

Applying High Impact Changes to Cancer Care

Excellence in cancer care

Produced by the Cancer Services Collaborative Improvement Partnership



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Endorsement

“By 2008 the NHS will provide patients in England with services that compare well with world-class standards ... Waiting for treatment will have been reduced to the point where it is no longer the major issue for patients and the public.”

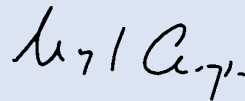
This is our commitment as outlined in the *NHS Improvement Plan* which was published in June 2004. The NHS has undergone a period of intense change over the last seven years. Driving that change has been the principle of reorganising and improving services to ensure patients are being diagnosed and treated faster and better.

We recognise that nowhere is this more important than in services for patients with cancer. That is why in the *NHS Cancer Plan* we set out a series of staged milestones and targets to be achieved by 2005.

Waiting for a specialist assessment, for diagnostic tests and for treatment can be a major cause of anxiety for patients who suspect they may have cancer and for their families.

Thanks in no small part to the work of the Cancer Services Collaborative, cancer networks and clinical teams throughout the country, the redesign of cancer services is well underway and patients are seeing the benefits. In the coming months, the focus of those involved in delivering services for people with cancer, will be the waiting times targets for December 2005: 31 days from decision to treat until first treatment and 62 days from urgent GP referral to first treatment.

We know these are challenging and we know in some areas there is a lot of work to be done. However, I think this document shows that they can be achieved and more importantly how they can be achieved. It details a series of changes which are tried and tested and are already making an enormous difference and distils the solutions to a complex and overwhelming challenge into a set of clear and tangible changes which will have the greatest impact for patients.



Sir Nigel Crisp

Chief Executive of the NHS
February 2005

Foreword

Over the last 5 years, clinical teams across England providing care and treatment for patients with suspected or diagnosed cancer have been involved in redesigning the way care is delivered for patients.

Through the work of the National Cancer Programme directed by Professor Mike Richards and the Cancer Services Collaborative 'Improvement Partnership', every cancer network and the majority of clinical teams providing cancer care have been engaged in service improvement.

The result is the development of the cancer High Impact Changes. These changes are significant in that if implemented they will not only achieve but exceed the cancer waiting times targets. If implemented, they will ensure that patients are offered greater choice, more effective, efficient and safer services enabling them to receive treatment in a timely way, free from unnecessary delays and duplication.

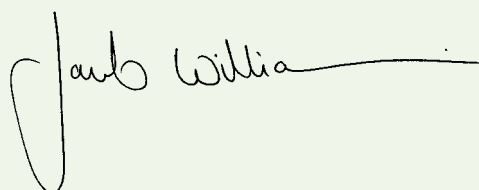
The cancer High Impact Changes are those changes which are going to make the biggest difference for the patient's journey in the NHS. They are significant in that they:

- Focus on the whole patient journey from GP referral to diagnosis, treatment options and follow-up.
- Demonstrate what needs to change at different parts of the patient process in order to make the biggest difference in the overall journey.
- Are clinically validated, tried and tested with real teams and real patients.

Health care professionals and managers responsible for cancer services will now be focusing on redesigning the patient pathway involving the Multi-Disciplinary Teams and implementing the cancer High Impact Changes. There is the potential that if these changes are adopted and implemented across England, no patient with suspected or diagnosed cancer would ever have to wait for an appointment, or a diagnosis and could be offered follow-ups when they need care.

Through the work of the Cancer Services Collaborative 'Improvement Partnership' the development of the cancer High Impact Changes is significant in leading the way in healthcare service improvement, not only in England but this work is receiving considerable interest from Canada, Australia, New Zealand, America and Europe.

By implementing what we know to really work and make the biggest difference, we should be able to ensure excellent standards of care for anyone (including ourselves and our families) suspected of having, or diagnosed with cancer.



Janet Williamson

National Director

Cancer Services Collaborative 'Improvement Partnership'

February 2005

Executive summary

1 'Cancer High Impact Changes' sets out a number of practical steps that can be taken to reduce cancer waiting times and improve patients' experience of care. This document builds on extensive experience developed by the Cancer Services Collaborative Improvement Partnership (CSC'IP') over the past few years.

2 The top high level changes for cancer services are focused around four key stages in the patient pathway

- Referral.
- Diagnosis.
- Treatment planning.
- Follow Up.

