South West Strategic Clinical Network

Audit of Patients Diagnosed with Cancer following an Emergency Admission

SUMMARY

"Interventions should aim to reduce the proportion of patients who are diagnosed as emergencies to the absolute minimum dictated by tumour aggressiveness, having removed the potential influence of either healthcare or patient factors"[1]

This audit investigated the details behind patients who were diagnosed with cancer following an emergency admission. We learned that this group of patients have diverse and often complicated symptoms that do not readily match the standard cancer symptoms set out in referral guidance. Many were also in the middle of GP initiated investigations when they became unwell and were admitted. Some patients remain reluctant to visit their GP.

GPs also reported issues with knowing what investigations and referrals were suitable and had difficulty accessing some tests. Also many CCGs are working with GPs to reduce "inappropriate referrals" to hospital in general and can cause GPs to be more reticent to refer. A long waiting list for diagnostic services is a barrier to referral.

Enjoyable process with a very good educational value

Very Informative in a supportive environment

The feedback from the meeting held to discuss the audits were very positive and demonstrated how much the individual and the health community learned about the management of this group of patients.

More of this type of meeting please

Excellent meeting, lots of positive discussion, respectful

As a result of this audit a number of actions were agreed.

- Better access to diagnostic tests was the development most often cited by GPs.
- Some GPs in some locations have access to hospital advice without the need for referral. This needs to be formalised and expanded to be available across the South West. Communication of contact points to be collated and shared asap
- The newly created Acute Oncology services are having an impact on the management of this group of patients. This includes the creation of urgent clinics. These services should be publicised and supported to develop further.
- Further audits would be of benefit - targeting other groups of patients particularly those with Mental Health issues and/or learning difficulties

Objectives

This project aimed to understand the reasons behind the late diagnosis for the group of patients who are diagnosed following an emergency admission and to agree practice actions to address the issues identified. It also looked to provide a better understanding of the management of patients diagnosed with cancer following an emergency admission – with actions agreed by the hospital to address any issues identified (linking to development for Acute Oncology).

The original bid proposal is at Appendix 1.

Background

The mortality outcomes for patients diagnosed with cancer as a result of an emergency admission are known to be poorer than those of patients diagnosed by other routes. Poorer one year mortality figures relative to comparable European countries for various cancers across the UK have long been equated to late diagnosis. This project, funded by the South West Strategic Clinical Network, set out to better understand the management of these patients and explore the background of such cases to identify any themes by which emergency admissions could be avoided or the experience of care following admission could be improved.

Method

The aim of the project was to identify patients diagnosed with cancer as a result of an emergency admission and to carry out a General Practice Significant Event Analysis (SEA) of the case. At the same time secondary care would carry out a review of the case. Both parties would then come together at a joint meeting to discuss the cases in detail and identify any areas where action could be taken.

All acute trusts in the Southwest were invited to take part in the audit. The organisation of the time, venue, collection of completed SEAs and hospital reviews was organised by Sam Allen from the SW SCN. Most of the meetings were chaired by local Macmillan GPs who were invaluable for keeping the meetings appropriately challenging whilst facilitating shared learning and understanding of all the issues affecting both primary and secondary care at present. Where a Macmillan GP was not available or in post the Clinical Director of the SW SCN chaired the meeting.

TABLE 1 – Health Care Communities involved

Hospital Area	Number of SEAs	Meeting attendees
Yeovil District Hospital	12	• 5 GPs • CCG Lead for Cancer (also a GP) • Lead Nurse for Cancer • Clinical Nurse Specialist • Acute Oncology Nurse • Consultant Oncologist • Cancer Services Manager • SCN Clinical Director • SCN Network Manager Total 14
Musgrove Park, Taunton	12	• 6 GPs • CCG Lead for Cancer (also a GP) • 2 Surgeons

