Timed Cancer Diagnostic Pathways

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National Cancer Vanguard 2016-18

- Single national cancer vanguard – ‘Accountable Clinical Network for Cancer’ – Greater Manchester, Royal Marsden Partners & UCLH Cancer Collaborative (covering 10 million popn)

- Design & test innovations that, at scale, would lead to radical improvements in cancer outcomes

- Precursors/ model for Cancer Alliance structures focussing on Implementing ‘Achieving World Class Cancer Outcomes’

- ‘Each vanguard will take a lead on the development of new care models which will act as the blueprints for the NHS moving forward and the inspiration to the rest of the health and care system’(www.england.nhs.uk/ourwork/futurenhs/new-care-models)
Some NCV Outputs

Citizen-led social movement: ‘Cancer Champions’

‘Gateway C’ – online primary care cancer education platform

Behavioural nudges in screening: Changes to screening letter

Optimising medicines: Pharma Challenge

7d face to face palliative care: Pilot work

Can-guide: New SDM tool to aid decision making in advancing disease

Cancer Intelligence Service

Digital pathology feasibility pilot

Rapid Cancer diagnostic units

Best practice timed pathways

New system level governance models

Personalised follow up pilots using technology
Degree of variation between Cancer Alliances

<table>
<thead>
<tr>
<th></th>
<th>Colorectal Cancer</th>
<th>Lung Cancer</th>
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<tbody>
<tr>
<td><strong>Stage 1 + 2 (‘Early stage’)</strong></td>
<td>36 to 46%</td>
<td>21-33%</td>
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<tr>
<td><strong>5 year survival</strong></td>
<td>57 to 64%</td>
<td>12 to 18%</td>
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<tr>
<td><strong>Variation in last years 62d performance</strong></td>
<td>Median 73% (range 62-82)</td>
<td>Median 71% (range 64-83)</td>
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Faster Diagnosis Standard

“...patients should receive a definitive diagnosis or ruling out of cancer within 28 days of a referral”

- This will apply to patients who are:
  - Referred urgently by their GP (two week wait)
  - Referred with breast symptoms
  - Patients referred urgently from cancer screening programmes
1. Set out a standard streamlined way of diagnosing cancer in 3 (now 4) pathways (high volume, poorly performing on 62d metrics)

2. Using times to structure → to deliver FDS

3. Cover GP & hospital elements, initially ‘aspirational’ but deliverable by 2020

4. NHSE agreed to add to Planning Guidance from 2018
Why are best practice pathways needed?

1. Marked *unwarranted variation* between hospitals/ alliances

2. Standardised pathway is *easier to benchmark, audit & improve*

3. Shorter time to treatment *better for patients*

4. Less appointments mean *more convenience and saved resource*

5. Evidence based clinical guidance to help *deliver the FDS and 62d*
Patients have told us they are less anxious because:

- Fewer visits to hospital
- Quicker access to diagnostic tests
- Clearer communication with patients
More patients treated within 62 days
# Faster Diagnostic Pathways

## Principles

1. Clinically led
2. Patients involved
3. Broad stakeholder engagement
4. sMDT by day 21
5. Patient aware Cancer YES/ NO by day 28 latest

## Recognised Enablers

1. Daily senior triage of referrals
2. Straight to test/ one stop clinics
3. Reporting scans (‘hot’ or <24h)
4. Diagnostic ‘bundles’
5. Pathway navigators
6. Clear agreed protocols
7. Avoid repeated MDT’s
Process

Lung, Colorectal, prostate & oesophago-gastric cancers selected

Clinical leadership teams described; evidence and discussions commence

Pathway consensus agreed within working groups

Consultation with national CEG’s, national bodies

Publication for all alliances/commissioners/patients

NHS England approval

Pathways refined following collation of all feedback

National alliance event(s) with clinicians attending from alliances

Incorporation into NHS England planning guidance

Less than 18 months start to finish
Disruptive technologies:

1. MP MRI scanning pre-biopsy
2. Increased perineal biopsy options (incl LA)
3. Sector approaches diagnostics/biopsies
4. Alliance level prostate MDT’s
Colorectal

28 day pathway

Day 0
- Urgent GP referral
  - Including locally mandated information

Day 0 to 3
- Clinical triage
  - (with telephone consultation)

Day 3 to 14
- Straight to test (STT)
  - Colonoscopy or CT Colon / CT / Flexi Sig +/- OGD

Day 14
- Staging Investigations
  - Contrast CT
  - Chest / Abdo / Pelvis
  - MRI +/- TRUS (rectal cancer)
  - Bloods (incl. CEA)

Day 21
- MDT
- Communication to patient on outcome
  - (cancer confirmed or all-clear provided)

