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| **Programme Director** | Paul Roche | **Status** | Draft |
| **Owner** | Laura Boyd | **Version** | 0.11 |
| **Author** | Laura Boyd | **Date** | 15/05/13 |

# Transforming Cancer Services for London

## Best Practice Commissioning Pathway for the early detection of lung cancer

**Amendment history:**

| Version | Date | Amendment history |
|---|---|---|
| 0.1 | 11/02/13 | Production of original document |
| 0.2 | | Circulated with the Early Detection Group; feedback included:<br>• Emphasis on communication<br>• The information flow between primary and secondary care |
| 0.3-0.6 | March 2013 | Circulation with Primary Care and Prevention Board and the London Cancer lung pathway group; feedback included:<br>• Need for brevity<br>• Greater focus on prevention and risk stratification<br>• Concern expressed about who makes the decision about ordering CT |
| 0.7 | 16/04/13 | Early Detection Group:<br>• Importance of linking this pathway to the Best Practice Commissioning Pathway for lung cancer<br>• Communication between patient and health professionals |
| 0.8 | 24/04/13 | Workshop with London Cancer Alliance; feedback included:<br>• Importance of reporting on the CXR<br>• Links with A&E and ensuring CXRs are reported on<br>• Role of radiology in reporting on CXR<br>• Using other instances when CXRs are taking place to screen for those at risk of lung cancer, e.g. pre operative CXRs |
| 0.9 | 07/05/13 | Early Detection Group recommended the process for the recall of patients where the CXR was normal but there was still concern was tightened<br>MDT has responsibility for requesting the next test for the patient where there is a query of cancer |
| 0.10 | 13/05/13 | Creation of document for CPE meeting |
| 0.11 | 15/05/13 | Review by Paul Chiles |
| 0.12 | 29/05/13 | Updated following comments from the 21/05/13 CPE meeting ensuring consistency with the best practice commissioning pathway for lung cancer and to ensure balanced approach between primary and secondary care on smoking cessation. |
| 0.13 | | CCLAG provided comments on the role of the key worker in appendix. They were also concerned about the recall system for patients who's symptoms persisted for 3 months. |

**Forecast changes:**

| Anticipated change | When |
|---|---|
| | |

**Reviewers:**

| Name | Title / responsibility | Date | Version |
|---|---|---|---|
| ED Group | Early Detection and Population Awareness group | 05/02/13, 17/04/13 07/05/13 | 0.1 |
| CCLAG | Cancer Clinical Leadership Advisory Group | 26/02/13 | 0.2 |
| Primary Care and Prevention Board<br>(North Central and North East London) | | March 13 | 0.3 – 0.6 |
| London Cancer Lung pathway group | | March 13 | 0.6 |
| London Cancer Alliance workshop<br>(Liz Sawicka, Consultant General and Respiratory Medicine, South London NHS Trust) | | 24/04/13 | 0.6-0.11 |

**Approvals:**

This document must be approved by the following:

| Name | Title / responsibility | Date | Version |
|---|---|---|---|
| CCLAG | Cancer Clinical Leadership Advisory Group | 06/06/13 | 0.12 |
| Cancer Commissioning Board | Cancer Commissioning Board | 01/07/13 | |

**Distribution:**

All London CCGs
Integrated Cancer Systems
Pan London Cancer User Partnership
Charity Partnership

**Document status:**
This is a controlled document.

**Related documents:**

These documents will provide additional information.

| Ref no | Document ref | Title | Version |
|---|---|---|---|
| 1 | | A Model of Care for Cancer services: August 2010<br>http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/Cancer-model-of-care.pdf | |

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|---|---|---|---|
| 2 | | Lung cancer: The diagnosis and treatment of lung cancer Issued: April 2011<br>**NICE clinical guideline 121** guidance.nice.org.uk/cg121<br>http://www.nice.org.uk/nicemedia/live/13465/54202/54202.pdf | |
| 3 | | Saving 1000 Lives – improving outcomes. A strategy for earlier diagnosis of cancer in London. Commissioning guidance for London PCT clusters, March 2012 | |
| 4 | | Best Practice Commissioning Pathway - Lung pathway 2013/14 (for use in 2013/14 contracts) 30/01/13 | 1.0 |

**Table of contents**

# 1. Objective of this document.

The objective of this document is to:-

(a) Define best practice for the early detection of lung cancer for GPs in terms of a pathway and referral guidelines;

(b) Recommend adoption of best practice to London CCGs and propose next steps towards implementation.

