Leeds: Early Diagnosis Project updates

Cancer Cascade Event, 11\textsuperscript{th} May 2017

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Programme Manager
Objectives:

• To provide overview of Leeds Cancer Strategy and structure
• Focus on Early Diagnosis work stream projects
  • ACE
    • Model, rollout and emerging findings
  • 28 Days Faster Diagnosis Standard
    • Scope
    • Progress to date

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PEG is Executive strand of Leeds Health and Wellbeing Board

Emerging enabling work streams/ themes:
- Patient experience
- Primary Care
ACE: Background and National context

• National Programme
• Funded by Cancer Research UK and Macmillan
• Design, develop and test out pathway and MDC model for non-specific symptoms
  • ‘Gaps’ in NICE NG12 Referral Criteria
  • Appetite and weight-loss linked
  • Anaemia and unexplained laboratory findings
  • ‘General condition and GP intuition’
• Leeds – 1 of 6 pilot sites across England
Leeds: The ACE vision

“We will develop and launch a pathway for Leeds focused on improved patient experience and outcomes by getting the quickest, most accurate diagnosis for people with non-specific but concerning symptoms.”

‘I think this will be really useful – and support primary care where there are gaps in referral options currently.’

Lead GP

‘This is in effect a front door specialty – this will ultimately reduce hospital admissions if we get this right’

Acute Medicine Consultant

‘Much of this activity is currently in the system, there are efficiencies to be had in moving the work around and managing in a more co-ordinated way’

General Manager

‘We need to sell this concept: this is about providing rapid access to diagnostics. This is not only about cancer’

Consultant & Informatics Lead

‘We need to stop patients bouncing around the system – the ping-pong effect’

Oncology Consultant

‘Through ACE we can optimise the skills of our workforce, our resources and existing estate - a move away from silo working’

ACE Project Sponsor
Leeds data: routes to diagnosis

Routes to Diagnosis (excluding non-melanoma skin cancer)

% 2015 2016

2ww 46.4 49.6
Screening 5.1 6.1
Emergency 15.4 15.4
Other 33 28.9

Other referrals (to test, routine, urgent); local screening (prior cancer); incidental findings

Source: PPM (run February 2017)
Leeds data: route and clinical activity

2016 – Events in 6 months to diagnosis (excluding non-melanoma skin cancers)

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<thead>
<tr>
<th>Route</th>
<th>2ww</th>
<th>Non 2ww</th>
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<tbody>
<tr>
<td>Admissions - Emergency</td>
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<td>0.5</td>
</tr>
<tr>
<td>Admissions - Other</td>
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<td>0.7</td>
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<tr>
<td>Bloods</td>
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<td>Diagnoses</td>
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<td>Surgeries</td>
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</tr>
<tr>
<td>Other 2wws</td>
<td>1.1</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Source: PPM (run February 2017)
What ‘change’ do we want to achieve?

• Improve patient experience
• Increase earlier stage detection of malignancy and other serious diseases
• Reduce emergency presentations
• Reduce admissions – patients presenting with non-specific symptoms
• Optimise use of diagnostic testing for non-specific symptoms
• Maximise effectiveness across healthcare economy
ACE referral process and pathway

• Patients presents at GP with a range of non –specific symptoms
• GP Request ACE Blood test battery through OrderComms (including Chest X-ray)
• GP acts on results & makes referral (if appropriate) to ACE pathway
• Patient is booked in for Nurse led assessment
  • Comorbidity evaluation / Psychological screening/ Dietetic screen
  • Drugs review (including compliance)
  • Baseline physiology (observations, body composition, ECG, PFT/spirometry, TUG, shuttle-runs, stair climb,)
• MDC meeting ➔ MDC Plan
  • Diagnosis – findings functional and not organic – refer back to GP with plan
  • Patient booked for further tests
  • Diagnosis and referral therapeutic services
• Communication to GPs / Patient and others
Modelling and rollout

• Initial ambition to reach total of 150 - 200,000 patient population, throughout the pilot project

• Target population based on GPs ranked by practice deprivation score – focus on areas of need in line with proposed benefits (public health input)

• Leeds city wide approach – engagement across 3 CCG areas with c. 40 practices in the 1st year

• Engaging with practices on a 1-1 basis through primary care project GP Lead and CCG primary care teams

