

Cancer Commissioning Intentions: Direct Access Diagnostics

Transforming Cancer Services Team

May 2020

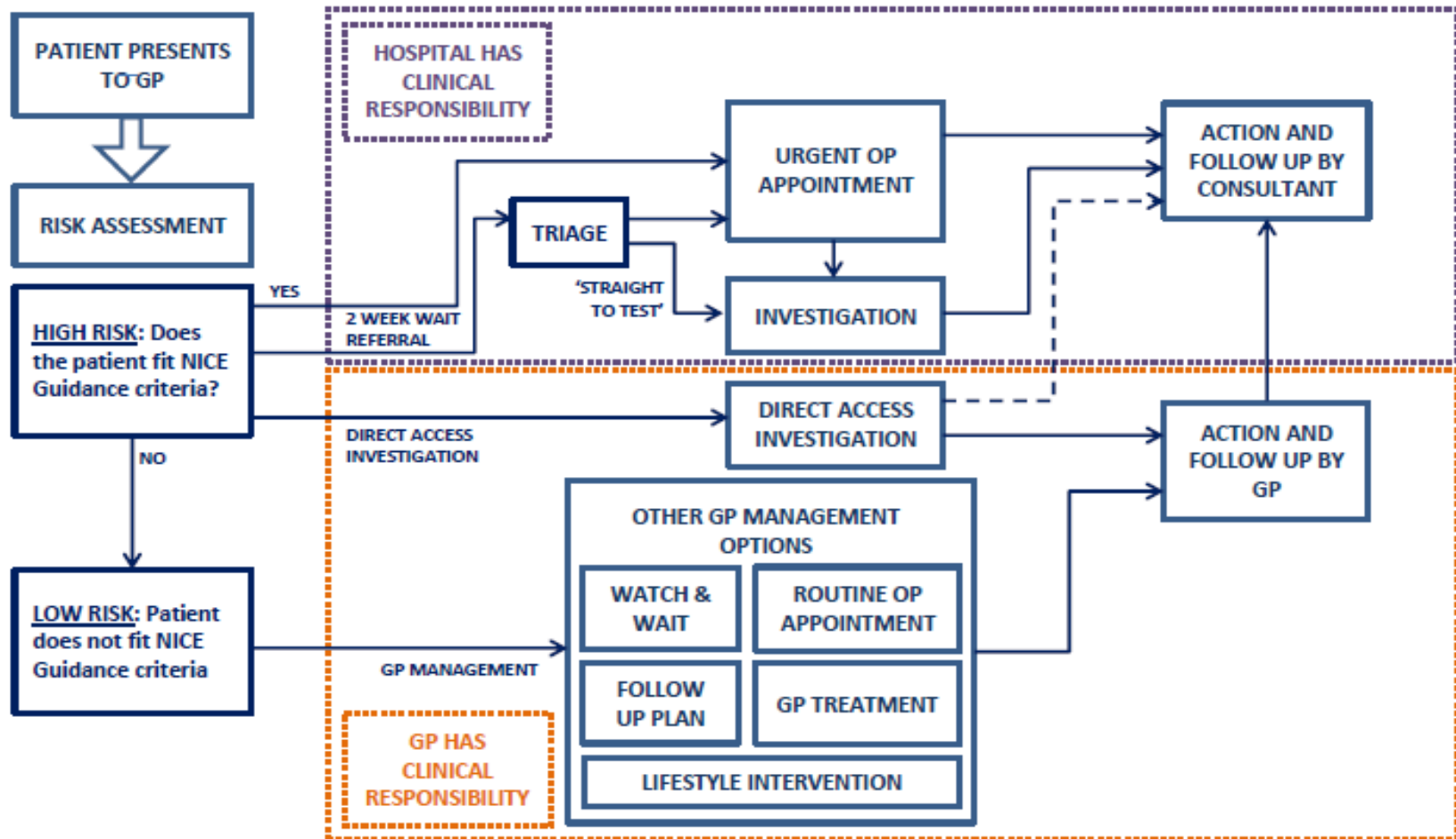


Direct Access Diagnostics

What does 'Direct Access' mean?

Direct access: “When a test is performed and primary care retain clinical responsibility throughout, including acting on the result.” (NICE, 2015)

Primary Care Risk Assessment & Diagnostic Pathway



Direct Access Diagnostics

Underlying Rationale

ACHIEVING WORLD-CLASS CANCER OUTCOMES

A STRATEGY FOR ENGLAND
2015-2020



Report of the Independent Cancer Taskforce

CANCER STRATEGY 2015 - 2020

“GPs should have direct access to four types of tests. As at the end of 2014, **only 30% of CCGs commissioned direct access to all four**, with 22% commissioning none at all.”

“The potential exists therefore to save both time, and a considerable number of outpatient appointments, if GPs could refer directly for these tests. At present, **this is much more difficult than it needs to be in most parts of the country, despite the implications for releasing scarce capacity.**”

