



Rapid diagnostic and assessment pathways

Implementing a timed **colorectal cancer** diagnostic pathway

A handbook for local health and care systems

April 2018

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Description	Rapid diagnostic and assessment pathways illustrate how timely and effective care can be provided to patients presenting with cancer symptoms. Delivery of the pathways will support us to provide the highest quality care to our patients, and reduce variation in patient access to diagnostic and treatment options. This handbook sets out how diagnosis within 14 days and diagnosis within 28 days can be achieved for the lung cancer pathway.
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- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request.

Please contact 0300 311 22 33 or email england.contactus@nhs.net stating that this document is owned by the NHS Cancer Programme, Operations & Information, NHS England.



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Rapid diagnostic and assessment pathways illustrate how timely and effective care can be provided to patients presenting with cancer symptoms. Delivery of the pathways will support us to provide the highest quality care to our patients, and reduce variation in patient access to diagnostic and treatment options.

This handbook sets out how diagnosis within 28 days can be achieved for the colorectal cancer pathway. We have identified useful resources that can support you with implementation, and have highlighted the key role of cancer alliances in delivering large scale transformation across whole systems.

The pathway in this document has been shaped by the NHS England Clinical Expert Group for Colorectal Cancer.

Clinical Expert Groups (CEGs) bring together clinical leaders who provide tumour specific clinical expertise. Their role includes ensuring that advice on best practice cancer pathways is evidence-based and is available for anyone involved in the improvement of cancer services. This includes cancer alliances, commissioners, clinicians, managers, and patients.

This guidance complements existing resources such as NICE Guidelines (including NG12) and should therefore be read alongside such guidance.

The National Cancer Vanguard is a leader in developing and defining best practice timed pathways. The Vanguard includes Greater Manchester Cancer, RM Partners, and the University College London Hospitals Cancer Collaborative.

For any questions about this document please email the NHS Cancer Programme at england.cancerpolicy@nhs.net.

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The [national cancer strategy](#) sets out an ambitious aim for the NHS to make significant progress in reducing preventable cancers, increasing cancer survival and improving patient experience and quality of life by 2020.

Survival rates for cancer in England have never been higher, and overall patients report a very good experience of care. However, we know there is more we can do to ensure patients are diagnosed early and quickly, and this will have a major impact on survival. We also know that patients continue to experience variation in their access to care, which needs to be addressed.

Early diagnosis, fast diagnosis, and equity of access to treatment and care are central to the National Cancer Programme and the transformation of services we want to achieve by 2020/21.

Faster Diagnosis Standard (FDS)

We are implementing a new diagnostic standard for cancer that emphasises the importance of receiving a diagnosis or ruling out of cancer within 28 days. For patients who are diagnosed with cancer, this means treatment can be offered earlier. For those who are not diagnosed with cancer, this communication of an 'all clear' reduces the anxiety felt at a very stressful time.

Cancer alliances are leading their local commissioners and providers to drive earlier and faster diagnosis. The rapid diagnosis and assessment interventions they are putting in place now will help to ensure the Faster Diagnosis Standard is met for patients when fully

introduced from April 2020.

The new Cancer Waiting Times system should be used to support the collection of the new faster diagnosis data items. This data can be used to audit how long it takes for patients to have their diagnosis communicated to them, and understand where to make improvements to shorten pathways. The focus is on reducing variation for patients and providing a consistent timed pathway.

Teams may improve beyond the pathways in this handbook, radically shorten the diagnostic time period further, building on local innovation to deliver sustainable pathways. The aim is to enable patients to have their diagnosis communicated to them in the shortest time possible, having experienced high quality care.

E-referrals service (eRS)

The NHS e-Referral Service is the process for referring all consultant-led first outpatient appointments from 1 October 2018. Resources for implementation are here.

Faecal Immunochemical Test (FIT)

FIT should be undertaken for all low risk symptomatic patients prior to referral (DG 30 guidance). Systems should increase laboratory capacity for FIT to meet current NICE guidance, and review endoscopy capacity. NHS England is coordinating further research and evaluation studies on the use of FIT for symptomatic patients.



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How to achieve success:

- ❑ **Engage with patients** throughout the pathway redesign and implementation stages to ensure that changes will benefit your patients in terms of clinical outcomes and patient experience.
- ❑ **Ensure board or executive level sponsorship** in each organisation to ensure prioritisation of pathway implementation (board-level reporting of progress and diagnostic performance)
- ❑ **Establish a cross-system implementation team** to enable access to limited resources, implement changes, overcome organisational divisions and structures, and avoid 'silo' working. This could include GPs, consultants, clinical nurse specialists, pathway navigators, cancer alliance leads, and CCG and Acute trust leads (e.g. contracts, IT).
- ❑ **Identify clinical champions across the pathway**, across disciplines and departments, to ensure clinical leadership and endorsement on the ground. This can help you to quickly resolve problems, and develop and implement additional solutions to service challenges throughout implementation.
- ❑ **Engage and communicate regularly with key stakeholders** throughout the implementation process. Use local networks for communication, such as newsletters and GP events, to build awareness. Sharing positive feedback can be powerful.
- ❑ **Establish workforce development for teams** in order to support new ways of working across the whole pathway (e.g. network radiologists with buddying between individuals with different levels of experience, joint masterclasses on the pathway).



