Reducing Emergency Presentations

A review of emergency presentations to hospitals which led to a diagnosis of cancer, in NHS Coastal West Sussex and NHS Hastings and Rother CCGs, by the South East Cancer Clinical Network (covering a population of over 655,000 patients)

Why are emergency presentations important?
In the UK, in 2015, 1 in 3 people diagnosed with cancer were diagnosed on an emergency presentation. In hospital patients 20% of new cancer diagnoses are made following an emergency presentation. Reducing emergency presentations can improve patient outcomes, so it is important to understand why they happen.

What did we do?
The SE Cancer Clinical Network identified Coastal West Sussex and Hastings and Rother CCGs had high rates of emergency presentations. The SE Cancer Clinical Network worked with the two CCGs to develop two GP audit tools that align with the SE Cancer Network Emergency Presentation Network template. Analysis of the data enabled identification of factors that could affect patient outcomes and the potential for improvements.

What were the objectives?
1. To determine if cancer presentation is a legitimate pathway
2. To understand the events which may lead to an emergency presentation and whether these processes can be improved
3. To generate awareness of the audit
4. To promote the findings of the audit and share the results at a practice meeting to share the overall lessons learnt.

Who took part in the audit?
The SE Cancer Clinical Network identified Coastal West Sussex and Hastings and Rother CCGs had high rates of emergency presentations. The SE Cancer Clinical Network worked with the two CCGs to develop two GP audit tools that align with the SE Cancer Network Emergency Presentation Network template. Analysis of the data enabled identification of factors that could affect patient outcomes and the potential for improvements.

Where are Hastings and Rother and Coastal West Sussex CCGs, and what are their demographics?

<table>
<thead>
<tr>
<th>CCG</th>
<th>Population size</th>
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<tbody>
<tr>
<td>Hastings and Rother</td>
<td>140,505</td>
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<tr>
<td>Coastal West Sussex</td>
<td>205,703</td>
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What were the reasons?

1. GPs identified definite or possible delays in the diagnostic pathway, including:
   - Primary care delay (e.g. patient not seen for investigation)
   - Secondary care delay (e.g. GP did not request further investigation)
   - Patient delay (e.g. patient did not return for follow-up)

2. Analysis of the data revealed that delays in the diagnostic pathway were common, with a median delay of 4 weeks between the primary care referral and the secondary care appointment.

Why did this occur?

1. GPs identified factors that contributed to the delays, including:
   - Poor communication between primary and secondary care providers
   - Limited access to specialist services
   - Inadequate record keeping by primary care providers

2. Analysis of the data revealed that delays in the diagnostic pathway were common, with a median delay of 4 weeks between the primary care referral and the secondary care appointment.

Next steps

1. The SE Cancer Clinical Network is promoting the findings of this audit to all the practices and sharing the lessons learnt to help improve patient outcomes.
2. GP knowledge and communication will be improved by training and education.
3. Continuity of care will be improved by developing a structured pathway for patient referral and follow-up.
4. Improved access to diagnostic services will be achieved by developing a multi-disciplinary team approach.

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