Faster Cancer Treatment - Pathways Project

Breast Tumour Stream

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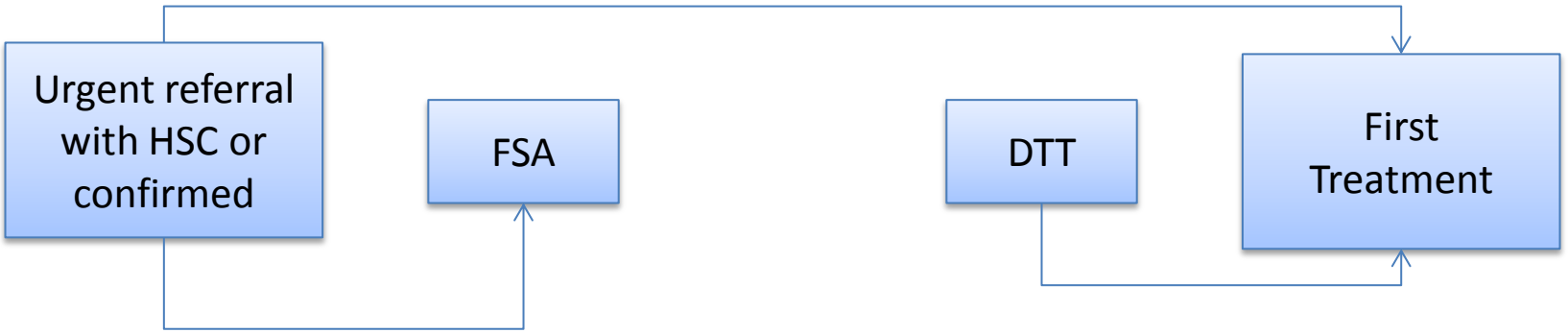
MOH Expectations

The **"Faster Cancer Treatment"** programme aims to improve the quality and timeliness of services for cancer patients across NZ

Indicator 1:
85% patients with high suspicion of cancer (HSC) treated within 62 days



Indicator 2:
85% patients with HSC seen by a specialist within 14 days

Indicator 3:
85% patients with a confirmed cancer (CC) treated within 31 days

What was the Problem

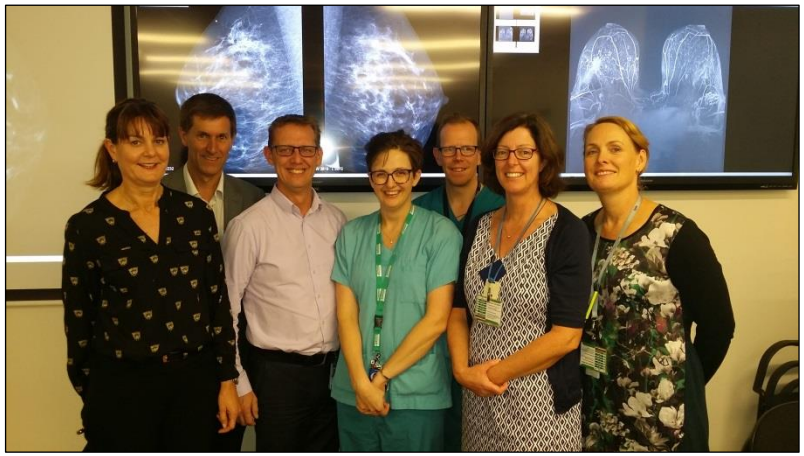
Between Jan 14 and July 15, patients referred to ADHB with high suspicion of breast cancer waited too long to see a specialist and too long to receive definitive treatment

Impact

- Patient fear & anxiety
- Family stresses
- Staff pressure – No targets set
- Poorer health outcomes

Delays in treatment contribute to poorer patient outcomes and increased stress on women, their family and staff *(JAMA Oncol. 2016;2(3):330-339. doi:10.1001/jamaoncol.2015.4508).*

Engaging the winning team with a commitment and a promise



- Ms. Eletha Taylor
- Mr. Mike Puttick
- Paula Whitlock
- Dr. Jeremy Whitfield
- Dr. Robyn Oldfield
- Gabby Ikitau
- Paul Birch

"If we do what is right by our patients and stay focussed on that, then the target will take care of itself".

