

Report to the Wessex Cancer Alliance Board				
Title:	Update on cost, delivery and outcomes of the Wessex Cancer Non Specific Symptom pathway			
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Date:	13 th September 2023			
Purpose	Assurance or reassurance X	Approval	Ratification	Information
Summary of paper:	<p>A Nationally prescribed service, funded though the National Cancer Programme, was set up across Wessex in the form of the Rapid Investigation Service, providing a single virtual model of care for all patients across Wessex.</p> <p>The model has been operational since summer 2020 and has seen a steady increase in new referrals since that time. The current activity suggests a monthly referral rate of around 150 people per month accepted from across over 90% of practices in Dorset, Hampshire and IoW. This equates to a cost per patient of approximately £375 currently. There is a consistent conversion to new cancer diagnosis of between 4-5%, the breakdown of which is included in the paper. The board is asked to note the development and outcomes of the service to date and to support next steps to complete economic evaluation and consider potential applicability of new services (e.g. Breast Self Referral service and GRAIL) for the future of the service.</p>			
Implications: (Clinical, Organisational, Governance, Legal?)	Clinical and economic / commissioning.			
Key risks and mitigations:	There is a risk to the sustainability of the RIS service, and wider transformational services such as the breast self referral pathway and, going forwards, the GRAIL trial. All these services are funded by transformation monies currently. WCA request collaboration from ICB colleagues to ensure rigorous and transparent economic evaluation of the service and decisions on future commissioning strategies.			
Summary: Conclusion and/or recommendation	<p>It is recommended that the Board agree:</p> <ol style="list-style-type: none"> 1. To note the current outcomes of the service 2. To identify key contacts to work with the WCA to consider future commissioning 			

NON-SPECIFIC SYMPTOM PATHWAY SUMMARY OF SERVICE, OUTCOMES AND COSTS

NON-SPECIFIC SYMPTOMS (NSS) PATHWAY SERVICE SUMMARY

The Wessex Model

The NSS pathway provides a route of referral to secondary care for patients presenting with non-specific symptoms suspicious of cancer providing a solution for previously un-met need. Previously some of these patients would not have been eligible for existing site specific NG12 cancer referral pathways and the NSS referral route allows a route into secondary care for this cohort of patients, for example through the criteria of GP gut feeling. The pathway also offers a route for those people who might meet the criteria for more than one pathway who therefore didn't have a single clear route previously. The NSS pathway therefore both meets a previously unmet need and provides a streamlined approach where there were multiple possible routes for a patient to be referred. The NSS pathway is designed to deliver an improved patient experience for this cohort of patients who typically would have presented multiple times in primary and/or secondary care and/or to multiple different pathways.

The NSS pathway in Wessex operates using a virtual, centralised service model facilitated through a central service hub run by University Hospital Southampton (UHS). The centralised Hub Service is called the Rapid Investigation Service (RIS). The service model designed and implemented by the Wessex Cancer Alliance (WCA) was developed to ensure equity in access across the Wessex geography ensuring that people were not disadvantaged by where they live. The centralised model means that access is not focused on any physical location and allows the service to operate with economy of scale, a reduced carbon footprint and minimises the need for patient and staff travel, in turn providing greater flexibility for patients and staff.

The service is designed to facilitate local access to diagnostics for patients, digitally requesting diagnostics at all acute hospital sites across Wessex. People access their tests close to home while at the same time allowing them access equitably to a single centralised NSS service through virtual consultation.

Unlike other cancer pathways, the NSS pathway commits to onward management of patients with serious non cancer conditions in compliance with the national service specification requirement to reduce referrals back to primary care. This increases efficiency and delivers a better experience for this group of patients as well as those diagnosed with a cancer.

Patient Feedback

Semi structured telephone interviews were offered as a route to provide feedback for the first group of patients through the service. This was conducted on behalf of the service by Wessex Voices between October and February 2021 and an independent report produced with findings and recommendations.

This report was based on the feedback from 40 patients and 1 carer who had experienced the non-specific symptom service.

