

Midland Cancer Network

**Review of Lung and Bowel Cancer
Elective Pathways**

July 2010

REPORT NOT FOR CIRCULATION

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Executive Summary

For the 2009/2010 year, the Midland Cancer Network (MCN) agreed to focus efforts on lung and bowel cancer - the two most commonly diagnosed cancers in NZ. The MCN has established regional lung and bowel cancer work groups that link back to local districts and into the national cancer control governance structure.

As a component of this work, the MCN secured funding to look at opportunities to improve equity of access, and where possible, reduce the wait times for the “elective” events in the lung and bowel cancer pathways. This exercise had two key elements. Firstly, a series of meetings was held with relevant staff at the three MCN DHBs to explore current practices and their views on the reasons for delays in the ‘patient journey’. Secondly, a range of data was collected from the DHBs on the patients waiting pre-diagnosis and for those diagnosed with either of the cancers over a three month period, the time between each step in their diagnosis and treatment.

It was found that across the MCN region, practices and processes vary. These variations exist: between DHBs; between departments in the same DHB (treating the same condition) and; in one instance within the department. As a consequence, patient wait times varied for both assessment (FSA) and specialty-based diagnostics (bronchoscopy and colonoscopy). This situation presents a medico-legal risk for each DHB. It would be prudent for each DHB to address the specific recommendations arising from their particular circumstances.

Overall, the greatest gains could be achieved by the standardisation of processes and practices within and across the DHBs, including:

- The development and introduction of agreed referral protocols for GPs (including e-referral);
- Access to radiology for primary care;
- Secondary based activities such as triaging and prioritisation (for both FSAs and specialty based diagnostics);
- The pooling of referrals for FSAs and specialty based diagnostics;
- The development of pre FSA “straight to test” criteria and guidelines;
- Improved wait list management.

These steps would minimise the variation in wait times for patients presenting with the same symptoms and; reduce the overall wait times. DHBs should move to jointly develop standardised processes and practices as soon as possible.

For those diagnosed with cancer, there are delays in accessing further necessary investigations (e.g. CT scans) and sometimes treatment, due to resource constraints in the relevant departments. It is evident that radiology is a key component and greater involvement and ownership by, and resourcing of, those departments would allow more timely access for cancer patients.

The number of patients being diagnosed during an acute admission (i.e. not having come through an ‘elective’ pathway of FSA, diagnostics etc) is cause for concern. All possible initiatives within primary care to reduce the volume of “late presenters” should be supported.

The ongoing work of the MCN would be enhanced by the development of a regional infrastructure to support multidisciplinary team meetings and establishing a regional information system to manage patient care along the continuum.

REPORT NOT FOR CIRCULATION

Introduction

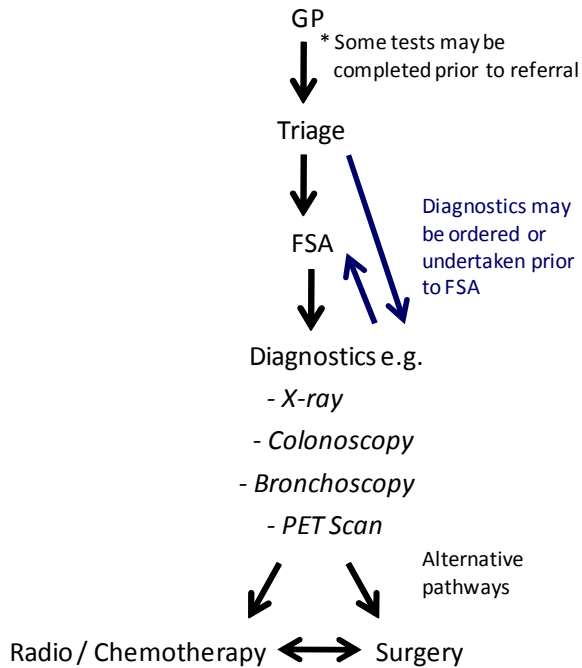
The Midland Cancer Network (MCN) is an association of all groups involved in the care of patients with suspected or diagnosed cancer. It covers Waikato, Bay of Plenty and Lakes DHBs, including primary care and non-government organisations and hospital services. Co-ordination and liaison between all the relevant parties is important to ensure the patient has both the most efficient and supportive care through their diagnosis and treatment.

Along with the other regional networks, the MCN agreed to focus efforts in the 2009/10 year on the two most commonly diagnosed cancers in NZ - lung and bowel cancer.

The Midland Cancer Network has established regional lung and bowel cancer work groups with the purpose of leading service improvement for the respective tumours. These regional work groups link back to local districts as well as into the national governance structure through New Zealand lung and bowel cancer work groups. Both of these national groups are in the very early stages of development. One of the objectives of the network is to increase regional consistency.

Because there are a number of components to the diagnostic and treatment pathway for these cancers, patients 'wait' at each point for the next step to occur. Clearly, the goal is to minimise the waiting time and ensure the patient moves as efficiently as possible through the steps. Equally important is that all patients (in similar clinical circumstances) have the same speed of access. In this regard, the MCN has received funding to look at opportunities to improve equity of access, and where possible, reduce the wait times for the 'elective' events in the lung and bowel cancer pathways.

The elective patient pathway was identified as:



Note: Depending on the patient's condition, they may be referred to palliative care at any point in the pathway.

Given the ongoing work of the Midland Cancer Network, some of the practices described in this report may already be in the process of change.

It should also be noted that "average" waiting times will always be affected by outliers who require additional diagnostics etc.

Process

There were two key elements to the review process.

Firstly, a series of meetings was held with relevant staff at the three MCN DHBs. Those interviewed included:

Re:lung: respiratory physicians, radiologists, cardiothoracic surgeons, medical and radiation oncologists.

Re:bowel: gastroenterologists, general surgeons, radiologists, medical and radiation oncologists.

At these meetings, the pathway, timeframes and blocks/delays were discussed and a number of key questions were asked. These included:

- are patients referred to different specialties with the same symptoms e.g general medicine and respiratory, general surgery and gastroenterology?
- is there a consistent process for triaging of patients where this occurs?
- are there different wait times depending on referral specialty?
- where wait times are long (either for assessment and/or diagnostics) what are the barriers to reducing the wait times?
- specific to colonoscopy, what resources are applied to this service? Also, similar questions as above about wait times, consistent triaging, etc
- once a diagnosis (of either lung or bowel cancer) is made, what is the wait time to treatment (be that surgery, RT or chemo)?
- where that treatment is delivered by another DHB, are there issues in the referral/assessment process?

Secondly, a range of data was collected from the DHBs on the patients waiting pre diagnosis and, for patients diagnosed with either lung or bowel cancer between 1 October and 31 December 2009, the time between each step in their diagnosis and treatment.

