Peninsula Cancer Alliance

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Site specific RDS – Bladder Pathway

PROJECT BRIEF

Prepared by: BK (SSG Support Manager)

Context/ Background

The Peninsula Cancer Alliance (PCA) has been allocated £2.23m to deliver year 3 of the Rapid Diagnostic Programme in 2021/2022.

All five providers across the alliance are in the process submitting proposals for funding with deliverables being agreed via the PCA Site Specific Groups (SSG)

The funding allocated covers the continuation of the NSS pathway and site-specific improvements in dermatology/ urological/ colorectal/ gynaecological/ lung /breast and Upper GI 2ww cancer pathways.

Rapid Diagnostic Services (RDS) are designed to speed up cancer diagnosis and support the NHS long term plan ambition to achieve earlier diagnosis with improved patient experience for all patients with cancer symptoms or suspicious results.

It is the national RDS vision that all suspected cancer pathways become an RDS by 2024.

Aim and Objectives

The alliance focus for urological 2ww pathways includes the implementation of a standardised one stop haematuria clinic and the prostate optimal timed cancer pathway across the five provider trusts by April 2022.

A Bladder Task and Finish Group via the Peninsula Cancer Alliance Urology site specific group has been set up in order to:

1. Identify symptoms that may facilitate an earlier referral of suspected bladder cancer form primary care
2. Identify differences in pathways across the alliance, sharing good practice and clarifying the ‘pinch point’ that lead to delays
3. Standardising good practice across the alliance where possible

(Implementation of the prostate optimal timed pathway is being progressed via the SW Prostate Cancer Transformation Steering Group).

Project Scope/Actions

Each trust intends to collect data on the mode of presentation and keys steps in the pathway for approx. 100 patients with a histological diagnosis of bladder cancer with the following objectives:

1. To understand presenting symptoms of patients with a new diagnosis of bladder cancer
2. To understand which diagnostic modalities are employed in different hospitals
3. To understand the timings to key checkpoints in the diagnosis and early treatment of patients

The aim of this is to identify other symptoms/ red flags that patients are presenting with and to allow for completion of a gap analysis of the diagnostic pathway of each trust's pathway in order to agree one diagnostic algorithm for the alliance and to implement / agree required tests for a haematuria one stop clinic.

Programme Management and Reporting

This programme will be managed as part of the overall PCA schedule of work and monitored through the PCA Programme Group monthly meeting and reported to the PCA Board quarterly

Programme Clinical Leads: Dr Joe Mays (PCA GP Lead) & Mr John Renninson (PCA Clinical Director)

Site Specific Clinical Lead: Mr Nick Burns- Cox (Consultant Urologist)

Programme Lead: Sarah-Jane Davies (PCA Manager)

Project Support: Beth Kingshott (PCA Support Manager)

MOU's have been signed off with providers.

Risks

Currently working under extremely challenging circumstances due to COVID 19 outbreak. This has heavily impacted access to diagnostics for both radiology and pathology, and added to workforce pressures due to COVID testing regimes, new infection control measures and managing patient throughputs on sites and waiting lists.

Expected project outcomes/ deliverables

Urology Site specific RDS will support the Faster Diagnosis Standard with live reporting 2021 Q3. It Is expected that by embedding the RDS principles into urological 2ww pathways that it will:

- Speed up cancer diagnosis across the pathway by improving cancer pick up rates leading to improved diagnostic pathway, timely treatment and better outcomes.
- Achieve FDS targets with diagnosis or all clear given within 28days of referral
- Ensure equitable access to best practice pathways
- Improved patient experience

Monitoring/ Evaluation

Urological 2ww cancer pathway will meet the national RDC vision and 2019/20 implementation specification by April 2022 by embedding the core RDS principles

