



Rapid diagnostic and assessment pathways

Implementing a timed **oesophago-gastric cancer** diagnostic pathway

A handbook for local health and care systems

April 2019

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- 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.

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Rapid diagnostic and assessment pathways	Rapid diagnostic and assessment pathways		
World class cancer care in England	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 fourth pathway, on diagnosis of oesophago-gastric cancer, complements these existing handbooks. The handbook will support cancer alliances and constituent organisations to adopt consistent, system-wide approaches to managing this complex diagnosis pathway. It will support the on-going improvement effort to shorten diagnosis pathways, in line with modern clinical practice, and improve patient experience. The pathway will prepare systems for the introduction of the Faster Diagnosis Standard in April 2020.
System transformation			
The oesophago-gastric cancer diagnostic pathway			
The case for change	This handbook sets out how diagnosis within 28 days can be achieved for the oesophago-gastric 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 request			
The benefits			For any questions about this document please email the england.cancerpolicy@nhs.net
Timed pathway			
28-day	This handbook complements existing resources such as NICE Guidelines (including NG12) and should therefore be read alongside such guidance.		
Additional information			Cally Palmer National Cancer Director, NHS England
Audit tool	The pathway in this document was developed by a multi-disciplinary consensus group with clinical leaders from local and specialist services across England, and expert advice from cancer alliances including: Cheshire and Merseyside, Greater Manchester Cancer, Northern, RM Partners, Thames Valley and the UCLH Cancer Collaborative.		Professor Dave Shackley Medical Director, National Cancer Vanguard
Resources	The National Cancer Vanguard led the development of the first three pathways we published in April 2018. Cancer alliances have since led local transformation programmes to reduce the time it takes to diagnose lung, prostate and colorectal cancers, and to ensure patients receive timely communication of the outcome.		Mr William Allum NHS England Cancer Surgery CRG – OG Lead On Behalf of the Clinical Consensus Group

Rapid diagnostic and assessment pathways	World class cancer care in England
World class cancer care in England	The NHS Long Term Plan sets out ambitious aims for improving cancer outcomes over the next 10 years. A step change is needed to narrow the gap between the UK and comparable countries and to deliver the very best outcomes for patients in England.
System transformation	
The oesophago-gastric cancer diagnostic pathway	Over the next 10 years we will continue to transform cancer systems, so that from 2028 an extra 55,000 people each year will survive for five years or more following their cancer diagnosis. A cornerstone of this will be to galvanize efforts to diagnose cancers early. Our ambition is to diagnose three in four cancers at stage one or two by 2028.
The case for change	
The request	
The benefits	
Timed pathway	
28-day	We will find more cancers before symptoms appear, support people to come forward early when symptoms do appear, and ensure that the system can respond quickly and effectively, with the right tests, assessment and referral. Importantly, we will address variation in access to care and offer excellent patient experience.
Additional information	
Audit tool	
Resources	<p>Faster Diagnosis Standard (FDS)</p> <p>From April 2020, a new standard will be in place to ensure patients receive a diagnosis or ruling out of cancer within 28 days. For patients with a diagnosis, treatment can be offered earlier. Patients with an ‘all clear’ will receive timely communications that reduce anxiety at a very stressful time.</p> <p>The timed pathways will help to ensure the new standard is met for patients when fully introduced.</p>

From April 2019, the new Cancer Waiting Times system should be used to support the collection of the new faster diagnosis data items. This data will support local teams 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, to 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 the highest 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. Effective use of eRS with an agreed dataset for referral can facilitate a faster and more efficient diagnostic pathway. Resources for implementation are [available from NHS Digital](#).

Inter-provider transfers (IPT)

A new approach to recording IPTs (and a checklist to support local development of a minimum clinical dataset) is described in the [National Cancer Waiting Times Monitoring Dataset Guidance v10.0](#). This should encourage collaboration among providers to ensure timely transfers that are required.

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System transformation

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 will help you to deliver on target reporting times for histology and imaging investigations. It can also help you to quickly resolve problems, and develop 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** to support new ways of working across the whole pathway (e.g. reporting radiographers with buddying between individuals with different levels of experience, joint masterclasses on the pathway).

Your cancer alliance

Cancer alliances commissioners and providers together, on behalf of STPs and ICSs, to drive system-wide transformation.

They provide clinical, operational and transformational leadership.