An excerpt from the report on overall comments is below:

The interviewees went on to speak very highly of the RIS, often saying 'you couldn't fault it'. The things that they appreciated about the service were:

- *Its speed and convenience*

- *That the team were all polite, professional, helpful and responsive*
- *That people were given a thorough set of tests and checks*
- *Being telephoned when they were told that they would be*
- *Being told that they could call back with any future concerns. Several times people said “they made it sound like nothing was too much trouble” and this was very reassuring.*

The seven recommendations made in the report pertaining to the service directly are included below, all of which have been addressed or reviewed:

- To ensure the ‘Welcome Call’ advises people about the types of questions they will be asked about their medical history
- To ensure that calls with the RIS team check any accessibility issues (e.g. translations, other accessible formats, caring responsibilities, needing a carer’s support, transport needs) to support people’s specific needs
- To clarify with patients when the RIS expect to be able to share scan results prior to tests taking place
- To explore whether there is additional support that could be provided, by the service or GPs, around unexplained weight loss, particularly where this may be linked to stress
- On discharge from the RIS, to be explicit with patients about whether they should proactively contact the GP or wait to be contacted
- To date written summaries, not to use acronyms and provide clarity about what findings mean, including any implications for medication use
- Review equality monitoring data for those using the service to ensure use of the service reflects the communities of Wessex

Service Benefits

AREA OF IMPACT	BENEFITS	DIS-BENEFITS
Patients & Equality	Provides a solution to previously un-met need for patients presenting with non-specific symptoms suspicious of cancer and for those with presentations meeting multiple referral routes with no clear single route identifiable	Difficulty in quantifying baseline cost model against which to assess viability of RIS service.
	Provides dedicated expert clinical assessment and review leading to faster cancer diagnosis for this complex patient cohort	Requires additional clinical capacity
	Provides an opportunity and time for people to be properly heard therefore allowing root cause of issues to be drawn out leading to fewer contacts post interaction	
	Patient navigator and extended consultation allows opportunity for people where appropriate to manage their health and to alleviate anxiety	
	Reduces inefficiency with a commitment to right place first time and avoidance of unnecessary tests	

	Provides appropriate onward referral for both cancer and non cancer patients where there is a significant diagnosis	Potential speeding up of non cancer diagnosis also, but at a time when resources are stretched.
	Provides an equitable service model for the whole Wessex geography, whilst ensuring access to tests locally to patients	Feels 'outside' to some parts of the geography due to the virtual nature of the clinical team.
	This pathway increases patient safety providing a direct referral route enabling rapid diagnostics and providing an opportunity to prevent late presentations and poorer outcomes This pathway and service hub provides a high-quality patient experience and a single point of contact for the patient	
	Reduced need for patient and clinical staff travel	
Clinical Teams	Provides a solution to previously un-met need for patients presenting with non-specific symptoms suspicious of cancer and for those with presentations meeting multiple referral routes with no clear single route identifiable	No face to face patient contact
	Reduces inefficiency with a commitment to right place first time and avoidance of unnecessary tests	
	This pathway increases patient safety providing a direct referral route enabling rapid diagnostics and providing an opportunity to prevent late presentations and poorer outcomes	
	The service provides feedback to primary care on referrals and individual patient cases as part of education and continued shared learning to inform future referrals and wider pathway support to the system	
	Reduced need for travel and ability to work more flexibly	
Environment	Reduced carbon footprint through fewer patient and staff journeys	
	Reduced carbon footprint as less estate required as no physical clinic	
Cost & Efficiency	Reduces inefficiency with a commitment to right place first time and avoidance of unnecessary tests	Is an additional service with associated infrastructure and staffing costs
	Provides appropriate onward referral for both cancer and non cancer patients where there is a significant diagnosis	Reduction in delay can increase pressure on already long waiting lists.
	Reduced multiple presentations through primary and secondary care by providing a clear route for diagnosis and assessment of symptoms	
	Reducing re presentations	

ACE Pilot Sites – Evidence to support efficiency assumptions

Prior to the publication of the Rapid Diagnostic Centre Programme service specification multidisciplinary diagnostic centre (MDC) projects were undertaken to explore the opportunity and potential benefits of a non-specific symptom referral route.

