Cancer Vanguard work on timed ‘best practice’ pathways in prostate, colo-rectal, oesophago-gastric and lung cancer

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Aims

To develop *and* demonstrate implementation of one or more “best practice timed pathways”.

In early 2017, the three vanguard partner medical directors (Dave Shackley, Kathy Pritchard-Jones, Nicholas Van As) initiated a pan-vanguard project to develop detailed consensus ‘timed best practice’ pathways:

Lung, Prostate, O-G and Colorectal pathways chosen for biggest impact in terms of:
- Improved 1 year survival rates,
- Increase screening uptake (where relevant)
- Reduce variation between providers and CCGs
- Improve and sustain cancer waiting times performance
Working Groups

• Vanguard sites’ tumour-specific clinical pathway directors were tasked with forming working groups to develop new consensus pathways and implement the national optimal lung cancer pathway (NOLCP).

• Working groups were asked to include commissioners, primary care representatives, patients and finance leads.

• Final membership reflected the challenges in each pathway, e.g. prostate radiologists were closely involved as defining criteria for pre-biopsy MRI is considered vital for that pathway.
Pathway Development

Clinical Leads set the following remit:

• Align their existing pathways and look for opportunities for more ambitious timescales
• Produce pathways based on best practice, consistent with meeting (and in some cases exceeding) national cancer standards.
• Build on/feed into national service specifications and any other high quality work in the country.
• Pathways should aim to lower the stage of diagnosis at treatment.
• Define the metrics for demonstrating impact, including patient experience feedback.
• Work with NHSE on implementation guidance for Cancer Alliances
Benefits of Vanguard Leadership

• The Vanguard works across three cancer systems meaning that replicability is built into the design of the pathways.
• The pathways will be implemented across a population of 10.8m and a large number of organisations, increasing credibility.
• Gaps in pathways can be identified and rectified in real time.
• Part of the Vanguard’s core aims is to spread learning around best practice and implementation.
• Initial learning from this work identified the importance of:
  • clinical leadership
  • resourcing for project management support to the clinical groups
  • QI approach (i.e. PDSA cycle) and local dissemination
  • engaging commissioners through STP cancer commissioning boards.
Implementing the National Optimal Lung Cancer Pathway (NOLCP)
Day 1 - 5

Suitable for potentially curative treatment?

Curative Intent Management pathway*

Test bundle requested at first OPA including at least: PET-CT and as required: detailed lung function and cardiac assessment / ECHO.

Meet with LCNS and receive information.

Day 21

Full MDT discussion of treatment options

Follow-up Lung Cancer Clinic
Cancer Confirmed and treatment options discussed.
Research trial considered.
LCNS present

OPA with treating specialist (within 3 working days)

Further investigation(s)?

Yes

Further discussion needed?

Yes

No

No cancer: Manage/discharge

*Refer to separate numbered pathway for detail

# Low threshold for curative intent pathway; may discuss with wider MDT if unsure

Some or all diagnosis and staging tests may be in a tertiary centre

+ all patients with stage IV cancer should be routinely offered an assessment

£ Reflects the aim for reduced time to treatment; the national target remains 62 days

Throughout pathway: • consider entry into a research trial • offer supportive & palliative care, e.g. by LCNS, GP, specialists in palliative care • encourage smoking cessation

Day 1 - 3

CT same day / within 72 hours

No

GP

Urgent or routine CXR

Day 1 - 5

High clinical suspicion?

No

Day 33

Day 42

Day 49£

Maximum times

CT normal?

Yes

CT abnormal?

No

CT suspicious of lung cancer?

Lung cancer unlikely

Further management according to local protocol with options of further management of CT findings by primary care or secondary care (see separate detailed algorithm)

CT same day / within 72 hours

TRIAGE (by radiology or respiratory medicine according to local protocol) Lung cancer suspected?

Fast track lung cancer clinic. Meet LCNS.

Diagnostic process plan / diagnostic planning meeting prior to clinic

Treatment of co-morbidity and palliation / treatment of symptoms

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No

Manage

Day 0 - 3

NICE referral guidance

CT within 24 hours if clinically indicated; inpatients seen within 48 hours by acute oncology, respiratory and/or palliative services

Day 21

Hospitals referrals (A&E, internal or incidental findings) for suspected lung cancer

CT within 24 hours if clinically indicated; inpatients seen within 48 hours by acute oncology, respiratory and/or palliative services

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London Cancer NOLCP Gap Analysis (Apr 2017)

**Does Your Hospital Meet Each Milestone?**

- 3 to Day 0 X-ray To CT
- 3 to Day 0 Hospital suspected lung CA referral CT performed and reported
- Day 0 - Day 3 Triage by radiology or respiratory medicine according to local protocol
- Day 3 - 5 Fast track lung cancer clinic, Meet LCNs
- By Day 21 if suitable for curative treatment: PET-CT and lung function and cardiac assessment / ECHO (as required)
- By Day 21 if not suitable for curative treatment: Pathological diagnosis if appropriate
- By Day 21 Full MDT discussion of treatment options
- By Day 28 Further investigations if suggested by MDT
- By Day 28 Follow-up Lung Cancer Clinic
- Cancer confirmed and treatment and research options discussed, LCNs present
- By Day 33 OPA with treating specialist
- By Day 42 Any further investigations
- By Day 62 First treatment
UCLH CC Gap Analysis Actions

The main gaps identified and actions:
1. Guaranteeing CT before OPA within 5 days
   • X-ray, CT and first OPA identified as biggest opportunity for compressing current pathway.
   • UCLH introduced a new 1 stop CT clinic
   • Homerton introduced a new radiographer reporting workforce enabling chest x-ray report- subsequent CT within 24 hours.

