Colorectal Best Timed Pathway: Project overview

Mr Dave Smith
Project overview

- By April 2020 the new faster diagnosis performance standard (FDS) of confirmation of cancer diagnosis (or no cancer) by day 28 following first referral from GP will be implemented.

- If we can combine straight to test (STT) for appropriate patients with first clinic appointment within 7 days for those not appropriate for this pathway, we can reduce the time to a diagnosis and ultimately treatment.

- GM Cancer is looking to work alongside the STT approaches that have already started across GM, complimenting what is already working and being flexible to regional needs and preferences.
2 week wait Lower GI compliance (GM wide); 2018/2019

- 2018/2019: 2WW compliance: **84.6%**
- Total number of 2WW referrals: **27,375**
62 day colorectal compliance (GM wide); 2018/2019
28 day pathway: NHS England

Potential time delays

3 days

11 days + 7 days + 7 days

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 symptomatic 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.
The transformation funded project

• With STT pathways helping to generate more clinic capacity, the 7 day appointment can be potentially achieved for patients who are not suitable for STT and need a clinic appointment.

• Just under £1 million split GM wide, to spend out end of March 2021, focused on staff resources
  • Band 7 CNS and Band 4 Navigator roles

• Importance of engagement with primary care
  • Change to pathway
  • Patient information leaflet
Project timeline April 2019 – Jan 2020

Project initiation
April 2019

Initial scoping meetings completed
15th May

Further engagement with Trusts / CCGs regarding proposals
12th June – Mid August

Project moves into implementation stage. Recruitment commences in Trusts.
August / Sep 2019

New STT pathways launched
Jan 2020

Deadline for submission of proposals from Trusts
12th June

Funding decisions made and approved by PAB, communicated to Trusts
19th August

New roles start in post. New STT pathways detailed planning commences.
Dec 2019
Project Outcome Measures

1. Achieve Faster Diagnosis Standard (28d) by March 2020 (*While not yet widely released, we anticipate the FDS National Standard to be set at least 85%), including associated outcomes that sit under this as displayed in the Outcome Measures Framework).

2. Reduce to <50% the percentage of patients who require an OPA before endoscopy, releasing OPA capacity.

3. Reduce the number of DNAs and cancellations for first investigation by 30%.

4. Decrease by 30% the number of occasions that secondary care needs to contact primary care in relation to a urgent colorectal cancer referral i.e. needing more information that was not included in the original referral.

5. More than 90% of suspected colorectal cancer patients rating their diagnostic pathway as good/very good/excellent by end March 2021 (scale for patient experience survey to be confirmed).
Improving the pathway: A patient’s point of view

Saeed Shakibai
The Role of Primary Care

Dr Karen McEwan
Referral Information

- Co-Morbidities
- Medication e.g. – metformin, anti-coagulants
- Mental capacity
- Renal Function
- Functional status
- BMI/ Weight

Identifies those patients suitable for “Best Timed Pathway”
Preparing Patients

- Informing patients of a suspected cancer referral
- Importance of being available for appointment at short notice
- Provision of explanatory information letter
- Check renal function
- Safety - netting
The Bigger Picture

• Promoting and Supporting lifestyle change
  • Improve outcomes for patients undergoing cancer treatment
  • Reducing risk of cancer (primary and recurrence)
  • “Teachable moment”
  • Consistent message

• Longer Term Follow-up
  • Stratified follow-up
  • Managing late effects of treatment
  • Importance of Treatment Summaries
Realising the Benefits: Trust & Clinical Perspective

Sajal Rai
Clinical Lead
GM Colorectal Pathway Board
Key elements for success

Emphasis on the ‘Straight to Test’ element.

Maximise (safely) the number of referred patients going for a test first. (colonoscopy, CTC, Flexi sigi + CT, CT scan, CT scan with 3-day prep etc).

A robust triage and assessment of referred patients done by experienced personnel as per JAG recommendations.

- Endoscopy background
- Telephonic or face to face.
- Material risks discussed
- Alternatives discussed with high risk patients
Key elements for success

Key role for Cancer Navigator
- Chase up patients for appointments
- Harvest all results/ help in the switch-off process
- Booking for MDT discussion where appropriate
- Collection and audit of all data

• Trusts need an efficient switch off process to meet the 28 day rule.

• Agreement in place with local CCG for discharge/ follow-up of switched off patients.

• Regular feedback to primary care to improve quality of referrals.

• Education (both at GP surgery level and at the Hospital)
Pitfalls

Lack of buy-in into the process

Patients themselves (usually due to lack of information)
- Fail to keep appointments/ not available for phone calls
- Essential for patients to be aware they are being referred on a suspected cancer pathway

Endoscopy departments
- Concerns about patient safety
- Cancellations on the day/ Datix

Radiology departments
- Cancellations/ delays of tests

Very strict/ ambiguous local criteria for STT
- Gradual decline in number of patients going for straight to test.
Pitfalls

Lack of a robust switch-off process (Inform patients and GPs of results)
  • Pathway breach as patient not informed in time

Inadequate senior clinical support for CNS/Navigator
  • CNS/Navigator should have access to Consultant at all times (Consultant in clinic of the day/On call)

Lack of regular monitoring of the pathway by the local steering group
  • Undetected decline of the pathway
  • Regular audits/data review essential

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