**Once the content is agreed, each of the three pathways will be formatted to ensure they read as compelling business cases for adoption by every CCG in London.**

# 2. Background

Early detection has always been a fundamental part of the work to improve cancer services both nationally and in London. The London Cancer Programme (now Transforming Cancer Services for London programme) set up a workstream to implement the early detection recommendations from the *Model of Care* published in August 2010, and *Saving 1000 Lives* published in March 2012.

One of the recommendations was to create best practice pathways for use by GPs to enhance the early detection of cancer. These are being agreed for 3 tumour types: colorectal, lung and ovarian cancer. The aim is to encourage GPs to lower the threshold of suspicion at which point they refer a patient for diagnosis and to ensure that a definitive diagnosis is reached as quickly as possible.

These early detection pathways will link to the Best Practice Commissioning Pathways which set out best practice for the secondary care treatment of cancer. These have been agreed for colorectal, breast, lung and brain/CNS cancers to date.

This paper outlines national guidance for referral (including GP direct access to tests) for suspected lung cancer cases. This paper does not include best practice for diagnostics nor staging of the tumour type, which is included in the Lung Cancer Best Practice Commissioning Pathway, agreed by the Cancer Commissioning Board in December 2012. Prevention is also an important aspect of any system within this context, particularly relating to smoking as this is implicated in many types of cancer. The paper will therefore also describe how the identification of smokers and referral to specialist practitioners can be improved through all primary and secondary care settings.

# 3. Early Detection of lung cancer.

## 3.1 About lung cancer

There are more than 39,000 new cases of lung cancer in the UK each year and with more than 35,000 people each year dying as a result of the condition; it is the most common cause of cancer - related death in both men and women. Smoking is the single biggest risk factor for lung cancer, and causes more than four in five cases of lung cancer.1

Lung cancer continues to be diagnosed at a late stage – The National Lung Cancer Audit showed that in 2010 70% of cases were stages IIIB or IV at the time of diagnosis. In 2007 about 40% of cases were diagnosed via emergency admission and 22% of lung cancer cases were referred through the two-week urgent referral pathway (29). Outcomes are significantly worse for those diagnosed following an emergency presentation.2 Whilst the number of diagnoses has fallen since the 1990s, this decline has begun to stagnate.

It is believed that patients present late due to a lack of awareness of the symptoms that are characteristic of lung cancer. NICE (2011) has highlighted the need for coordinated campaigning to raise public awareness. We also know the biggest single thing we can do to reduce lung cancer incidence is to reduce smoking prevalence.

## 3.2 National guidance

National [NICE] guidelines for the referral of suspected cancer were published in February 2005. Updated guidelines replaced these in April 2011, following the emergence of new evidence about diagnosis and staging of lung cancer.

Key changes from an early diagnosis perspective concern improved communication and ensuring that a lung cancer Clinical Nurse Specialist is available at all stages of care to support patients and carers.

NICE has also published guidance on the issue of brief interventions and referral for smoking, recommending that GPs (and other health care professionals) use every opportunity to discuss smoking with their patient and direct those who want to give up to specialist stop smoking services and/or offer pharmacotherapy to support any quit attempt3.

[1] www.cancerresearchuk.org

[2] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133511.pdf

[3] http://www.nice.org.uk/nicemedia/live/11375/31864/31864.pdf

# 4. Prevention and risk stratification: Identifying those at risk of lung cancer

The biggest thing we can do to improve lung cancer outcomes is to prevent the development of this disease. Smoking is the most significant risk factor for lung cancer and there are services across London to support people to stop smoking, however, not all health professionals are aware of these or the most appropriate referral pathways.

## **4.1** Primary care: the role of pharmacy

Pharmacy can play a key role in identifying those at risk of lung cancer and supporting initiatives to reduce smoking prevalence. There are numerous opportunities to provide brief interventions around smoking in the pharmacy setting, from raising the issue of health risks and advising on the best way to quit, through to participating in community campaigns such as No Smoking Day. All pharmacy staff can be involved in this and training is available for those who want to become stop smoking advisors and offer on-site treatment programmes - contact either the local stop smoking service or see www.NCSCT .co.uk for free online training .

