points are the criteria for sustainability.

1. Do we have an agreed plan to enable sustained delivery of the cancer waiting time standards? To include:

- Content of the plan includes: implementation of effective clinical pathways, effective management of inter-Trust transfers, active patient navigation arrangements, robust data and information systems
- The plan has been endorsed by the PCT Board with strong commitment to its implementation
- The plan is agreed by local trusts , and Cancer Network, and is jointly owned
- There is strong clinical commitment to implement the plan

We do not meet any of the criteria ☐
We meet some criteria but our plan is very weak ☐
We meet some of the criteria but our plan is in need of some strengthening ☐
We meet most of the criteria but our plan needs minor strengthening ☐
We meet all of the criteria ☐

2. Is our leadership on cancer waits being effective? To include:

- A formally designated Executive Lead
- Strong Clinical Leadership for Cancer Waits
- Clear and robust management structure for cancer waits delivery
- Clear and robust managerial processes for sustained cancer waits delivery
- Arrangements in place to monitor and review delivery against the plan and take corrective action where necessary
- Escalation policies to prevent breaches
- Regular reports to the PCT Board

We do not meet any of the criteria ☐
We meet some criteria but our leadership is very weak ☐
We meet some of the criteria but our leadership is in need of some strengthening ☐
We meet most of the criteria but our leadership needs minor strengthening ☐
We meet all of the criteria ☐

Self-assessment for Primary Care Trusts (2 of 5)

3. Have we commissioned effective redesigned tumour or symptom specific pathways for all patients with suspected or diagnosed cancer? To include:

- Do they incorporate the high impact changes have been implemented and sustained in each tumour site i.e.
  - one route into system
  - straight to test in major tumour sites
  - consultants pooling referrals
  - reducing unnecessary follow-ups
- we have implemented the NICE referral guidelines for suspected cancer (published June 2005 ref CG027) and this is subject to audit
- All patients managed through MDT
- All stages of the pathway are timed and designed well within the 62 day timescale
- Diagnostic services have capacity and provision to ensure cancer patients are treated urgently
- Pathways have been documented and shared with other trusts, PCTs and the cancer network
- Redesigned pathways have been tested against best practice nationally
- We have evidence that the pathways are actually being used and are being audited

We do not meet any of the criteria ☐
We meet some criteria but our pathways are very weak ☐
We meet some of the criteria but our pathways are in need of some strengthening ☐
We meet most of the criteria but our pathways need minor strengthening ☐
We meet all of the criteria ☐

4. Have clear systems been agreed and implemented for inter-Trust referrals? To include:

- A standardised referral system is in place and agreed between all key stakeholders
- Referral timelines are agreed and monitored
- Clinical pathways are agreed and in place which support inter-Trust transfers and deliver treatment within 62 days
- Consistent information and communication strategy to support referrals
- The systems and pathways are understood and used by all MDTs
- There is no duplication or delay to test/investigations
- A named person is accountable for the referral systems in each Trust
- There are defined timescales for onward referrals
- There is an effective escalation policy in place

We do not meet any of the criteria ☐
We meet some criteria but our transfer systems are very weak ☐
We meet some of the criteria but our transfer systems are in need of some strengthening ☐
We meet most of the criteria but our transfer systems need minor strengthening ☐
We meet all of the criteria ☐

Self-assessment for Primary Care Trusts (3 of 5)

5. Do we have a robust patient specific database, information and administration system(s) that are an integral part of the Trust's procedures? To include:

- We have complete patient level data capturing all urgently referred cancer patients
- Data is of high quality and is used every day by staff involved with cancer patients
- The MDT reviews real time data and information
- Patients without cancer are rapidly removed from the database
- The cancer system is integrated into other hospital systems such as PAS, radiology/pathology rather than stand alone with manual input of all data
- We use our cancer information actively in the management of our service

We do not meet any of the criteria ☐
We meet some criteria but our systems are very weak ☐
We meet some of the criteria but our systems are in need of some strengthening ☐
We meet most of the criteria but our systems need minor strengthening ☐
We meet all of the criteria ☐

6. Do we have effective service level agreements and contracts with providers that will deliver the 62 day standard on a sustainable basis?