Primary Goals

- **Develop an improved clinical pathway**

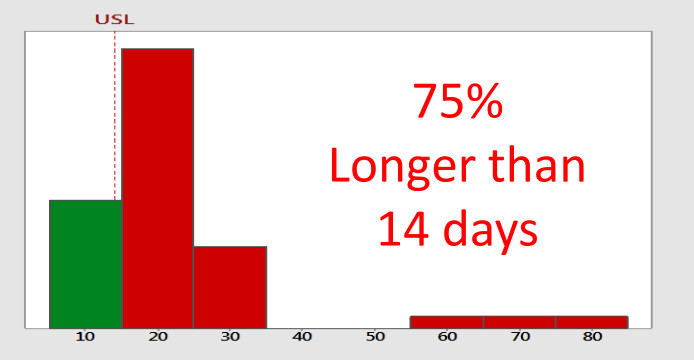
  that is faster, more efficient and better for patients with breast cancer or a high suspicion of breast cancer, while maintaining excellent and safe quality of care

- **Achieve (or smash) the Ministry target *as a by-product of our promise to focus on the patient***

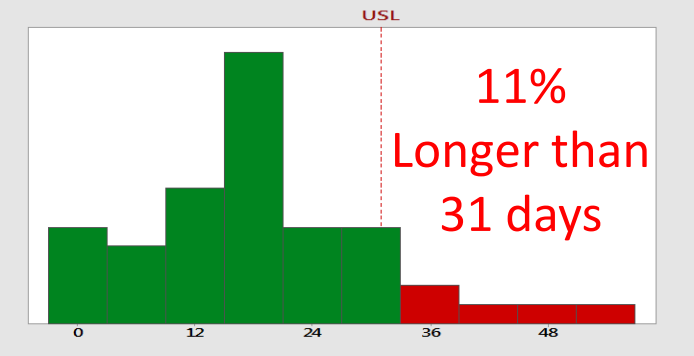
  85% treated on time, by 1 July 2016