Furthermore, patients with symptoms such as persistent chest infections, coughs, breathlessness and chest or shoulder pain are likely to attempt to self-medicate in the first instance often via the pharmacy. Pharmacists are also therefore in an ideal position to identify symptoms in at-risk individuals and advise them to visit their GP, contributing to the early detection of lung cancer[4].

## 4.2 Primary care: the role of GPs

Patients present in primary care settings everyday for a variety of conditions. Whenever a smoker attends a GP or practice nurse appointment, there is almost always an opportunity to ask about and record smoking status, whether related to the presenting problem or the patient's history and offer a referral to a stop smoking practitioner. Advice from a health professional can be one of the most important triggers for a smoker to make a quit attempt and evidence shows that this is at least twice as effective when an offer of support is provided at the same time e.g. medication and referral to a specialist.

Very Brief Advice (VBA) is a simple tool that can be used opportunistically in less than 30 seconds in almost any situation with a smoker involving establishing and recording smoking status (ASK); advising on how to stop (ADVISE) and; offering help (ACT). Training is available on-line through either the NCSCT (www.NCSCT.co.uk) or BMJ e-learning (www.learning.bmj.com) where it is also possible to earn CPD points.

[4] http://www.rpharms.com/news-story-downloads/professionalmattersarticlelungaudit.pdf
http://www.bopawebsite.org/news/view/pharmacists-play-a-key-role-in-lung-cancer-detection
http://www.rpharms.com/cancer-awareness/lung-cancer.asp

Ensuring there is a relationship between the GP surgery and the local stop smoking service is important so that smokers can be referred swiftly and appropriately, ideally with feedback provided to the GP on the patient's progress.

### 4.3 Prevention: secondary care

As with primary care, every NHS touch point provides an opportunity to talk to every patient about their smoking status. All hospital staff should be encouraged to undertake the Very Brief Advice training mentioned above so that they know to:

1. Ask the patient about their smoking status
2. Record a patient's smoking status
3. Give brief advice
4. Sign post to stop smoking services

Please see appendix C for published best practice as to the components of effective smoking cessation in secondary care.

### 4.4 Risk stratification

There are two Risk Assessment Tools (RAT) currently in pilot by the Department of Health: the Q tool and the Hamilton tool. GP practices are encouraged to participate in these pilots and this pathway will be updated once the evaluation of the tools is complete. Links to the tools: http://www.macmillan.org.uk/Documents/AboutUs/Health_professionals/PrimaryCare/GPIntroPack.pdf and http://qcancer.org/

## 5. Diagnosis: summary of referral to diagnostics from the GP

Chest radiography (CXR) is advocated as the best first line test for suspected lung cancer. More than 90% of patients are symptomatic at the time of diagnosis. CXR findings are abnormal in the vast majority of symptomatic patients. However a normal chest x-ray does not exclude a diagnosis of lung cancer. NICE 2005 guidelines describe high-risk symptom patterns warranting an urgent referral to CXR and lists a clear set of symptoms where the patient must be referred urgently for CXR. The NICE guidelines also provide a clear list of symptoms where the patient must be referred immediately.

### 5.1 Urgent referral

The NICE guidance[5] provides a list of risk factors where the GP should "consider" referral to CXR: smoking related COPD, previous exposure to asbestos, previous history of cancer (especially head and neck), worked in occupations associated with exposure to asbestos, have a family member who

[5] http://guidance.nice.org.uk/CG121

may have suffered heavy exposure to asbestos. In London it is recommended that all patients with these high –risk symptoms are referred for CXR. CXR reports should be returned to the GP ideally within 3 but no more than 5 working days.

## 5.2 Reducing patient delay in attending CXR

To reduce patient delay in attending CXR, it is recommended the GP explains to the patient that they have concerns and that the patient should attend CXR without delay.

## 5.3 Referral information –best practice

Sufficient information needs to be provided on the referral form to allow the radiologist to do a proper risk assessment, and interpret the radiographic appearances in the light of the history. This must include the patient's smoking status.