- SLA's/contracts are agreed with all cancer providers
- We are confident that the volumes of care required can be delivered
- SLAs/contract are regularly reviewed and action taken as appropriate
- We are confident that they will deliver the standard sustainably

We do not meet any of the criteria ☐
We meet some criteria but our SLAs are very weak ☐
We meet some of the criteria but our SLAs are in need of some strengthening ☐
We meet most of the criteria but our SLAs need minor strengthening ☐
We meet all of the criteria ☐

7. The delivery of cancer waiting times for our patients is based on long-term sustainable solutions and best practice rather than short-term (11th hour) solutions. To include:

- The standards are met without the use of waiting list initiatives
- Delivery is not dependant on temporary posts
- Cancer waiting times delivery is based on an MDT approach and not reliant on one person alone
- Capacity and demand for diagnostics has been assessed and plans to sustain waiting times are in place
- Our delivery can be sustained without de-prioritising other urgent patients

We meet none of the criteria ☐
We meet some criteria but our solutions are very weak ☐
We meet some of the criteria but our solutions are in need of some strengthening ☐
We meet most of the criteria but our solutions need minor strengthening ☐
We meet all of the criteria ☐

Self-assessment for Primary Care Trusts (4 of 5)

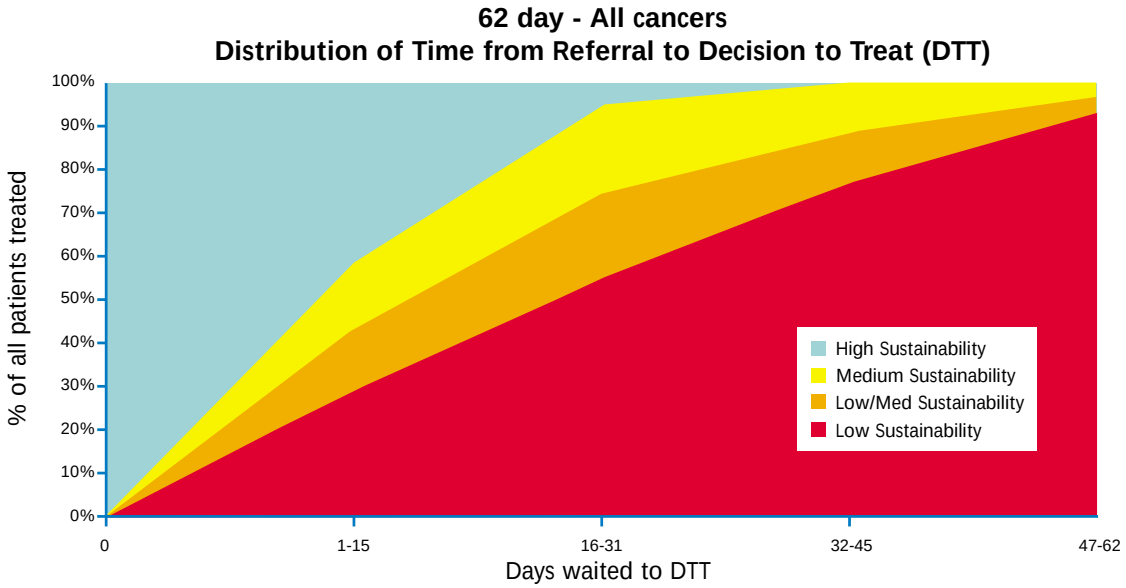
8. Is our Cancer Network effective in assisting the sustainable delivery of the standard?

- there is a clearly defined and agreed role for the network in relation to cancer waits
- The responsibilities include supporting the development of effective inter-Trust transfer arrangements and patient pathways
- the Network has a clear plan with agreed actions and milestones
- the network monitors and benchmarks trust cancer waits performance
- there are regular reports from the Network on work relating to cancer waits
- the Network produces effective cancer waits results

We do not meet any of the criteria ☐
We meet some of the criteria but our network is very weak ☐
We meet some of the criteria but our network needs some strengthening ☐

9. Our data shows that our patients diagnosed with cancer arrive at a decision to treat for within national benchmarks of sustainable practice

Plot your trust's aggregate data (for all tumour sites together) onto the diagram



Our data is all in the low zone ☐
Our data is in the low and low to medium zones ☐
Our data is the low to medium and medium zones ☐
Our data is in the medium zone ☐
Our data is in the high zone ☐

Self-assessment for Primary Care Trusts (5 of 5)

Self-assessment Summary

Based on our answers to the questionnaire, and our own judgment of other relevant local factors our assessment of the sustainability of the delivery of cancer waits in this trust is set out below:

- We meet no confidence that we can deliver the standards sustainably ☐
- We have some confidence but it is low ☐
- We meet some confidence but it needs strengthening in some areas ☐
- We have a good degree of confidence with only minor area of concern ☐
- We are very confident ☐

Reasons for the summary assessment

Signed _____

Dated _____

Sustaining Delivery of the Cancer Waits Standards

Self-assessment for Strategic Health Authorities (1 of 5)

This is a practical Assessment Tool to help identify the likelihood of sustaining the delivery of the cancer waiting time standards.