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

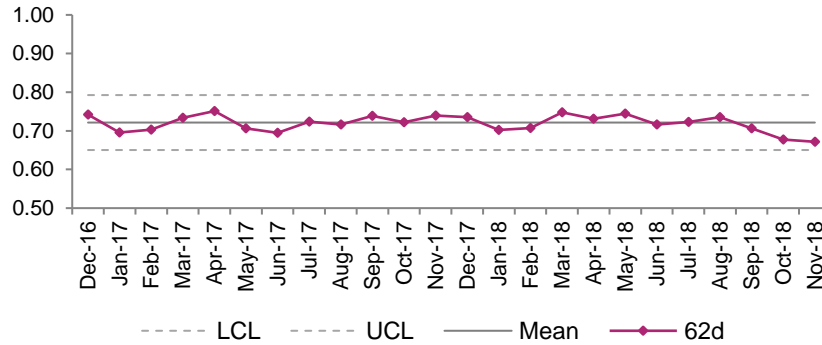
Your cancer alliance will ensure:

- Senior stakeholder prioritisation of pathway implementation
- Development of clinical leadership
- Coordination of cancer services
- Access to national learning and resources by local organisations
- Provision of transformation and change management expertise to support improvement

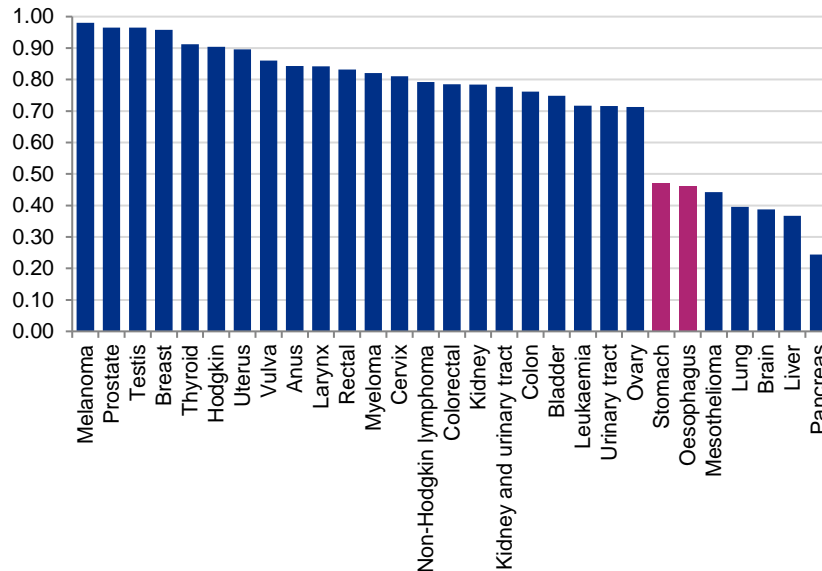
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The case for change

62 day performance, upper gastrointestinal cancers Dec16-Nov18 (SPC chart)



One year net survival by cancer type. Patients diagnosed 2012-2016



Oesophago-gastric (OG) cancer is currently the fifth most common cause of cancer in the UK affecting around 16,000 people each year, and the fourth most common cause of cancer death.

- Between 2015 and 2018 only **71.1% of patients diagnosed with upper gastrointestinal cancer commenced treatment within 62 days of referral**. This varied by cancer alliance with a range of 61.3% to 81.4%.
- For oesophago-gastric cancer patients in England diagnosed between 2011 and 2015, **one-year age-standardised net survival was 43.9% for oesophageal cancer and 43.2% for gastric cancer**.
- In 2016, only **23.0% of oesophago-gastric cancers were diagnosed at an early stage**. This varied by cancer alliance with a range of 21.2% to 33.1%.

Patients with oesophago-gastric cancer have some of the **poorest outcomes** and longest intervals between referral and commencement of treatment amongst all cancers in England at present.

A streamlined and more efficient pathway will improve these avoidable delays and should reduce the **considerable variation** that is currently seen.

