THE ACE PROGRAMME

A PROGRAMME THAT WILL ACCELERATE, COORDINATE, AND EVALUATE (ACE) LEARNING TO ACHIEVE THE EARLIER DIAGNOSIS OF CANCER

Brian Knowles – ACE Programme Lead
What is ACE?

- A cancer early diagnosis programme that incorporates 60 NHS projects

- Projects are working towards:
  - improving **diagnosis at stage I & II**
  - reducing **emergency admission rates**
  - improving the overall **patient experience**

Why is it unique?

- A ‘bottom up’ approach that gives teams a national voice and collaborative focus

- The DH Policy Research Unit will perform a robust clinical and economic **evaluation**, that will inform national policy and commissioning intent

Concepts to explore & work-streams include:

- Straight to test vs direct GP access for colorectal referrals
- Interventions to improve bowel cancer screening uptake
- Proactive approaches to lung – access to CT & screening patients at high risk of lung cancer
- Single Q theory – merging urgent & routine referrals or lowering referral thresholds
- Use of IT & decision support tools in primary care to identify high risk patients
- Improving screening offer for vulnerable & hard to reach groups
- Assertive role for non GP primary care professionals – e.g., community pharmacists
- Diagnostic pathways for patients with vague symptoms
- Wave 2 – Multidisciplinary diagnostic centres (MDC)
ACE Programme  A programme to Accelerate, Coordinate and Evaluate early diagnosis projects

ACE project locations – Wave 1

**Doncaster CCG** – community pharmacy direct referral to chest x-ray pilot, cancer awareness raising programme with Doncaster Rovers football club

**Airedale, Wharfedale & Craven CCG** - electronic referral system from GPs to radiology to get triage advice on suitable imaging for suspected cancer patients who present with vague symptoms

**North Kirklees CCG** – improving screening uptake amongst South Asian population group

**Calderdale & Greater Huddersfield CCGs** – improving uptake for screening programmes working with GP practices
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**Time-line & Outputs**

**Following evaluation, evidence and materials produced from September 15 will include:**

1. ‘How to’ implementation guides e.g. for triage based straight to test services
2. Sample business cases
3. Economic and clinical evaluation reports
4. Case studies

**How ACE will help**

- ACE evidence & outputs will inform the implementation of more effective cancer pathways locally
- Help cancer services achieve earlier cancer diagnosis
- Improve patient experience
- Inform commissioners and policy makers about best practice and barriers to implementation
Bowel Screening Cluster

• Testing various interventions, using primary care engagement and GP endorsement, working in partnership to reduce health inequalities
• Evidence base is contradictory – at best, several interventions together have shown to improve uptake. E.g., a combination of:
  • Health supporters/trainers/champions who can provide information and support in raising awareness
  • Text reminders & letters that are GP practice branded & endorsed
  • Leaflets, poo catchers, gloves available separately to actual invite
  • Opportunism: CRUK funded programme of marketing and direct mail
  • Sustained moderate investment in time, personnel, contracting mechanisms, information and incentivisation to secure engagement
• We know that ....Doing stuff works...but ....
• “it is essential that these initiatives are evaluated and that lessons are collated and shared.” (Cancer Strategy 2015)
Screening innovation & challenges

• 2 Learning Disability Networks utilising PHE Health Equity Assessment Tool to reduce inequalities and promote equality
• What are the best opportunities for reducing inequalities in screening by focusing on – specific groups, geography with worst outcome, those of lower socio-economic status, to achieve most lives saved
• ACE RESULTS - tailored reminders to people who haven’t returned their kit, increase between 2.5 – 5 % uplift
• Pushing boundaries of the NBCSP and challenging the consent model - GPs email request for replacement kits, desk top requesting using EMIS, use of third party resource to do the chasing of non-responders
• ODR process for PHE to share data with third party linked to CCG
• Colonoscopy defaulters following positive FOBt screening
• ‘Lines to take’ to influence FIT roll-out and implementation having been recently authorised by the NSC – now with Ministers
Colorectal Cluster

- 12 projects focused on the implementation of ‘Straight to test’ (STT) initiatives
- Essentially projects fall into 2 groups:
  - Referred patients are telephoned by nurse specialist in secondary care, triaged to appropriate first test – flexi-sig, colonoscopy, CTC
  - Direct access from primary care, based on robust referral criteria, organise the bowel prep and appoint to first appropriate test
- Is the diagnostic interval shortened - from referral – to first test – to diagnosis?
- What happens to overall endoscopy activity? – any changes in numbers & conversion rates for different tests performed?
- Does the proportion of routes to diagnosis change? 24% of CRC diagnosed via emergency route
- Does access to STT improve diagnosed cancer stage, more likely for non-urgent referrals
- Primary care history/contact
CRC – early results & evaluation

- 2ww referrals - Early results indicate introducing telephone triage model prior to straight to endoscopy test REDUCES diagnostic interval by 10 days (range 9 – 13 days)
- Median wait for first diagnostic test is 12 days in pathway that includes STT, compared to 23 days for those referrals seen in clinic (range 17 – 31 days)
- Median wait to first treatment is 40 days for those via STT (range 32 – 48 days)
- Median wait for first treatment is 46 days (28 – 55 days) for those seen in clinic
- Added incentive to combine joint surgery and oncology clinics on the same day following earlier MDT discussion
- Outputs – provision of ‘How to’ guides, business plans for triage teams, telephone protocol, referral forms and CRC symptom criteria, best practice tariff for flexi sig pathway
CRC – early results & evaluation 2

- Direct access project in the London Cancer Qualitative Collaborative
- 564 patients now undergone a direct access endoscopy in 2015 for routine & non urgent referrals
- Direct access flexi sig has a cancer pick up rate of 1%
- Direct access coionoscopy has a 2.3% cancer rate
- The stage at diagnosis was T1 or T2 in 57% (n=7)
- The average age of the patient a with cancer was 52 years (range 40 – 66 years)
- The average time between seeing the GP and the date of the endoscopy test identifying cancer was 24 days

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CRC innovation & challenges

- Trusts adopting hospital based triage – limited migration to true primary care direct access
- More increasing appetite to adapt referral criteria & reduce age limit for referral for patients with concerning rectal symptoms
- Overall capacity constraints in endoscopy cited as ‘too challenging’
- Real challenge for Trusts to provide the required ACE dataset in order to measure pathway changes and evaluate impact
- How well the Trust manages their data has been key – dependant on strong clinical oversight and a dedicated cancer data manager
- If the data is well managed, much easier to extract required data items (via Somerset CR/Infoflex) or directly feed into a bespoke dataset
- More diagnostic data allegedly available in the mandated COSD – still wide variation in completeness
- Key driver will be the 28 day standard to reach confirmed diagnosis
More information

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http://www.cancerresearchuk.org/health-professional/early-diagnosis-activities/ace-programme