It should be noted that the wait times referred to by the interviewees were based on their perception/knowledge. Where these timeframes differ from that shown by the data analysis, these differences have been noted. However, due to small sample sizes, no conclusions are drawn as to which 'view' is more accurate.

The scope of the work did not include a review of the role or operation of the palliative care service within the care continuum.

Findings

General Observations

Across the MCN region practices and processes vary. These variations exist: between DHBs; between departments in the same DHB (treating the same condition) and; in one instance, within the department. An overview of the situation is outlined in the tables at the beginning of the sections on each cancer type.

Elective Pathway for Lung Cancer – All DHBs

	Waikato	Bay of Plenty	Lakes
Department has agreed triage process for FSA?	Yes	No	Yes
Department has pooled FSA list?	Yes	No	Yes
Is a bronchoscopy undertaken without an FSA?	No	Yes	Yes
Is there primary care access to CT?	No	Yes	Yes
Department has pooled bronchoscopy list?	Yes	No	No ⁽¹⁾
Is there intra-district variability in access to diagnostics?	Yes	Yes	No
All lung cancers are referred to the Chest Conference?	Yes	No	Yes

⁽¹⁾ Urgent cases go on the next available list

Elective Pathway for Lung Cancer – DHB Specific Comments and Recommendations

Waikato DHB

The perception is that respiratory physicians become involved with cases of lung cancer later than is desirable. One of the reasons behind late GP referral is their difficulty in obtaining timely access to a publicly funded chest x-ray.

All requests for FSA come to one respiratory physician. Referrals for suspected lung cancer may be accompanied by a phone call from the GP. FSA requests are triaged within one day (of receipt in the department) and those classified as Urgent can be seen

within a week to ten days. The department operates a pooled list system for FSAs. Relevant blood tests are ordered at the time the FSA is arranged and lung function testing occurs at the same time as the FSA.

A decision as to whether or not to undertake further investigations is based on clinical acumen. Because of ethical and perceived medico-legal reasons, patients are not directly placed on a bronchoscopy list before an FSA. The department's view is that, ideally, the patient should receive a CT prior to a bronchoscopy, but because of the difficulty in obtaining timely CTs, bronchoscopy may be undertaken first. This can generally be provided within one week of the FSA. Each respiratory physician has their own bronchoscopy list, but pooling does occur as required. The department has three bronchoscopy lists per week.

A CT scan is requested at the time a bronchoscopy is arranged and improvements within the radiology department means it can usually be provided within 2-3 weeks, but on occasions it can take up to 6 weeks (historically the patient could have waited 2-3 months). At the time of the review the respiratory department understood that CT equipment is available for additional scans, but this is not fully resourced. Parallel to this review has been a quality improvement initiative utilising Lean Thinking methodology to improve access and waiting times to CT and CT FNA. In addition Waikato is in the planning stages of a full radiology review.

There are also major delays in obtaining FNAs through radiology. Thames patients are able to obtain a more timely CT locally. There is currently no bronchoscopy service there, but it is intended to set one up in the near future.

All patients diagnosed with lung cancer are presented at the weekly Chest Conference. But depending on the nature of the cancer, some may have already have been referred on to oncology prior to presentation. The Chest Conference is managed by the lung cancer clinical nurse specialists. They become involved as early as the time of the FSA if the diagnosis is clear. There is a need for videoconferencing facilities. In the past there has been teleconferencing ability but this was inadequate. However, it may be useful to reinstate this facility while clinical multidisciplinary meeting videoconferencing is developed. The capacity of the Chest Conference also needs to be considered as the number of patients being presented increases.

The Midland Cancer Network PET-CT initiative has involved working with stakeholders to improve and standardise the PET-CT systems and processes. In the past PET requests were considered at Chest Conference. Approved requests were "signed off" by the oncology department. There are now agreed guidelines for the type of patient who should be referred for a PET scan and if it is clear the patient meets these guidelines a PET can be obtained prior to the Chest Conference.

Waiting times post diagnosis to surgery, radiation and medical oncology (for other than small cell carcinoma) are variable. Access to palliative care is perceived as good.

Recommendations

It is recommended that Waikato DHB:

1. Reviews radiology department resources available for requests from primary care for Chest X-rays in order to reduce wait times.

2. Reviews radiology department resources available for requests from hospital specialist for CT scans and other diagnostics to ensure timely access.
3. Urgently considers a regional upgrade and development of telemedicine facilities and equipment for the Chest Conference and for other cancer multidisciplinary team meetings.

Lakes DHB

General

As a result of the “patient and service mapping of the lung cancer pathway” exercise in 2009, improvements have been made to the management of patients with suspected lung cancer.

Pathway

If a GP suspects the possibility of lung cancer and contacts radiology directly, a chest X-ray can be arranged that same day. Written requests marked urgent take between 2-3 weeks and routine requests up to 10 weeks.

GP referrals to secondary care can be either made directly to the respiratory physicians or to General Medicine. If to the latter, triage of the referral leads to it being passed over to Respiratory Medicine. Similarly Taupo patients are referred directly to the respiratory service rather than first being seen by general physicians at Taupo Hospital.

The two respiratory physicians follow a common triage process. Suspected lung cancer referrals are separated out, categorised as Urgent and generally seen within two weeks. In some instances diagnostics (e.g. CT) are ordered at the time the FSA appointment is given. Since waiting time for a CT can be up to 10 days, the FSA may take place before this diagnostic test has been completed.

A bronchoscopy for tissue diagnosis can be undertaken within a week of deciding that this investigation is required. If a percutaneous biopsy is required, this is usually available within 3 weeks.

Once a lung cancer diagnosis has been made, all cases are referred to the Chest Conference at Waikato Hospital. These are held weekly. Regarding PET scans, if it is clear that a patient will receive “aggressive” therapy, a PET scan will be arranged prior to the Chest Conference. In other situations, Lakes DHB’s policy is that any decision as to whether or not a PET scan is required is made at the Chest Conference.

Lakes DHB’s experience is that if the Chest Conference decides that surgery would be beneficial, then the Cardiothoracic surgeon will arrange an FSA before scheduling the patient for the operation. On occasions, when the Waikato service has declined a patient, the Lakes physicians have sought an opinion from the Auckland cardiothoracic service. Post surgery follow-up care is provided locally at Rotorua by the respiratory physicians.

Any patients referred to the Waikato Oncology service are seen and commence treatment within acceptable timeframes. Where the physician is of the view that this treatment is likely, then they may refer to Oncology at the same time as to the Chest

Conference (Waikato Oncology advised that this practice did not really speed up the process).