Rapid diagnostic and assessment pathways	The request	
World class cancer care in England	<p>“The patient pathway from referral to decision to treat for oesophageal or gastric cancer is one of the most complex cancer pathways. The combination of endoscopy and biopsy, CT and PET-CT imaging, interventional staging and comprehensive comorbidity assessment highlights this complexity. Unlike other more common cancers, the initial diagnostics are undertaken at local units and the more invasive staging investigations require specialist decision and intervention.</p>	<p>booking and reporting of the diagnostic and staging investigations. It is expected that once a decision is made at the local unit to refer to the specialist centre, a booking for the PET-CT (if indicated) should be made so it is available for the Specialist MDT meeting.</p>
System transformation		
The oesophago-gastric cancer diagnostic pathway		
The case for change		
The request		
The benefits	<p>The key features of this pathway are to improve the streamlining of the transfer between local unit and specialist centre with defined responsibility for the respective steps. This should be integrated with timely</p>	<p>The proposed changes are simple but do require better administration of existing pathways. Their implementation is anticipated to reduce waiting times for critical investigations and decision making and enable prompt starts for treatment for those diagnosed with oesophago-gastric cancers”</p>
Timed pathway		<p>Mr William Allum, on behalf of the Clinical Consensus Group</p>
28-day		
Additional information	Features of a faster pathway	
Audit tool	Patient information	<p>Provided at point of referral, but also as regular updates to inform the patient of next steps and timings. Information can empower patients and help to manage anxiety by setting out what can be expected from the diagnostic process. This information can improve patient experience and encourage attendance.</p>