Initial manual audit against Indicators

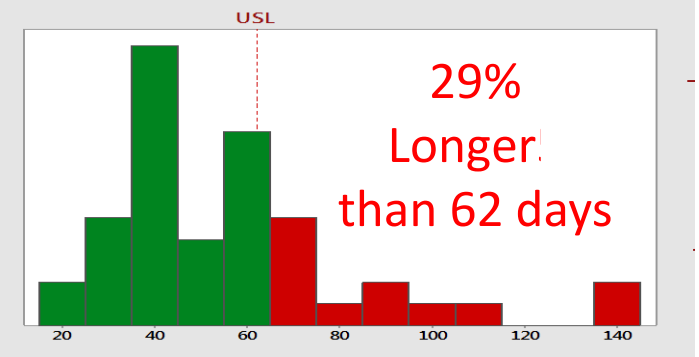
Indicator 2
14 Days



Indicator 3
31 Days



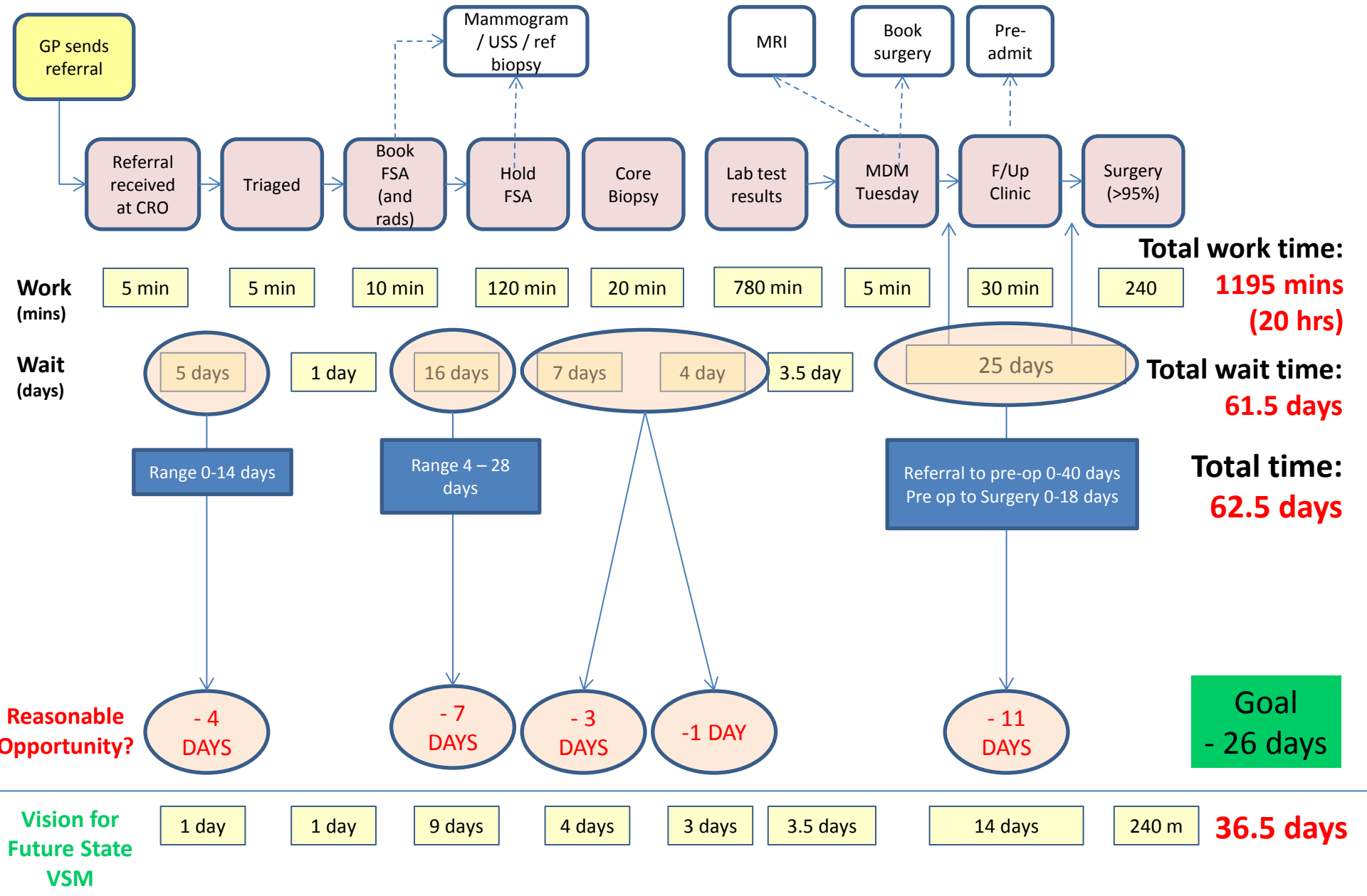
Indicator 1
62 Days



Audit

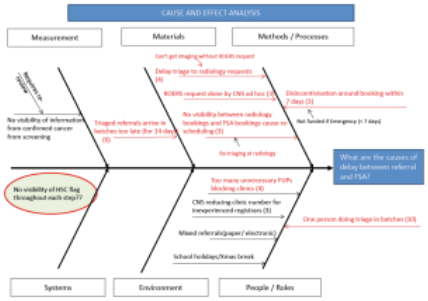
- 49 patients (randomly selected)
- Electronic record trail
- Validated with clinical lead
- Used to build detailed value stream map

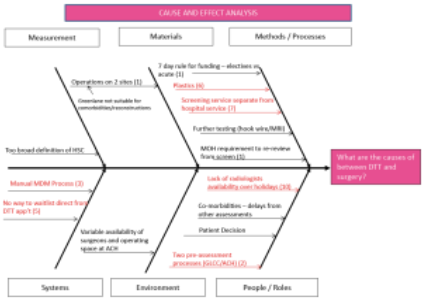
Creating Belief (VSM)

