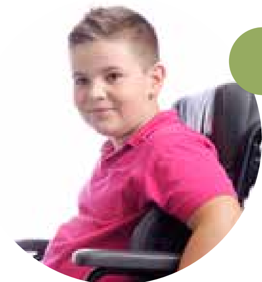
NHS
Wessex
Cancer Alliance

# Plan to Implement Cancer Primary Care Strategy for Wessex 2021/22



# Backgound

Following the drawing up of the recent draft Cancer Primary Care Strategy for Wessex document and the realignment of the MacMillan GPs to the Wessex Cancer Alliance, there is a need to co-ordinate the activities of all the GPs employed by Wessex Cancer Alliance to optimise the effectiveness of our interventions, ensure widespread representation of primary care views throughout the alliance and optimise communication between us.

To facilitate this process, we have agreed to draw up areas which as a group, we wish to focus on during the coming year which are in line with the strategy document .

These actions can then feed into another of our main goals which is to deliver a co-ordinated education programme to all cohorts of primary care.

Progress on our goals will be reviewed periodically at the Wessex Cancer Alliance Primary care group meetings. Our education programme will also be coordinated through these meetings

We all recognise the importance of the voice of primary care being heard whenever significant discussions are taking place about cancer care in Wessex.

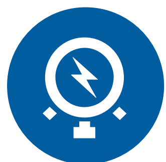
Clearly all of this is on the very significant ongoing background of the challenges posed by Covid which has a significant impact on what GP practices and PCNs are able to do in terms of cancer work and on the diagnostics available in our hospitals.

# The Cancer Primary Care Strategy for Wessex document

## This essentially divides activities into 4 broad areas:

1. **Prevention**

2. **Earlier Diagnosis**



3. **Faster Diagnosis**

4. **Personalised Care**

# Prevention

We acknowledged that prevention is an important part of our work, though this is not an area where we will be able to demonstrate short term improvements. However, focusing on increasing confidence for health care professionals to deliver very brief advice when interacting with patients (eg during long term condition reviews, post natal appointments, contraceptive reviews, following fast track referrals not resulting in a cancer diagnosis) has the potential to be very powerful.

We also acknowledged that many other agencies and campaigns have an important part to play in prevention including social prescribers as does publicity at Covid vaccination centres

The following are areas we intend to focus on :

## Obesity, Smoking and Alcohol

The actions we intend to take are:

1. **Focus on very brief interventions in these areas** providing training for primary care utilising existing resources which may include RCGP resources, CRUK resources and local authority Public Health alcohol interventions. We will also look at how to capitalise on the educational opportunities following a fast-track cancer referral when cancer is not diagnosed
2. **Working with Social Prescribers to make every contact count and highlight prevention opportunities** - it was suggested that linking in with the national academy for social prescribers and communities against cancer to develop cancer awareness with social prescribers and primary care administration staff
3. **Innovative techniques to target prevention-** this includes targeting patients when they hit 40 years of age, targeting different communities e.g. patients with learning disability, utilising new technology eg smoking cessation app.
4. **Promoting cancer prevention in the NHS workforce –** Working with primary and secondary care to promote resources for use with staff through the Prevention and Earlier Diagnosis Toolkit

**By 31st March 2022**

## Outcome Targets

1. 100% of PCNs will have been offered staff training re: delivering Very Brief Advice (VBA).
2. 20% of PCNs will have taken up the offer of VBA training.
3. An infographic will have been disseminated to all NHS staff about cancer prevention.
4. 100% of PCNs will have been given access to the Prevention and Earlier Diagnosis toolkit

# Earlier diagnosis

This is an area where we may be able to demonstrate improvement using a focused Local Improvement Scheme with Primary Care Networks and the introduction of a Primary Care Toolkit.

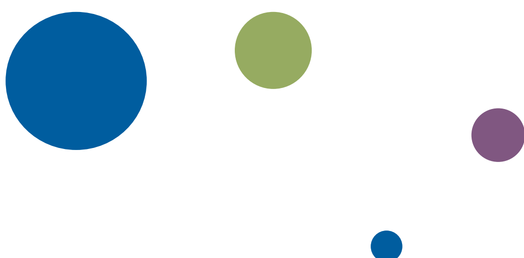
## Cervical screening

This continues to be an area of importance with differing screening rates across Wessex with a number of hard to reach groups eg areas of deprivation, certain ethnic minorities, women who have never had a smear, learning disability, serious mental illness

It was felt that this should be our main screening focus this year looking at any conclusions from previous cancer alliance work in this area. The aims will be to improve the message to primary care, focusing on areas of low uptake and possible provision of a pack to practices.