Direct Access Diagnostics

Underlying Rationale

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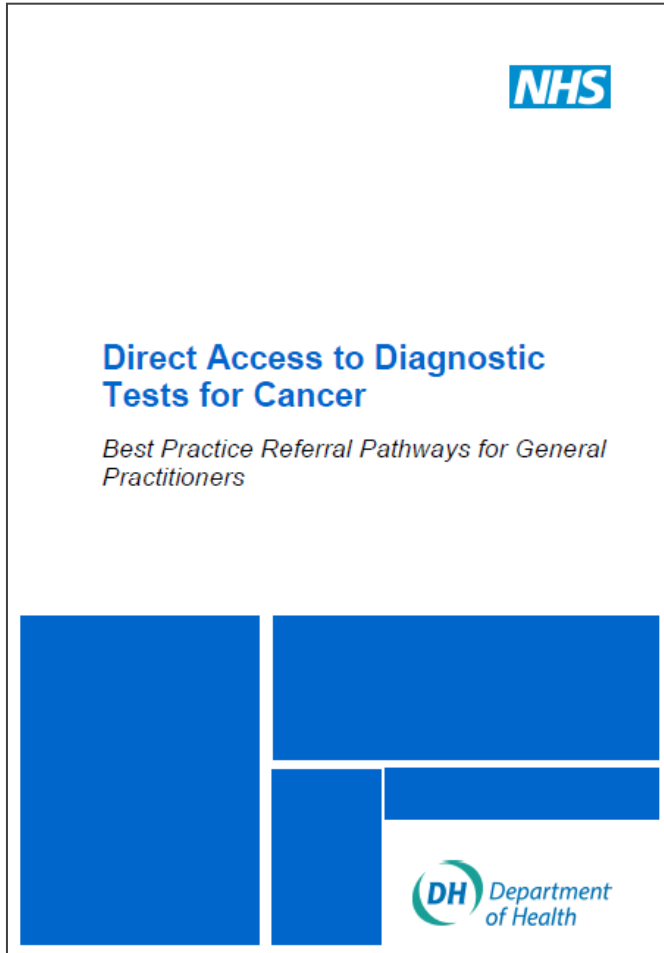
CANCER STRATEGY 2015 – 2020 Recommendations

17: NHS England should **mandate** that **GPs have direct access to key investigative tests for suspected cancer** (blood tests, chest x-ray, ultrasound, MRI, CT and endoscopy) by the end of 2015.

24: By the end of 2015, NHS England should develop the rules for a new metric for earlier diagnosis measurable at CCG level. Patients referred for testing by a GP, because of symptoms or clinical judgement, **should either be definitively diagnosed with cancer or cancer excluded and this result should be communicated to the patient within four weeks.** The ambition should be that CCGs achieve this target for 95% of patients by 2020, with 50% definitively diagnosed or cancer excluded within 2 weeks.

Direct Access Diagnostics

Underlying Rationale

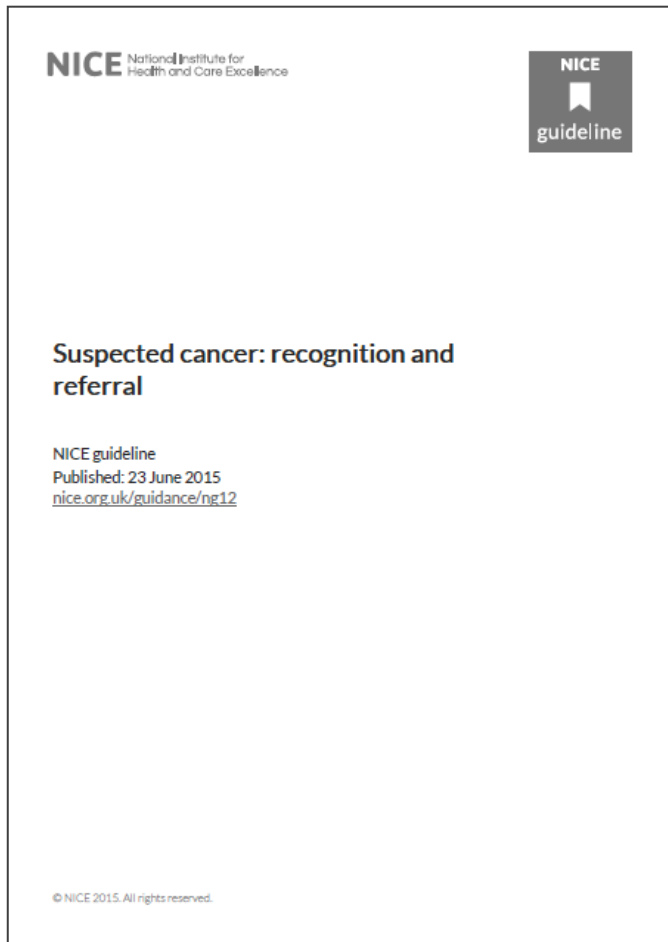


DH 2012

“...commissioners and local providers will want to consider the four priority areas for diagnostics for improving earlier diagnosis of cancer:

- ***Non-obstetric ultrasound:*** to support diagnosis of ovarian cancer
- ***Chest X-ray:*** to support diagnosis of lung cancer
- ***Flexible-sigmoidoscopy:*** to support the diagnosis of colorectal cancer
- ***Brain MRI:*** to support diagnosis of brain cancer”

Underlying Rationale



NICE GUIDANCE 2015 (NG 12)

- Previous NICE Guidance (2005) had a positive predictive value of diagnosing cancer of around 5% - this delivered a conversation rate of two-week-wait referrals of around 10% over all cancers.
- NG12 aims to lower the **positive predictive value of diagnosing cancer from 5% to 3%** which will increase the number of patients requiring investigation and lower the conversation rate.
- A number of diagnostic pathways involved direct access investigations.

Underlying Rationale

NICE National Institute for
Health and Care Excellence



Suspected cancer

Quality standard
Published: 30 June 2016
www.nice.org.uk/guidance/qs124

NICE QUALITY STANDARD 2016 (QS 124)

- GPs have direct access to diagnostic endoscopy, ultrasound, MRI, X-ray and CT for people with suspected cancer.
- People presenting in primary care with symptoms that suggest oesophageal or stomach cancer have an urgent direct access upper gastrointestinal endoscopy.
- Adults presenting in primary care with symptoms that suggest colorectal cancer, who do not meet referral pathway criteria have a FIT.
- People with suspected cancer who are referred to a cancer service are given written information encouraging them to attend.