Resources	Service models	<p>Implementing the following service models can reduce variation and make improvements to patient flow:</p> <ul style="list-style-type: none"> • Clinical triage to optimise direct access to diagnostics • Local service agreements for faster access to radiology and histopathology reports • Predetermined algorithms and standards of care, with simultaneous booking of all investigations • Networking (e.g. hub and spoke) to optimise use of existing resources and expertise, particularly useful for improving radiology and histopathology reporting 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 • Pathway navigators for administrative support and value in tracking patients for improved flow

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The benefits

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 to specialist centres if possible
- Potential to avoid emergency admission and development of complications whilst on the pathway which can affect both outcome and survival
- Potential for earlier recognition and initiation of pre-optimisation for treatment that could reduce complications and adverse outcomes

For clinicians:

- Using a nationally agreed and clinically endorsed pathway to support quality improvement and reconfiguration of oesophago-gastric cancer diagnostic services
- The use of predetermined diagnostic algorithms and standards of care to streamline clinical decision-making and reduce delays for MDT discussion.
- Working across primary and secondary care to ensure high quality referrals into a streamlined service
- Improved ability to meet increasing demand and ensure best utilisation of the highly skilled workforce

For systems:

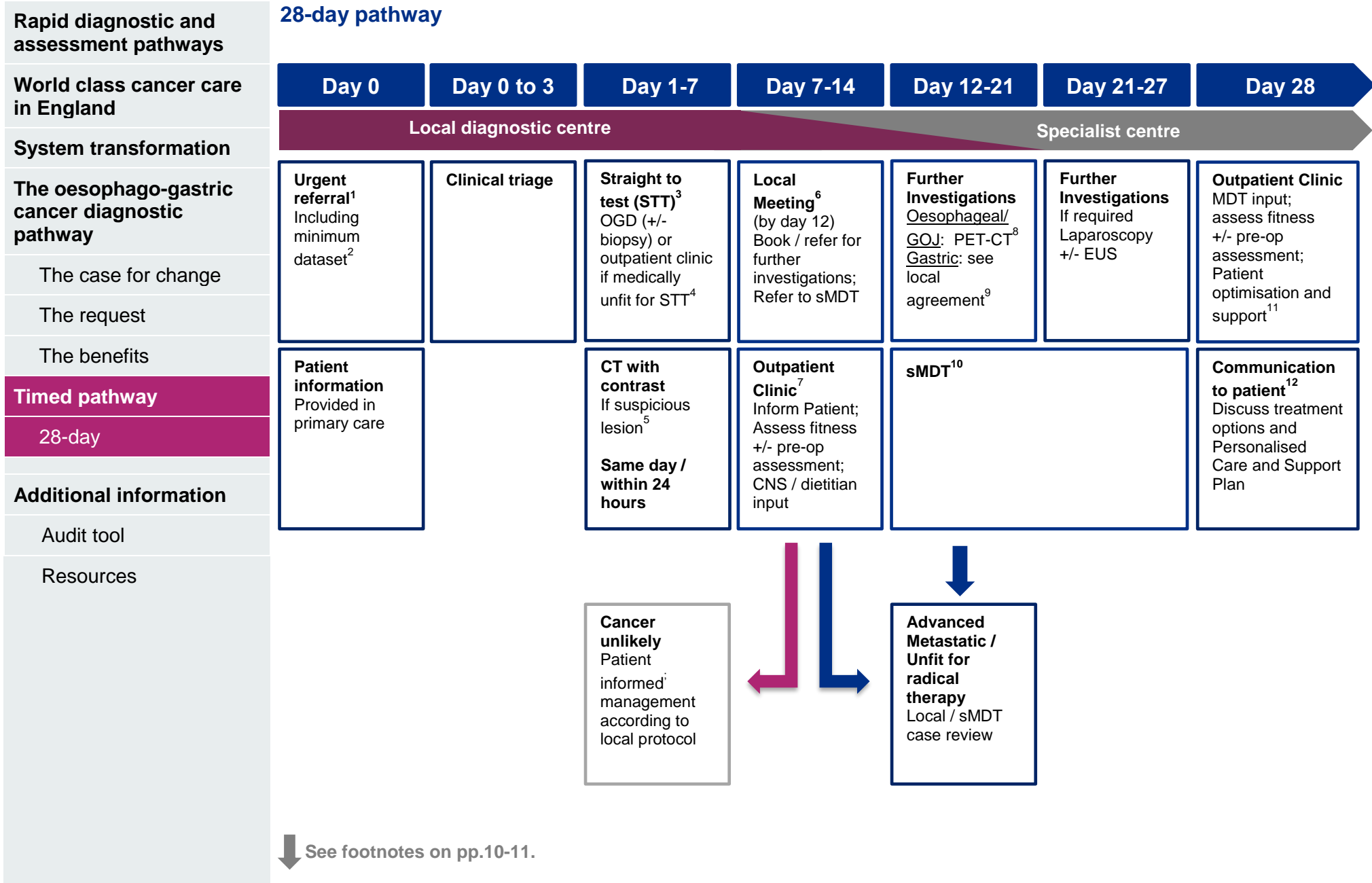
- Reduce demand in outpatient clinics with increased straight to test provision and use of pathway navigators
- Reduced medically unjustifiable delays in care
- Allow resources to be targeted at patients with cancer by eliminating load of non-cancer patients earlier in the 62 day pathway
- Improved performance against national standards (particularly 62 day performance and the new Faster Diagnosis Standard)
- Improved quality, safety, and effectiveness of care with reduced variation and improvement in outcomes