As lateral CXRs are currently not routine, it is recommended the referring GP includes information if the patient is experiencing posterior pain so that a lateral CXR can be obtained.

## 5.4 Where the CXR suggests lung cancer (or is normal but lung cancer is ***still*** suspected):

- The patient should be urgently referred to a member of the lung cancer MDT (usually the chest physician)
- As per NICE guidance[6], if the chest X-ray is normal but there is a high suspicion of lung cancer, patients should be offered urgent referral to a member of the lung cancer MDT
- An onward referral should be faxed/ sent electronically from the radiology department to the MDT within one week
- A copy of the onward referral should also be faxed/ sent electronically to the GP within 3 days and no more than 5 working days week

Local guidelines within provider units should be followed, so that the patient can be seen and assessed without delay. This may include automatic referral for a 2WW appointment with simultaneous communication to the GP, according to local guidelines.

The chest physician or radiologist will determine if a contrast CT scan of the chest, liver, and adrenals (and other areas if clinically necessary) is required and provided recent blood tests and renal function tests are available via the referring GP, this will, where appropriate, be organised to take place before the patient is seen.

[6] http://publications.nice.org.uk/lung-cancer-cg121/guidance

If a CT scan of the chest is deemed appropriate by either the radiologist or chest doctor, arrangements should be made for the patient to have the CT before the 2 week clinic appointment Where there is a query of cancer, arrangements for follow up should be made by the MDT with a report returned to the GP.

### 5.6 Where the CXR is normal, the GP is reassured, but symptoms persist:

The GP should give clear safety-netting advice to the patient to return for review if symptoms persist and where symptoms do persist, a CXR should be repeated 3 months later.

### 5.7 Other incidences where CXRs take place:

i A&E

CXRs that take place in A&E must be reported. It is the responsibility of whoever has requested the CXR to act on the results and also to ensure that a copy of the report is returned to the GP and to the MDT where appropriate. These x-rays should be reported by a radiologist as well.

ii Pre operative CXRs

There is an opportunity to identify lung cancer cases in high risk populations who are having pre operative CXRs for other investigations. It is the duty of the requesting doctor to ensure the CXR is reported on and that the patient is referred on to the MDT where appropriate.

## 6. Communication

### 6.1 Health professionals

CXR reports should be returned to the GP ideally within 3 days and no more than 5 working days. GPs should receive a clinic letter containing appropriate information, including what the patient has been told, after each outpatient appointment ideally within one week of the appointment. Please see appendix for LCA developed guidelines.

### 6.2 Patient and carer facing communication

Best practice guidelines for communication with the patient and GP applicable for all cancer pathways are being drawn up and these will be circulated separately.

It is recommended commissioners refer to the guidance issued by NICE on communication; emphasis on improved communication is included in the updated 2011 NICE guidance. A key addition is the importance of lung cancer Clinical Nurse Specialist available at all stages of care to support patients and carers.

## 7. Adoption and implementation of best practice.

It is recognised that the definition of best practice set out on in this paper will have implications for CCGs in terms of referrals for diagnostic tests (CXR).

There will therefore be a process of work with CCGs during the second quarter, July - September 2013 to discuss the implications and to analyse what agreement to best practice would mean for each CCG. This will include activity volume and cost analysis. It will need to include reference to primary care systems (decision support software), and primary care education to ensure that all GPs are aware of and follow best practice at all times. This will be linked through primary care commissioning and contracting.

Following the agreement to commission best practice on a CCG basis, this will be built into Commissioning Intentions for 2014-15 in September 2013, for implementation from April 2014.

## 8. Process for agreeing the definition of best practice.

This document has been developed via clinical engagement through both Integrated Cancer Systems and discussions through the Programme's Early Detection and Population Awareness workstream. Following discussion at the CPE, the document will be discussed by the following Programme governance groups:-

- Pan London User Partnership Group - 19th June
- Cancer Clinical Leadership Advisory Group – 6th June 2013
- Cancer Commissioning Board – 3rd July 2013

Following approval and the CCB, the definition of best practice will be put forward to CCGs for adoption and implementation.