Underlying Rationale

NICE GUIDANCE 2015 (NG 12)

Lung Cancer: CXR

Oesophageal Cancer: Upper GI endoscopy

Stomach Cancer: Upper GI endoscopy

Pancreatic Cancer: Abdominal CT scan

Gall Bladder Cancer: Abdominal ultrasound

Liver Cancer: Abdominal ultrasound

Colorectal Cancer: Occult blood in faeces

Ovarian Cancer: CA125, Pelvic ultrasound

Endometrial Cancer: Pelvic ultrasound

Testicular Cancer: Testicular ultrasound

Brain/CNS Cancer: Head MRI scan (or CT)

Myeloma: Protein electrophoresis, B-J protein

Sarcoma: Soft tissue ultrasound

NICE National Institute for
Health and Care Excellence



Suspected cancer: recognition and
referral

NICE guideline
Published: 23 June 2015
nice.org.uk/guidance/ng12

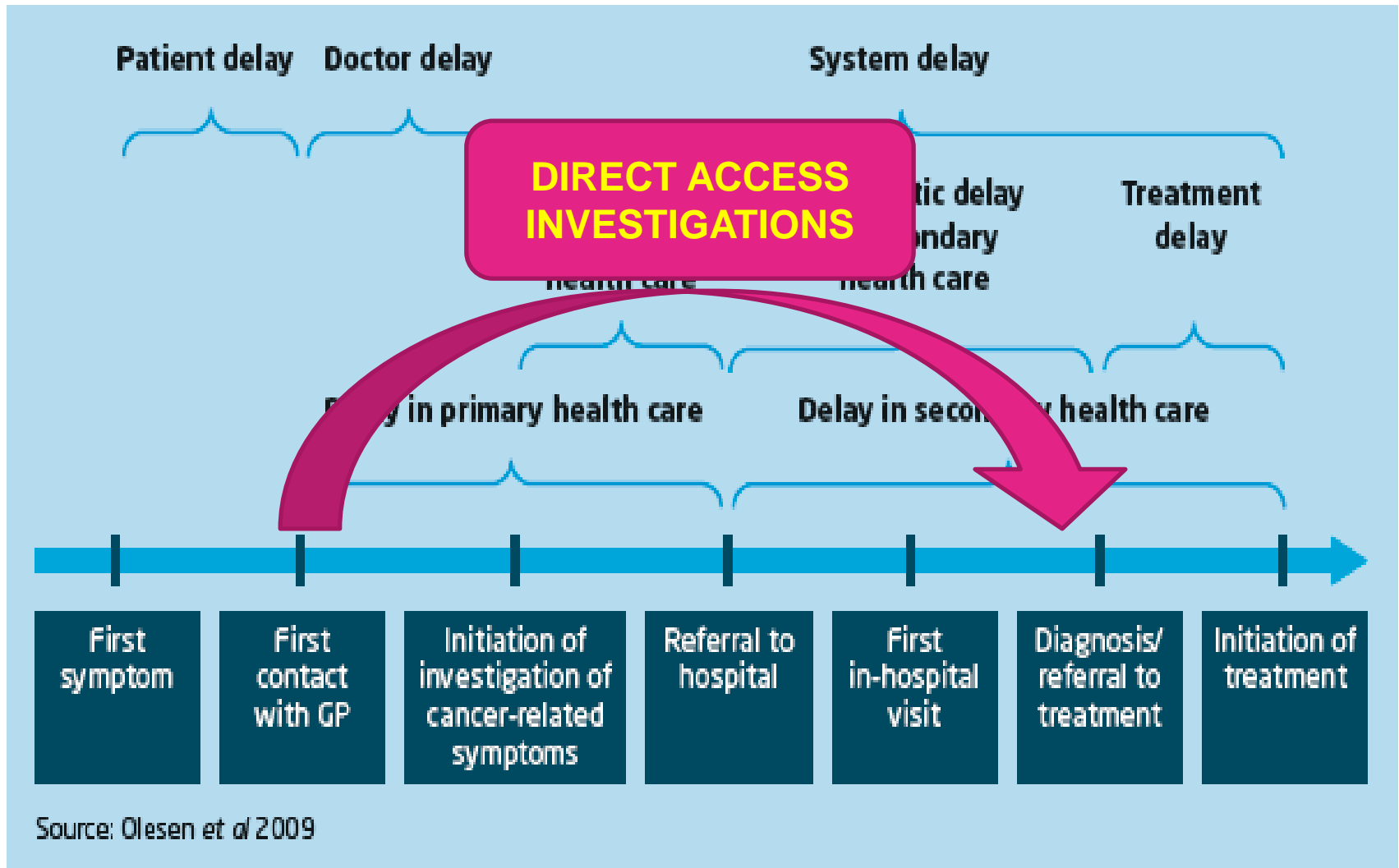
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Commissioning Intentions Direct Access Diagnostics