		• 6 Clinical Nurse Specialists • Cancer Services Manager • SCN Clinical Director • SCN Network Manager Total 18
Plymouth Hospital	8	• 7 GPs • Macmillan GP • 1 Oncologist • 1 Acute Oncology Nurse • SCN Clinical Director Total 11
University Hospital Bristol	14	• 4 GPs • Macmillan GP • Consultant Oncologist • SCN Clinical Nurse Lead • SCN Project Manager • SW Commissioning Support Manager Total 10
North Devon Hospital	4 SEAs plus 2 verbal reports of recent cases	• 2 GPs • Macmillan GP • Consultant Oncologist • Cancer Manager from acute trust Total 5
North Bristol Hospital	6	• 4 GPs • Macmillan GP • Consultant Oncologist • Lead Cancer Nurse • 2 Cancer Nurse Specialists • 2 acute oncology nurses • SCN Manager • S. Glos commissioning support Total 13
Royal Devon and Exeter Hospital	8	• 8 GPs • Lead Cancer Nurse • Oncologist staff grade • Consultant Oncologist • Service and Design Service Manager • Macmillan GP Total 14
Torbay Hospital	12	• 11 GPs • Oncology Consultant • Acute Oncology Nurse • Lead Cancer Nurse • Clinical Lead Consultant for Cancer Total 17
Weston Hospital	6	• 5 GPs • Consultant Clinical Oncologist • SCN Clinical Director • SCN Network Manager

		• SCN Project Manager Total 9
Gloucestershire Hospitals	4	• 3 GPs • Macmillan GP • CCG Senior Commissioning Manager • CCG Commissioning Manager • Clinical Director for Cancer • Cancer Services Manager • Clinical Nurse Specialist • SCN Clinical Director Total 10
Total 9 Health Care Communities	86	63 GPs 36 Hospital Staff

RESULTS

All the meetings involved robust discussion and unsurprisingly the themes across all areas of the Southwest were similar and can be broken down into;

- Patient factors
- Primary care factors
- Incentives and drivers
- Diagnostics
- Secondary Care factors
- Communication
- CCG

PATIENT FACTORS

- Patient delay in attending GP – patients are often very aware of their symptoms but choose to delay attending practice, though lack of suitable availability of health care professional may also be a factor for some patients
- Patient views are not always clearly documented in primary or secondary care notes and patients can and will dictate their own management; some patients are reluctant to accept investigations
- Hard to reach populations – from stoical farmers to patients with learning difficulties/dementia and the capacity to make informed decisions
- The impact of severe mental health issues was a common factor discussed and the difficulties engaging and having sufficient time to help this group of patients
- Carers reluctant to seek help with their own symptoms
- The role of Public Health and the Be Clear on Cancer promotions - the need to remove the taboo/fear of cancer

PRIMARY CARE FACTORS

- GP time and list size
- Management of uncertainty
- Unusual diagnoses
- Difficulty of diagnosing cancer in patients with multiple co-morbidities
- Perceived impact of continuity of clinician in primary care
- Safety netting- who and how?

- Symptoms that do not fit 2ww criteria or lack of 2ww (neurology or metastases)
- Need to lower the threshold for higher investigations
- Need to act on a hunch
- Change in pattern of presentation to surgery. Systems for discussing with those patients who miss an OP appointment (eg alerts from trust to surgery)
- Clinical examination is an important part of making the diagnosis
- Normal investigations are not always reassuring- both CXR and bloods can be falsely reassuring
- Weight loss is a late presentation but beware of loss being explained away by patient (eg dieting)

INCENTIVES/DRIVERS

- Financial – can be perverse
- Consultant to consultant referral - outside “referral for treatment rules” however a great deal of confusion surrounds those patients picked up on investigation who need a quick hospital opinion rather than being sent back to their GP for a 2WW referral
- GP may hold the patient for too long with ethos of “don’t admit, don’t refer”

DIAGNOSTICS

- X ray – GPs to have lower threshold for ordering especially in smokers and ex-smokers over 70, also in patients with worsening COPD
- Delays for MRI/CT scan
- Little information available on waiting times for each test
- Clarity on access to appropriate investigation and whose responsibility is the follow up investigation (eg CXR repeat in 6weeks)
- Transport issues when immobile
- Anxiety about quality of AQP tests and reports
- Delays in receiving reports

SECONDARY CARE ISSUES

- Rapid discharge – process can be so fast that there is no time for investigations to be reviewed and actioned
- Quality of discharge summaries often poor
- Importance of one MDT taking responsibility for a patient with multiple site cancer
- Acute Oncology service developing in all trusts across SW but many GPs not aware of this service nor how to access it
- Further development of Acute Oncology service to ensure those patients with terminal cancer presenting as an emergency have rapid access to palliative care team
- Recognition that a third to a half of all patients diagnosed with metastatic disease present as emergencies