Day 28
- Clinic review
  - With CNS support
  - With CNS support

Patient information
- Provided in primary care

Outpatient clinic
- Only if not clinically appropriate for straight to test

Cancer unlikely
- Patient informed; management according to local protocol

Footnotes:
1. Referral information will be locally determined with commissioners but should include investigation results (FBC, ferritin, CRP, MCV, U&E / eGFR, FIT), comorbidities, performance status, medications, and DRE. Note that FIT testing currently includes all low risk asymptomatic patients (NICE DG30).
2. Telephone consultation can be used to determine suitability for straight to test and pre-assessment. Bowel prep can be arranged during triage or by primary care depending on local arrangements.
3. It is envisaged that when the new guidance on multidisciplinary team meetings is published in summer 2018, there will be a recommendation that some patients on clear and agreed cancer pathways may be discussed more briefly either at the beginning, or end, of the MDT.
### 28 day pathway

<table>
<thead>
<tr>
<th>Day -3 to 0</th>
<th>Day 0 to 3</th>
<th>Day 1 to 6</th>
<th>Day 14</th>
<th>Day 21</th>
<th>Day 28</th>
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<tbody>
<tr>
<td>Direct access CXR (urgent or routine)</td>
<td>Direct access or escalation to CT (same day/within 72 hours)</td>
<td>Clinical triage Led by radiology or respiratory based on local protocol</td>
<td>Fast track lung cancer clinic (consultant-led) Meet CNS, diagnostic process plan, treatment of co-morbidity and palliation, treatment of symptoms</td>
<td>PET CT, spirometry (at least) Detailed lung function and cardiac assessment/ECHO (as req’d) Further investigations</td>
<td>Communication to patient on outcome (cancer confirmed or all-clear provided)</td>
</tr>
</tbody>
</table>

**Patient information**

Provided in primary care

**Direct biopsy**

(option)

- CT result normal
- Patient informed; management according to local protocol

- Cancer unlikely
- Patient informed; management according to local protocol

**Maximum target times provided**

Footnotes:

1. This pathway represents a high-level view of the referral to diagnosis section of the NHS England National Optimal Lung Cancer Pathway (NOLCP). Please see the ‘Resources’ pages for more information on this pathway and how to implement it in full.

2. It is envisaged that when the new guidance on multidisciplinary team meetings is published in summer 2018, there will be a recommendation that some patients on clear and agreed cancer pathways may be discussed more briefly either at the beginning, or end, of the MDT.
Rapid diagnostic and assessment pathways

Prostate cancer diagnostic pathway

Day 0
- Urgent GP referral
- Including locally mandated information

Day 0 to 3
- Clinical triage
- Based on local protocol

Day 3 to 14
- mpMRI before biopsy
- Prostate biopsy (by day 9)
- Further investigations if required for staging

Day 21
- sMDT
- Communication to patient on outcome (cancer confirmed or all-clear provided)

Day 28
- Review biopsy and plan further management

Timed pathways
- 28 day pathway
- 21 Day
- 14 day

Additional information
- Audit tool
- Resources

Maximum target times provided

This is a straight to test pathway using mpMRI. The 21 day pathway should be used when an immediate MRI is not required or is contraindicated.

See footnotes on page 11
Alliances & Funding

Refreshing NHS Plans for 2018/19
Published by NHS England and NHS Improvement

CCG responsibility to deliver by April 2020

NHS England Cancer Transformation Fund

GMHSCP Transformation Fund

Circa £1m over 2 years to deliver transformation per pathway

Median time Reduced 7-10d*

* caution: growing demand!
National Learning

1. Through a committed team and clear respected clinical leadership, clinical consensus can emerge in a short time frame.

2. Clinical consensus is pivotal before commissioning/broader system ‘buy-in’: Guidance has been positively received.

3. Future pathways should set out broader guidance incl for primary care, treatment windows, recovery package & after care.

4. Benchmarking and audit against the pathways will drive future improvement.
Learning in Greater Manchester

1. Engagement GP’s/ Trusts & CCG commissioners from start – think about sustainability after transformation funding runs out

2. Link into all relevant established networks (Clinical & operational); Educational days

3. User involvement is key. Must be visible.

4. Need open appointment of clinical lead and transformational lead for each pathway, all working closely at alliance level. LEADERSHIP.

5. Maintaining momentum requires energy & persistence & faith

6. Unexpected benefits can arise (better information for patients, easier communication with patient, new biopsy options in prostate, sector approaches for diagnostics)

7. Evaluation (outcomes/ experience/ ‘stories’) is critical in selling to commissioners
Next steps

1. Sustainably deliver the 4 pathways as described incl. delivery of FDS in every alliance

2. Consider replicating in other pathways using the initial 4 as a template (H&N/ HPB/ Gynae...)

3. Rapid diagnostic centres + non specific but concerning symptoms then broader roll out