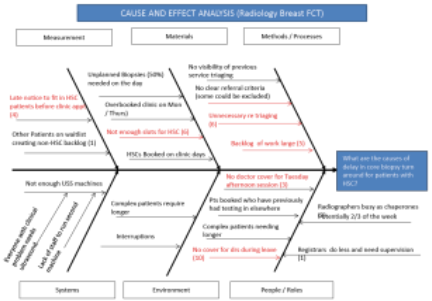


Discovering the root causes of delay

Ishakawa diagrams were used to collect subject matter expert's knowledge







Root Causes
Multiple sequential patient visits / appointments too far out
Not enough clinic slots available in surgery or radiology & a backlog
Only one person triaging and in batches – No leave cover
Mixture of paper, email and electronic referrals and triaging
Too many unnecessary follow-up appointments in clinics
Unable to always get radiology before FSA with surgeon
No cover plan for radiologists on leave
Unnecessary re-triaging in radiology
No visibility of high suspicion of cancer in radiology after referral

A series of Cause and Effect Workshops

Cause of delay between:

- Referral and FSA
- Referral to radiology and DTT
- DTT and Treatment

Solutions

- New Triage Protocol:
  - Convert all paper referrals to e-triage
  - Process referrals within 12 hours
  - Daily surgical triage roster (NEW 1 business day rule)
  - Stop unnecessary re-triaging within the pathway (3 hours saved per week to be reused to create slots for radiology)
  - Call patient to confirm app't. Don't send letter with one contact not two

Embed everything within a Standard Operating Procedure

- One-Stop-Clinic & New Clinic Template:
  - One appointment in one location at one time for patient
  - Design new clinic scheduling template with a single booking process
  - Ring-fenced appointments (surgery & radiology) so always have enough appointments
  - Re-design pathway and flow with time frames and make visible as new standard

Solutions Continued….

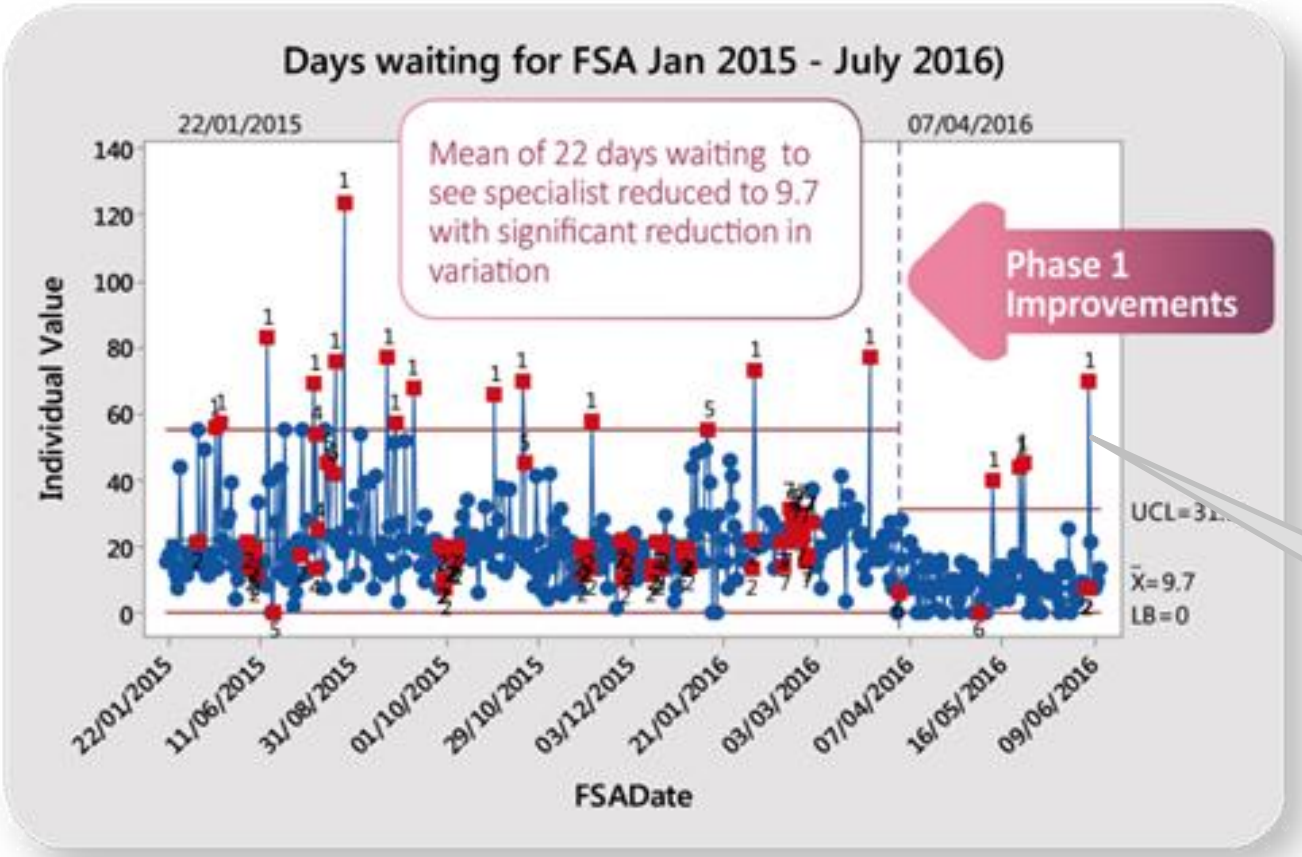
- CNS led virtual follow-up (2-10 yrs.)
  - Semi-automated follow up that bring patients in only on a concerning radiology finding (most recurrents are found in between these app'ts)
  - Free up unnecessary SMO work