The key questions are in bold and the bullet points are the criteria for sustainability.

1. Do we have an agreed plan to enable sustained delivery of the cancer waiting time standards? To include:

- Content of the plan includes: implementation of effective clinical pathways, effective management of inter-Trust transfers, active patient navigation arrangements, robust data and information systems
- The plan has been endorsed by the SHA Board with strong commitment to its implementation
- The plan is agreed by local trusts PCTs , and the Cancer Network, and is jointly owned
- There is strong clinical commitment to implement the plan

We do not meet any of the criteria ☐
We meet some criteria but our plan is very weak ☐
We meet some of the criteria but our plan is in need of some strengthening ☐
We meet most of the criteria but our plan needs minor strengthening ☐
We meet all of the criteria ☐

2. Is our leadership on cancer waits being effective? To include:

- A formally designated SHA Executive Lead
- Strong Clinical Leadership for Cancer Waits
- Clear and robust management structure for cancer waits delivery
- Clear and robust managerial processes for sustained cancer waits delivery
- Arrangements in place to monitor and review delivery against the plan and take corrective action where necessary
- Escalation policies to prevent breaches
- Regular reports to the PCT Board

We do not meet any of the criteria ☐
We meet some criteria but our leadership is very weak ☐
We meet some of the criteria but our leadership is in need of some strengthening ☐
We meet most of the criteria but our leadership needs minor strengthening ☐
We meet all of the criteria ☐

Self-assessment for Strategic Health Authorities (2 of 5)

3. Have effective redesigned tumour or symptom specific pathways been commissioned for all patients with suspected or diagnosed cancer? To include:

- The SHA has a clear picture of whether pathways incorporate the high impact changes in each tumour site i.e.
  - one route into system
  - straight to test in major tumour sites
  - consultants pooling referrals
  - reducing unnecessary follow-ups
- The SHA monitors whether these pathways have been implemented and are subject to audit
- the NICE referral guidelines for suspected cancer have been implemented (published June 2005 ref CG027) and this is subject to audit
- All patients managed through MDTs
- All stages of the pathway are timed and designed well within the 62 day timescale
- Diagnostic services have capacity and provision to ensure cancer patients are treated urgently
- Pathways have been documented and shared with other trusts, PCTs and the cancer network

We do not meet any of the criteria ☐
We meet some criteria but our pathways are very weak ☐
We meet some of the criteria but our pathways are in need of some strengthening ☐
We meet most of the criteria but our pathways need minor strengthening ☐
We meet all of the criteria ☐

4. Have clear systems been agreed and implemented for inter-Trust referrals? To include:

- A standardised referral system is in place and agreed between all key stakeholders
- Referral timelines are agreed and monitored
- Clinical pathways are agreed and in place which support inter-Trust transfers and deliver treatment within 62 days
- Consistent information and communication strategy to support referrals
- The systems and pathways are understood and used by all MDTs
- There is no duplication or delay to test/investigations
- A named person is accountable for the referral systems in each Trust
- There are defined timescales for onward referrals
- There are an effective escalation policies in place

We do not meet any of the criteria ☐
We meet some criteria but our transfer systems are very weak ☐
We meet some of the criteria but our transfer systems are in need of some strengthening ☐
We meet most of the criteria but our transfer systems need minor strengthening ☐
We meet all of the criteria ☐

Self-assessment for Strategic Health Authorities (3 of 5)

5. Do we have a robust cancer waits information System? To include:

- We have complete patient level data capturing all urgently referred cancer patients
- Data is of high quality
- Patients without cancer are rapidly removed from the database
- We have specific information to enable us to review performance by tumour site and with reference to inter-Trust transfers
- We have information to enable us to review the performance of all organisations, including cancer networks

We do not meet any of the criteria ☐
We meet some criteria but our systems are very weak ☐
We meet some of the criteria but our systems are in need of some strengthening ☐
We meet most of the criteria but our systems need minor strengthening ☐
We meet all of the criteria ☐

6. Are there effective service level agreements and contracts in place between PCTs and providers that will deliver the 62 day standard on a sustainable basis?