3 At referral the following processes can reduce waits

- Having demand management systems in place.
- Referral protocols for all tumour areas being agreed between primary and secondary care.
- Streamlining the referral route - one route, single queue, one point of contact.
- Pooling referrals.
- Defined patient pathways.
- Robust booking and scheduling systems.

4 To reduce waiting times through the diagnostic phase the following should be considered:

- Triage patients 'straight to test' prior to the first outpatient visit.
- Matching capacity to demand for diagnostic tests.
- Combining tests and visits (one or two stops).
- Agreed protocols for diagnosis and staging.
- Extended roles for nurses and radiographers (e.g. for endoscopy, TRUS biopsy and radiology).
- Results communication systems.
- Proactive pathway management - using trackers and navigators.

5 Effective multi-disciplinary team working is critical for treatment planning. All cancer patients should be discussed. Effective coordination of MDT meetings helps to ensure that:

- All relevant information is available.
- Decision are recorded and communicated to all relevant parties.
- Waiting times are monitored proactively.
- Further steps in the pathway are planned, booked and coordinated.

6 Consultant-led follow up can often be reduced, thereby releasing capacity for other essential tasks. Effective strategies include:

- Gaining clinical and managerial buy in to redesign the service.
- New/extended roles - e.g. nurse-led follow up.
- Releasing patients from routine follow up, but with patients empowered to contact the service if needed.
- Implementations of agreed protocols.

7 Case studies illustrating what can be achieved are included at the end of the report. These show the benefits of:

- Electronic booking of appointments from primary care (Newcastle Upon Tyne).
- A 'straight to test' approach for patients with colorectal symptoms at Glenfield Hospital, Leicester - benefiting both 'urgent' and 'non-urgent' categories of patients.
- Extended roles for nurses in the colorectal service at the Whittington Hospital, London.
- Extended roles for radiographers at James Cook University Hospital, South Tees
- A rapid access transrectal ultrasound (TRUS) and biopsy service at York Hospitals.
- The use of a tracker to ensure that lung cancer patients move seamlessly through the care pathway at University Hospitals of Leicester.
- Reduced follow up for breast cancer patients at Royal United Hospitals, Bath.

Introduction

The Challenge:

Maximum one month (31 days) wait from diagnosis to first treatment for all cancers by December 2005.

Maximum two months (62 days) wait from urgent GP referral to first treatment for all cancers by December 2005.

Beyond 2005:

The 2008 aspiration is to eliminate all unnecessary waits.

The Cancer High Impact Changes - Their origin and benefits.

The identification of High Impact Changes as a means of accelerating evidence-based service improvement was pursued by the Cancer Services Collaborative 'Improvement Partnership' (CSC'IP') during phase 2 of its activity (2001-2003).

This approach has now been developed and refined with support from many hundreds of frontline staff.

Cancer High Impact Changes can bring about service redesign to reduce unnecessary delays for patients, contribute towards the delivery of the cancer waiting times targets, to enhance the patient's experience of care and to improve the working lives of staff thereby helping to ensure sustained improvement in performance.

Despite the variations between tumour services, consistently successful approaches have been identified for each of the major tumour service pathways. These techniques have been promoted widely to clinical teams and they are now demonstrating significant and sustained improvements.

There remains, however, a continuing challenge to reach wider audiences and NHS leaders to promote their potential impact as well as meet the challenges facing us as we strive towards the 2008 aspirations.

As one of its top priorities, during the next 12 months, the CSC'IP' will actively promote the Cancer High Impact Changes to these key audiences.

What are the Cancer High Impact Changes?

Since its inception the CSC'IP' has systematically tested new approaches, distilled best practice and collated a breadth of examples of implemented changes based on redesign principles. These changes are evidence based and have been proven to make a **real difference** and have a **real impact** upon delays to a patient pathway and the patient experience itself.

The CSC'IP' Cancer High Impact Changes can be cross-referenced and linked into the generic NHS MA Ten High Impact Changes. However the Cancer High Impact Changes represent a specific set of changes for each individual tumour service that have all been extensively tried and tested to make the difference within cancer services.