The journal article summarising the finding from this study states, ‘patients with non-specific symptoms more frequently have multiple GP consultations before referral, potentially contributing to longer intervals from presentation to diagnosis of cancer. Patients in this cohort are also associated with higher rates of cancer diagnosis via emergency presentation and of late-stage cancer diagnoses, both of which contribute to poorer clinical outcomes and poorer patient experience of care.’ (Chapamn, et al., 2020)

The same study found that 28% of patients had had 3 or more previous consultations, (Chapamn, et al., 2020) and noted that patients with non-specific symptoms, ‘often experienced greater numbers of GP consultations before referral than those with site specific symptoms’ (Chapamn, et al., 2020)

The study had an outcome of 8% of patients being diagnosed with a cancer, 239 with a single cancer and one patient diagnosed with two cancers. In 16 cases the cancer was classified as recurrence. It also notes that in addition over 5% of cases were diagnosed with non cancer conditions. (Chapamn, et al., 2020) The paper notes further work is planned to look at the detail of the non cancer diagnoses.

The study also resulted in a report looking at pathway costs, and the ways in which Cancer Research UK had estimated or developed assumptions about cost savings. They conclude that these pathways could be assumed to provide cost avoidance through reduced levels of emergency and primary care presentations, ‘NCD data show that patients with non-specific symptoms often have more primary care consultations than those with alarm symptoms (3+ consultations; 21% vs 32% ‘vague’) and are more often diagnosed via emergency presentation (16% vs 34% ‘vague’). Therefore, the introduction of a planned pathway for rapidly addressing clinical concern should have a tangible impact on non-elective activity, so it is reasonable to expect a reduction in this area. Similarly, positive impacts may also be demonstrated in the number of primary care consultations prior to referral, which have been shown to be higher amongst this patient group in the NCD analyses.’ (Poirier & Chapman, 2019).

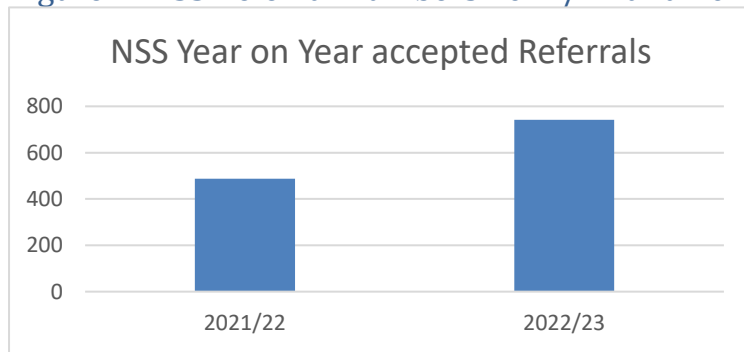
ACTIVITY HEADLINES

Referral Number Growth

Referrals have continued to rise since the launch of the service with a marked increase seen in 22/23 which is continuing into 23/24 with June 23 seeing the highest ever number of accepted referrals in a single month, 116, with a further 27 processed and redirected giving a total of 143 referrals in a single month.

90.2% of all practices across Wessex have now referred to the service.

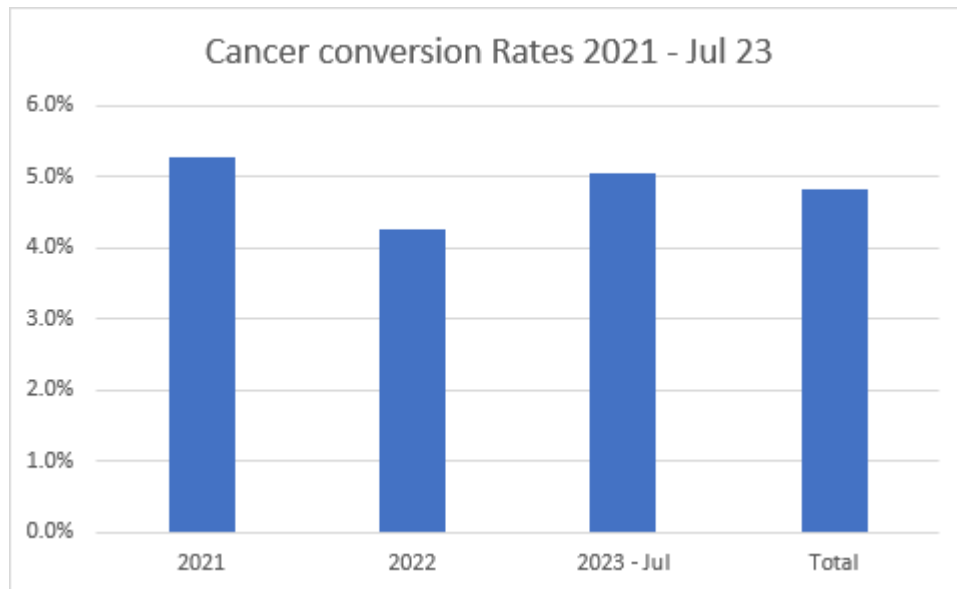
Figure 1: NSS Referral Numbers 2021/22 and 2022/23