- SLA's/contracts are agreed with all PCTs and cancer providers
- We are confident that the volumes of care required can be delivered
- SLAs/contract are regularly reviewed and action taken as appropriate
- We are confident that they will deliver the standard sustainably

We do not meet any of the criteria ☐
We meet some criteria but our SLAs are very weak ☐
We meet some of the criteria but our SLAs are in need of some strengthening ☐
We meet most of the criteria but our SLAs need minor strengthening ☐
We meet all of the criteria ☐

7. The delivery of cancer waiting times for our patients is based on long-term sustainable solutions and best practice rather than short-term (11th hour) solutions. To include:

- The targets are met without the use of waiting list initiatives
- Delivery is not dependant on temporary posts
- Cancer waiting times delivery is based on an MDT approach and not reliant on one person alone
- Capacity and demand for diagnostics has been assessed and plans to sustain waiting times are in place
- Our delivery can be sustained without de-prioritising other urgent patients

We meet none of the criteria ☐
We meet some criteria but our solutions are very weak ☐
We meet some of the criteria but our solutions are in need of some strengthening ☐
We meet most of the criteria but our solutions need minor strengthening ☐
We meet all of the criteria ☐

Self-assessment for Strategic Health Authorities (4 of 5)

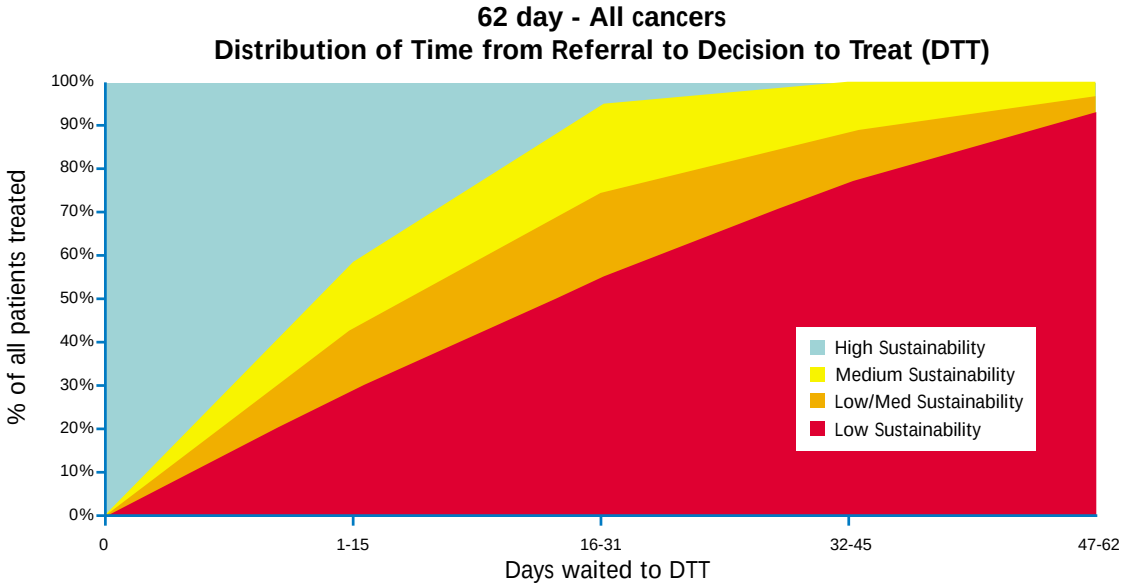
8. Is our Cancer Network effective in assisting the sustainable delivery of the standard?

- there is a clearly defined and agreed role for the network in relation to cancer waits
- The responsibilities include supporting the development of effective inter-Trust transfer arrangements and patient pathways
- the Network has a clear plan with agreed actions and milestones
- the network monitors and benchmarks trust cancer waits performance
- there are regular reports from the Network on work relating to cancer waits
- the Network produces effective cancer waits results
- We formally review the performance of the network at least annually

We do not meet any of the criteria ☐
We meet some of the criteria but our network is very weak ☐
We meet some criteria but our network needs some strengthening ☐

9. Our data shows that our patients diagnosed with cancer arrive at a decision to treat for within national benchmarks of sustainable practice.

