Emergency Diagnosis

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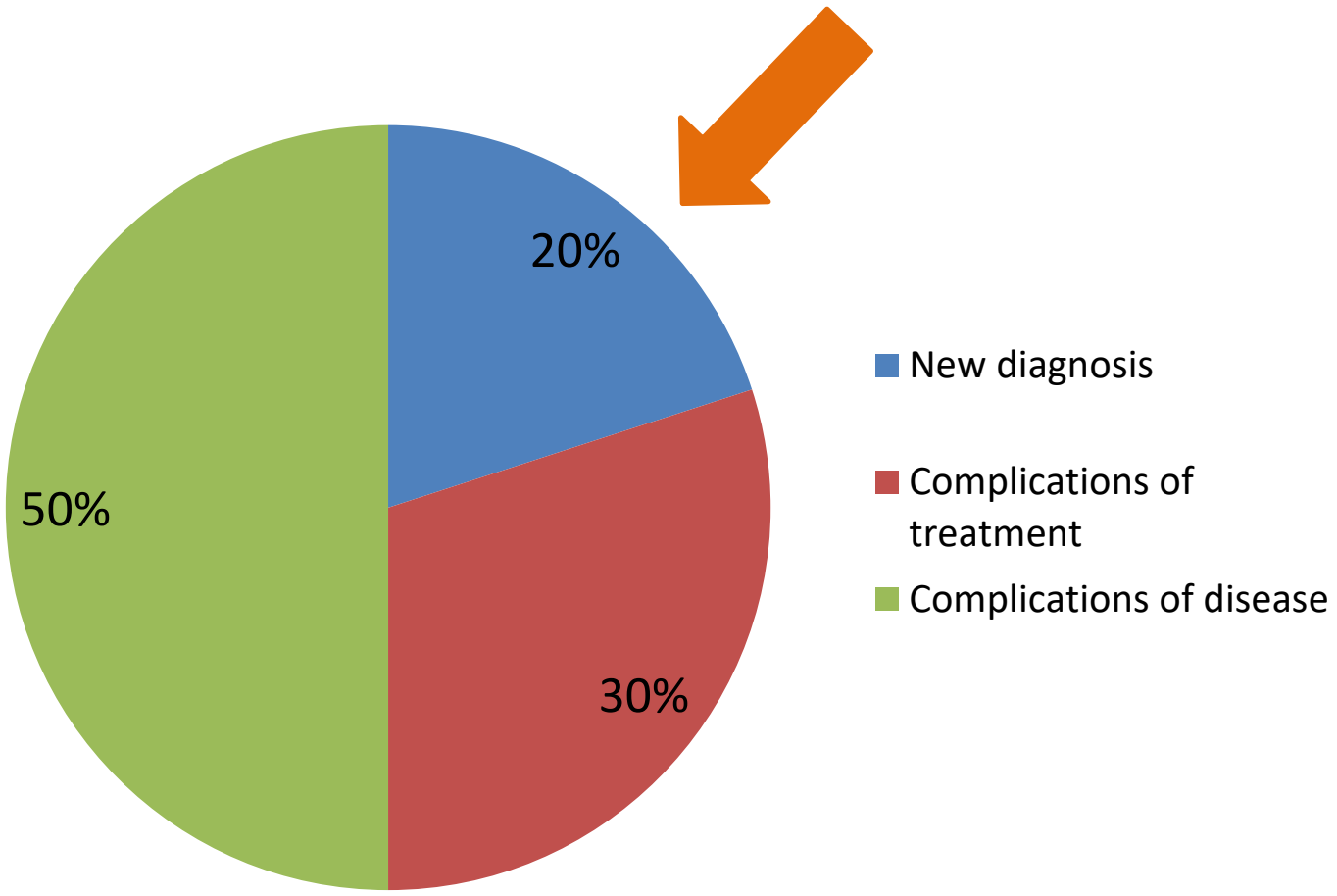
“Urgent Care and Cancer”



Aims of the session

- Concept and significance of emergency diagnosis
- Data quality (local audit findings)
- Data challenge
- Practical steps to improve data accuracy