There are a few more points worth noting about the Lakes service:

- Efficiency has improved with the appointment of two cancer nurse co-ordinators;
- In an attempt to speed the process up, chest X-ray and CT were scheduled for the same day. The majority of patients indicated that they would prefer to have a few days “space” between these investigations so they can come to terms with the likelihood of the diagnosis before it is confirmed;
- A detailed clinical audit of about 60 Lakes patients is currently underway – as part of a larger externally funded study¹;
- The Midland Cancer Network and Rotorua have an initiative underway to develop a local media campaign², to be launched in a few months time. The goal is to encourage patients with symptoms suggestive of lung cancer to visit their GP earlier. This should increase the number of Lakes DHB lung cancer patients presenting with earlier stage disease, thus improving the overall survival rate. It is anticipated that this will lead to an increased number of chest x-ray requests and possibly an increased number of ‘suspected lung cancer’ referrals to respiratory services. The service considers that at present they are just coping with the current referral volume and any increase would require additional resource;
- Lakes’ experience is that very few patients DNA for their FSA, but post FSA and diagnosis, a number will DNA subsequent appointments.

Recommendations

It is recommended that Lakes DHB:

1. Monitors the referral rate – with additional resources (including SMO time) made available if indicated, to ensure that the current efficient process can be maintained.

Bay of Plenty DHB

Most referrals from general practice are made directly to the respiratory service and are accompanied by a Chest X-ray report. There is no agreed rostering for the triaging of referral letters and each physician triages independently. Thereafter, there is no standard process that is followed for patients with suspected lung cancer.

If the referral information from the GP strongly suggests the likelihood of lung cancer, two of the physicians will schedule a patient directly for a bronchoscopy. The third physician undertakes an FSA with the patient before putting them on the bronchoscopy waiting list. Inevitably this process takes longer.

While it is considered that the majority of patients with respiratory symptoms are referred directly to Respiratory Medicine, there is no clear process for the transfer from General Medicine of any such patient referrals.

¹ Funded by the Health Research Council

² The Midland Cancer Network “Early Detection of Lung cancer Initiative”

DNAs are more common among Māori patients and tend to be at the FSA stage.

Following bronchoscopy, the patient may wait up to four weeks for a straight CT (for staging) and a similar time period for a diagnostic CT (CT plus FNA). Therefore, if both are required, the process may not be completed for up to two months.

If a GP is advised that the chest X-ray they ordered indicates lung cancer, they can request a CT scan. Such requests are triaged by a hospital radiologist. It is the view of Dr Graham that a patient with a positive chest X-ray should first have a bronchoscopy.

Currently the Tauranga radiology service considers it is overwhelmed with CT requests (hospital generated and primary referred). This situation has been compounded by the increased medical oncology service now being provided on-site.

Whakatane patients have their bronchoscopy at Tauranga, but subsequent radiological investigations are done at Whakatane. Waiting times for CT are shorter at Whakatane. This creates an intra-district inequity of access (Western versus Eastern Bay).

Post diagnosis, patients for whom it is believed surgery may be indicated are referred to the Chest Conference. (Post surgery follow-up care is provided locally at Tauranga by the respiratory physicians). Some of the remaining patients may be referred directly to Oncology and/or Palliative Care. There is no standard approach among the three physicians as to which patients are referred to Chest Conference.

Not all of the physicians attend Chest Conference and none attend routinely. Historically telemedicine facilities were available and this was considered valuable.

The Bay of Plenty Oncology department manages the budget for PET scans. The department accepts any such recommendation from Chest Conference, but will also consider direct requests from the respiratory physicians.

The cancer care co-ordinator endeavours to increase the efficiency of the process e.g. by directly receiving Chest Conference outcomes, she is able to expedite recommendations.

Recommendations

It is recommended that Bay of Plenty DHB:

1. Institutes a formal rostering process for the triaging of GP referrals.
2. Audits the current triage process to determine if a consistent approach exists for the categorisation of suspected lung cancers.
3. Develops a standard process for the transfer to Respiratory Medicine of patients referred to General Medicine with respiratory symptoms.
4. Develops an agreed standard approach from referral to bronchoscopy.
5. Agrees the criteria for referral to Chest Conference.
6. Assesses whether the current CT resource is appropriate (at both Tauranga and Whakatane).

Elective Pathway for Bowel Cancer – All DHBs

	Waikato		Bay of Plenty		Lakes	
	Gastro	Gen Surg	Gastro	Gen Surg	Gastro	Gen Surg
Joint triaging of FSA requests?	No		Yes		No	
Same criteria used for triaging of referrals?	No		Yes		No	
Criteria used for deciding access to colonoscopy?	Clinical acumen	Local scoring tool ⁽¹⁾	National guidelines (with local variation)		Clinical acumen	Local scoring tool
Pooled colonoscopy list?	No	Yes	Yes		Yes	Yes
Colonoscopy offered without FSA?	No ⁽²⁾	Yes	Yes		Yes	No
Surveillance guidelines able to be met?	Yes	Yes	Only by returning lower priority symptomatic patients		No	No

(1) Tool not yet validated (but “approved” for use by MoH)

(2) Except where referral has come from General Medicine

Elective Pathway for Bowel Cancer – DHB Specific Comments and Recommendations

Waikato DHB

General

General practitioners decide whether to refer to Gastroenterology or General Surgery. There is no joint triaging of referrals suggestive of bowel cancer.

Gastroenterology

GP requests for an FSA are routed to the department through the referral centre. This can take up to seven days. The service has defined a minimum data set (including investigation results) that should be contained within the referral letter. The department SMOs triage referrals on a rotation basis. Clinical acumen is used to accord priority. Approximately 40% of all referrals are returned to the GP. To date, there has been no auditing of the prioritisation process used. Referrals classified as Category 1 (suspected bowel cancer) are generally seen within 2-4 weeks.

At the time of FSA, clinical acumen is used to determine which patients should be offered a colonoscopy. Urgent/semi-urgent colonoscopies are delivered within about 3 weeks. While there is currently no pooling of colonoscopy lists, waiting times for each SMO are broadly similar. On occasions in the past, the department has delivered colonoscopy services for patients from General Surgery lists.

The department believes that the use of a nurse for triaging may reduce the time from GP referral to colonoscopy by up to five weeks. This individual could identify referrals containing symptoms suggesting colorectal cancer, see patients in a more timely manner than the current FSA outpatient process, facilitate an early colonoscopy appointment, provide an assessment on appropriate bowel preparation and identify medical conditions/therapies that may impact on colonoscopy (e.g. anticoagulation, insulin). They could also provide a transition to the Colorectal Specialist nurse should a malignant lesion be identified. Finally they would be in a position to audit and improve the patient journey from referral to diagnosis.