- Radiology changes
  - Ring fenced appointments (as above)
  - Removal of re-triaging of all previously triaged patients (non-cancer also = 3 hrs per week)
  - Used to clear back log to ensure new process successful

- Scrum Room changes
  - Changes to Production Planning Templates that reflect visibility of FCT Target

Is it working?

Referral to FSA (Now a one-stop-clinic)

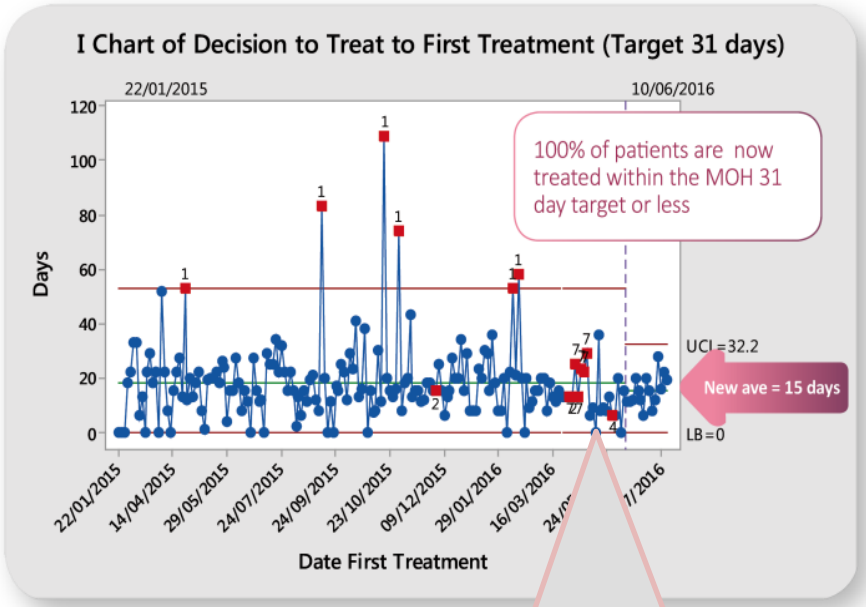


Referral to FSA went from 78% waiting longer than 14 days to 12%

Breaches due to triaging roster process / patient choice

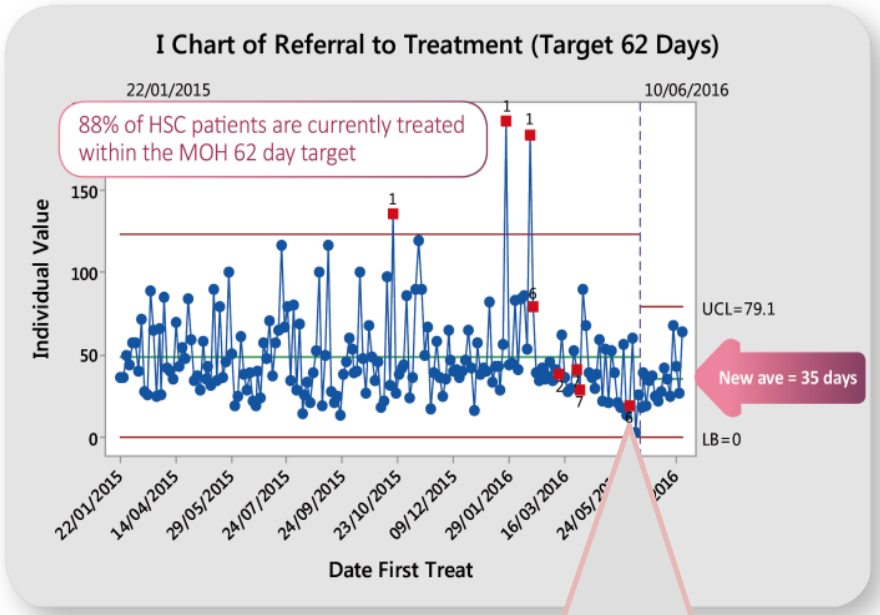
Is it working?

Patients with Confirmed Breast Cancer



Improved from 89% to 100% treated within 31 days

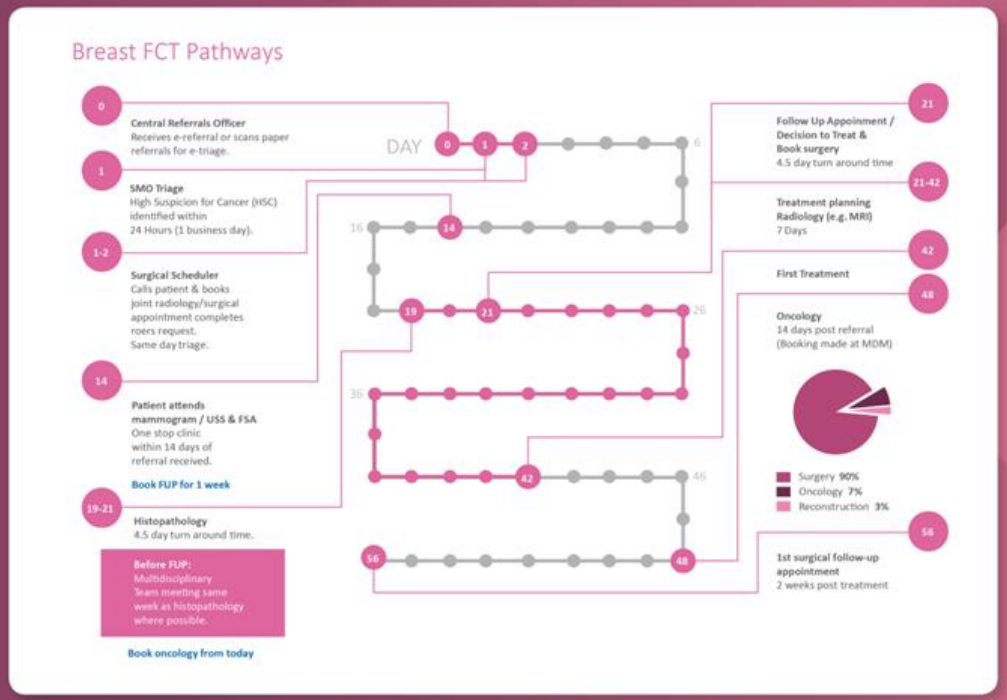
Patients referred with High Suspicion of Breast Cancer