The above chart illustrates a 52% increase in referral from 2021/22 to 2022/23.

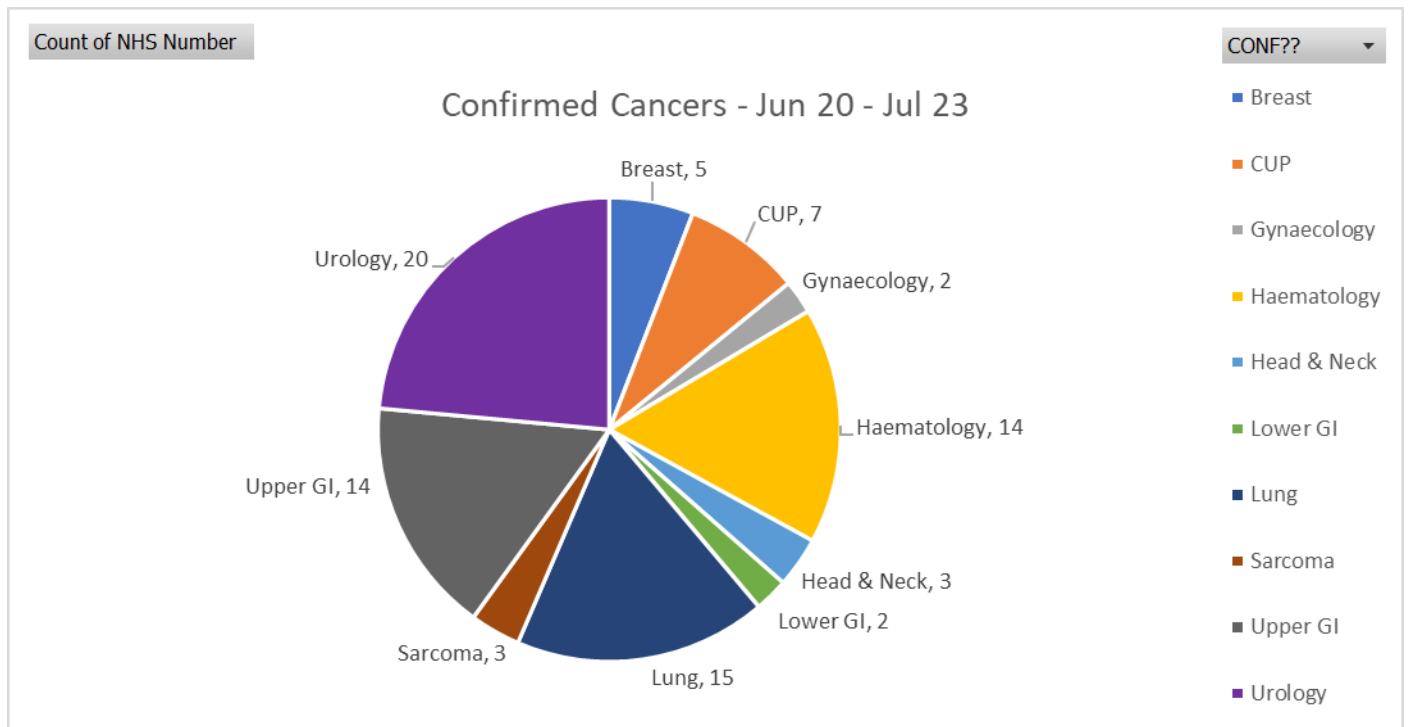
Diagnoses

The conversion rate continues to fluctuate around 4-5% which is in line with other site-specific pathways and NICE guidance.



The service continues to refer into a variety of specialities with a broad range of cancers diagnosed as illustrated below.