The Gastroenterologists consider that colonoscopy is the “gold standard” diagnostic test and do not order barium enemas. CT colonography is rarely used and restricted to patients with a medical history that contraindicates use of colonoscopy or those patients in whom colonoscopy is technically impossible.

Sometimes referrals are received from General Medicine and these patients may be placed directly on a colonoscopy list (without an FSA). However, routine direct access colonoscopy is not regarded as acceptable due to safety concerns.

If a bowel cancer is diagnosed, referral is made to a colorectal surgeon and the patient is usually seen in an outpatient clinic within four weeks, having had a CT within about 10 days of the colonoscopy. Following the surgical FSA, surgery generally occurs within 2-4 months.

The department would like to see the hospital work towards a situation where all referrals of possible bowel cancer (i.e. patients requiring colonoscopy) are triaged at one common point.

Currently, the Gastroenterologists have the capacity that enables them to screen patients of a lower priority in the familial group recommended for surveillance. They also meet the national guidelines for follow-up surveillance post polyp removal.

The department believes that additional colonoscopy lists could be provided by utilising the facilities at Thames Hospital. Greater access to Gastroenterology assessments (and colonoscopies) was ranked number one, in a Waikato Hospital survey of perceived ‘unmet need’ by GPs completed in 2008.

General Surgery

All FSA requests to General Surgery are triaged by one consultant (who does not specialise in colorectal surgery). If the referral is deemed Urgent, the aim is to see the patient within approx two weeks. Otherwise, the average waiting time for an FSA is around four months. All the consultants in the department see patients with suspected bowel cancer and may refer to the pooled colonoscopy list. If a GP contacts a colorectal surgeon directly with what appears to be an obvious cancer, the patient may be accepted without going through any other triage process. Some of these (as well as some of those patients referred for an FSA) may be placed directly onto the colonoscopy waiting list. Such cases have their bowel prep arranged by staff in the Medical Day Stay unit.

Colonoscopies are carried out by five general surgeons. There are seven half day endoscopy lists a week. The colorectal surgeons have developed a scoring tool to

determine priority for colonoscopy. Most of the surgeons use this tool. To date, it has not been validated. Access to colonoscopy is determined by both priority and by waiting time (i.e. a low scoring patient has their priority increased the longer they wait). The average waiting time from FSA to colonoscopy is approx forty days, with a wide range.

Post diagnosis, any of the general surgeons will perform surgery for colon cancer, but all rectal cancers are operated on by the colorectal surgeons. The colorectal surgeons share patients across their lists as necessary – the other general surgeons have their own lists. Because only the two colorectal surgeons perform surgery for rectal cancer, sometimes non-rectal cancer patients may be transferred from their lists to other general surgeons who have shorter waiting times. This process is managed by the colorectal nurse specialist. The department has a board on which the name of every patient with bowel cancer is placed. Patients are generally operated on in chronological order, but a number of factors can alter the priority (e.g. a phone call from the GP advising of a change in the patient's condition).

The colorectal surgeons receive referrals from all Midland DHBs of patients with complex colorectal cancer. These patients, together with local complex patients, are discussed at a weekly multi-disciplinary meeting.

Post colonoscopy referrals from a gastroenterologist may be seen immediately if the surgeon is available while the patient is still in the endoscopy suite. At that time, a staging CT is arranged and the patient is placed on the surgical waiting list. Otherwise such referrals are given an urgent FSA.

Access to the Oncology service for patients with rectal cancer is considered good. However, waiting times for bowel cancer patients can vary.

Currently General Surgery meets the guidelines for both post operative and familial surveillance colonoscopies. Where the diagnosis has been made by a gastroenterologist, it is the surgeon who undertakes follow-up post operatively.

The view was expressed that the surgeons would be open to the gastroenterologists taking patients from the surgical colonoscopy list. In the opinion of the surgeons, the gastroenterologists have a higher threshold for who should be seen and who should have a colonoscopy.

Regarding improvements to the service, the following suggestions were made:

- Better education of GPs so that they become more honest, accurate and complete with their referrals. To assist this, the department is working on a standard referral form.
- Establish a database that would assist validation of the scoring system.
- Decant patient follow-ups to GPs, thus enabling additional FSAs to be seen.

Recommendations

It is recommended that Waikato DHB:

1. Requests that the Gastroenterology and General Surgery departments agree a minimum data set that should be contained within the GP referral letter.

2. Establishes a process within General Surgery whereby FSA referrals suggestive of bowel cancer are prioritised by a colorectal surgeon.
3. Requests that the Gastroenterology and General Surgery departments audit their respective triage process used for both referrals for FSA and access to colonoscopy.
4. Establishes a process whereby all patients being considered for a colonoscopy (for suspected bowel cancer) are triaged at a common point.
5. Requests that the relevant departments agree a common prioritisation tool for access to colonoscopy (with recommended timeframes) and pool waiting lists.
6. Considers the appointment of a colonoscopy nurse specialist to enable timely, appropriate access to colonoscopy and reduce inpatient admissions related to bowel preparation.
7. Assesses the need for additional colonoscopy lists and the options to deliver these, without adversely impacting key quality indicators.
8. Establishes a process for transfer the follow-up care of suitable bowel cancer patients to GPs.

Lakes DHB

General

General practitioners decide whether to refer to Gastroenterology or General Surgery. There is no joint triaging of referrals suggestive of bowel cancer.

Gastroenterology

Referrals that may suggest bowel cancer are categorised as Urgent (Cat 1) and are generally seen within two to four weeks. In some instances patients are placed directly onto the endoscopy list prior to the FSA. The clinicians use clinical acumen to determine priority for both FSA and colonoscopy i.e. they do not use the national prioritisation tools or any local variation of them. The gastroenterologists pool their endoscopy lists. Urgent colonoscopies are done within 2 weeks, while Routines are generally done within two months.

CT colonography is used in a minority of cases e.g. if it is not possible to complete a colonoscopy.

If a cancer is detected, the patient usually sees the surgeon within 2 weeks.

The gastroenterologists attempt to follow the national guidelines re both familial screening and surveillance, but they are struggling to meet the recommended timeframes. Expansion of the endoscopy service is limited by Lakes DHB only having a single endoscopy room that is running at capacity of nine half day lists per week.

General Surgery

The General Surgeons categorise suspected bowel cancer referrals with major alarm symptoms / signs / investigations as Urgent (Cat 1). However, such patients only make up a small proportion of new referrals. Patients with less clear symptoms and/or signs can be categorised as Semi-urgent (Cat 2) and the FSA wait time for these patients is between four and six months.

The General Surgeons do not undertake colonoscopies prior to an FSA. They consider that the possible complications from bowel prep require the patient to be seen and consent gained.

The department has developed a scoring system for colonoscopy based on the presenting symptoms and/or signs. The scheduler uses the score generated to determine priority for colonoscopy access.