The top high level cancer changes are focused around the following four stages in the patient pathway:

- One route into the system - i.e. at the point of referral.
- A 'straight to test' approach - i.e. at diagnostic stage.
- Appropriate and timely decision-making leading to prompt treatment - i.e. at the decision to treat stage.
- Reduced consultant led follow-up - i.e. at the follow up stage.

How can the Cancer High Impact Changes help my Trust?

By providing Trusts and their clinical teams with a tangible set of tools to apply locally to match their local circumstances to help to address cancer waiting times 2005.

All SHAs have Local Delivery Plan agreements with the Department of Health which include delivery of the 31 and 62 day targets on a commissioner basis. As part of local performance management arrangements, SHAs PCTs will be working with local health partners to plan, support and manage delivery of the cancer wait targets and the Cancer High Impact Changes are key to this.

What should be our next steps?

The Cancer Services Collaborative 'Improvement Partnership' fund locally based Service Improvement Leads and teams in each of the 34 Cancer Networks. The Service Improvement Lead and their team of facilitators are already working with clinical teams in hundreds of Trusts across the country.

These teams are skilled and experienced in redesign techniques and are available to support Chief Executives and their Trusts to maximise the potential to improve performance.

Implementing the High Impact Changes – the Key messages.

- Clinical teams who have redesigned patient journeys have exceeded the cancer waiting time targets and have sustained their performance.
- If clinical teams implement what we already know works, patients would not have to wait for treatment.
- CSC'IP' can work locally with both clinical and redesign teams providing the skill, advice and support to help achieve the cancer waiting time targets.

High Impact Changes explained

Cancer high impact changes explained

The Cancer High Impact Changes have been drawn from across the pathway and apply to all patients with suspected and diagnosed cancer.

Underpinning these four changes are:

- Robust data collection (to inform service planning and performance management of targets for senior managers).
- Maximum use of skill mix and extended roles.
- Service improvement methodology.
- The patient experience.

The components necessary to achieve the High Impact Changes are shown below:

At Point of Referral - One route into the system

Cancer High Impact Changes to achieve 'one route':

- Demand management systems in place.
- Streamlined referral route - one route, single queue, one point of contact.
- Referral protocols for all tumours agreed with Primary Care.
- Pooled referrals.
- Clearly defined and agreed patient pathways.
- Robust booking and scheduling systems in place.

Issues at point of referral

Patients with suspected cancer are referred to acute settings through a wide variety of routes, with varying levels of urgency and by a multitude of different processes. This might be expected to an extent given the range of symptoms that can constitute a suspected cancer.

However we know that patients are not always referred according to protocol, are not identified as having a suspected cancer despite having indicative symptoms or patients may wait on one consultant's list whilst other consultants' lists within the same team are shorter. Patients may be referred inappropriately when they should be managed in primary care, or in a worse case scenario patients sit in routine queues for weeks or months before being diagnosed with cancer.

It is important to simplify and streamline referral processes to ensure patients get on the path to diagnosis speedily. This requires a coordinated approach across primary and secondary care with a strong emphasis on the patient pathway.

Impact Area – One Route into System

Service Delivery

- Demand managed more effectively.
- Booked appointments with a choice of date.
- Shorter waiting times through eliminating the number of queues and reducing the complexity of the booking mechanisms.

Patient Experience

- One visit to hospitals for tests.
- Patient aware that consultant is fully informed about test results at OP appointment.

Clinical Outcomes

- Timeliness of test results (i.e. consultant has all test results before first patient consultation).
- Earlier diagnosis.
- Decision of how to treat patients at Multi-Disciplinary Team meeting sooner.

Benefits for Staff

- Reduction in time staff spend managing waiting lists and queues.

Diagnostics - Reducing the number of steps and streamlining the pathway¹

Cancer High Impact Changes to reduce the number of steps:

- Straight to test prior to outpatient visit.
- Results communication systems in place.
- A review of capacity and demand in diagnostic services.
- Combined tests and visits, e.g. single visit clinics, one-stop.
- Colorectal (bowel) pooled endoscopy referrals.
- Colorectal (bowel) one preparation only.
- Colorectal - straight to staging at diagnosis (appointment given to patient before leaving endoscopy/radiology for staging tests).
- Agreed protocols for testing and imaging.
- Common CT protocols and reporting formats.
- Extended roles in endoscopy and radiology supported by training.