Figure 2: Confirmed Cancers by Site



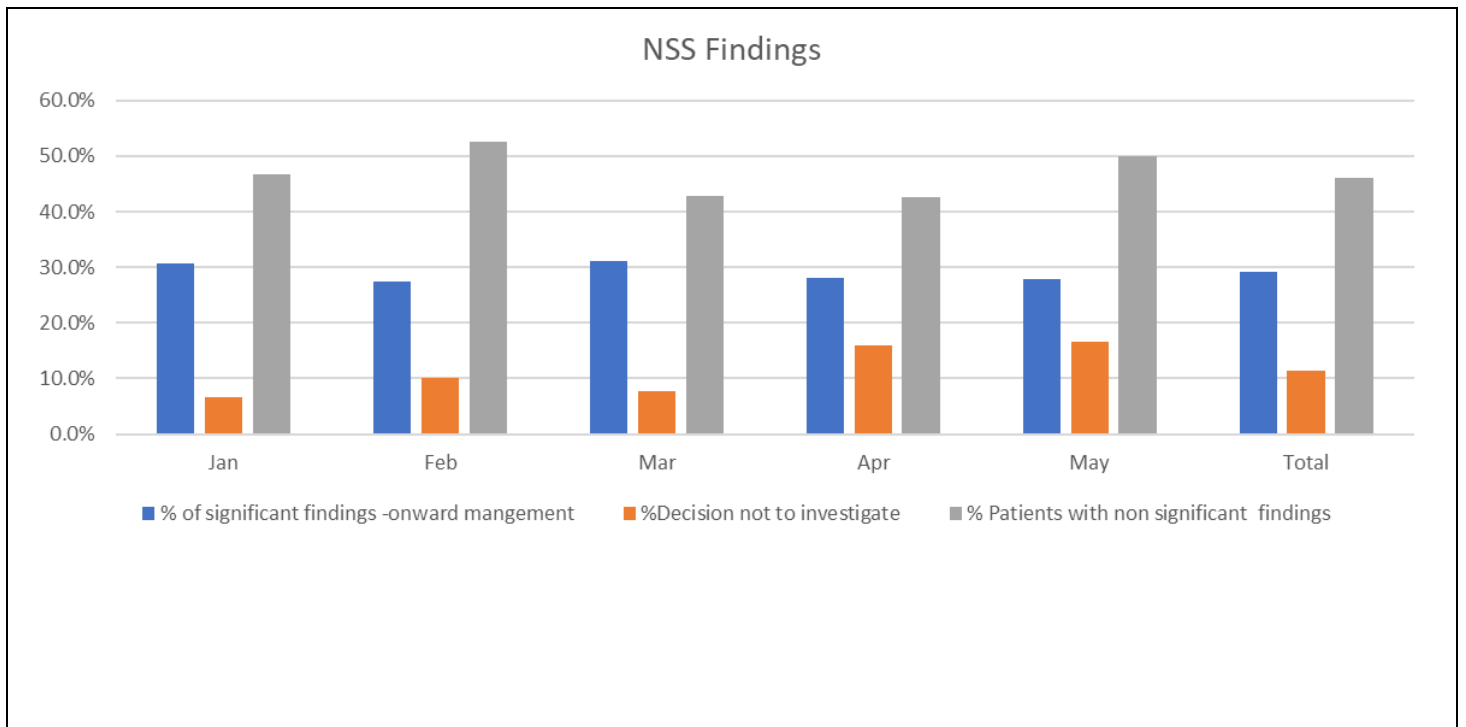
DNA Rates

Due to the NSS pathway being delivered completely virtually, it delivered a low DNA rate of 1.2% through April-August 2023 against a national picture 7.6 % across all outpatient services. [NHS England » Reducing did not attends \(DNAs\) in outpatient services.](#)

Creating a very efficient service with little wasted clinical resource.

Significant non cancer findings

Data for 2023 is consistent with the year 1 data that around 30% of patients who are referred on to the NSS pathway have findings or a diagnosis made which required one or more onward referrals to a specialist secondary care team.



RUNNING COSTS

Running costs for the non-specific symptom's pathway were **£676,098** including systems costs, consumables, and staffing. To note staffing would rise for 24/25 in line with any national pay awards. Based on current planning the service expects to run to a steady state of ~150 pts per month

This equates to £375.61 per patient. This figure will fall further if the GRAIL service is incorporated into the existing infrastructure.