Depending on anaesthetic availability, endoscopy lists may be cancelled in favour of a theatre list. The use of CT colonography is similar to that of the Gastroenterologists. Because of the longer waiting times in General Surgery, periodically some high priority surgical patients are scoped by the Gastroenterologists. The overall average wait time from GP referral to colonoscopy is reported as 168 days.

If a cancer is detected, access to further diagnostics, surgery (done at Lakes) or Waikato oncology is achieved within a short timeframe.

The department is currently unable to meet the recommended guidelines for familial and post surgical surveillance colonoscopy. In some instances patients wait more than a year beyond the recommended timeframe.

Recommendations

It is recommended that Lakes DHB:

1. Considers the development of a joint triaging system (with recommended timeframes) for bowel cancer referrals and pool those patients between the two departments.
2. Establishes a process whereby all patients being considered for a colonoscopy (for suspected bowel cancer) are triaged at a common point.
3. Agrees a common prioritisation tool for access to colonoscopy (with recommended timeframes) and pool waiting lists.
4. Reviews the current impediments to accepting patients directly onto an endoscopy list. In this regard, the use of a Clinical Nurse Specialist, together with the provision of written information, may be sufficient to overcome the perceived medico-legal risk.
5. Assesses the increased resource required to meet the recommended timeframes for FSA, colonoscopy and surveillance screening.

Bay of Plenty DHB

General

General practitioners decide whether to refer to Gastroenterology or General Surgery. However, the two departments operate a common triage process for access to colonoscopy in suspected cases of bowel cancer.

Gastroenterology / General Surgery

Three Gastroenterologists together with one General Surgeon, meet weekly to prioritise GP referral letters and to decide which patients will be offered a colonoscopy.. The group

use the national guidelines with some local variations as the basis for triage. Grade 1 receive a colonoscopy within two weeks, Grade 2A generally within 5 months and Grade 2Bs are sent back to the GP (the national guidelines recommend that these patients should be seen).

Patients are placed on a common waiting list. In situations where the patient's colonoscopy will occur without an FSA, the patient receives literature and is contacted by a nurse about the bowel prep process.

If colonoscopy 'fails', CT colonography is requested. Note: GPs may refer directly for CT colonography. Because of resource constraints, such GP referrals are now combined with referrals for Barium enema as "Colon Imaging" referrals. The radiologist then decides which diagnostic to undertake. Some of these GP requests for "Colon Imaging" are for patients whose referral to either gastroenterology or general surgery has been declined. Obviously this just shifts the demand from one hospital department to another. The radiology department has the capacity to undertake more work, but there is no funding for extra sessions.

Where a bowel cancer is diagnosed by the Gastroenterologist, the patient is referred for a surgical FSA (triaged as Category 1 and seen within one to two weeks). In clear cut cases, the patient may be placed on the surgical waiting list at the same time as the FSA is arranged. A patient referred (by the GP) to the surgery department with a definite cancer diagnosis is given an urgent FSA appointment and is not considered at the colonoscopy triage meeting.

Patients referred to radiology for either a CT or MRI wait between 3-4 weeks.

There is a weekly MDT meeting (G/E, Surgery and Radiology +/- Oncology) at which patients' diagnostic results are discussed. At this meeting, a patient may be placed on a waiting list for surgery (operation usually done within 2 weeks) or referred to oncology etc. Chemo/radiotherapy for rectal cancer is undertaken at Waikato, while other Chemo is delivered at Bay of Plenty. Waiting times for both services are considered acceptable.

The DHB is presently following the national guidelines (and timeframes) for both familial and surveillance colonoscopies. However, this workload is impinging on the organisation's ability to meet GP referrals for symptomatic patients (the irony is that the incidence of cancer in this group is higher than that in the surveillance groups). This situation is under review as staff consider where to cut back. Tauranga presently has 14 scope sessions a week, of which approximately two thirds are colonoscopies.

Referrals to Whakatane Hospital are triaged by general surgery using different triage criteria to Tauranga. There is no wait list for colonoscopy and CT waiting times are much shorter than at Tauranga. This creates an intra-district inequity of access (Western versus Eastern Bay).

Recommendations

It is recommended that Bay of Plenty DHB:

1. Increases its delivery of colonoscopies (with a corresponding increase in resources) and review the extent to which it will meet the national guidelines re surveillance scoping.

2. Agrees a common triage system for access to colonoscopy across the two DHB sites.
3. Reviews the present level of funding applied to the Tauranga radiology department.
4. Addresses the inequity of access to both FSA/colonoscopy and radiology between Tauranga and Whakatane hospitals.

REPORT NOT FOR CIRCULATION

Other Services

Thoracic Surgery

The surgeons have a perception that lung cancer diagnosis is made later than should be the case (the precise reason(s) were not explored). Their involvement in the process begins at the time of the Chest Conference. If a patient is accepted for surgery at the time of the Conference, they go on the first available list. An FSA is undertaken prior to surgery, but because the department operates a pooled list, this may not be with the operating surgeon.

Every two weeks there is, in theory, an all day thoracic list. But this may be “taken over” by an urgent cardiac case. This lack of ‘dedicated’ theatre time and/or ward beds means delays can occur from acceptance at Chest Conference to surgery. In the UK, there is a six week time limit from diagnosis to surgery and the clinical director believes a time limit should exist in NZ. To assist in speeding up the process, he would like to explore the possibility of developing guidelines around when patients could be “fast-tracked” to a thoracic surgeon.

His perception is that fewer patients than might be expected are being accepted for surgery (a view shared elsewhere in the region). Because the Chest Conference is always held on the same day of the week, the thoracic service cannot rotate its attendees.

Oncology

Lung Cancer

The goal is to start treatment within two weeks of the patient being seen by the oncologist. Patients can wait between two and five weeks from referral to being seen. Some clinicians refer directly to oncology at the same time as to the Chest Conference. The view of oncology is that this does not really speed the process up.

Endobronchial ultrasound is not available at Waikato. A small number each year are referred to Middlemore for this investigation and this delays the diagnostic and treatment process. There is a view that a tertiary level provider should have endobronchial ultrasound available. (While there is an Auckland endobronchial ultrasound service, the Northern DHBs have identified a need for additional capacity, which will be provided at North Shore).

Following the completion of radiation therapy at Waikato, a follow-up MRI may be requested. In the case of a Bay of Plenty patient, such a request can be ‘rejected’ because of an administrative policy that requires the patient to have been seen at Bay of Plenty within six weeks of the request.

Recommendation

It is recommended that Waikato DHB:

1. Undertakes a cost benefit analysis of the local provision of endobrochial ultrasound.

Bowel Cancer

Waikato patients are referred to a multi-disciplinary meeting which is attended by a medical oncologist. Patients from other DHBs are usually referred directly to the oncology department.