Issues at the point of diagnosis

Linked to referral into the system, the diagnostic phase in a patient's pathway is characterised by several visits for investigations and consultant outpatient appointments. These tests and appointments are frequently uncoordinated, resulting in delays and anxiety for patients awaiting a diagnosis.

It is possible to eliminate unnecessary visits and reduce delays by looking at the way the diagnostic phase of the patient pathway is organised. There are several approaches to tackling this issue, but one that has proven to be particularly effective is ensuring that patients receive all their tests prior to first consultant appointment.

This 'straight to test' approach for suspected colorectal cancer requires that patients who are referred for a specialist opinion regarding lower GI symptoms should normally be directed to a diagnostic test in the first instance. This requires a clear history to be obtained from the patient either by the referring doctor, or by telephone or by post by the hospital in order to direct the patient to the most appropriate test.

Impact Area – Straight to Test

Service Delivery

- Appropriate use of clinical slots and expertise.
- Increased capacity for consultant slots.
- Shorter waiting times.

Patient Experience

- Appropriate sequencing of steps.
- Increased capacity for consultant slots.
- Shorter waiting times.

Clinical Outcomes

- Appropriate use of clinical slots.
- Increased capacity for consultant slots.
- Shorter waiting times.

Benefits for Staff

- Consultants not having to ask patients to return for subsequent visits once tests are complete.

¹ Cancer High Impact Changes to reduce the number of steps based on an 11 point Colorectal and Upper Gastro-intestinal Plan to assist with reducing patient journey times. (The Belfry Plan, January 2005.)

At Decision to Treat Stage - Multi-disciplinary team effectiveness for decision-making to achieve timely and appropriate treatment

Cancer High Impact Changes:

- All patients discussed.
- Joint clinics with oncology.
- Pooled referral for treatment.
- Mechanisms to ensure full team presence (either physical or virtual, e.g. via video-conferencing).
- Full sets of patient-level information available to support decision making (investigations, results, etc.).
- Processes to record decisions made as well as other patient data such as cancer waiting times.
- Processes to ensure decisions are communicated to all relevant team members including primary care.
- Processes to ensure the patient's onward journey is planned, booked and co-ordinated.
- Treating day case work as the norm for elective surgery.
- Recognising the importance of pre-assessment processes.
- Utilising available theatre time.
- Robust theatre booking and scheduling systems in place.

Issues at the decision to treat and subsequent treatment stages.

Multi-disciplinary team function is critical to the onward journey for individual patients, ensuring they are on the correct treatment path.

There is a range of treatment options that cancer patients might be offered. Commonly these are surgery, chemotherapy, radiotherapy, palliative care or supportive care. It is essential that a decision regarding treatment options are agreed by the multi-disciplinary team in discussion with the patient.

In order that this decision-making process works effectively, the multi-disciplinary team functionality itself must be strong and could be seen as possessing the following characteristics as those highlighted in the bullet point on the left.

Once the treatment plan is agreed with the patient, there should be a swift progression to treatment. Whilst broader than cancer, the generic High Impact Changes for treatment should be utilised to ensure that this stage in their journey does not cause delay for cancer patients.

Impact Area – Appropriate & timely decision making

Service Delivery

- Enables clarity of care pathway to be agreed with appropriate treatment referral.
- Enables patient-level data to be captured to evaluate effectiveness of the service.

Patient Experience

- Enables pre-booking and coordination of next steps or treatment.
- Patient involved in decision-making.
- Patient pathway the core process.

Clinical Outcomes

- Ensures effective decision-making regarding best treatment for the patient with all key staff present.

Benefits for Staff

- Enables team decision-making process.

At Follow-up Stage - Reduced consultant-led follow-up to increase capacity

High Impact Changes:

- Gain clinical and managerial buy-in to redesign the service.
- Initiate cross boundary and cross professional working – possibly seeking consensus within the network tumour site-specific groups.
- Design and implement standardised follow up protocols.
- Design new/extended roles right training provision, e.g. nurse led follow up.
- Provide patients with information about follow up protocols and contact details of key staff (e.g. nurse led, telephone & patient triggered follow up).
- Measure progress continuously to monitor sustainability and clinical capacity.
- Communicate benefits to staff and patients.