For comparison costs per patient for previous years were:

22/23: £911

22/23: £684

This demonstrates efficiency gains made from developing processes and systems at the service became established as well as from year 1 to 2 the increase in delivery as the service moved from early implementation into more sustained business as usual delivery.

To note for 23/24 referrals have grown month on month and it may be that the average spend per patient will fall by the end of the year. Figures correct at the time of writing, August 23. The current figure has been given using continuation of current activity and doesn't model in any growth so is conservative.

Breakdown:

AREA OF SPEND	COST
Medical staff (inc. GPs)	157,733
Nursing staff	171,370
Admin & Clerical staff	164,431
Facilities and telephony	14,012
Digital solutions	62,950
Other	12,000
TOTAL COST	£562,909

Fixed costs account for £76,962.

To further note costs do not include those of imaging performed which are currently badged under block contracts for cancer referrals at acute Trusts.

To note if GRAIL brought online via the RIS there would need to be some additional administrative and clinical staff recruited to support this with associated additional running costs.

ASSOCIATED RUNNING COSTS: SELF REFERRAL

Digital solutions and other similar costs would be a shared cost across any pathway or service facilitated through the NSS infrastructure.

For example, the breast self-referral pilot service, and shortly the testicular self-referral pilot service will also utilise this infrastructure.

Any future pathway development to enable GRAIL, or any other pathways, would also use this infrastructure at no additional cost.

The breast self-referral pilot currently runs using the existing infrastructure plus costs for the below:

AREA OF SPEND	COST
Clinical posts	£168,395
Admin & Clerical staff	£68,754
Facilities and Misc	£21,464
TOTAL COST	£258,613

GRAIL: HOW THE MODEL COULD WORK

Context

NHS-Galleri is a new test which uses a single blood sample to test for over 50 types of cancer.

The current trial and further future pilot of the Galleri test forms part of ambitions of the NHS Long Term Plan to increase the proportion of cancers diagnosed at early stage from 50 to 75% by 2028. By screening blood samples of people who are showing no symptoms of cancer, it is expected that this will identify patients who may have early-stage cancer who can then be investigated and treated appropriately, with the prospect of better long-term outcomes. From early studies, the test is expected to have a specificity of 99.5% of and a false positive rate of 0.5%.

There is a need to provide a safe service/pathway to support the introduction of this testing which includes support for those receiving both a positive or a negative Galleri result. Where negative people may still require support and advice. A central approach to this will ensure that primary care is not overwhelmed through this. For those with positive results, with one or more cancer signals, there will be a need to ensure those people receive the appropriate downstream testing, are tracked, and supported through this and are referred either onwards or back to their GP following results.

The national team have outlined the expectation that NSS pathway be used to support the implementation of Galleri testing as a natural place for these services to sit. It has infrastructure in place to support communication with patients, GPs, and secondary care across the geography as well as to request tests locally for the patient whilst maintaining tracking and oversight of the patient pathway.

A service to underpin the Galleri testing would effectively be bolted into the existing NSS pathway infrastructure with the need for little in the way of additional clinical and administrative staff to facilitate the safe running of the pathway.

National Planning and Feedback from GRAIL Clinical Trial Pilot Sites

The national Standard Protocol for delivery of Galleri testing states that, 'Although Galleri testing can return one or two specific cancer signal origins (CSO), all patients should be referred in the first instance to non-specific symptom pathways as a single point of entry for all CS detected Galleri test results for further investigation....Experience from the Galleri trial suggests that this is the quickest and most secure way to ensure accurate communication from the Galleri testing programme to patients and the relevant investigating clinician.'

Recommendations shared at National GRAIL Learning event by pilot sites:

- To use a single point of access model to improve referral pathways and avoid the need to determine appropriate tumour site pathway and mitigate against requirement for additional referrals between specialties.
- To use dedicated coordinator to each specific point of access site to ensure the referral was made to the appropriate tumour site – also aids in management of dual CSOs.
- To put clinical champions in place to ensure awareness in secondary care.
- To put clinical teams/processes in place to ensure follow up takes place in line with agreed protocols.