CI No	Direct Access Investigation	Quality Requirement	Rationale
1.3	Gastroscopy	Urgent: Maximum 2 weeks by end of 16/17 Non-urgent: Maximum 6 weeks	NG12
2.1	Non-Obstetric Ultrasound	Urgent: Maximum 1 week by end of 16/17 Non-urgent: Maximum 2 weeks Report next working day	NG12
2.2	CA125 & Transvaginal Ultrasound	Maximum 2 weeks by end of 16/17 Report next working day	NG12 & Best Practice Commissioning Pathway
2.3	Chest x-ray & x ray	Urgent: Same day investigation & report	NG12
2.7	Abdominal CT Scan	Urgent: Maximum 2 weeks by end of 16/17	NG12
2.8	Brain MRI	Urgent: Maximum 2 weeks by end of 16/17	NG12

Direct Access Diagnostics Commissioning Intentions

Underlying Rationale



Implementation Barriers for Direct Access Diagnostics

- London has lower direct access to key investigations compared with national figures
- Local variation in investigation rates, access
- Secondary Care factors
 - Diagnostics capacity
 - Anxiety regarding increased demand
- Primary Care factors
 - Capacity
 - Anxiety regarding clinical responsibility, safety netting
- 'Request to test' delays
- 'Test to report' delays
- Primary < = > secondary communication

Implementation enablers for Direct Access Diagnostics

- Clinical/ managerial leadership (primary and secondary care)
- Clinical/ managerial engagement (primary and secondary care)
- Project planning/ project management
- Agreed clinical criteria
- Customised investigation request forms
- GP educational materials
- Vetting/ audit of requests
- Feedback to users

Direct Access Diagnostics

General benefits

- Significant improvement in early diagnosis rates and therefore cancer survival rates
- Improvements in patient experience
- Improved management of cancer risk by GPs
- Treatment at early stage is less expensive
- Potential for Trusts to improve overall performance by reducing waiting times for consultant referrals, improving resource management
- Earlier implementation will lead to earlier incorporation of new 28 day target (“... *definitively diagnosed with cancer or cancer excluded and this result communicated to the patient within four weeks*”)

Direct Access Diagnostics

Actions

Actions for Commissioners:

- Ensure pathways are upgraded to incorporate NG12 guidance and QS 124
- Ensure diagnostic capacity is available
- Support implementation through GP education/development activities

Actions for Providers:

- Ensure GPs have urgent and non-urgent direct access to key investigations
- Ensure quick turnaround of reports of direct access investigations

Actions for GPs:

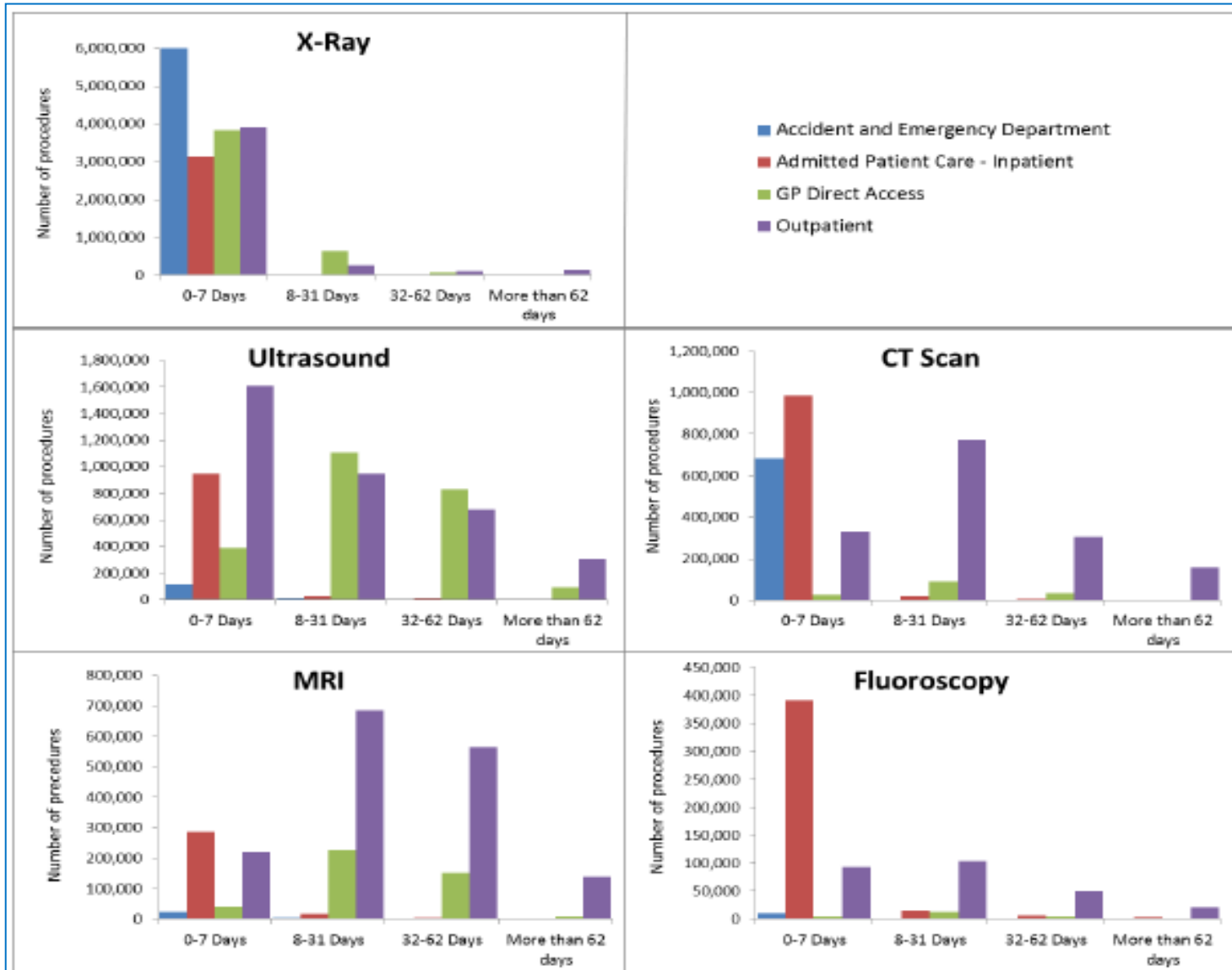
- Understand and use the new NICE Guidance
- Understand that clinical responsibility for direct access investigations remains with them for further investigation and follow up
- Ensure management systems are capable of tracking high risk patients

Additional data slides

The following slides include data to support current access to diagnostics for optional inclusion in this presentation.

