Strengthening operational governance on cancer performance: the journey from despair to hope to success
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Importance of Strengthening Operational Governance on Cancer Performance
Introduction

- Where were we?
- IST support
- Improvements made:
  - Cancer Operational Meeting
  - MDT tracking
  - PTL Meeting
  - Cancer Training
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Background

- Failing performance
- High numbers on the PTL
- High number of interim managers
- Turnover in cancer team
- Dermatology issue
- Clinical Admin Team (CAT) restructure + turnover
- Acceptance
IST involvement

– Demand & Capacity Review on 1st OPA, Diagnostic and IP wait
– Advice around PTL meeting
  – Attendees
  – Format
  – Expectations
– Training
  – Support on content and delivery
Turning point

- Demand & Capacity work complete and capacity on line and gap quantified.

- Expectation that 2ww performance should be sorted for Quarter 1 2016.

- Reality – at the end of April we had 268 breaches = whole quarter tolerance gone by end of the first month.

- Agreed an ambitious but realistic goal of passing 62 day by Quarter 3 2016
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2WW cancer operational meeting

- Daily Cancer Ops Meeting
  - Snapshot of breaches and referrals
  - Attended by all specialties ranging from Booking Officer to Service Manager
  - Senior Chair
  - Visual management, high impact
  - Very quick to set up
  - Engaged and empowered teams who can own the pathway
2WW Cancer Operational Meeting

How did we do it?

- Executive and operational buy in
- Planned approach
  - Not a repeat of the PTL
  - Quick and easy
  - Designated time and space
  - Supportive
- High priority operationally
- Informed teams of what was needed and when
2WW Cancer Operational Meeting

How is it maintained

- Still very quick
- Active participation
- Supportive
- Challenging
- Feedback on performance and impact
- Patient focused
- Valuable meeting
2WW Cancer Operational Meeting

Then
- 2ww outpatients
- Lead and completed by chair person
- Service managers and their deputies
- Next available appointment - failed
- Variation of chair person - failed

Now
- 2ww OP, Radiology and Endoscopy
- Teams write their own stats and highlight issues/actions
- Booking officers with support
- Test specific waiting times
- Average referrals per day
- Treatment dating sheet
- Median waits
Informed choice

- Recognised high number of breaches due to choice
- Recognised GPs were not always having the suspected cancer conversation
- Developed a script with input from stakeholders

*Your GP has referred you very urgently to exclude a potentially serious issue such as cancer. We strongly advise you to accept this appointment.*

- Trained booking staff with clinical support
- 88 2ww *choice* breaches in April ’16 – 89.5%
- 39 2ww *total* breaches in June ’16 – 97.2%
- 1 complaint, continually monitored
Patient Tracking

- Discussion with the MDT co-ordinators about priority of tracking
  - Tracking was a lower priority than it should have been
  - Co-ordinators were unable to track every day
  - Discussed how we tracked patients and improvements
  - Management identified support for improvements
# Tracking Worklists

<table>
<thead>
<tr>
<th>Date</th>
<th>Next Action</th>
<th>Next Action Date</th>
<th>Previous Action</th>
<th>Diagnosis/1st Def Treatment</th>
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<td>OPA + MNOP 23/06</td>
<td>23/06/2017</td>
<td>Recurrence of pleomorphic sarcoma</td>
<td>awating histology</td>
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<td>31/03/2017</td>
<td>OPA 31/03</td>
<td>31/03/2017</td>
<td>Incisional biopsy confirms SCC 14/06</td>
<td>Plastics OPA 11/07</td>
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<td>18/05/2017</td>
<td>OPA 18/05</td>
<td>18/05/2017</td>
<td>Punch biopsy - Confirms SCC. MDT 08/06</td>
<td>Needs further excision in Plastics Pla. Plastics OPA</td>
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<td>28/04/2017</td>
<td>OPA 28/04</td>
<td>28/04/2017</td>
<td>Recurrently seen to DTT</td>
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<td>OPA 19/05</td>
<td>19/05/2017</td>
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<td>26/05/2017</td>
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**Royal Berkshire Hospital**

July 2017

15
Patient Tracking

- Breach board in MDTC room
  - White board on the wall
  - Separated by month, patient initial, site and Hospital number
  - Any patient at risk of breaching in this month or next
  - Very visible to whole team
  - Predict performance
PTL Meetings

Then
- Originally just looked at the patients the MDTc were concerned about
- Discussed every patient for every site in one meeting
- Good attendance from service managers and deputies
- Chaired by Director of Ops for Planned Care
- Had separate sheets based on stage in pathway…failed!
- Tried to make the PTL smarter…failed!
- Staff came to the PTL to get actions

Now
- Separated the PTLs over 2 meetings
- Good attendance from service managers, deputies and booking staff
- Chaired by a member of the cancer management team
- Changed the PTL to be colour coded and with just relevant information
- Three sheets on the PTL, 62 day, 31 day and summary 2ww
- Staff come to PTL with completed actions, or update beforehand
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PTL distribution

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Cancer training

- IST review of training
- Cancer training was introduced beyond the cancer team
- All members of the clinical admin teams attended
- Continue to be rolled out once a month
- Training for the consultants is currently in the planning stages.
- Small changes based on feedback
Summary

- Patient focused
- Logical approach broken down into manageable chunks
- Culture change regarding patient choice
- Ethos that we must push for continuous improvement
Any Questions?