General

Overall, the clinicians in the three DHBs were generally satisfied with the service provided by the oncology departments. The perception is that the wait times for FSA in medical oncology are longer than those for radiation oncology.

Radiology

Staff at both Waikato and Bay of Plenty are of the view that increased resources are required to adequately meet the requirements for the investigation of both suspected lung and bowel cancer.

Data Analysis

The following points should be noted in respect of the data:

- It is based on data extracted from DHB systems and there may be issues with the reliability of some of the records;
- The three month period from 1 October to 31 December 2009 was selected because historic volumes indicated sufficient patient numbers would be gathered to allow some valid analysis to be completed. The assumption was made that the majority of these would follow an 'elective' pathway. However, this was not the case and the low numbers of elective patients limit the drawing of any definitive comparisons or conclusions.

Waiting Lists

Because of the changeover in their Patient Management System, Lakes DHB is unable to provide useful historic data on their waiting lists.

FSAs

Patients are referred to all relevant services for conditions other than suspected cancer and a number of them will receive the same 'urgency' category. Because there is currently no "flagging" of suspected cancer in the hospital systems at the point of referral, it is not possible to separate out the different groups³. At Lakes, respiratory referrals and FSAs are counted within General Medicine, so specific data is not available.

Bronchoscopies

In the three DHBs, it is unusual for patients to be placed on an electronic waiting list for bronchoscopy – patients are 'admitted' as either 'acute' or 'as arranged'.

Colonoscopies

The information provided on colonoscopy waiting lists is included at Appendix 1 (Bay of Plenty) and Appendix 2 (Waikato). The data on average waiting time by urgency category does not show the expected pattern – whereby the most urgent would wait the shortest time. This suggests either that the clinician does not view the categorisation as determinative or that there is little attention paid to booking patients in order of priority. While it is accepted that a number of patients may remain on the list (with high scores) for long periods due to factors outside the hospital's control, a review of the long wait patients (and the reasons) would nevertheless be a useful exercise.

The data presented below represents all colonoscopies. However, it is assumed that it is likely that those with suspected bowel cancer will have a high priority.

The variation in the number of surveillance scopes between the two DHBs (given their relative populations) requires further investigation, as both DHBs state they are meeting the recommendations in terms of surveillance.

³ This issue has been raised with the DHBs by the MCN and discussions are ongoing as to how this could be incorporated into the patient management systems.

Colonoscopy Wait List		Waikato ⁽¹⁾			Bay of Plenty			Lakes ⁽²⁾		
Date		Gastro	Gen Surg	Total	Gastro	Gen Surg	Total	Gastro	Gen Surg	Total
June 2008	Diagnostic Colonoscopies	27	103	128	181	243	424	6	97	103
	Surveillance Colonoscopies	322	577	899	718	422	1140	N/A	N/A	N/A
	Total	349	680	1027	899	665	1564			
December 2008	Diagnostic Colonoscopies	35	238	273	116	317	433	6	82	90
	Surveillance Colonoscopies	356	679	1035	739	425	1164	N/A	N/A	N/A
	Total	391	917	1308	855	742	1597			
June 2009	Diagnostic Colonoscopies	40	189	229	176	289	465	11	108	119
	Surveillance Colonoscopies	378	745	1123	750	435	1185	N/A	N/A	N/A
	Total	418	934	1352	926	724	1650			
December 2009	Diagnostic Colonoscopies	21	265	286	275	204	479	6	98	104
	Surveillance Colonoscopies	404	846	1250	973	502	1475	N/A	N/A	N/A
	Total	425	1111	1536	1248	706	1954			

(1) Surveillance scopes include those with either a 'staged' or 'planned' flag.

(2) Gastroenterology volumes include both gastroscopy and colonoscopy.

Waiting Times

The data below is based on patients who were entered into the national Cancer Registry from the three MCN DHBs between 1 October 2009 and 31 December 2009.

The volume of patients for which there is useful data is less than half of the registered patients. For the remainder, either the patient was admitted acutely i.e. did not follow an 'elective' pathway or there is no data available in the DHB system. Available waiting time data is shown below:

Number of Patients	Waikato		Bay of Plenty		Lakes	
	Lung	Bowel	Lung	Bowel	Lung	Bowel
Elective pathway	12	14		8	2	5
Inpatient	22	20		42	10	6
No data/other	4	21			0	2
Total	38	55	28	50	12	13

Lung Cancer

FSA

	Waikato				Bay of Plenty				Lakes			
<i>Category</i>	<i>No of patients</i>	<i>Wait time from referral to FSA (days)</i>			<i>No of patients</i>	<i>Wait time from referral to FSA (days)</i>			<i>No of patients</i>	<i>Wait time from referral to FSA (days)</i>		
		<i>Low</i>	<i>High</i>	<i>Average</i>		<i>Low</i>	<i>High</i>	<i>Average</i>		<i>Low</i>	<i>High</i>	<i>Average</i>
All patients	12	6	119 ⁽¹⁾ (29)	25 (16) ⁽²⁾	5	21	192 ⁽⁵⁾	70	2	6	29	18
Category 1	9	6	28 ⁽³⁾	14	N/A ⁽⁴⁾				N/A ⁽⁶⁾			
Category 2	3	19	119 ⁽¹⁾ (29)	56 (24) ⁽²⁾	N/A ⁽⁴⁾				N/A ⁽⁶⁾			

⁽¹⁾ This was an internal referral – unclear whether referral date is to previous specialty. Without this referral, the longest wait was 29 days.

⁽²⁾ By excluding the patient waiting 119 days, the average drops to 16 days (24 days for Category 2 patients).

⁽³⁾ This was over the Christmas period.

⁽⁴⁾ No triage categories were provided.

⁽⁵⁾ With this patient excluded, the average wait time reduces to 39 days.

⁽⁶⁾ Only one patient has a triage category shown in the dataset.

Bronchoscopy

	Waikato				Bay of Plenty				Lakes			
<i>Category</i>	<i>No of patients</i>	<i>Wait time from FSA to bronchoscopy (days)</i>			<i>No of patients</i>	<i>Wait time from FSA to bronchoscopy (days)</i>			<i>No of patients</i>	<i>Wait time from FSA to bronchoscopy (days)</i>		
		<i>Low</i>	<i>High</i>	<i>Average</i>		<i>Low</i>	<i>High</i>	<i>Average</i>		<i>Low</i>	<i>High</i>	<i>Average</i>
All patients	12	1	197	58	5	0	56	18	1	18	18	18

In all instances, the date of bronchoscopy is recorded as the diagnosis date in the Cancer Register.

