Long-term Plan

- Systemwide aspirations
- ICS
- Population Medicine
- Inequalities
- Unwarranted Variation
- Technology
Challenges

- Stakeholder perspective
- Personalised Care vs Unwarranted Variation
- Access – Continuity
- Performance Targets – Inequalitites / System thinking
- New Technologies – Data Quality
- Interface with Social Care
- Celebrating Achievement vs a culture of transparency
- Continuously improving high quality safe compassionate care – Workforce
- Tangible Chance vs nurturing positive behaviours.
Lung Cancer

- Leading Cause of cancer death in UK for both Men and Women (35,620 deaths in 2016 >20% of all cancer deaths)
- Smoking causes around 85% of lung cancers
- Socioeconomic variation
- Unwarranted variation
- Geography - based on proximity of specialist centres
- Inequalities & socio-demographic issues
- Service configuration – local vs specialist
- Access to specialist curative treatments
<table>
<thead>
<tr>
<th>Deliverable / milestone</th>
<th>Salisbury NHS Foundation Trust</th>
<th>Royal United Hospitals Bath NHS Foundation Trust</th>
<th>University Hospitals Bristol NHS Foundation Trust</th>
<th>North Bristol NHS Trust</th>
<th>Taunton and Somerset NHS Foundation Trust</th>
<th>Yeovil District Hospital NHS Foundation Trust</th>
<th>Weston Area Healthcare Trust</th>
<th>Gloucestershire Hospitals NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients will have access to a same day walk-in chest X-ray service</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adoption of SWRDPLC (not timescales)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systems will allow patients with a negative diagnosis to leave the pathway without the need for an outpatient appointment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All GP Chest X-rays will be reported consistently, using the South West Chest X-ray Reporting Tool (or locally agreed alternative)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collect Information on chest X-ray codes and related activity and outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-ray and CT reporting backlogs will be cleared, facilitating a reduction in time between diagnostic activities and supporting either same day chest x-ray and CT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiographers will be trained to report X-rays either CXR or others so as to enable same day reporting of CXRs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Q1 2018/19 Timed pathway steps

[Diagram showing the steps involved in the pathway with different colors representing different stages: Wait for OPA, Wait for CT report, Wait between CXR and CT, Wait between CXR perform to report. The steps are listed as CDP, NRDP, NBT, GLOS, TST, YDH, SDH, PHNT.]
Percentage of GP referred CXR's reported as highly suspicious of cancer Q1 2018/19

- SDH
- YDH
- TST
- RUH
- NBT
- GH

0.00%  5.00%  10.00%  15.00%  20.00%  25.00%  30.00%  35.00%

Q1...
Your GP has referred you for a chest X-ray.

We encourage you to have your chest X-ray as soon as possible as some conditions may worsen if not treated promptly.

Radiation risk

A chest X-ray is associated with a low dose of radiation and therefore carries a small risk. It is carried out under strict control to ensure that this dose is as low and safe as possible. We all receive a little radiation from the environment - a chest X-ray dose is equivalent to 2 days of exposure to sunlight.

What happens after the X-ray?

Your GP will receive the result of your chest X-ray as soon as possible, but usually within 72 hours.

In some cases, a chest X-ray may identify a shadow in your lungs, for which there may be several possible reasons. Sometimes a shadow has been present for many years and is nothing to worry about, but in some patients it is important to check for any suggestion of important conditions such as lung cancer. A hospital specialist may therefore decide that a CT scan would be helpful to look at your lungs in more detail.

You therefore may receive an appointment for a CT scan after you have undergone a chest X-ray.

If you are referred for a CT scan, you may receive a subsequent appointment to be seen in the RUH Respiratory clinic.

If you have any questions about your chest X-ray result or your CT scan appointment, please contact your GP.

If you do not hear from the RUH within 5 days, please contact your GP for your chest x-ray result.
Outcomes from Royal United Hospital Bath

Chest x-rays at RUH (April 1st to August 21st 2018)

- CX1: 3438
- CX2: 1079
- CX3: 100

CX3 reports with diagnoses at RUH (April 1st to August 21st 2018)

- Lung cancer: 21
- Other diagnosis: 79

Non lung cancer diagnoses for CX3 reports (April 1st to August 21st 2018)

- CT scan awaited: 51
- No referral received: 11
- Referred for surgery: 4
- Seen in other Trust: 3
- CUP: 4
- Lymphoma: 1
- Sarcoi: 1
- Pleural malignancy: 1
- Sarcoma: 1
- Other: 1

n=79
Lung Cancer Screening

People aged from 55 to 74 and 364 days who have ever smoked invited to Lung Health Check.

Lung Health Check:
- Spirometry
- Lung cancer risk
- Smoking cessation

Low risk: no LDCT
Referred to GP if significant lung disease e.g. COPD is diagnosed.

High risk: offered LDCT

Suspected lung cancer referred to rapid access lung clinic

Key:
A = suspected lung cancer on any LDCT or ≥300mm$^3$ or ≥8mm max. diam. and Brock risk ≥10%
B = indeterminate result:
B$^1$ ≥80 to <300mm$^3$ or ≥6mm and <8mm.
B$^2$ ≥300mm$^3$ or ≥8mm max. diam. and Brock risk <10%
B$^3$ 5 to 6 mm diameter
C = no significant finding or nodule <80mm$^3$ or <5mm max. diam.