Issues at the point of follow-up

A significant proportion of follow up appointments are described as being clinically unnecessary, wasting valuable resources and causing unnecessary anxiety for patients. The recently published '10 High Impact Changes' document from the Modernisation Agency (September 2004) states that 75% of all outpatient DNAs are for follow up appointments and the rate varies between specialties but is often 10-40%.

While this may not be the case for cancer patients, who are more likely to attend follow up appointments, we still need to ensure that follow up procedures are clinically appropriate, make best use of resources and enhance the experience of care for patients. Redesigning follow up protocols to provide care at the right setting by the right person will free up a significant amount of clinical resources.

Impact Area – Appropriate & timely decision making

Service Delivery

- Potential reduction in DNA (Did Not Attend) rates.
- Increased level of nurse-led follow-ups where appropriate.
- Redirected Consultant time for other clinical priorities.
- Improved clinic scheduling to see new patients.
- Compliance with follow-up protocols can be audited.
- Active discharge of (breast) cancer patients after regular follow-up for five years.

Patient Experience

- Follow-up in the community near to home.
- Patient choice.
- Reduction in the number of visits.
- Nurse led clinics offering patients more time.
- Enhanced continuity of care in nurse led clinics.
- Positive patient satisfaction surveys.
- Reduces patient anxiety.

Clinical Outcomes

- Increased capacity to see new patients sooner.
- Provision of rapid access to service for diagnosed cancer patients.
- Reduces patient anxiety.

Benefits for Staff

- Enhanced nurses/therapists roles.
- Training opportunities.
- Reduced duplication and non value added time.
- Enhances timely decision making.

Case studies

The following illustrative set of examples describe the main principles of the cancer high impact changes. These examples follow the patient pathway and have impact on more than one of the change principles.

Newcastle upon Tyne Hospitals NHS Trust (Breast)

Electronic "end to end" booking speeds up the process for breast patients

Why was the change undertaken?

There was a growing number of fax referral forms that GPs were using. Many of these faxes were not arriving in time, going astray, incorrectly filled or with vital information missing.

How was the change achieved?

- Direct electronic referral was set up from GP surgery to the electronic breast clinic slot i.e. 'end to end' booking for suspected breast cancer patients.
- The time from GP referral to the patients appointment time being confirmed back to the GP was established as 7 minutes.
- Time span allows the GP to confirm the appointment time to the patient while she is still in the surgery.

What was the impact?

GP is able to identify an agreed appointment time with the patient in the surgery. The patient now leaves the surgery with a "cast iron" appointment time thus improving patient satisfaction by being aware of time scale.

At present this has impacted on over 100 patients. Fourteen GP practices were initially involved in this pilot. It is now being rolled out to the remaining 30 practices.

University Hospitals of Leicester (Colorectal)

Over 85% of colorectal diagnoses (benign or malignant) are now being made within 1 month through replacing the standard referral route of GP to outpatient clinic with the 'Straight to Test' protocol.

Why the change was undertaken?

Before the new 'Straight to Test' protocol was introduced only 30% of electively-referred colorectal cancer patients were referred through the 2 week wait route, of these fast tracked cancer patients only 70% were diagnosed within a month of referral.

How was the change achieved?

First the colorectal team developed their colorectal test protocol and agreed on the new 'Straight to Test' sequence (primary care, gastroenterology, radiology, surgery). They developed a new primary care referral proforma and administration processes before they tested the new 'Straight to Test' initiative. Through carrying out a dry run they could help predict demand and assess and realign capacity.

What was the impact?

Overall 85% of diagnoses (benign or malignant) are made within 1 month. Due to the success the new initiative is currently being rolled out across the City.

The Whittington NHS Trust (Colorectal)

All colorectal patients benefit from role development for nurse led clinics.

Why the change was undertaken?

Some patients were experiencing up to 15 weeks wait for investigations and results.

How was the change achieved?

Firstly the whole system approach was taken to map and improve the patient pathway by the whole colorectal team.

The following ideas were tested and implemented:

- The Clinical Nurse Specialist undertook an extended role and a protocol driven nurse led clinic has been established.
- Referrals are triaged by the Consultant Gastroenterologist.
- All patients under 40 with bright red bleeding are now seen routinely at the nurse led Rectal Bleeding Clinic.
- Three nurse endoscopists provide a nurse led Flexible Sigmoidoscopy and Biopsy clinic for urgent referrals.
- Nurses provide a flexible sigmoidoscopy biopsy in the endoscopy unit in conjunction with a consultant gastroenterologist.
- During the clinic rectal examination, the nurse carries out proctoscopy and injection of piles.
- A consultant is available in the clinic to offer support and advice if a patient requests.