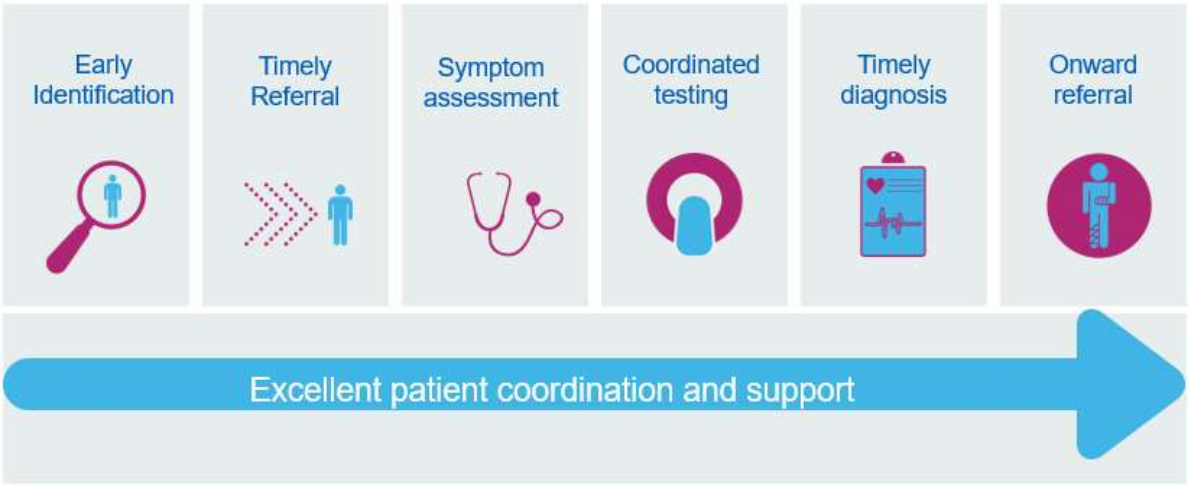
(see Appendix 1) and the pathway will be signed off against the RDC checklist (Appendix 2).

The Bladder Task and Finish group aims to construct a dashboard of key metrics to monitor the quality of timelines and progress within the bladder programme and PULSE surveys will be run to explore and evidence our patients' diagnostic experiences.

The PCA has Regional Business Analyst Support providing a performance dashboard which includes a weekly tumour site tool.

NHS England & Improvement will nationally evaluate the RDC programme and the PCA will contribute to the RDC/S Minimum dataset.

Appendix 1: National Vision for all Suspected Cancer Pathways



Appendix 2: The Rapid Diagnostic Service Design Checklist (2020/21)

Requirements	Translation into practice	Met?	Evidence / Actions
Operational leadership	Accountability identified for relevant specialisms and provider delivery groups leading implementation of RDS		
Single point of access (referred once) for patients	Patient under care of RDS until a diagnosis is received (cancer, a serious non-cancer diagnosis, non -serious diagnosis or resolution of symptoms).		
	Tracked and supported transition to non-specific symptoms pathway from a site-specific pathway (or vice versa) where applicable.		
	Fast track re-admittance process for patients discharged from NSS (or surveillance) to avoid re-referral and unnecessary testing.		
Single point of contact	Named CNS / Navigator communicates to patient at referral.		
Optimal pathway embedded	Optimal pathways for rapid reporting of diagnostic tests and multi-disciplinary decision-making.		
	'One stop' models as appropriate, wrapping diagnostic testing around the patient in as few visits as possible.		
Co-ordination of care between Trust and GP	CNS /Navigator led telephone advice line for GP's		
	Navigator to support discharge process back to GP		
	Care management plans from secondary care are understandable by GPs		
Excellent patient support and co-ordination (national quality markers met)	GP informs patient they're on a suspected cancer pathway and provides supportive information.		
	CNS/Navigator contacts patient on referral and explains / coordinates next steps.		
	Cancer diagnosis communication led by Consultant in the presence of CNS in suitable environment.		
	Specific needs of patients with protected characteristics are considered through pathway.		
	Facilitated hand over to specialist centre where applicable		

Making Every Contact Count (MECC)	Engage patients in conversations about improving their health by addressing risk factors.		
	Establish links with relevant LA services		
28-day standard achieved	NSS and RDS patients tracked and meet 28-day standard		
RDS Evaluation data reported	Resource assigned to collect dataset and all data items available from launch of RDS		