LDCT = low radiation dose CT

New nodules on interval LDCT: see protocol section 5.1.2
Incidental Findings

Minor incidental findings are common on LDCT and have the potential to cause increased unnecessary investigations and anxiety to participants.

Incidental finding reporting, and management should be based on the following principles:

The finding should be clinically significant.

Clinically insignificant findings should not be reported to the GP or participant.

There should be agreement between the LDCT targeted lung cancer screening programme and primary care as to the nature and benefit of the recommended interventions.

Recommendations for clinical correlation by primary care of CT findings should be avoided, and if made, should be specific.

The purpose of the scan is not to identify diseases other than lung cancer. However, if other significant conditions are identified that require action, then either an appropriate referral will be made and/or the GP and participant will be informed. Action on incidentally detected conditions will follow NICE guidance;
Any screening programme has potential benefits and harms. For lung cancer screening, if 1000 eligible individuals are screened 3 times, it is estimated that:

- 779 will have all normal scans
- 180 will need an extra scan but will not have lung cancer
- 41 will be diagnosed with lung cancer
- 13 will need an invasive procedure to rule out lung cancer
- 4 cancers would never have caused the person harm (overdiagnosis)
- Thanks to screening, 3 will not die from lung cancer

Figure: Infographic depicting estimated outcomes in the US National Lung Screening Trial under the Lung-RADS nodule management protocol
Clinical Variation

| Some variation is warranted | • The NHS is not monolithic  
|                           | • Local needs and priorities shape services  
|                           | • Innovative approaches are helpful |
| Some is unwarranted        | • Patient outcome vary  
|                           | • Clinical practice can be different across areas  
|                           | • Providers’ costs for similar items also range widely |
| Raising performance        | • Greater productivity often leads to better care  
| improves quality and       | • If all providers’ cost bases were at the median level, the total savings would be more than £5billion |
| efficiency                 | |

Standardize practice in a manner that does not unduly restrict clinician autonomy or the ability to provide individualized care
Rapid Diagnostic Service

- NHSE Specification (TBC)
- 15% of Alliance Funds for 2019/20 to be spent on development of rapid diagnostic service for patients with serious but non-specific symptoms
- = £900,000 for SWAG.
- Co-ordinated and rapid series of tests.
- Not necessarily same day but a reduced number of appointments
- Holistic Diagnostic Assessment – Not a rule in- rule out service but get a diagnosis
- Single point of access
- Participation in minimum dataset
SWAG Specification

- **Service to be delivered within PCNs**
- **Money to be spent on clinical time and networking.**
- **NHSE Spec estimates 80 patients / 100,000 per year**
- **Consider broadening scope to include 2ww referrals of limited clinical value**
- **Don’t want to add additional unnecessary steps where further investigations clearly defined.**
Expression of Interest

- To be submitted by 31st July 2019

- STP Lead
- Secondary care lead
- PCN Lead

- Lead clinician (Can be Secondary care lead or PCN Lead)
- Geographical area and population to be served.
- Providers involved in project

£10,000 budget to support project planning and business case.
Outcomes: NHSE will specify

ACE programme reported on:

• Patient Characteristics – demographics / co-morbidities
• Cancer Diagnoses
• Non-cancer diagnoses
• Stage of Cancer diagnosis
• Interval times of pathway
• Patient Experience
Benefits

NHS

Patient
Equality
NHS long term plan focus on reducing inequalities.

Substantial improvement in early diagnosis over past 30 years but one-size-fits-all services have often failed to engage with the people most in need, leading to inequalities in access and outcome.

Figure 13: Breakdown of the life expectancy inequality gap between the most and least deprived deciles, males, England, 2014 to 2016.

Learning from LeDeR Programme

Key Themes – Diagnostic masking and access to investigations

Valuing people definition of LD – needs based rather than IQ threshold – will apply to much broader population.

Learning will apply to all vulnerable groups not just those with LD – an opportunity to reduce inequalities in Cancer outcomes across the whole population.

‘Tim told the staff in hospital he was losing weight. His sister felt that no one had listened to him.’
Person Centered Care
Person Centered Care

[flexible] gender identity

“which category do you identify/define yourself?”
Patients with mental health conditions have:

- poorer access to cancer services
- poorer experience once they are on cancer pathways
- similar incidence rates for cancer as the general population but significantly **higher mortality rates**.
- poor early experiences influencing their perception of healthcare
- inadequate support for their additional needs from clinical staff
We will use a ‘double diamond’ methodology to understand patient experience, define the problem and prioritise solutions

Double diamond methodology

In the **first phase**, we aim to **expand** our focus, gathering patient input from different sources and using different methodologies to gain a nuanced understanding of mental health patients’ experience.

In the **second phase**, we aim to **narrow** our focus, focusing on key themes and defining the problem to agree on which problems to prioritise.

In the **third phase**, we aim to **expand** our focus, gathering best practice and running co-design workshops with patients and clinicians to understand the range of ways we can improve.

In the **fourth and final phase**, we aim to **narrow** our focus, prioritising the interventions that will have the greatest impact and moving to delivery.

**Discover**

- Talk to patients, interviews, engagement

**Define**

- Focus on themes and define problem

**Develop**

- Best practice, co-design

**Deliver**

- Prioritise delivery planning for most impact
Clinical Advisory Groups

- Standing Agenda item - inequalities work
- Discuss emerging patient experience data
- Support small programmes at work testing new approaches.
- Collaborative evolution of services
Standardize practice in a manner that does not unduly restrict clinician autonomy or the ability to provide individualized care.