2. The pathology 72 hours turnaround time
   • Histopathology processes reviewed to accelerate porters’ delivery times and pathologist immediate availability.

3. Waiting times for PET CT.
   • PET remains a challenge, aiming for a new ‘single queue’ system to alleviate waiting times issues in NCL and NEL.
Manchester’s Refined Optimal Pathway - RAPID

The GM Lung Pathway Board developed the RAPID pathway which exceeds the NOLCP.

UHSM optimal pathway running for > 12 months:

- 526 GP referrals with suspected lung cancer.
- ~90% of patients completed CT scan, hot reporting of CT and physician triage within 7 calendar days of referral.
- 46% of patients with lung cancer commenced treatment within 28 days of referral (94% within 62 days of referral).
- Over 90% of patients received CT and triage within 7 days.
- Estimated 100 lives/yr could be saved in GM by shortening the pathway to Rx to 28 days

Sectorising Manchester into 4 centralised MDTs made it possible to deliver this pathway
Collaboration with PHE on Prostate Pathway
Prostate 62 day performance across UCLH Cancer Collaborative
Single Trust Pathways – Rolling Year Nov 16-Oct17

Average length of time for single trust pathways between the start of the cancer pathway, Date first seen, Decision to treat date, and Treatment start date

Collated by Centre for Cancer Outcomes, UCLLH Cancer Collaborative
Prostate 62 day performance across UCLH Cancer Collaborative Intertrust Pathways – Rolling Year Nov 16-Oct17

Average length of time for the 300 **UCLH** Treated pathways between Start of cancer pathway, Date first seen, Decision to treat date, and Treatment start date grouped by referring trust
Implementation and Measurement
The implementation challenge

Challenge 1: Understanding where to focus resources
• A gap analysis against the pathway is a vital first step in understanding the challenging aspects of pathways.

Challenge 2: Attempting to remove identified gaps
• Results of gap analysis to be presented to all sections of health economy (inc. commissioners, finance leads etc.) to towards a whole systems solution.

Challenge 3: Finding the resource of expertise to implement new pathways
• The Prostate pathway is reliant on expertise in performing and reporting MRI scans. UCLH Cancer Collaborative is looking into networked radiology reporting.
The implementation challenge

Challenge 4: Meeting radiology turnaround times
• Both prostate and chest radiologists have re-arranged their working times to enable ‘hot reporting’. This is a change to working pattern not an increase in reporting volume.

Challenge 5: Commissioning obstacles
• In developing the Colorectal pathway we have used the influence of the Vanguard to make the case for a change in policy regarding STT tariffs. In future Alliances could similarly look to speak with one voice.

Challenge 6: Delays around Inter Trust Transfer.
• Combining Lung MDTs in Manchester has been proven to be successful in getting patients from across a large population to treatment earlier.
How to Measure

UCLH CC have begin to measure compliance with the NOLCP, below is an example

NOLCP specifies CT within 72 hours from suspicious X-ray
New 28 day diagnosis standard

- From April 2020 Trusts will have to show compliance with 28 days diagnosis.
- In preparation UCLH Cancer Collaborative performed an audit of current pathways against this standard

<table>
<thead>
<tr>
<th>Pathway</th>
<th>Compliance</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brain and Spine</td>
<td>X</td>
<td>Day 42</td>
</tr>
<tr>
<td>Breast</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Bladder</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Colorectal</td>
<td>✓</td>
<td>New pan vanguard pathway in development which will accord with standard</td>
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<tr>
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<tr>
<td>Haematology</td>
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<td></td>
</tr>
<tr>
<td>Head and Neck</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Lung</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Ovarian</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Penile</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Prostate</td>
<td>✓</td>
<td>New pan vanguard pathway in development which will accord with standard</td>
</tr>
<tr>
<td>Renal</td>
<td>X</td>
<td>The Royal Free pathway only specifies timings from day 31.</td>
</tr>
<tr>
<td>Sarcoma</td>
<td>X</td>
<td>Some Sarcoma pathways include a first biopsy at day 28.</td>
</tr>
<tr>
<td>Skin</td>
<td>X</td>
<td>Pathway to be confirmed</td>
</tr>
<tr>
<td>Testicular</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Upper GI (OG)</td>
<td>✓</td>
<td>New pan vanguard pathway in development which will accord with the standard.</td>
</tr>
<tr>
<td>Upper GI (HPB)</td>
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</tbody>
</table>