Sharing these pathway steps with patients:

It can be useful to reflect on the information patients receive at each step of the diagnosis pathway. Patient feedback suggests that stress can be reduced during the diagnosis stage if patients are made aware of the next consultation and/or test dates, and given an idea of when their results will be available. This can also allow patients to manage their time effectively in advance, instead of waiting for a formal phone call or letter on what and when the next step on the pathway will be.

Can you improve the information you provide patients about this pathway? Do your patients always know their next step, or key pathway timings?

28-day pathway



Rapid diagnostic and assessment pathways	28 day pathway
World class cancer care in England	Footnotes:
System transformation	<ol style="list-style-type: none"> 1. This pathway should be used for patients who meet NG12 criteria for suspected cancer pathway referrals. In a scenario where the GP refers the patient for a direct access test and the upper gastrointestinal endoscopy is abnormal and suspicious of cancer, patients could be followed up by secondary care directly from endoscopy (without the need for an additional referral from their GP). The patient would then join the pathway after the first diagnostic test (labelled on this pathway diagram as 'straight to test'). The National Cancer Waiting Times Monitoring Dataset Guidance v10.0 sets out these rules. Cancer Alliances may set out local arrangements to facilitate patient access to this pathway. 2. A minimum dataset to accompany the referral and facilitate straight to test and immediate CT scan is: patient demographics, FBC, eGFR, anticoagulant status, performance status, co-morbidity, locally agreed nutritional assessment tool (e.g. MUST assessment with referral for dietitian assessment if score 2 or greater), medication, need for interpreter, and mental capacity to consent. 3. OGD should be performed to BSG/AUGIS quality standards to minimise false negative or inadequate biopsies. Histology results taken during endoscopic procedures should be reported within 72 hours of the biopsy. 4. In this cohort of patients (those medically unfit for straight to test) the recommended first line investigation should be contrast CT. This should be performed and reported within 5 days so that this cohort can progress on the pathway in the same timeframes. 5. If a suspicious lesion is identified, patients should have access to a CNS with expertise in oesophago-gastric cancer for support (from this stage onwards). Patients should have a same day CT to reduce repeat visits and improve patient experience. If this is not possible, CT should be on the next day (i.e. within 24 hours). This should be reported within 72 hours, ideally by a radiologist with an established gastroenterology interest. 6. 'Local Meeting' in the context of this pathway is a local unit MDT where these exist. The core roles at the local meeting are lead clinician, radiologist and pathologist, to review investigation results with a pathway navigator. An oncologist with an interest in oesophago-gastric cancer and a radiologist with an established gastroenterology interest should be present at the Local Meeting. The capacity required to deliver these core roles should be reflected in job plans. <p>Patients considered suitable for radical therapy should be booked (or referred) for appropriate staging tests as set out in the pathway, and should also be referred directly to the sMDT. Input of sMDT clinicians to local meetings (e.g. via videolink) can facilitate faster staging decisions.</p>
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Rapid diagnostic and assessment pathways	<p>7. Personalised care and support planning should be based upon the patient and clinician(s) completing a Holistic Needs Assessment, usually soon after diagnosis. The HNA ensures conversations focus on what matters to the patient, considering wider health, wellbeing and practical issues in addition to clinical needs and fitness. This enables shared decision-making regarding treatment and care options.</p> <p>8. For oesophageal/GOJ cancer: PET-CT should be performed in line with the NICE quality standard on oesophago-gastric cancer, which includes a seven-day standard from requesting to reporting. Further investigations could be provisionally booked at the same time as PET-CT is booked (as part of a predetermined standard of care to reduce delays) or booked into dedicated weekly slots available to perform these tests within 7 days of the PET-CT report. Laparoscopy +/- EUS should not be performed until the PET-CT report is reviewed by the specialist MDT, and EUS should only be used in select cases where it will help to guide ongoing management.</p> <p>9. For gastric cancer: Protocols should be developed collaboratively between local units and specialist centres for gastric cancer staging. A subset of suspected gastric cancers may be suitable for direct referral to specialist centre for laparoscopy and this may be agreed across a cancer alliance level as part of a predetermined standard of care. Other cases may need sMDT review to determine most appropriate staging, in which case the sMDT should take place as soon as possible to determine a complete diagnostic plan.</p> <p>10. The core membership of the sMDT must align to the relevant NHS England service specification for oesophago-gastric cancer (specialised commissioning). As a minimum, the specialist MDT meeting should include a radiologist and oncologist who both have a specialist interest in oesophago-gastric cancer, in line with the NICE quality standard on oesophago-gastric cancer. Investigation results should be reviewed with a pathway navigator or co-ordinator.</p> <p>National guidance on how to maximise effectiveness of MDT meetings will be available from NHS England by mid-2019. Locally agreed, clear criteria for referral to sMDT can also support with efficient pathway management. One example of how the sMDT could be managed for the oesophago-gastric pathway is to have a pre-MDT triage process at the specialist centre (to review referral +/- PET-CT and identify the required further staging tests), with the full sMDT taking place following these further investigations. Another example would be to hold a full sMDT at time of review of PET-CT, where treatment options would be pre-agreed based on the potential outcome of further investigations.</p> <p>11. Early consideration of patient's fitness for radical therapy should be addressed as soon as possible in the pathway to minimise delays in expediting treatment. All patients diagnosed with cancer should see a specialist dietitian within 7 days of diagnosis and this should ideally be at the specialist centre. Local protocols and initiatives should be developed in collaboration with perioperative medicine, elderly care and specialist dietitians.</p> <p>12. Cancer waiting time rules (including 'clock start' and 'clock stop') are set out in the National Cancer Waiting Times Monitoring Dataset Guidance v10.0 which will be available from April 2019.</p>
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Audit tool