What was the impact?

Consultant clinic capacity has increased and non-urgent waits have reduced from 15 weeks to 8 weeks. All urgent referrals now are seen within the NHS cancer plan targets. This service improvement has impacted on all patients referred since August 2001.

James Cook University Hospital – South Tees (Radiology)

Improvement to the fluoroscopy service and reduced waits for barium examinations.

Why the change was undertaken?

A review of the service processes for fluoroscopy examinations identified that there were waits of up to 11 weeks for urgent barium swallows, 5 weeks for urgent barium enemas and long waits of up to 40 weeks in some cases for other non urgent examinations. This was due the following bottlenecks and constraints in the system:

- Lack of access to lists.
- Poor of use of skill resources.
- Poor scheduling.

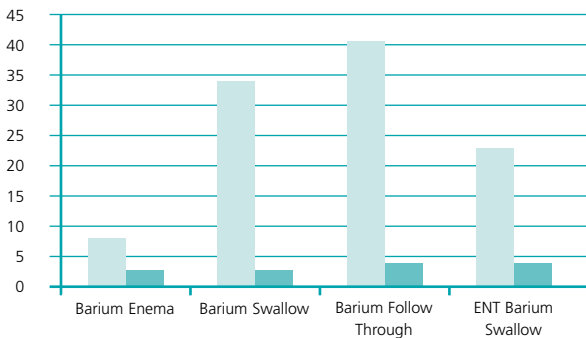
How was the change achieved?

- Clinical Lead for Fluoroscopy was given responsibility for monitoring waiting lists and taking appropriate action to address backlogs.
- Introduction of the four tier structure – Assistant Practitioners in fluoroscopy and Advanced Practitioners.
- Independent reporting of barium enema examinations by two Advanced Radiographer Practitioners.
- Additional training of Radiographer Practitioners both to perform and report.
- Barium enema examinations.
- Radiographer vetting of barium enema / barium swallow & meal requests.
- Independent performing / reporting barium swallows / meals.
- Additional radiographer sessions to clear the backlog of referrals, utilising empty lists due to Consultant Radiologists on leave.
- Dedicated VFL swallowing clinics, with dual reporting, provided for patients with swallowing disorders now provided by Lead Advanced Radiographer Practitioner and Speech & Language Therapists.

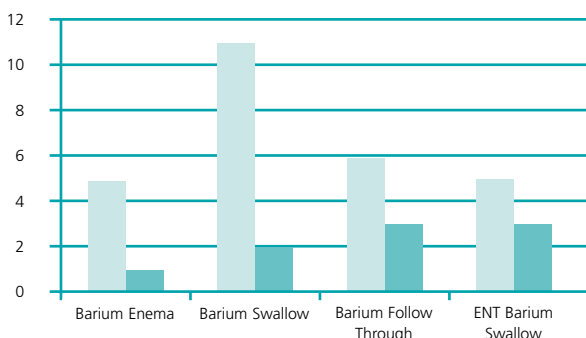
What was the impact?

- Backlog of barium enema referrals cleared, resulting in increased capacity and enabling provision of slots for same day barium enema examinations following failed colonoscopy.
- Increased capacity has allowed the backlog of other examinations, such as small bowel meals, to be cleared thus reducing waiting times for barium procedures.
- Delays in vetting process eliminated for barium enemas / barium swallows.
- Overall capacity increased which allows urgent / emergency inpatients and outpatients to be examined promptly.
- Improved access for VFL examinations, for patients with swallowing disorders.
- Patient Satisfaction survey highlighted the improved access and patient friendly service.

James Cook University Hospital - South Tees Number of weeks waiting for non-urgent Barium Studies



James Cook University Hospital - South Tees Number of weeks waiting for urgent Barium Studies



■ April 2003 ■ October 2004

Source: Radiology Service – Improvement Case studies & Learning from phase 2 & 3 pilot sites – document June 2004.

York Hospitals Improving Rapid Access – (TRUS and Biopsy)

Through developing a standardised service Ultrasound waiting times decreased from over 20 weeks to 4 weeks.

Why the change was undertaken?