## 9. Action requested.

**The CCB is asked to approve the content of this document.**

# Appendix A – Best practice communication between primary and secondary care

A set of guidelines produced by the London Cancer Alliance

**General principles:**

1. Communication needs to be timely and concise.

2. Use fax back route/electronic means for urgent communications. Urgent meaning those that need to be with GP within 24 hours.

3. Quality of communications:-
   a. Must include what the patient has been told
   b. Who told the patient
   c. Who was there with the patient eg named partner/friend
   d. What written/other information was offered
   e. Next steps – when is patient being seen or treatment started
   f. Actions for GP – for information only or suggesting specific GP actions ( including information for Macmillan or district nursing colleagues)
   g. Named care worker in secondary care
   h. Intent of treatment (curative/palliative)
   i. Any additional information required from GP e.g. co-morbidities status
   j. Summary of medication and alterations to medication
   k. Contact details for further information/discussion

4. Key points of change along patient journey:-
   a. Referral
   b. Investigations
   c. Diagnosis
   d. Treatment Planning at MDT
   e. Start of treatment(s)
   f. End of treatment(s)
   g. Completion of active management of cancer (Treatment Record Summary)
   h. Follow up(s)

**At diagnosis**

The GP is informed, by telephone or by fax, within 24 hours of the patient being told the diagnosis, along with the general management plan (further investigations and treatment). The letter must include:-

- What the patient has been told e.g. prognosis
- Who told the patient
- Who was there with the patient e.g. named partner/friend
- What written/other information was offered
- Next steps – when is patient being seen, further investigations or treatment started
- Actions for GP – for information only or suggesting specific GP action
- Named care worker in secondary care
- Intent of treatment ( curative/palliative)
- Any additional information required from GP

If the patient is told their diagnosis in the joint clinic, then the administrator in clinic will fax the information confirming diagnosis to the GP that afternoon.

All inpatients that are given a new diagnosis of lung cancer will be given a discharge letter to be taken to their GP upon discharge. In addition, for some patients, the GP surgery will be contacted by phone or fax.

**MDT discussions and decisions**

The decisions made at the MDT meeting are conveyed to the patient verbally by their cancer nurse specialist The patient is also offered a written copy of this information and a detailed letter summarising the MDT's management plan is dictated for the GP. This letter will be sent by post or electronically to the GP within 24 hours. It will be made clear when the patient is being seen and by whom, to discuss MDT decisions. Feedback by the GP will be invited.

**Letters from clinics**

These will be organised to an agreed format with diagnosis and staging information, intent of treatment and medication highlighted as above. The format can be an agreed template with core fields and areas to add free text.

**Treatment Record summary**

A planned meeting between clinician (CNS or doctor) at the end of active treatment with discussion of diagnosis, response to treatment and next steps to be sent to GP. The TRS should cover psycho-social aspects, sign posting to services, anticipated side effects of treatment and signs of disease progression, with management plans clearly highlighted. Holistic needs assessment will be undertaken with an approved instrument and summarised. The letter will be sent within 48 hours of the interview.

# Appendix B – best practice for smoking cessation in secondary care

Published evidence suggests that the necessary components of an effective smoking cessation in secondary care are:

- A systematic process to identity and record patients who smoke
- Staff trained to deliver 'very brief advice'
- Prescription of nicotine replacement products (NRT); a range of NRT products must be available in the hospital formulary
- A referral system to local smoking cessation services; best practice is an electronic referral system

The supporting processes identified to implement a successful smoking cessation programme for inpatients are:

- Engagement with key stakeholders in the Trust
- Brief intervention training of staff (NCSCT provide a free online training module)
- Developing patient information leaflets
- Standardising process for identification of smokers
- Setting up referral process
- Ensuring a range of Nicotine Replacement Therapy (NRT) is available in hospital formulary
- Appropriate documentation to support the process
- Developing GP letter

Additionally an electronic referral system can be implemented in secondary care to assist with the identification and referral of smokers within the secondary care setting, meaning patients can be quickly and easily referred to a stop smoking service regardless of where they live in the country. In the system pilot at Queen Alexandra Hospital in Portsmouth, the Trust saw a 600% increase of referrals to stop smoking services compared to the same time the previous year. London Trusts including Lewisham, Imperial, South London and Barts & The London have already implemented this system. For more information please visit www.ncsct.co.uk .