Your cancer alliance

Cancer alliances are the local strategic leaders for cancer, driving the change needed across the country to achieve world class cancer care in England.

There are 19 cancer alliances across the country, and these organisations bring together local leaders to implement the cancer strategy at a local level.

NHS England provides support, funding and guidance to help cancer alliances improve outcomes and reduce variation for their populations.

Your cancer alliance will work across the local system to ensure:

- Senior stakeholder prioritisation of pathway implementation
- Development of clinical leadership (e.g. pathway transformation leads)
- Successful coordination of cancer services
- Access to national learning and resources by local organisations
- Provision of transformation and change management expertise to support improvement



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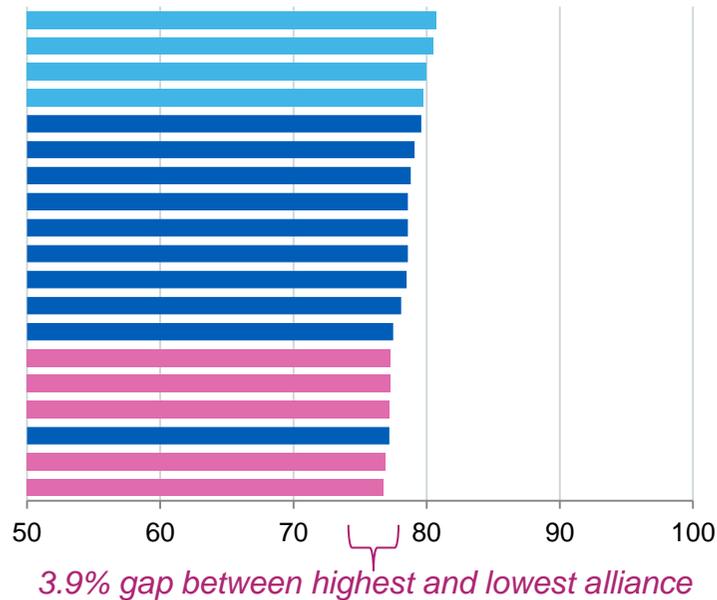
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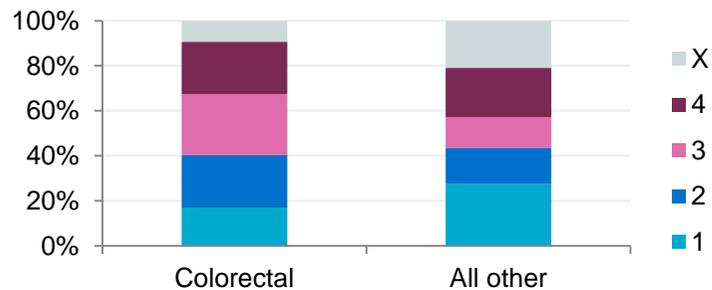
One-year survival for colorectal cancer, by alliance, 2011-2015, ONS



Colorectal cancer is the fourth most common diagnosed cancer in England, and is the third most common cancer in both men and women.

- For colorectal cancer patients in England diagnosed 2011 to 2015, **one-year age-standardised net survival was 78.4%**. This varied by cancer alliance with a range of 76.8-80.7%.
- For colorectal cancer patients in England followed up to 2016, **five-year age-standardised net survival was 60.5%**. This varied by cancer alliance with a range of 57.3-63.7%.
- In 2016, only **40.3% of all colorectal cancers were diagnosed at an early stage**. This varied by cancer alliance with a range of 36.1-45.6%.
- There is **considerable** variation in Routes to Diagnosis. Patients from the **least deprived quintile are less likely to be diagnosed through an emergency presentation** (by nine percentage points). More deprived patients also have lower survival at given Routes to Diagnosis.

Stage at diagnosis, 2016





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“In spite of improvements in the results of treatment for patients with colorectal cancer, fewer people diagnosed in England survive the disease than patients in comparable countries such as Norway and Switzerland. International benchmarking shows that we are 7% behind these countries in (estimated) five year survival for colorectal cancers. There are also significant differences between the regions in England.

Early diagnosis confers the best chance of cure. Lowering the threshold of referral for patients with colorectal symptoms to scaled up and streamlined diagnostic services should impact the unwarranted national and international variation in outcome.”