• Testing phase February 2017 – went live March with 14 practices across Leeds

• Now also set to receive internal LTHT referrals through the Acute Meds Team
Summary of findings to date:

• 26 referrals to the ACE Project so far:
• 9 male & 16 female referrals aged between 24 to 91
• 7 referrals stated that if this pathway had not been available the patients would have been referred to 2ww pathways to: colorectal, lower GI, Upper GI, Haematology or for straight to test CT imaging*
• 4 patients attended their GP practice 1 time before referral made/ 1 patient saw their GP 7 times*
• Symptoms – 11 patients have had weight loss/ 6 have had abdominal pain/ bloating/ 5 COPD, breathlessness/ 4 bowel issues/ 4 nausea/ 2 limb tremors
• Duration of symptoms – 9 patients have had symptoms for 2/3 months

*From information completed by GPs on the referral form
Emerging Themes

• Rate of referral lower than anticipated currently

• Community cooperation (at all levels) needs change
  • Engagement, insight and redesign
    • Need a clearer narrative, based on data and value, to drive this

• MDC Admin, Nursing and MDC Forum working well
  • Each element is essential

• Prognostic tools still experimental
  • 1 cancer to date (through Acute Meds referral)
  • Conversion rates anticipated low

• Anticipated diagnostic cohorts realised
  • Non-organic, pre-existing organic, frailty, inflammatory/reactive
  • Fuller outcomes analysis planned at 50 cases
  • Will help with model scale-up and definition of referral criteria
28 Days Faster Diagnosis Standard (FDS)

- Cancer Taskforce recommendation that all patients should receive/have communicated to them a ‘definitive’ diagnosis of cancer or have cancer ‘definitively’ ruled out within 28 days of an initial referral (and 50% within 14 days)
- Aim to speed up access to diagnosis and ensure that patients who aren’t diagnosed do not wait and worry
- Big opportunities:
  - Centre the pathway on the patient more explicitly
  - Focus on better communication
  - Speedier and more efficient diagnosis, encouraging links between primary and secondary care
- ‘Early priority’ and a Secretary of State commitment
- Full roll out by 2020
- Leeds is one of five pilot sites
  - To test and inform development of the standard rules
  - Explore impact on services of delivery of the FDS
Project scope: Leeds

- Gynae – Endometrial pathway
- Head and Neck – neck lumps
- Urology - Prostate
- Leeds city wide project across 3 x CCG areas/107 general practices
- Service improvement initiative
- Principles 28 Days FDS aligned to pilot project
Progress to date: Data Collection

2ww cohort

- Referral date collected but additional functionality added to Patient Pathway Manager (PPM) to collect “date patient told diagnosis”
- Data coming through from March 2017 - further work with teams to ensure the accuracy of this data and assess the impact of the standard

Non-2ww cohort

- Further work to explore how we collect data within primary care systems prior to a 2ww referral being made
- Potential to explore in Leeds through OrderComms data for GP requested tests (e.g. PSA) so could report that as start of pathway.
- Explore potential through the Leeds Care Record integrates primary, secondary and social care data in Leeds

National challenge - is this possible/ feasible and assessing resource/ system implications for wider roll out?
Progress to date: Clinical areas

- Working with clinical teams in the 3 areas to identify and implement service improvements to the pathways, including:
  - STT Hysteroscopy for gynae referrals – developing work and process between primary and secondary care
  - Review of MDT schedules and booking of patients - gynae
  - Exploring potential to increase 1st seen clinics for Head and Neck along with pilot of Nurse Practitioner clinics
  - Understanding routes to diagnosis for Head and Neck cancers – focus on direct requests for ultrasound to inform further potential change
  - Education sessions to support primary care making referrals to the Head and Neck pathways
  - Prostate – business case - additional capacity required for outpatient clinics – for diagnosis
  - Plus clinics - 1 week following diagnosis treatment decision
Summary: Challenges/ barriers

- Data definitions and identification of data
  - Clock ‘start’ (define potential outside of 2ww) and ‘stop’ across all clinical pathways

- Focus on behavioural change:
  - Primary Care referral
  - Secondary care collection and completion of data
  - Service improvement and change initiatives focus
  - Moving to 28 Days FDS as a measure

- Ensuring application across all clinical areas
For more information:

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