## Bowel screening

We were reminded that improving rates of bowel screening including inequality groups, has the potential to make a big impact on bowel cancer deaths. We were also reminded that a follow up letter or text from the patient's GP to patients who have not taken up the screening offer, results in higher screening rates. We are aware that Covid has placed constraints on bowel screening, but this is recovering. A toolkit will be developed for practices to use as a Qof QI project to increase bowel screening uptake.



## Promoting the use of symptomatic FIT testing

We all acknowledged the important role that FIT testing can play in the earlier diagnosis of bowel cancer and is an area we want to promote and provide education about. We want to target practices with low uptake of FIT testing. Provide education to primary care regarding when to use FIT testing.

This work will be delivered through the Local Improvement Scheme with Primary Care Networks and include a webinar to inform the PCN clinical leads about the reasons for increasing the use of symptomatic FIT with patients, identify areas for improvement in the PCN and share PCN learning and plans for improvement.

## Lung cancer

We all agreed the importance of promoting the earlier diagnosis of lung cancer including areas which are not part of the pilot and where there have not been incentives to look at high risk patients. This includes the message that negative chest X-rays miss a significant number of lung cancers, the importance of raised platelets and nonspecific symptoms not always traditionally linked to lung cancer and COPD review symptoms. Our actions in this area will be focused around primary care education of very brief advice and the understanding of NG12 in both clinical and non clinical primary care staff.

# Earlier diagnosis – *continued*

## Promoting prostate cancer awareness

We acknowledged that this needs to be targeted, as earlier diagnosis is more likely to have prognostic benefits in men with a family history of prostate cancer or who come from ethnic minority black populations. There are a number of campaigns including the Wessex cancer trust 'Action man campaign'. We are all aware of the ongoing work and proposals suggested by Mr Tim Dudderidge consultant urologist in UHS to create a self referral Prostate Health Test. There are two other pieces of work, at the time of writing; Targeted Prostate Health Checks and community development work to raise awareness of in high risk communities to and to access their GP if they would like to have a PSA test because of their status.

## Promoting the use of clinical decision support tools

Utilising technology to promote the earlier recognition of possible cancer symptoms in primary care and facilitating referral along NICE NG12 pathways is an important part of diagnosing cancer earlier. We are keen to promote the use of these tools in primary care this will be incentivized through the Wessex Cancer Alliance LIS and includes a showcase webinar and PCNs reflecting on the best tool to use.

## Earlier Diagnosis of pancreatic cancer

This is an area that Wessex Cancer Alliance has focused on. Promoting this to primary care especially the link with new onset type 2 Diabetes Mellitus.

## Promoting the PCN DES and QOF QI earlier diagnosis of cancer

We all affirmed our commitment to facilitating this with practices and discussed a letter which has been constructed to remind PCNs / practices of our offer of help.

## Outcome Targets

1. Local Improvement Scheme for Prevention and Earlier Diagnosis – aiming for 50% sign up by PCNs across Wessex.
2. Increasing screening uptake by 'levelling up' - aiming to reduce the screening gap for PCNs with lower screening rates by 50% e.g. a PCN with a cervical screening rate of 60% rather than the target of 80%, moves to 70%. This will be referenced with case studies.
3. Increasing screening uptake for inequality groups including learning disability, serious mental illness and ethnic minorities by 'levelling up' aiming to reduce the screening gap by 25%. This will be referenced with case studies.
4. Increasing bowel screening uptake by 3%
5. Increasing the use of symptomatic FIT testing in primary care by 10%.
6. Increasing the use of clinical decision support tools in primary care through the 50% sign up to the Local Improvement Scheme.
7. Increasing the number of fast-track referrals across Wessex by 7%.
8. Decreasing the cancer conversion rate across Wessex by 0.5%.
9. Increasing the awareness of the heightened risk of prostate cancer in African and Caribbean men

# Faster Diagnosis

## Rapid Investigation Service

We agreed the ongoing importance of promoting the service with targeted education in areas with low referral rates.

## Breast lump self-referral

We agreed to ensure we are involved with this pathway as it develops.

## Dermatology

We agreed to ensure there is involvement of Wessex Cancer Alliance GPs in this pathway as it develops.

## Lumps pathway

The lack of clear referral pathways for GPs throughout Wessex had previously been identified as an issue leading to difficulties for GPs and delayed diagnoses for patients presenting with lumps. A group has recently been set up to look at this issue.