At Waikato DHB, wait times were longer where a CT was undertaken prior to the bronchoscopy. The five patients who had their bronchoscopy first (or had a CT prior to referral) had an average time from FSA to bronchoscopy of 8 days – for the other seven patients the average was 94 days. This suggests that the wait for CT scans is a major contributor to delays in diagnosis (corroborated by the perception of the clinicians).

Treatment

	Waikato				Bay of Plenty				Lakes			
<i>Treatment</i>	<i>No of patients</i>	<i>Wait time from FSA to first treatment (days)</i>			<i>No of patients</i>	<i>Wait time from FSA to first treatment (days)</i>			<i>No of patients</i>	<i>Wait time from FSA to first treatment (days)</i>		
		<i>Low</i>	<i>High</i>	<i>Average</i>		<i>Low</i>	<i>High</i>	<i>Average</i>		<i>Low</i>	<i>High</i>	<i>Average</i>
All treatments	7	11	198	88	3	109	176	147	Nil			
Surgery	2	84	91	88	2	155	176	166				
Radiotherapy	4	11	112	62	1	109	109	109				
Chemotherapy	1	198	198	198								

As can be seen from the data, the longest wait time was for Chemotherapy (this included 89 days from Chest Conference to a Medical Oncology FSA and then 101 days wait from FSA to Chemotherapy) – this also aligns with the perception of the clinicians.

Bowel Cancer

FSA

	Waikato				Bay of Plenty				Lakes			
Category	No of patients	Wait time from referral to FSA (days)			No of patients	Wait time from referral to FSA (days)			No of patients	Wait time from referral to FSA (days)		
		Low	High	Average		Low	High	Average		Low	High	Average
All patients	14	22	186	68	8	3	149 ⁽²⁾	32	5	0	298	78
Gastro - All	5	22	186	70	4	8	20	15	1	0	0	0
Gastro – Cat 1	3	22	28	25	N/A ⁽³⁾				Nil			
Gastro – Cat 2	2	91	186	139	N/A				1	0	0	0
Gen Surg - All	9 ⁽¹⁾	41	108	67	4	3	149	50	4 ⁽⁴⁾	23	298	98

⁽¹⁾ All patients were Category 2

⁽²⁾ This patient was managed at Whakatane. Excluding them brings the average for all patients down to 16 days and the average for General Surgery patients also down to 16 days.

⁽³⁾ Categories were not provided.

⁽⁴⁾ One patient had a Category 2 (wait time 23 days), two had Category 3 (average wait time 169 days) and one patient did not have a category recorded (wait time 29 days)

Colonoscopy

	Waikato				Bay of Plenty				Lakes			
Category	No of patients	Wait time from FSA to colonoscopy (days)			No of patients	Wait time from FSA to colonoscopy (days)			No of patients	Wait time from FSA to colonoscopy (days)		
		Low	High	Average		Low	High	Average		Low	High	Average
All patients	14	3	108	37	8	15	29	21	2 ⁽¹⁾	3	48	26

⁽¹⁾ Three other patients had diagnostics, but not colonoscopies.

Treatment

	Waikato				Bay of Plenty				Lakes			
<i>Treatment</i>	<i>No of patients</i>	<i>Wait time from FSA to first treatment (days)</i>			<i>No of patients</i>	<i>Wait time from FSA to first treatment (days)</i>			<i>No of patients</i>	<i>Wait time from FSA to first treatment (days)</i>		
		<i>Low</i>	<i>High</i>	<i>Average</i>		<i>Low</i>	<i>High</i>	<i>Average</i>		<i>Low</i>	<i>High</i>	<i>Average</i>
All treatments	12	17	154	102	8	30	201	110	5	23	132	66
Surgery	10	17	154	101	8	30	201	110	5	23	132	66
Radiotherapy	1	101	101	101								
Chemotherapy	1	118	118	118								

Ethnicity

Due to the low number of patients, it is not possible to consider ethnicity in any detail. However it does not appear that there are patients of a particular ethnicity that wait longer for diagnosis or treatment than any others.

Capacity Planning

Capacity planning should be based on agreed guidelines for access and the changing demographics of the population. At present, no common guidelines exist across the network DHBs for access to FSA or diagnostics, and therefore there is 'inequity' of access both intra and inter DHB.

An example of this inequity can be seen in the number of colonoscopies⁴ undertaken per 10,000 population⁵ across the three network DHBs. While all three DHBs have increased their access over the last three years, Waikato remains consistently lower than the others (and it is unlikely that the variation can be solely explained through any demographic differences).

	Waikato			Bay of Plenty			Lakes		
Colonoscopy Volumes	2007/08	2008/09	2009/10*	2007/08	2008/09	2009/10*	2007/08	2008/09	2009/10**
Gastroenterology	550	407	479	508	1,332	1,340			
General Surgery	961	1,071	1,227	426					
Total	1,511	1,478	1,705	934	1,332	1,340	518	587	626
Population	347,700	349,860	352,040	204,090	206,680	209,270	103,280	103,850	104,350
Per 10,000 population	43	42	48	46	64	64	50	57	60

*Forecast based on March YTD volumes

**Forecast based on February YTD volumes

While there is also a slight variation in bronchoscopy access, the low numbers preclude any meaningful comment.

	Waikato			Bay of Plenty			Lakes		
Bronchoscopy Volumes	2007/08	2008/09	2009/10*	2007/08	2008/09	2009/10*	2007/08	2008/09	2009/10**
Respiratory Medicine	228	228	243	139	158	176	66	55	56
Population	347,700	349,860	352,040	204,090	206,680	209,270	103,280	103,850	104,350
Per 10,000 population	7	7	7	7	8	8	6	5	5

*Forecast based on March YTD volumes

**Forecast based on February YTD volumes

FSAs in respiratory, gastroenterology and (in particular) general surgery include conditions other than suspected cancers. In addition, as previously noted, Lakes DHB record respiratory FSAs (both waiting and attendances) within general medicine. Therefore it is not possible to do population comparisons for these.

However, once agreed prioritisation practices are implemented, it should be possible in the future to project the required volumes and identify necessary resources – for both FSAs and diagnostics.

It should also then be feasible to estimate the impact of a bowel screening programme, given the target population and overseas evidence of the flow-on to diagnostics.

⁴ It is acknowledged that colonoscopies are performed for other reasons apart from suspected bowel cancer.

⁵ Currently no recommendation exists in NZ for the "ideal" number of colonoscopies per 10,000 population.

Conclusion

There are different prioritisation practices (both for FSA and diagnostics) between DHBs, and between departments within the same DHB (treating the same condition). Therefore there can be no assurance that patients with exactly the same symptoms will receive the same level (or timeliness) of access. While no prioritisation process can eliminate the need for clinical acumen, the relevant departments (across the DHBs) should consider adopting a common scoring / prioritisation tool. Any such policy should be accompanied by an audit process that would assess consistency of application.