Mr Michael Machesney
NHS England Colorectal Cancer Clinical Expert Group

Features of a faster pathway

Patient information	Provided at point of referral, information resources can empower patients and help to manage anxiety by setting out what can be expected from the diagnostic process (e.g. tests, timings and communications). This information can benefit patient experience and also encourage compliance, which will reduce delays along the pathway (i.e. reduced DNAs and re-booking of appointments). Best when co-produced with patients as part of a pathway improvement programme.
Service models	Implementing the following service models can support services to reduce variation and make improvements to patient flow: <ul style="list-style-type: none"> • Clinical triage to optimise direct access diagnostics, ensure patients in the ‘right place, first time’ • One stop models for a faster diagnostic pathway, particularly effective alongside hot reporting • Standardised diagnostic bundles with simultaneous booking of all likely investigations • Networking (e.g. hub and spoke) to optimise use of existing resources and expertise, particularly useful for improving radiology reporting turnaround times and access to specialist investigations.
Workforce utilisation	<ul style="list-style-type: none"> • Workforce development for teams to support new ways of working across the whole pathway • Co-location of medical, nursing, navigator and support staff to improve communication, aid business intelligence, reinforce team integration, and enable effective day-to-day working • Patient navigators for administrative support and value in tracking patients for improved flow



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For patients:

- Empowerment from information about the diagnostic process provided at point of referral
- Reduced anxiety and uncertainty of a possible cancer diagnosis, with less time between referral and hearing the outcome of diagnostic tests
- Improved patient experience from fewer visits to the hospital, particularly with 'one stop' services
- Potential for improved survival by using the faster pathway to prevent patient deterioration while waiting for tests and treatments

For clinicians:

- Using a nationally agreed and clinically endorsed pathway to support quality improvement and reconfiguration of colorectal cancer diagnostic services
- Working across primary and secondary care to ensure high quality referrals into a streamlined service that gets the patient to the right place, first time
- Improved ability to meet increasing demand and ensure best utilisation of highly skilled workforce

For systems:

- Reduce demand in outpatient clinics (ACE Wave 1 report highlights a 59% reduction in outpatient clinic appointments with implementation of straight to test)
- Reduced medically unjustifiable delays in care.
- Improved performance against national standards (particularly 62 day performance and the new 28 day faster diagnosis standard)
- Improved quality, safety, and effectiveness of care with reduced variation and improvement in outcomes





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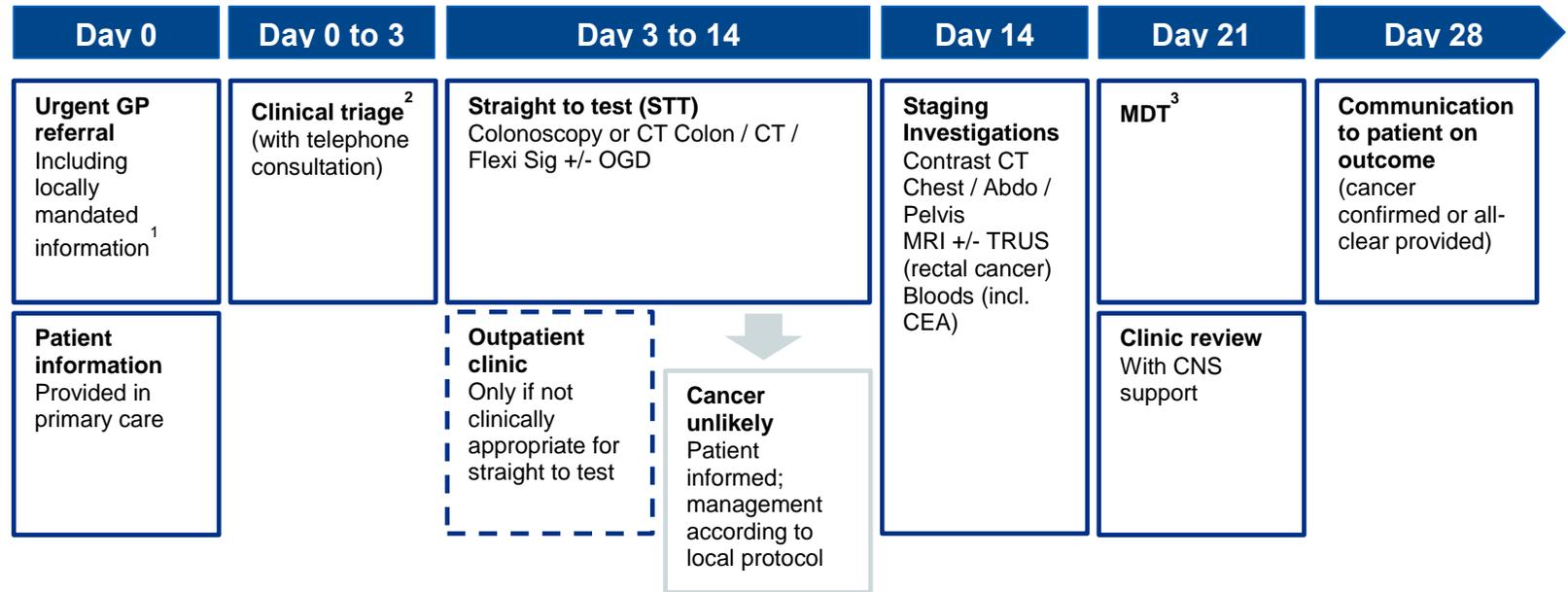
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Maximum target times provided