COMMUNICATION

- Access to advice - clear guidance re who and how to contact secondary clinicians for advice, many meetings resulted in clinicians sharing mobile phone numbers
- Need to ensure use of Advice and Guidance via Choose and Book

- No duty radiologist system - need to systematise access to advice re relevant investigations
- Improve communication re Acute Oncology service and 2ww clinic for Cancer of Unknown Primary
- Signposting of existing pathways
- HOT clinics and availability of GOD phone (gastroenterologist of the day) – need to be better communicated to GPs re availability
- Cancer Nurse Specialists are a great resource for GPs – not acknowledged generally
- Sharing MDT reports with primary care
- Improving education of GPs for correct choice of investigation/liaison/A&G with radiologists

A Taxonomy of Different Mechanisms that can contribute to an emergency diagnosis of cancer (*Lyratzopoulos G, Saunders CL, Abel GA)* [1]
Bold fonts indicate different factors contributing to the emergency presentation. Green fonts indicate potential for avoiding emergency presentation and vice versa for red fonts. Some patients may be exposed to more than one mechanism.

		Was the patient a 'first presenter'?‡	
		Yes	No
Did the patient seek medical help promptly?†	Yes	**Biological factors** (leading to a dramatic clinical presentation with minimal or no prior symptoms) Emergency presentation unavoidable	**Atypical symptoms** (making suspecting of diagnosis of cancer challenging) **Deficient investigation strategy** (e.g., wrong or untimely testing, false-negative findings or true-positive findings overlooked) **Medical error** Emergency presentation potentially avoidable§
	No	**Psycho-social patient factors** (lack of knowledge of cancer symptoms, nonconducive beliefs or attitudes about cancer **Healthcare factors** (geographical, practical or financial barriers to elective care) Emergency presentation potentially avoidable¶	

[1] Lyratzopoulos G, Saunders CL, Abel GA; Are emergency diagnoses of cancer avoidable? A proposed taxonomy to motivate study design and support service improvement.; Future Oncol. 2014 Jun;10(8):1329-33. doi: 10.2217/fon.14.80. Epub 2014 Jul 1.

FEEDBACK from the meetings

- Unanimously positive feedback
- The majority of attendees believed their involvement in this work would improve patient outcomes and experience
- All attendees committed to sharing the outcomes with their respective colleagues
- “Very informative in a supportive environment”
- “Excellent meeting, lots of positive discussion, respectful”
- “More of this type of meeting please”
- “Enjoyable process with a very good educational value”
- “How to engage GPs who most need learning on cancer - those GPs who attended are already interested and committed to this type of work so how do we share the outputs and improve quality in other practices?”

ACTIONS

Southwest Strategic Clinical Network

1. Share paper from this audit with all relevant stakeholders - Macmillan GPs, GPs involved in audits, Clinical leads in trusts, and CCG cancer leads
2. Develop further audits to improve shared understanding between primary and secondary care in relation to Early Diagnosis. Negotiate with NHS England primary care commissioners and CCGs.
3. To support development and uniformity of provision for timely access to investigations for GPs
4. Consider possibility of CCGs commissioning a rapid access Diagnostic Clinic
5. Streamline best pathway for onward referrals for all abnormalities diagnosed on GP/routine investigations
6. Develop and support reformation of financial incentives around Advice and Guidance to ensure it is timely, easy and appropriate for clinicians.
7. Share best practice HOT clinics across SW
8. Future meetings to include a radiologist, consider choosing controversial cases which may reveal failures in the systems and ensure rotation of GP practices to spread learning