Waiting times were in excess of 20 weeks with poor patient flow across healthcare boundaries, resulting in patients having to visit the hospital several times.

How was the change achieved?

- Development of Rapid Access Prostate Cancer Assessment Clinic.
- Exploration of new ways of working: specially trained nurse to run the clinic and training of a Sonographer to perform TRUS and Biopsy.
- Standardised protocols for examination.
- Introduction of a booking system.

What was the impact?

- Decreased waits from over 20 weeks to 4 weeks.
- Direct booking system has maximised patient choice of appointment time.
- Reduced number of patient visits to the hospital.
- Reduced waiting times from referral to diagnosis and treatment.
- Radiologists time for other procedures has increased.
- Role Development opportunity for Clinical Nurse Specialist and Sonographer.

University Hospitals of Leicester – (Lung)

Role redesign increases patient satisfaction and frees up vital clinical time.

Why was the change undertaken?

Through a review to improve lung services, the lung team at Glenfield Hospital identified that a great deal of the clinical nurse specialist time was being taken up trying to meet targets for patient booking and monitoring patient progress.

How was the change achieved?

Initially a preliminary job description was drawn up for the appointment of a lung tracker. This was to be a person responsible for following the patient through their journey and ensuring all relevant booking took place and documentation etc was always available when necessary:

- A spreadsheet was prepared onto which all diagnosed patients' details would be entered and subsequently monitored and checked.
- The tracker is notified of a patient at the point of a two week referral.
- The tracker pre-books investigations prior to consultation and the consultation appointment.
- All investigation results are made available for the Multi-Disciplinary Team meeting 2 weeks after consultation.
- The tracker attends and supports the Multi-Disciplinary Team.
- The patient has certainty and choice throughout their journey.
- The patient has someone they can contact to clarify or change appointments.
- Documentation follows the patient through their journey.

What was the impact?

All patients coming through the system as a diagnosed cancer are now supported in this way. The system continues to be successful and has been rolled out to the other trusts within the cancer network. Similar posts have now been appointed in other specialities.

The Royal United Hospital, Bath (Breast)

Follow up protocol for breast creates capacity for 1000 more patients.

Why the change was undertaken?

At the Royal United Hospital Bath, it was felt that a review of the protocols for family history and breast cancer follow-ups would lead to an improved use of clinic capacity. It was estimated that a minimum of 2000 outpatient appointment could be re-utilised in the surgical and oncology breast clinics.

How was the change achieved?

- Draft protocols were discussed with the cancer steering group and the primary care cancer representatives.
- Letters and questionnaires were sent to the relevant parties for ratification.
- An audit was made of medical records for patients on existing follow up (both family history and breast cancer patients) to determine eligibility.

What was the impact?

- A family History clinic self-assessment questionnaire has now been developed.
- Patients are now seen in the clinic or by the screening programme.
- Patients discharged from the follow up at 5 years are entered onto a mammographic screening program.
- Patients can self refer at any time.

Overall 1000 breast cancer patients have been discharged from clinical follow up at 5 years post treatment (was 10 years) and entered onto the mammographic screening programme, which has increased clinic capacity of 1000 per annum.

January 2005 update.

Since the implementation of this protocol, the department has moved on considerably in its development and is in the process of ratifying a revised protocol. For further details, please contact Sarah Hudson, Cancer Services Manager on 01225 824042, sarah.hudson@ruh-bath.swest.nhs.uk

The challenges now and for the future

The implementation of cancer specific high impact changes are a powerful lever to enable the delivery of cancer waiting times and significantly improve the patient's experience of cancer services.

There remains however some fundamental challenges:

- The adoption of evidence based Cancer High Impact Changes by wider audiences.
- Changing the mindset of NHS managerial and clinical leaders in order to understand and promote the impact of service redesign.
- 'Developing cancer services for tomorrow whilst trying to cope with the services of today'.
- 'Seeing the whole patient's journey through the eyes of the patients and their carers.'
- The positioning and promotion of cancer high impact changes to become a natural part of the commissioning process and service levels agreements.
- Getting the basics right to achieve, and where possible exceed, the 2005 targets and be in a position to meet the aspirations for 2008.
- Getting the basics right to achieve the NHS performance ratings
- Not losing the focus on cancer care as the healthcare agenda continues to re-prioritise, refocus and react.