Improved from 71% to 90% treated within 62 days

Sustaining improvements and embedding the new culture

Auckland DHB's improved pathway for treating patients with breast cancer

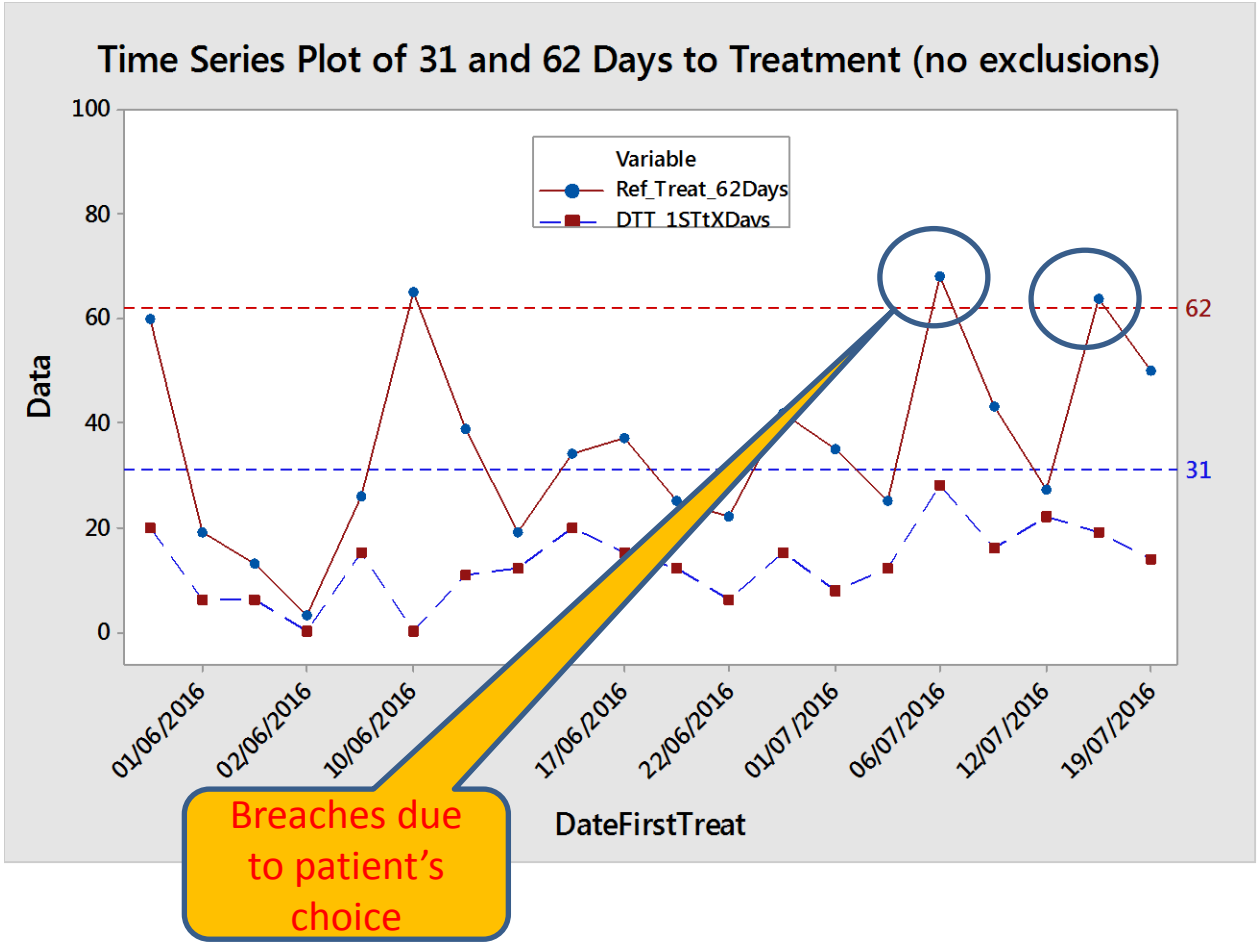


New Breast Cancer Pathway for Service

The breast cancer team believe that given new processes it is feasible to get to first treatment in under **50 days** for each patient

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Examples of visibility of performance at weekly team meetings