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.



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This tool can be used to undertake a baseline audit, identify areas for improvement, select measurements for improvement, and then conduct re-audits as part of continuous improvement.

Day	Pathway step	✓
0	GP referral – local agreements made ensure minimum dataset (as detailed in pre-referral information) can facilitate straight to test provision. Primary care provision of FIT testing prior to referral for appropriate patients should be in place and local protocols agreed.	
	Patient information resources developed for primary care – ensure patient engagement and empowerment	
0-3	Clinically led triage – should be Consultant supervised and delivered by appropriately trained clinician (e.g. CNS) – ensure local protocols in place & bowel prep arrangements agreed. Consider early opportunities for pre-habilitation or symptom control if necessary.	
3-14	Straight to test provision for all eligible patients – develop local protocols for appropriate first test ideally matched to resource provision between radiology (CTC) and endoscopy (Colonoscopy). Consider parallel booking of other relevant test e.g. OGD	
	OPA - Ensure provision for early outpatient consultation for patients unsuitable for straight to test for appropriate investigation planning	
14	Staging Investigations – Develop local arrangements for staging investigations (such as standardised diagnostic bundle), ideally should be booked at time of initial test. Can include same-day / one-stop model (see OSCARS example).	
21	MDT and discussion of treatment options (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).	
21-28	Clinic Review – Ideally Consultant supported by CNS. Consider pre-habilitation, symptom control, fitness for treatment and discussion regarding diagnosis & treatment options. Appropriate communication and contact with CNS should be considered throughout the pathway (e.g. at endoscopy, telephone consultation)	



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Guidance from the NHS England Clinical Expert Group on Colorectal Cancer:

- [Clinical Advice to Cancer Alliances for the Commissioning of the Whole Bowel Cancer Pathway](#) provides guidance to support the commissioning of best practice services.

Other resources for colorectal cancer pathway improvements:

- [Improving diagnostic pathways for patients with suspected colorectal cancer](#) from ACE Wave 1
- [Straight-to-test colonoscopy for 2-week-wait referrals improves time to diagnosis of colorectal cancer and is feasible in a high-volume unit](#) is an evaluation of straight to test in shortening time to diagnosis
- [Public Health England Return on investment tool: colorectal cancer](#) (to help local commissioners understand the economic case for early diagnosis of bowel, colon and rectal cancers)
- A non-mandatory [best practice tariff](#) is currently in place for straight to test in patients requiring lower gastrointestinal investigation. This resource includes criteria and a provider checklist.

Acknowledgements: This handbook was developed by the NHS Cancer Programme (with Mr Arun Takhar as Clinical Fellow) and builds on experience and expertise provided by the Clinical Expert Group for Colorectal Cancer (Mr Michael Machesney as Chair, Mr John Griffith as Vice Chair, and Beating Bowel Cancer and Bowel Cancer UK as secretariats), the National Cancer Vanguard (Dominic Cunnane, Lisa Galligan-Davies, Jacob Goodman, Nicola Hunt, Prof Kathy Pritchard-Jones, Mr David Shackley, and Dr Nicholas van As), and other exemplar sites (Mr Muti Abulafi, Mr Ayan Banaerjea, Dr David Burling, Mr Rai Sajal and Harriet Watson)

NHS England Change Model:

- [The Change Model](#) is a framework for any project or programme seeking to achieve transformational, sustainable change (refreshed on 4 April 2018).

Resources from NHS Improvement:

- [The Improvement Hub](#) provides a number of useful resources that can support service improvement including guidance, modelling tools, and webinars.
- [The Rapid Improvement Guide: Sustainable Delivery of the 62 Day Cancer Standard](#) sets out how these resources can be used to reduce waiting times and improve performance against the 62 day standard, with a focus on three elements:
 1. Reducing the time to first appointment
 2. Reducing the number of pathway steps
 3. Reducing the overall size of the patient tracking list (PTL)

Cancer Alliance Workspace

If a link has not been provided to a resource, it will be available on the Future NHS Collaboration Platform. Cancer alliances access this workspace for national guidance, for resources, and to share learning.