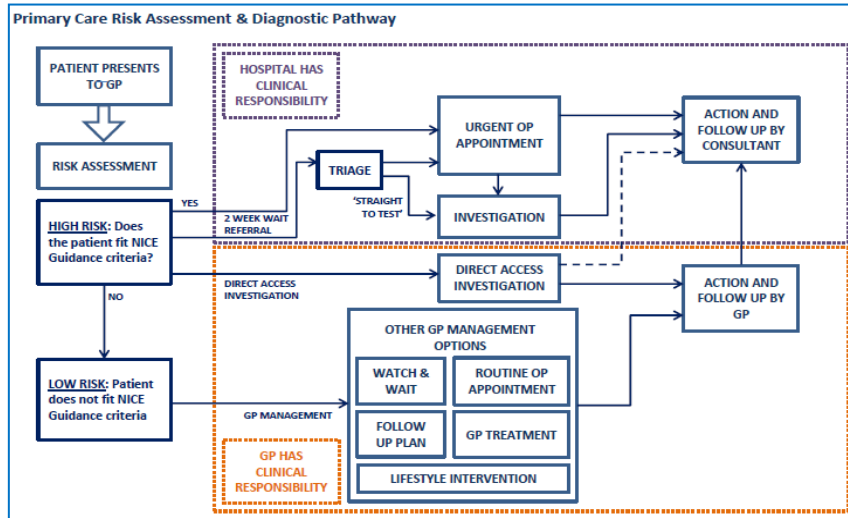
Direct Access Tests: Request to Test Delays

Graph 2: Imaging activity by number of days from date of test request to date of test, by modality and source of referral, 2014/15



CI 1.3 Direct Access to Upper GI Endoscopy

Key drivers of demand over next five years



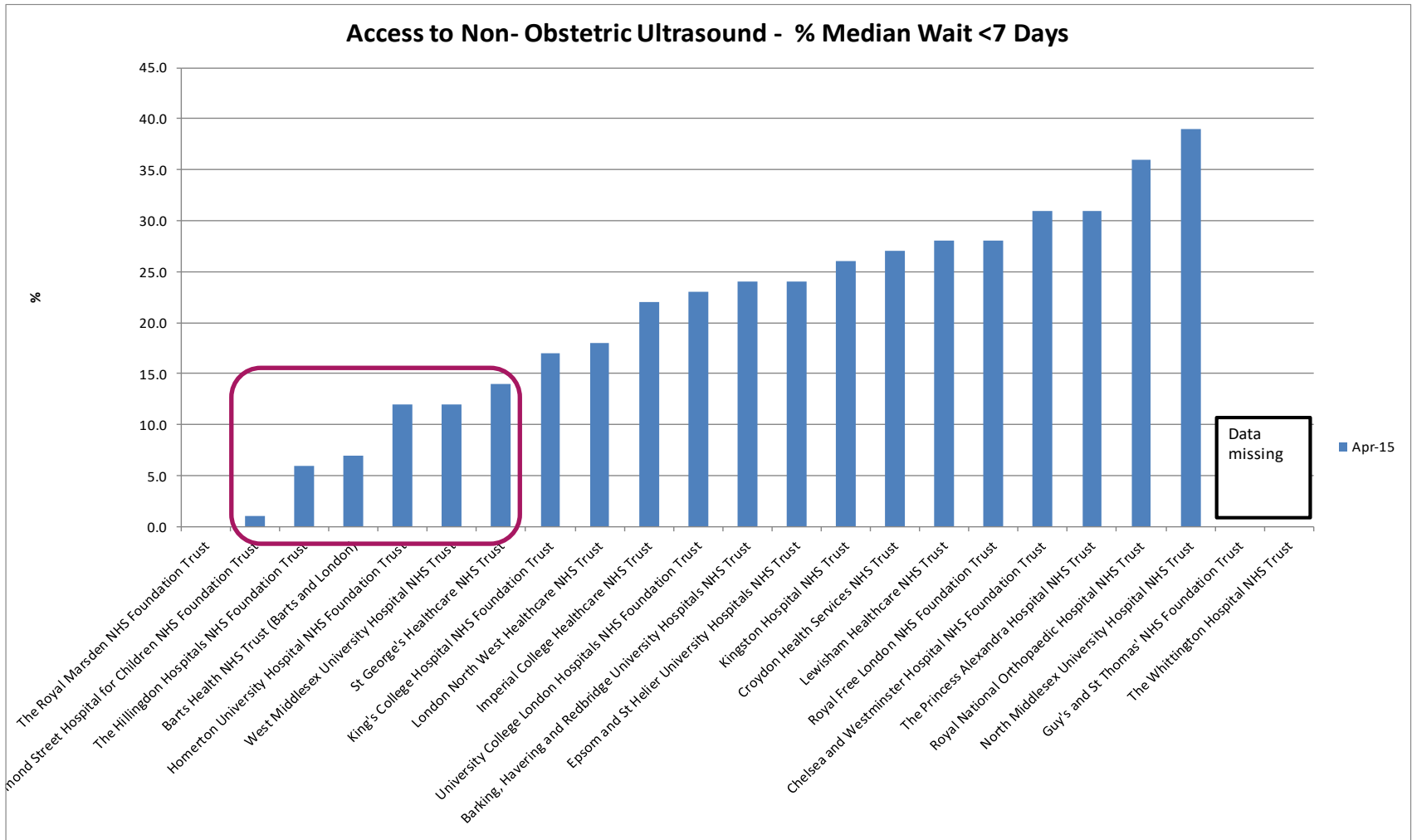
All NG12 pathways for stomach and oesophageal cancers are via Urgent (within 2 weeks) GP Direct Access to Upper GI Endoscopy