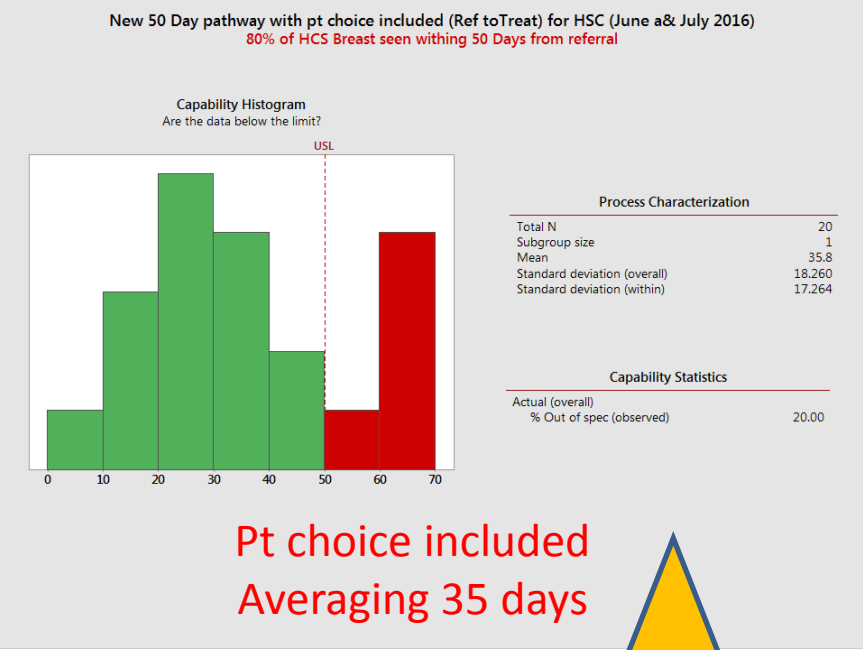


Keys to sustainability

- Strong clinical lead
- Trustworthy reporting
- Clear accountability
- Clear decision making principles
- Service managed SOPs
- Prospective tracking
- Mini MOS principles

Exciting new beginning

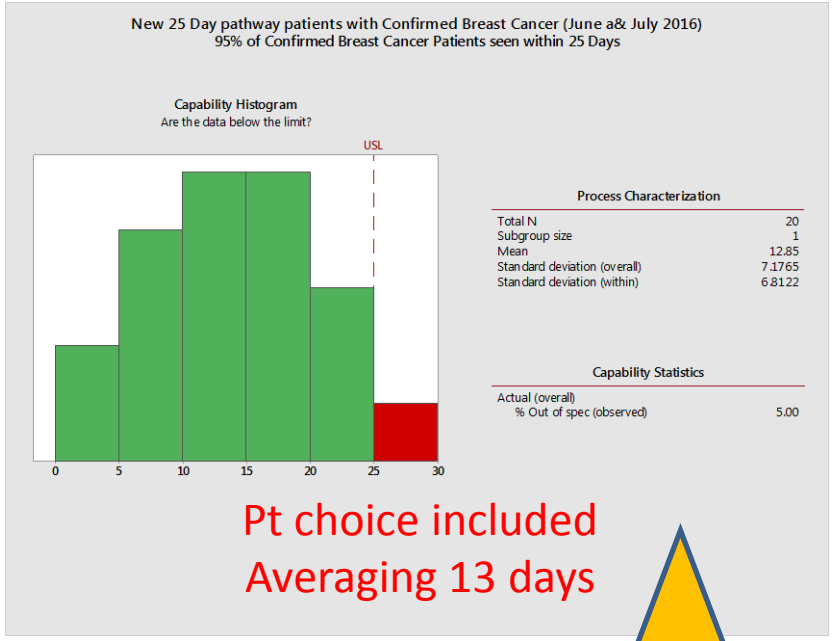
Improvements against New (50 Day) Pathway for HSC



Pt choice included
Averaging 35 days

80% HSC Patients Treated in 50 days

New (25 Day) Pathway for Confirmed Cancer



Pt choice included
Averaging 13 days

95% CC Patients Treated in 25 days

What Next?

- Apply a mini-MOS approach to continually see improvement
- Consider booking CC straight to surgery triage (inform patients up front)
- Review MDM processes
- Embed improvement into culture

Lessons Learned

- Keep the patient front and centre – targets are secondary
- Clinical leadership / ownership is critical to success and sustainability
- Communicate, communicate, communicate (the vision, the process and the results)
- Make data your friend - use it, correct it when it's wrong but don't get stuck if it's imperfect
- Celebrate (APAC / HCE etc.)