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 with primary care should be in place to ensure the minimum dataset is provided (as detailed in pre-referral information), to facilitate straight to test provision.	
	Patient information resources should be co-developed with patients.	
0-3	Clinically led triage should be consultant supervised and delivered by an appropriately trained clinician (e.g. CNS); local protocols need to be in place to reduce delays (e.g. management of anticoagulants).	
7	Straight to test provision for all eligible patients: Consider pooled lists and networking arrangements to maximise efficiency. Try to ensure endoscopists for patients on this pathway are experienced in OG cancer diagnostics, and perform to BSG/AUGIS quality standards to reduce re-scope/inadequate biopsy rate. Histology results taken during endoscopic procedures should be reported within 72 hours.	
	CT: Ensure processes are in place to book from endoscopy suite; consider dedicated slots to ensure same/next day scan.	
12	Local Meeting: Consider pathway navigator/co-ordinator and dedicated clinician time to facilitate process effectively. Protocols and pathways should be agreed between local and specialist centres to ensure patients can be booked for appropriate further investigations and referral to sMDT without delay.	
14	Outpatient Clinic: Ensure the patient is informed of likely diagnosis before they are contacted by the specialist centre for further appointments. Agree protocols for pre-assessment with the specialist centre, and protocols on optimisation that can be initiated locally to provide early opportunities for optimisation (e.g. smoking cessation and nutritional support). The patient should also have an opportunity to meet the specialist dietitian +/- local CNS.	
	The CWT system will record 'referral request received date' as part of the inter-provider transfer to the specialist centre. This data item can be used to audit pathway implementation, aiming to refer the patient to the specialist centre by day 14.	
12-21	Further investigations: Consider role of pathway navigators/co-ordinators and dedicated clinician time to facilitate early sMDT (if required) and review of PET-CT report prior to expedition of further staging investigations.	
21	sMDT for review and planning of potential treatment options- Where laparoscopy (or other further investigations) is required after staging then full sMDT discussion may need to be deferred until day 28, in which case provision for same-day clinic review with results should be considered. Alternative treatment options may be pre-agreed based on potential outcome of further tests.	
28	Outpatient Clinic: Cancer confirmed and treatment options discussed. A multi-disciplinary clinic with Surgeon, Oncologist, Anaesthetist and AHP's such as therapeutic radiographer, speech and language therapist and specialist dietitian should be considered. This aims to improve patient experience, improve communication, and prevent delays in starting treatment.	

Rapid diagnostic and assessment pathways	Resources	
World class cancer care in England	The Malnutrition Universal Screening Tool (MUST) provides details of a five-step score to identify patients who are malnourished, at risk of malnutrition, or obese. It also includes management guidelines which can be used to develop care plans.	NHS England Personalised Care Guidelines:
System transformation		<ul style="list-style-type: none"> • Personalised care resources can support you to ensure patients have choice and control over the way their care is planned and delivered. It is based on what matters to the patient and individual strengths and needs.
The oesophago-gastric cancer diagnostic pathway	Quality standards in upper gastrointestinal endoscopy: a position statement of the BSG and AUGIS sets out the minimum expected standards in upper gastrointestinal endoscopy (including 38 recommendations).	NHS England Change Model:
The case for change		<ul style="list-style-type: none"> • The Change Model is a framework for any project or programme seeking to achieve transformational, sustainable change (refreshed on 4 April 2018).
The request	NICE guideline (NG83) - Oesophago-gastric cancer: assessment and management in adults covers assessment and management of oesophago-gastric cancer in adults including radical and palliative treatment and nutritional support.	Resources from NHS Improvement:
The benefits		<ul style="list-style-type: none"> • The Improvement Hub provides a number of useful resources that can support service improvement including guidance, modelling tools, and webinars. • The rapid improvement guide to sustainable delivery of the 62 day cancer waiting time standard sets out how these resources can be used to reduce waiting times and improve performance against the 62 day standard, by: <ol style="list-style-type: none"> 1. Reducing the time to first appointment 2. Reducing the number of pathway steps 3. Reducing the overall size of the patient tracking list
Timed pathway	NICE quality standard (QS176) - Oesophago-gastric cancer sets out best quality care in four areas of management for patients with oesophago-gastric cancer.	
28-day		
Additional information	Guidelines for perioperative care in esophagectomy: enhanced recovery after surgery (ERAS®) society recommendations sets out a guideline on multidisciplinary care following surgical procedures, recommending guidelines to improve outcomes and quality for oesophageal resection.	
Audit tool		
Resources	Consensus guidelines for enhanced recovery after gastrectomy sets out recommendations for post-operative care of patients who have had gastrectomy, with evidence of improved outcomes.	
	Acknowledgements: This handbook was developed by the NHS Cancer Programme and builds on experience and expertise provided by the National Cancer Vanguard (George Hanna, Sarah Adams, Jonathan Vickers, James Leighton, Dip Mukherjee, Jake Goodman, Caroline Cook, Kathy Pritchard-Jones, Dave Shackley, Nicholas Van As), members of the consensus group (Bill Allum, Jonathan Booth, Lily Megaw, Guy Mole, Anna Murray, John Painter, Sheron Robson, Arun Takhar, Nigel Trudgill, Andrew Veitch, Arnold Victor, Chris Warburton), Tony Newman-Sanders as National Clinical Director for diagnostics and imaging, and Robert Logan as National Endoscopy Advisor.	

Cancer Alliance Workspace
 Cancer alliances access this workspace for national guidance, for resources, and to share learning. Please use this space to upload materials you have developed locally and that you think would be useful for colleagues implementing this pathway across the country.