NG12 also recommends non urgent direct access upper GI Endoscopy for some cases

Direct Access Upper GI Endoscopy		
Current	10% Increase	15% Increase
40129	44142	46148

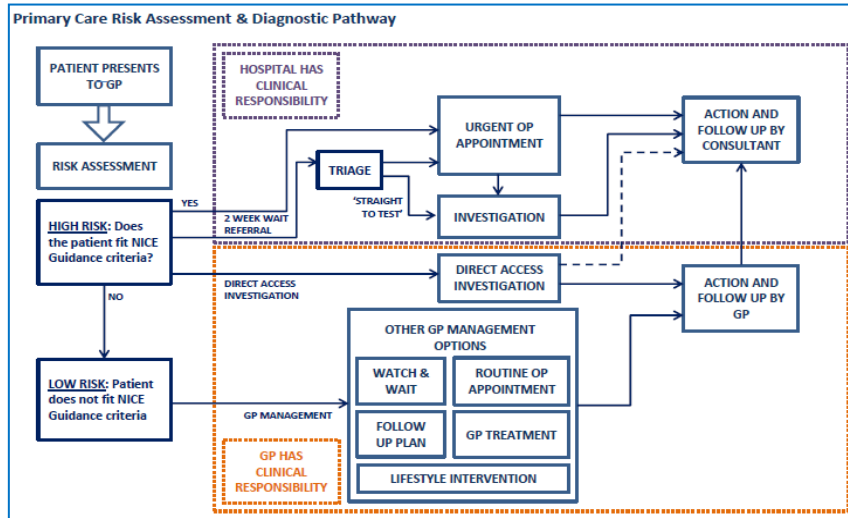
CI 2.1: Direct Access to non-obstetric ultrasound within 14 days

Median Waits for all referrals for U/S (not just GPs) in April 2015: access within 7 days (3 trusts), 8-14 days(3 trusts), more than 14 days (14 trusts), data missing (2 trusts)



CI 2.7 Direct Access to Urgent Chest XR

Key drivers of demand over next five years



Two NG12 pathways for lung cancer & mesothelioma:

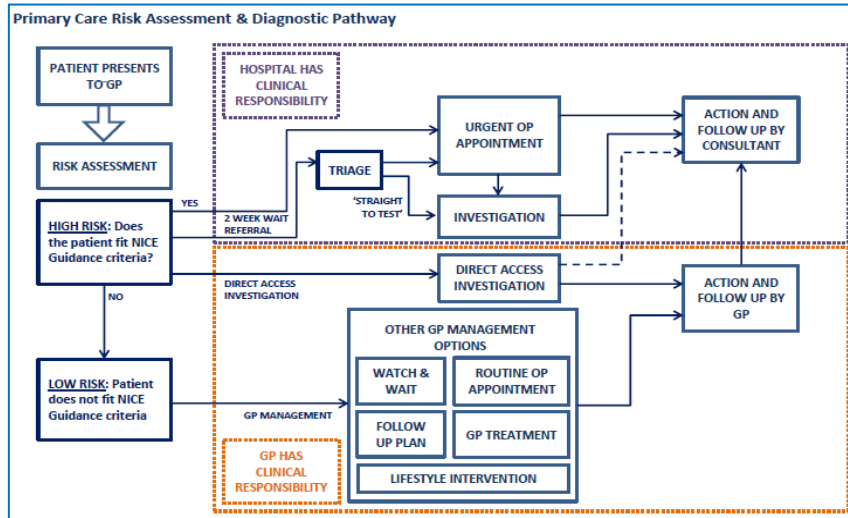
1. Haemoptysis age >40 - referral via 2 week wait pathway
2. Other symptoms - pathway is via Urgent (within 2 weeks) GP Direct Access Chest Xray

London Direct Access Chest Xray

Current	5% Increase	10% Increase
281465	295538	309612

CI 2.7 Direct Access to Abdominal CT Scans

Key drivers of demand over next five years



Two NG12 pathways for pancreatic cancer:

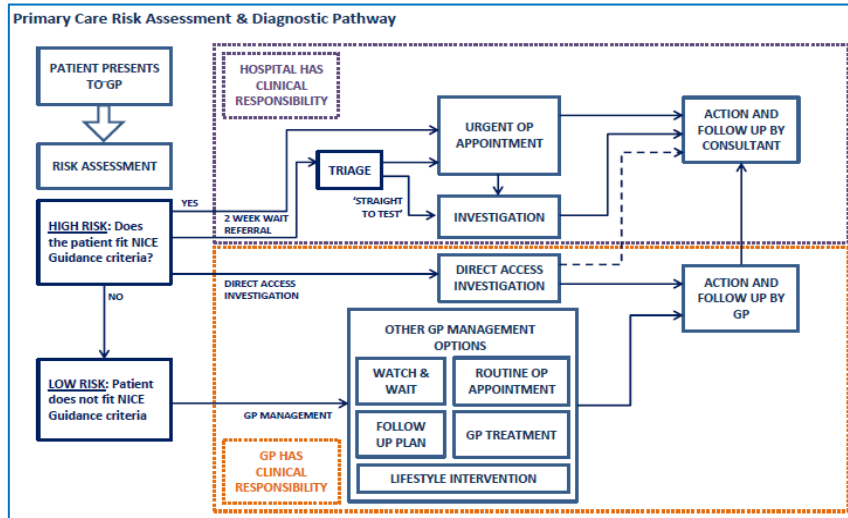
1. Jaundice - referral via 2 week wait pathway
2. Other symptoms - pathway is via Urgent (within 2 weeks) GP Direct Access to Abdominal CT Scan

London Direct Access Abdominal CT

Current	10% Increase	Matched to England Average
2455	2701	6858

CI 2.8 Direct Access to Brain MRI (&CT)

Key drivers of demand over next five years



The NG12 pathway for brain/CNS cancers in adults is via Urgent (within 2 weeks) GP Direct Access to Brain MRI

London Direct Access Brain MRI			London Brain/CNS 2WW Referrals	
Current	10% Increase	Matched to England Average	Current	Matched to England Average
4403	4843	8568	1710	1283

National Growth in Imaging Activity and Proportion of Direct Access Requests

Table 6: Imaging activity for groups of tests suitable for diagnosing cancer, for all patients referred and for those directly referred by a GP, April 2014 to March 2015

	Brain (MRI)		Kidney or bladder (Ultrasound)		Chest and/or abdomen (CT)		Chest (X-ray)		Abdomen and/or pelvis Ultrasound)	
	All	GP	All	GP	All	GP	All	GP	All	GP
2012/13	472,755	31,030	220,230	67,460	388,655	32,185	7,723,410	1,991,705	1,165,345	536,930
2013/14	528,870	39,540	220,075	65,450	438,245	39,180	7,691,055	1,931,250	1,246,225	570,235
2014/15	582,905	50,000	228,525	67,035	489,195	46,620	8,149,525	2,124,255	1,300,660	598,910
Growth	10.2%	26.7%	3.8%	2.4%	11.6%	19.0%	6.0%	10.0%	4.4%	5.0%

Direct Access Tests: Request to Test Delays

Table 7: Median number of days between date of test request and date of test for groups of tests suitable for diagnosing cancer, overall and for GP Direct Access, April 2014 to March 2015

	Brain (MRI)		Kidney or bladder (Ultrasound)		Chest and/or abdomen (CT)		Chest (X-ray)		Abdomen and/or pelvis (Ultrasound)	
	All	GP	All	GP	All	GP	All	GP	All	GP
2012/13	21	25	13	23	13	17	0	0	14	22
2013/14	21	25	13	23	13	16	0	0	15	24
2014/15	21	26	13	24	14	17	0	0	17	26

Direct Access Tests: Test to Report Delays

Table 8: Median number of days between date of test and date test report issued and Percentage of records where report issued on day of test, for groups of tests suitable for diagnosing cancer, for All referrals and GP Direct Access, April 2014 to March 2015

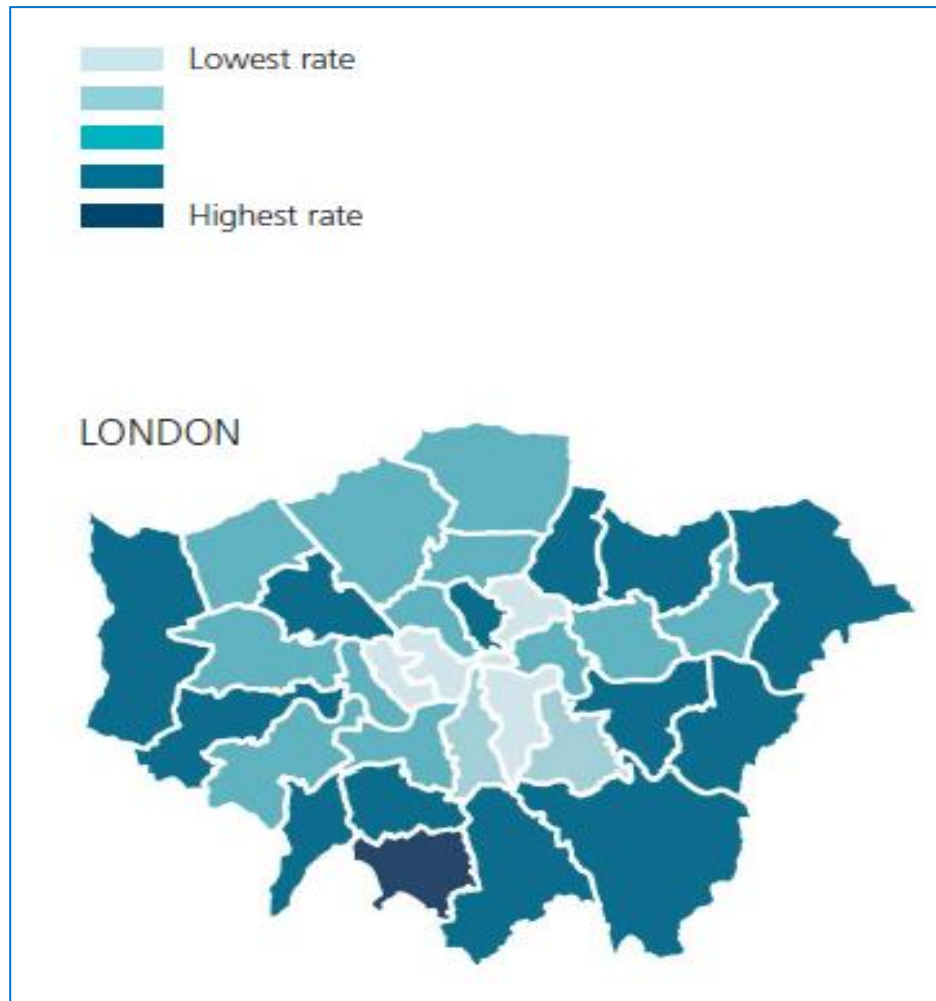
	Brain (MRI)				Kidney or bladder (Ultrasound)			
	All Median	All % Same day	GP Median	GP % Same day	All Median	All % Same day	GP Median	GP % Same day
2012/13	2	32%	3	17%	0	85%	0	80%
2013/14	2	34%	3	18%	0	89%	0	85%
2014/15	2	33%	3	18%	0	91%	0	88%