We can meet these challenges

The CSC'IP' will continue to support local NHS Leaders and their teams in the acceleration of the adoption of the cancer high impact changes. This evolving partnership will become stronger through addressing the challenges together and experiencing the new challenges as they emerge.

"Cancer High Impact Changes sets out actions that can be taken at each of four key steps in the care pathway for cancer patients: Referral, diagnosis, treatment planning and follow up. These actions have been tried and tested in different parts of the country - and have been shown to reduce waiting times and improve patients' experience of care. Our challenge over the coming months is to ensure that all services adopt these or similar changes to meet the promise of shorter cancer waiting times."

Professor Mike Richards

Summary and benefits

Implementation of the High Impact Changes have been shown to reduce waiting times, improve performance and have a direct impact on the quality of the patient experience from referral to treatment.

NHS Leaders have a key role in promoting and implementing these changes within their local organisations to make the difference.

This publication has been designed to give an illustration of what can be achieved by teams from across the country given the support of their local NHS Leaders and supported by teams, such as the Cancer Services Collaborative, who are able to provide advice and expertise to help tackle the challenges you face locally.

| Impact Area | Service Delivery | Patient Experience | Clinical Outcomes | Benefits for Staff |
|---|---|---|--|---|
| One Route into System | <ul style="list-style-type: none"> ● Demand managed more effectively ● Booked appointments with a choice of date ● Shorter waiting times through eliminating the number of queues and reducing complexity | <ul style="list-style-type: none"> ● Booked appointments with a choice of date ● Shorter waiting times, equity of waiting times | <ul style="list-style-type: none"> ● Likelihood of earlier diagnosis and treatment through protocol driven care ● Enable Trust to conform to National Guidelines for example Improvement Outcome Guidance | <ul style="list-style-type: none"> ● Reduction in time staff spend managing waiting lists and queues |
| Straight to Test | <ul style="list-style-type: none"> ● Appropriate use of clinical slots ● Increased capacity for consultant slots ● Shorter waiting times | <ul style="list-style-type: none"> ● One visit to hospital for tests ● Patient aware that consultant is fully informed about test results at out patient appointment ● Shorter waiting times | <ul style="list-style-type: none"> ● Timeliness of test results (i.e consultant has all test results before first patients consultation) ● Earlier diagnosis ● Decision of how to treat patient at Multi-Disciplinary Team meeting sooner | <ul style="list-style-type: none"> ● Consultants not having to ask patients back for subsequent visits once tests are complete ● Value of team decision-making processes |
| Appropriate & timely Decision Making | <ul style="list-style-type: none"> ● Enables clarity of care pathway to be agreed with appropriate treatment referral ● Enables patient-level data to be captured to evaluate effectiveness of the service | <ul style="list-style-type: none"> ● Supports booked care ● Patient involved in decision-making ● Patient pathway the core process | <ul style="list-style-type: none"> ● Ensures effective decision-making re: best treatment for the patient with all key staff present | <ul style="list-style-type: none"> ● Enhanced nurses / therapists roles ● Training opportunities ● Reduced duplication and non value added time ● Enhances timely decision making |
| Reduce Consultant Follow-Up | <ul style="list-style-type: none"> ● Potential reduction in DNA (Did Not Attend) rates ● Increased level of nurse-led follow-ups where appropriate ● Redirected Consultant time for other clinical priorities ● Improved clinic scheduling to see new patients ● Compliance to follow-up protocols can be audited ● Active discharge of (breast) cancer patients after regular follow-up for five years | <ul style="list-style-type: none"> ● Follow-up in the community near to home ● Patient choice ● Reduction in the number of visits ● Reduced waits ● Nurse led clinics offering patients more time ● Enhanced continuity of care in nurse led clinics ● Positive patient satisfaction surveys | <ul style="list-style-type: none"> ● Increased capacity to see new patients sooner ● Provision of rapid access to service for diagnosed cancer patients ● Reduced patient anxiety | |

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10 Key local contacts



The Cancer Services Collaborative Improvement Partnership
is part of the NHS Modernisation Agency

Contact details

Head Office

3rd floor St John's House
East Street, Leicester LE1 1NB

Tel: 0116 222 5110

Email: cancer.collaborative@npat.nhs.uk

Website: www.modern.nhs.uk/cancer