## Emergency presentations of cancers

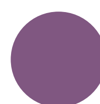
We are all aware of the survival benefits of trying to reduce the number of cancers diagnosed via emergency presentations. Whilst some of these presentations may not be preventable, lessons can often be learned from these patients. Previously, Bournemouth Hospital had been able to provide helpful feedback to practices about these patients. We agreed it would be useful to see how this could be replicated in Hampshire.

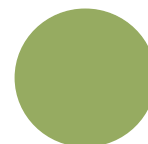
## Safety netting

We all acknowledged that promoting the importance of safety netting is important and that CRUK etc have a number of resources to support this

## Outcome Targets

1. Increasing the number of referrals to the Rapid Investigation Service by 50%.





# Personalised Care

We all agreed that this is an extremely important area .

## Cancer care review

Performing a structured cancer care review is part of the 2021/22 QOF requirement and has the potential to promote and improve personalised care. We heard that there is an excellent Ardens template to facilitate this and an excellent letter template used by Richard Roope's practice

## Right by you

We all agreed this is an important programme.

## End of life care

We agreed that it is important that this part of MacMillan cancer care is not overlooked following the Alliance's co-funding of the MacMillan GPs and that we 'feed into relevant groups'.

## Additional items

We agreed it is important to ensure there is primary care representation at forums where cancer is discussed.

We all agreed that PCN cancer champions would be a very positive development but probably not an immediate objective.

We all acknowledged the importance of the national cancer awareness campaigns.

## Education

This is clearly an important part of our work and potentially all the activities listed above feed into this in addition to numerous other topics.

We agreed that the Wessex Cancer Alliance GP meetings are the ideal conduit to facilitate and co-ordinate our educational activities.

As a group we are aware that a comparatively small number of GPs follow NG12 and that increasing adherence to NG12 would potentially lead to an increase in fast-track referrals and earlier diagnosis. We felt this is an important area to focus education.

# Personalised Care – *continued*

We had a number of thoughts about how to improve education including:

**A Cancer Alliance Newsletter aimed at primary care**

**Toolkit for primary care campaigns in tandem with national campaigns produced by the comms team**

**Looking at fast track referral conversion rates**

**Promoting the use of clinical decision support tools**

**Promoting Gateway C**

**Promoting how AccuRx can help, setting up ICE request panels**

**Promoting cancer education to practice nurses, administrative staff and pharmacists**

**Creating a webpage calendar for WCA educational activities with links to book sessions**

We all acknowledged the importance of co-ordinating our educational activities and bringing what we are doing to the group for information and potentially co-ordination.

## Conclusions and next steps

We all agreed that this is an exciting opportunity for us to work together more cohesively to build on previous significant achievements.

We agreed to regularly schedule time in our primary care GP group meetings to report back progress on all of our agreed goals.

We also agreed we need to give some thoughts about how we ensure the voice of primary care is fully represented in forums where cancer is discussed especially in the light of the changes to CCGs in April 2021.

It has also been decided to offer a Wessex wide LIS to support this implementation plan.

# Outcome Targets

## LIS

- 50% of PCNs to sign up to the WCA Prevention and Earlier Diagnosis Local Improvement Scheme

## Prevention

- 100% of PCNs will have been offered staff training re delivering very brief advice
- 20% of PCNs will have taken up the offer of very brief advice training
- An infographic will have been disseminated to all NHS staff about cancer prevention
- 100% of PCNs will have been given access to the Prevention and Earlier Diagnosis toolkit

## Earlier Diagnosis

- Local Improvement Scheme for Prevention and Earlier Diagnosis – aiming for 50% sign up by PCNs across Wessex.
- Increasing screening uptake by 'levelling up' - aiming to reduce the screening gap for PCNs with lower screening rates by 50% eg a PCN with a cervical screening rate of 60% rather than the target of 80%, moves to 70%. This will be referenced with case studies
- Increasing screening uptake for inequality groups including learning disability, serious mental illness and ethnic minorities by 'levelling up' aiming to reduce the screening gap by 25%. This will be referenced with case studies
- Increasing bowel screening uptake by 3%
- Increasing the use of symptomatic FIT testing in primary care by 10%
- Increasing the use of clinical decision support tools in primary care through 50% sign up to the Prevention and Earlier Diagnosis LIS.
- Increasing the number of fast track referrals across Wessex by 7%
- Decreasing the cancer conversion rate across Wessex by 0.5%
- Increasing the awareness of the heightened risk of prostate cancer in African and Caribbean men

## Faster Diagnosis

- Increasing the number of referrals to the Rapid Investigation Service by 50%

## Personalised Care

- Resources offered to all PCNS to support holistic cancer care reviews

# Notes

For a translation of this document or to request information in an accessible format, please email:
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