Emergency Diagnosis of cancer

- No nationally agreed definition
- Patients presenting to urgent/unplanned settings outside of 2ww
- Acutely unwell
- Often advanced disease +

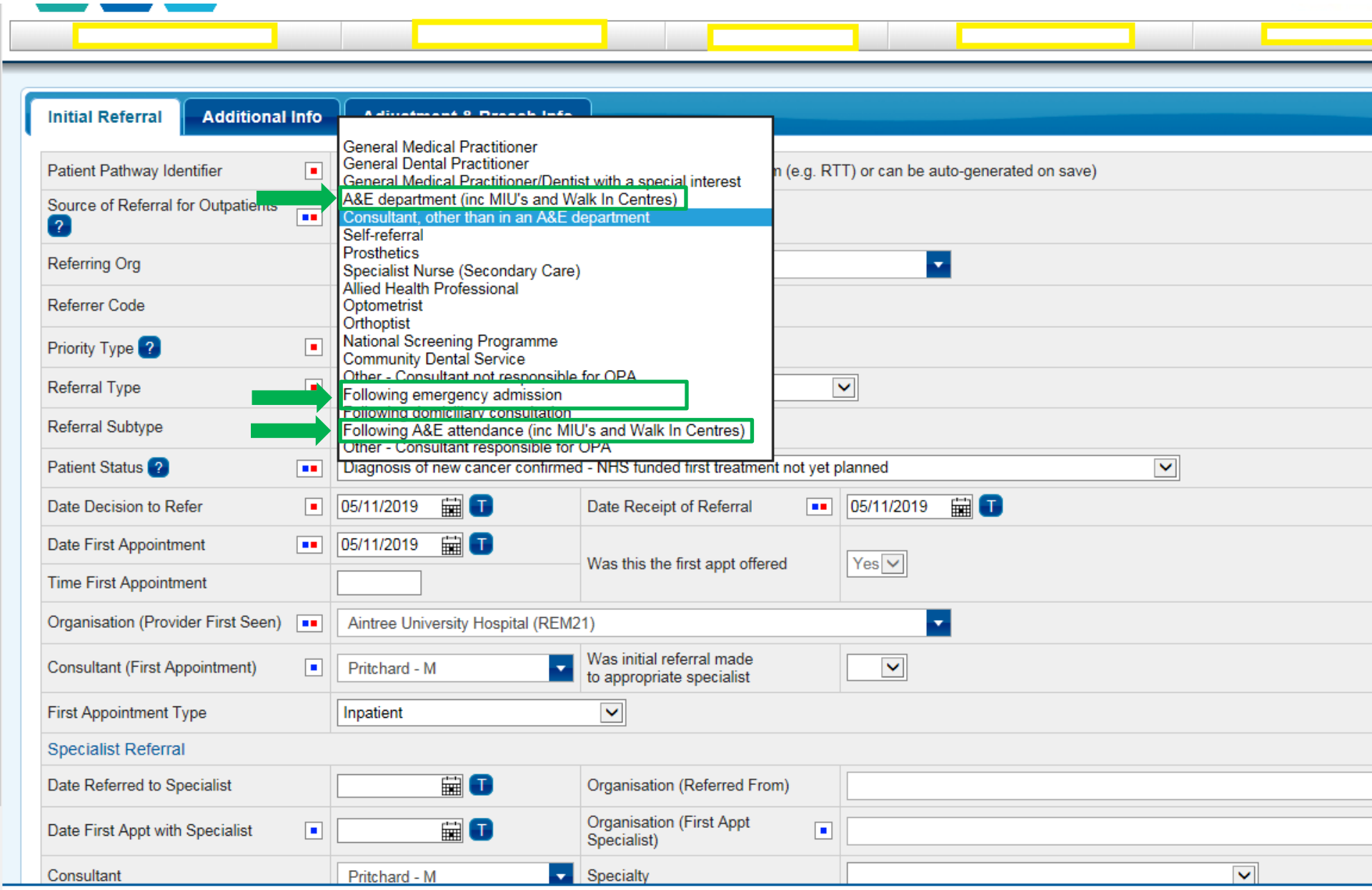
  poor prognosis

- Highest incidence: Lung; Urology; Brain; CUP; HPB; CRC

New patient on SCR

SCR ‘source of referral’ has 3 options in a drop down box relating to emergency diagnosis’:

- **A&E department (including MIU’s and Walk-In-Centre’s)**
  - *SCR reports identify these patients as ‘A&E’*
- **Following A&E attendance (including MIU’s and Walk-In-Centre’s)**
  - *SCR reports identify these patients as ‘Following A&E attendance’*
- **Following emergency admission**
  - *SCR reports identify these patients as ‘Following emergency admission’*


Initial Referral
Additional Info
Patient Pathway Identifier
Source of Referral for Outpatients
Referring Org
Referrer Code
Priority Type
Referral Type
Referral Subtype
Patient Status
Date Decision to Refer
05/11/2019
Date Receipt of Referral
05/11/2019
Date First Appointment
05/11/2019
Was this the first appt offered
Yes
Time First Appointment
Organisation (Provider First Seen)
Aintree University Hospital (REM21)
Consultant (First Appointment)
Pritchard - M
Was initial referral made to appropriate specialist
First Appointment Type
Inpatient
Specialist Referral
Date Referred to Specialist
Organisation (Referred From)
Date First Appt with Specialist
Organisation (First Appt Specialist)
Consultant
Pritchard - M
Specialty
(e.g. RTT) or can be auto-generated on save)
General Medical Practitioner
General Dental Practitioner
General Medical Practitioner/Dentist with a special interest
A&E department (inc MIU's and Walk In Centres)
Consultant, other than in an A&E department
Self-referral
Prosthetics
Specialist Nurse (Secondary Care)
Allied Health Professional
Optometrist
Orthoptist
National Screening Programme
Community Dental Service
Other - Consultant not responsible for OPA
Following emergency admission
Following domiciliary consultation
Following A&E attendance (inc MIU's and Walk In Centres)
Other - Consultant responsible for OPA
Diagnosis of new cancer confirmed - NHS funded first treatment not yet planned

Significance of data

- SCR --> COSD --> national dataset
- Increasingly used as measure for CCG and GP practice level performance
- Indicator for funding of early diagnosis and screening investments

Audit findings

"How many cancer patients are diagnosed as an emergency in North Mersey?"

- PHE (CCG level data)
- SCR reports for individual Trusts

SCR reports significantly below expected

Trust level audit

Data comparison

Tumour Group	SCR (% listed as via emergency route)	Patient notes audit (% via emergency route)
Urology 2017	1.6%	10%
CRC 2017/18	6.7%	21%
Upper GI 2018	22%	27%
Lung 2018	5%	36%
CUP 2018	29%	51%

Data accuracy

Emergency diagnosis coded correctly:

83% of emergency Upper GI diagnosis in 2018

75% of emergency CUP diagnosis in 2017

17% of emergency Lung diagnosis in 2018

34% of emergency Urology diagnosis in 2017

24% of emergency CRC diagnosis in 2017

Why is data accuracy so variable?

- National problem
- No standard definition
- Limited/variable SCR training
- SCR guidelines no info on ‘source of referral’ and options
- May not be obvious

Example 1

- Patient presents to ED with chest pain
- Chest CT performed
- Patient is discharged home same day
- CT resulted and lung cancer alert generated next day (post-discharge)
- Report reviewed by AED consultant and referred to cancer services triggering thoracic consultant vetting/review

- As referral to MDT comes direct from AED consultant these are often coded with source of referral as “AED referral”

Example 2

- Patient presents to ED coughing up blood
- Chest CT performed
- Patient admitted to ward
- CT resulted
- Inpatient thoracic referral requested
- Patient reviewed by Thoracic consultant
- Referred to Cancer Services

- As referral to MDT comes from Thoracic consultant, these are often coded with referral source “Consultant, other than in A&E Dept”

How can we improve this practically?

- Agreeing regional definition
- Steps for now; particularly for high risk groups:

  – Are they a current inpatient admitted via ED?

  OR

  – Did they have an emergency presentation/admission in the last week?
  – Was there an obvious trigger e.g. lung CT?
  – Was patient on a GP 2ww at the time?

Thank you

And questions?