Plot your SHA's aggregate data (for all tumour sites together) onto the diagram



Our data is all in the low zone ☐
Our data is in the low and low to medium zones ☐
Our data is the low to medium and medium zones ☐
Our data is in the medium zone ☐
Our data is in the high zone ☐

Self-assessment for Strategic Health Authorities (5 of 5)

Self-assessment Summary

Based on our answers to the questionnaire, and our own judgment of other relevant local factors our assessment of the sustainability of the delivery of cancer waits in this SHA is set out below:

- We meet no confidence that we can deliver the standards sustainably ☐
- We have some confidence but it is low ☐
- We meet some confidence but it needs strengthening in some areas ☐
- We have a good degree of confidence with only minor area of concern ☐
- We are very confident ☐

Reasons for the summary assessment

Signed _____

Dated _____

Section G

Acknowledgments and Key Contacts

Acknowledgments

Department of Health National Cancer Waits Project Team

The Cancer Services Collaborative 'Improvement Partnership' National Team

Intensive Support Team

Recovery and Support Unit

Cancer Network Service Improvement Leads

With special thanks to the individuals, Trusts and Networks who have contributed to this section of The 'how to' guide

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Further examples and ongoing learning can be found at www.cancerimprovement.nhs.uk/sustainability

Signposting

Signposting

The following resources and websites provide support for improvement in cancer services

1. CSC'IP' key resources

(a) Applying High Impact Changes to Cancer
www.cancerimprovement.nhs.uk/chic
(b) CSC'IP' Service Improvement Guides
www.cancerimprovement.nhs.uk/sigs
(c) CSC'IP' Service improvement Tool
nww.wils.nhs.uk
(d) Sustainability work stream
www.cancerimprovement.nhs.uk/sustainability
(e) Challenge of Implementation …lessons learnt from the demonstration sites
www.cancerimprovement.nhs.uk/demonstrationsites

2. Department of Health - Policy and guidance for cancer services

(a) NHS Cancer Plan, 2000
www.dh.gov.uk
(b) Manual of Cancer Standards
www.dh.gov.uk
(c) Improving Outcomes Guidance – detailed guidance for each tumour service
www.dh.gov.uk

3. Diagnostic services

www.endoscopy.nhs.uk
www.pathologyimprovement.nhs.uk
www.radiologyimprovement.nhs.uk

4. NHS Cancer Programme - key work-streams

- NHS Breast screening programme
  www.cancerscreening.nhs.uk
- Web-based tool to support self-assessment Peer Review
  www.cquins.nhs.uk
- Cancer Services Collaborative 'Improvement Partnership'
  www.cancerimprovement.nhs.uk
- National Clinical Audit support programme section on cancer
  www.ic.nhs.uk
- Informatics website which refers to the information flow between Trusts and Networks
  www.aswcs.nhs.uk/imt/NDP/default.htm

5. Other NHS Service Improvement work-streams and publicatications

NB. the modernisation agency programmes have now finished and their web pages are static)

www.modern.nhs.uk/action-on
www.modern.nhs.uk/theatres
www.modern.nhs.uk/daysurgery
www.cancerimprovement.nhs.uk/chemotherapy
www.cancerimprovement.nhs.uk/radiotherapy

Improvement Leaders' Guides (Series 1, 2 & 3)
www.wise.nhs.uk/cmsWISE/Tools+and+Techniques/ILG/ILG.htm

MA Research into Practice Team - evaluation of service improvement in cancer and related services
www.wise.nhs.uk

Glossary of terms

2ww	Two Week Wait
Ba	barium
ca	Cancer
CNS	Cancer Nurse Specialist
CSC 'IP'	Cancer Services Collaborative Improvement Partnership
CT	Computerised Tomography
CXR	Chest X-ray
DH	Department of Health
DTT	Decision to treat
GP	General Practitioner
Kub-u/s	kidney, ureter, bladder ultra sound
MDT	Multidisciplinary team
MDTM	Multidisciplinary team meeting
NICE	National Institute for Clinical Excellence (UK)
OP	Outpatient
OPA	Outpatient Appointment
PACS	Picture Archive and Communications System
PAM	Patient Access Manager
PAS	Patient Administration System
PCT	Primary Care Trust
PET	Positron emission tomography
PMDU	Prime Ministers Delivery Unit
pt	Patient
PTL	Patient Tracking List
RIS	Radiology Information System
SHA	Strategic Health Authority
SLA	Service level agreement
STT	Straight to test
TCI	To come in
u/s fna	Ultrasound fine needle aspiration
uss	Ultrasound scan

The Cancer Services Collaborative Improvement Partnership
is part of the NHS Modernisation Agency