Appendix 1

Original Bid Proposal

Project Title	**Audit of Patients Diagnosed with Cancer following and Emergency Admission**
Strategic Clinical Network name:	**South West Strategic Clinical Network**
Project Lead and details	**Project lead:** Helen Thomas Clinical Director, South West Cancer Network **Contact details:** Jonathan Miller South West Cancer Network Manager jonathan.miller@nhs.net
Collaborating organisations	CCGs in the South West, facilitated through Macmillan GPs
Project aim and objectives (max 200 words).	To understand the reasons behind the late diagnosis for the group of patients who are diagnosed following an emergency admissions. To agree practice actions to address the issues identified. The project will also provide a better understanding of the management of patients diagnosed with cancer following an emergency admission – with actions agreed by the hospital to address any issues identified (linking to development for acute oncology). **National theme 1 – Improving the evidence base**
Project approach: (max 500 words)	GPs will be funded to carry out a significant event audit (using the RCGP Template) of a cancer diagnosed following an emergency admission. The Hospital will also be funded to carry out a significant event audit on the same patient. The results of these audits will be discussed at a meeting between the GPs and the hospital team to draw out learning from the audits and agree actions for improvement - for both early diagnosis but also for the management of patients diagnosed following an emergency admission. Patients for whom an emergency presentation is the recommended route will be excluded (ie brain & CNS tumours, acute leukaemia and children).

<table>
<tr>
<td>Project time scales

Include key milestones and outputs

Funding must be spent by end March 2014.</td>
<td>
<table>
<tr><td>Identify Hospitals and GPs to participate, and number of reviews</td><td>Oct 2013</td></tr>
<tr><td>Format of hospital review to be agreed</td><td>Oct 2013</td></tr>
<tr><td>Significant Event Audits and Hospital reviews</td><td>Nov 2013 to Jan 2013.</td></tr>
<tr><td>Hospital reviews</td><td>Nov 2013 to Jan 2013.</td></tr>
<tr><td>Meeting to discuss review and agree actions</td><td>Feb- Mar2014</td></tr>
</table>
Timescales assume funding is confirmed by end of Sep 2013

Number of GPs involved - 168
Number of hospital staff involved 672 (assuming at least 4 hospital professionals are involved in the care of each patient)

Number of patients impacted. There are over 5000 patients diagnosed following an emergency admission in the South West. This projects aims to improve diagnosis for all these patients by leaning the lessons of the diagnosis of a sample. The case will be selected to include a range of diagnoses, including those with an unknown primary.

Primary Outputs
SEA Audit by GP and Audits by hospital
Action Plans to address issues identified
Delivery of action plans

Secondary Outputs
Reduction in patients diagnosed as an emergency across the South West
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<td>Please outline the resources currently in place to support delivery eg existing or new budget, skills or staff resources</td>
<td>GPs in the South West have experience of carrying out significant event audits.

The project will need to develop an agreed template for the hospital part of the review. This will be supported by the SCN Support Team.</td>
</tr>
<tr>
<td>Please outline the funding required and its purpose

Please give a separate breakdown of staff costs and other costs, and the requirement for each.

Please indicate likely</td>
<td>12 reviews carried for each of the 14 health care communities (based around an acute hospital.)

Funding to practice per review £125
Funding to practice to attend review meeting £250
Funding to develop template for hospital review £5000
Review meeting costs £300 each

Total funding £114,200
Of which £110,000 will be staff costs and £4200 meeting</td>
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timing of expenditure for each cost **Please indicate if you are adding additional funding to the project.**	costs Spend Oct £5k Nov £21k Dec £21 Jan £21k Feb £23k Mar £23k
Please outline the project management and governance plans (max 150 words)	The project will be managed by the South West Cancer Network Manager. Practice will receive funding for the SEA following the receipt of the completed RCGP SEA form. Hospitals will receive funding for their audits following receipt of the agreed template. Practices will receive reimbursement for attendance at the Review Meetings following confirmation of attendance. The South West Clinical Network will organise the review meetings, and will have a representative at each
Risks and Constraints (max 200 words) **Please refer to the main risks to delivery and how they will be mitigated**	The main risk is low uptake by GPs or participation by hospitals. The South West Cancer Network Clinical Director and Network Manger have met with each CCG to set out the priorities for 2013/14. The network is also supporting the lead GP for Cancer and Macmillan GPs from each CCG. These contacts are, and will be used to encourage local uptake. Appropriate funding for GP time has also been included to ensure that this is not a barrier to participation. Low uptake by hospital is also a risk. This has been mitigated by funding hospital participation and linking the activity to resolving issues relating to acute oncology. All providers in the South West had low scores for acute oncology Peer Review.