	Chest and/or abdomen (CT)				Chest (X-ray)				Abdomen and/or pelvis (Ultrasound)			
	All Median	All % Same day	GP Median	GP % Same day	All Median	All % Same day	GP Median	GP % Same day	All Median	All % Same day	GP Median	GP % Same day
2012/13	1	42%	2	32%	2	25%	2	29%	0	86%	0	84%
2013/14	1	40%	2	29%	2	25%	2	28%	0	89%	0	88%
2014/15	1	38%	2	27%	2	25%	2	28%	0	90%	0	89%

CI 1.3 Variation in Upper GI Endoscopy Rates

Map 18B: Rate of gastroscopy (upper gastro-intestinal endoscopy) procedures per population by CCG

Indirectly standardised rate, adjusted for age, sex and deprivation 2011/12

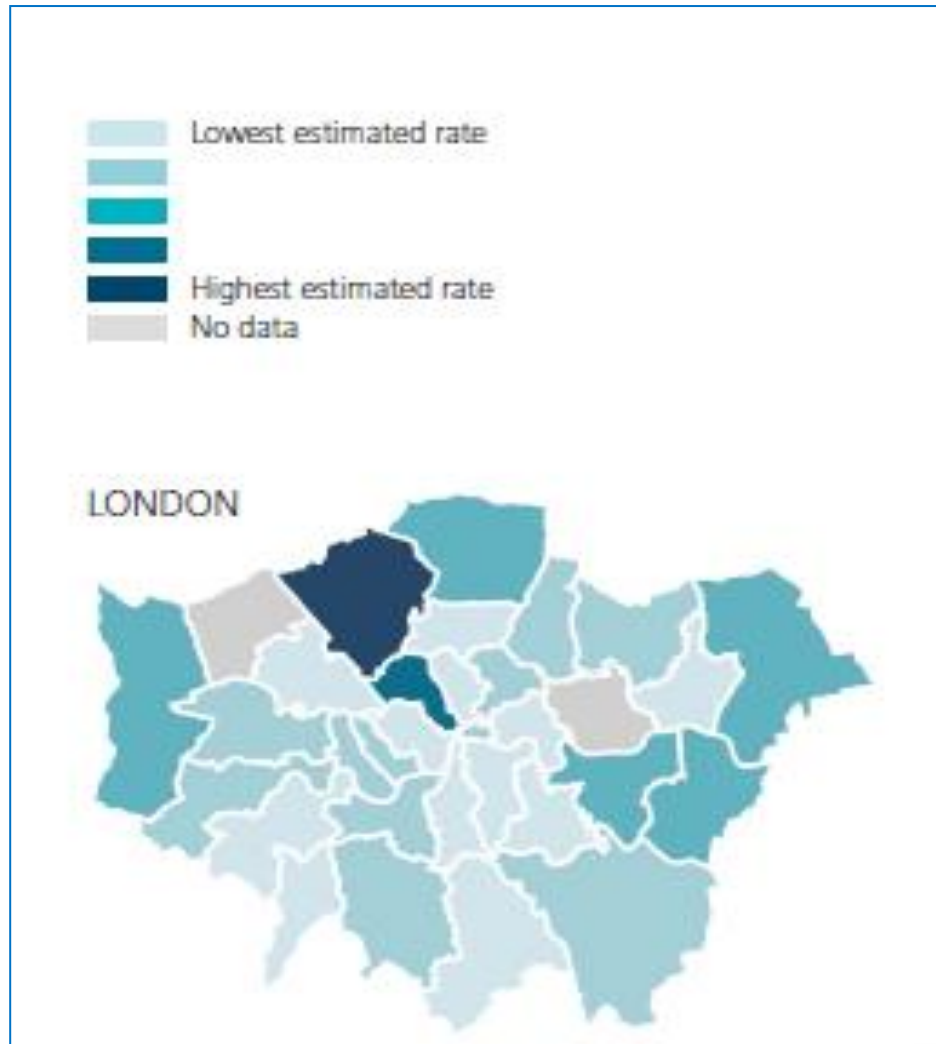


November 2013

The NHS Atlas of Variation
in Diagnostic Services

CI 2.2 Variation in CA125 Testing

Map 35: Estimated annual rate of use for carbohydrate antigen 125 (CA 125) tests ordered by GPs per practice population by PCT



November 2013

The NHS Atlas of Variation
in Diagnostic Services