The findings also indicate that there are presently avoidable delays at different points within the continuum from GP referral to receipt of treatment for those diagnosed with either lung or bowel cancer. These delays occur to varying degrees within departments and across DHBs.

At the point of referral, reduced wait times could be achieved by:

- Referral protocols (including standard referral templates) for suspected lung or bowel cancer being agreed between primary and secondary care;
- Streamlining the referral route – one route, single queue, one point of contact;
- Pooling referrals for FSA and specialty-based diagnostics;
- Triaging patients “straight to test” prior to the FSA.

In order to reduce wait times following initial diagnosis, DHBs need to ensure the required level of resourcing is provided to allow timely delivery of further essential investigations and relevant treatment.⁶

⁶ These suggestions for reducing wait times are consistent with the recommendations of the 2005 NHS publication: “Applying High Impact Changes to Cancer Care”, based on the work of the UK Cancer Services Collaborative Improvement Partnership

Appendix 1: Waikato Colonoscopy Wait List

Waikato Hospital - Inpatient waiting list summary : Colonoscopy

Qualifications:








Hospital = 5311

OpCode - Block code = 905 or 911 or 910 or 907

Source document : F:\BW WL data source .xlsx

Total On List as at 30 June 2008

On list as t 30/6/08 y 

			Values	
Row Labels	 BlockDesc	iwScore	On list	avg Time on list
 Gastroenterology				
 905	 Fibreoptic colonoscopy	2	9	592
		3	37	1008
		4	244	904
		5	38	1108
		60	20	1342
		(blank)	1	1289
 General Surgery				
 905	 Fibreoptic colonoscopy	2	1	643
		3	3	1121
		4	29	822
		5	231	1141
		50	3	673
		56	2	665
		60	276	1009
		70	43	780
		72	1	596
		73	4	576
		74	17	552
		75	1	664
		76	2	638
		77	1	587
		80	31	703
		84	1	587
		85	3	961
		86	10	607
		90	8	837
		95	11	586
		100	1	842
		(blank)	1	1085

Waikato Hospital - Inpatient waiting list summary : Colonoscopy


Qualifications:








Hospital = 5311

OpCode - Block code = 905 or 911 or 910 or 907

Source document : F:\BW WL data source .xlsx

Total On List as at 31 December 2008

On list as t 31/12/08 y 

			Values	
Row Labels	 BlockDesc	iwScore	On list	avg Time on list
 Gastroenterology				
 905	 Fibreoptic colonoscopy	2	5	562
		3	45	772
		4	311	742
		5	28	1043
		60	2	1114
 General Surgery				
 905	 Fibreoptic colonoscopy	2	2	405
		3	4	868
		4	27	823
		5	221	1134
		50	3	673
		56	2	665
		60	355	806
		65	5	469
		70	121	487
		73	3	572
		74	60	439
		75	4	434
		80	66	476
		85	7	631
		86	15	440
		90	5	698
		95	15	414
		(blank)	2	725

Waikato Hospital - Inpatient waiting list summary : Colonoscopy


Qualifications:


Hospital = 5311

OpCode - Block code = 905 or 911 or 910 or 907

Source document : F:\BW WL data source .xlsx

Total On List as at 30 June 2009

On list as t 30/6/09 y 

			Values	
Row Labels	 BlockDesc	iwScore	On list	avg Time on list
Gastroenterology				
905	Fibreoptic colonoscopy	2	7	393
		3	50	565
		4	335	627
		5	25	1042
		60	1	1114
General Surgery				
905	Fibreoptic colonoscopy	2	2	405
		3	4	868
		4	25	825
		5	217	1128
		50	3	673
		56	2	665
		60	422	526
		65	1	496
		70	107	361
		73	3	572
		74	50	299
		75	4	184
		80	55	327
		85	4	488
		86	15	219
		87	1	188
		90	6	281
		95	12	220
		(blank)	1	1085

Waikato Hospital - Inpatient waiting list summary : Colonoscopy


Qualifications:


Hospital = 5311

OpCode - Block code = 905 or 911 or 910 or 907

Source document : F:\BW WL data source .xlsx

Total On List as at 31 December 2009

On list as t 31/12/09 y 

			Values	
Row Labels	 BlockDesc	iwScore	On list	avg Time on list
Gastroenterology				
905	Fibreoptic colonoscopy	2	3	664
		3	21	152
		4	383	450
		5	18	1030
General Surgery				
905	Fibreoptic colonoscopy	2	3	270
		3	4	609
		4	23	811
		5	212	1133
		48	1	170
		50	3	673
		56	2	665
		57	1	106
		60	503	305
		65	5	208
		70	153	145
		73	3	572
		74	78	87
		75	11	31
		80	59	76
		85	9	62
		86	20	20
		90	3	311
		95	18	23

Appendix 2: Bay of Plenty Colonoscopy Wait List

Bay of Plenty Wait List		Jun-08	Dec-08	Jun-09	Dec-09	May-10
Colonoscopy						
Gastroenterology						
Urgent Grade 2	< 1 month	52	56	66	94	97
	1-2 months	22	20	73	60	77
	2-3 months	23	7	23	74	52
	3-6 months	43	19	12	43	109
	6-12 months	32	11	1	4	8
	12-18 months	9	3	1	0	0
<i>Total</i>		<i>181</i>	<i>116</i>	<i>176</i>	<i>275</i>	<i>343</i>
Surveillance		718	739	750	973	984
Overall Total		899	855	926	1248	1327
General Surgery						
Urgent Grade 2	< 1 month	13	16	15	6	8
	1-2 months	9	3	18	9	1
	2-3 months	1	34	15	5	3
	3-6 months	12	16	2	4	4
	6-12 months	12	2	3	5	1
	12-18 months	5	3	4	0	0
Semi-urgent Grade 3	< 1 month	15	46	14	13	28
	1-2 months	14	43	17	15	26
	2-3 months	20	13	15	6	7
	3-6 months	32	32	24	18	21
	6-12 months	54	31	54	15	8
	12-18 months	4	10	7	5	1
Non-urgent Grade 4	< 1 month	43	29	16	3	3
	1-2 months	0	12	7	9	2
	2-3 months	1	5	6	5	1
	3-6 months	2	16	48	26	10
	6-12 months	6	2	21	52	14
	12-18 months	0	4	3	8	0
<i>Total</i>		<i>243</i>	<i>317</i>	<i>289</i>	<i>204</i>	<i>138</i>
Surveillance		422	425	435	502	441
Overall Total		665	742	724	706	579
Grand Total		1564	1597	1650	1954	1906