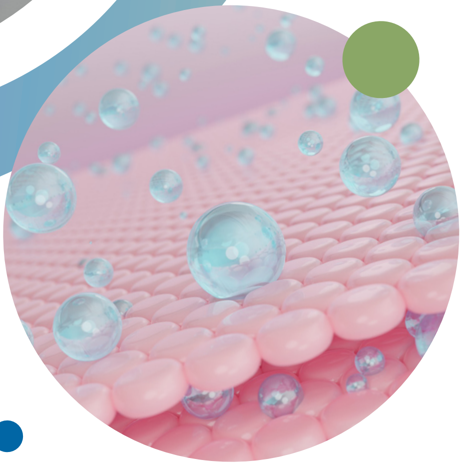
NHS
Dorset

PCN DES reports on Early Diagnosis of Cancer Specification 2023/24 in Dorset



PCN DES reports on Early Diagnosis of Cancer Specification 2023/24 in Dorset

The Network Contract Directed Enhanced Service (DES) for 2023/24 contained an Early Diagnosis of Cancer Specification. This required Primary Care Networks (PCNs) to take action on several aspects supporting the earlier diagnosis of cancer.

The PCN was required to:

1. Review referral practice for suspected and recurrent cancers, and work with its community of practice to identify and implement specific actions to improve referral practice, particularly among people from disadvantaged areas where early diagnosis rates are lower
2. Work with local system partners – including the NHS England Regional Public Health Commissioning team and Cancer Alliance – to agree the PCN's contribution to local efforts to improve uptake in cervical and bowel NHS Cancer Screening Programmes and follow-up on non-responders to invitations. This must build on any existing actions across the PCN's Core Network Practices and include at least one specific action to engage a group with low participation locally
3. Work with its Core Network Practices to adopt and embed:
    a. the requesting of FIT tests where appropriate for patients being referred for suspected colorectal cancer
    b. where available and appropriate, the use of teledermatology to support skin cancer referrals
4. Focusing on prostate cancer, and informed by data provided by the local Cancer Alliance, develop and implement a plan to increase the proactive and opportunistic assessment of patients for a potential cancer diagnosis in population cohorts where referral rates have not recovered to their pre-pandemic baseline
5. Review use of their non-specific symptom pathways, identifying opportunities and taking appropriate actions to increase referral activity.

Dorset Cancer Team collected reports from the Primary Care Networks (PCNs) in Dorset and with support from Wessex Cancer Alliance the reports were thematically analysed. Summaries of the responses to the questions were outlined below.

There are 18 PCNs in Dorset and 18 reports were received (100%).

Review Referral Practice

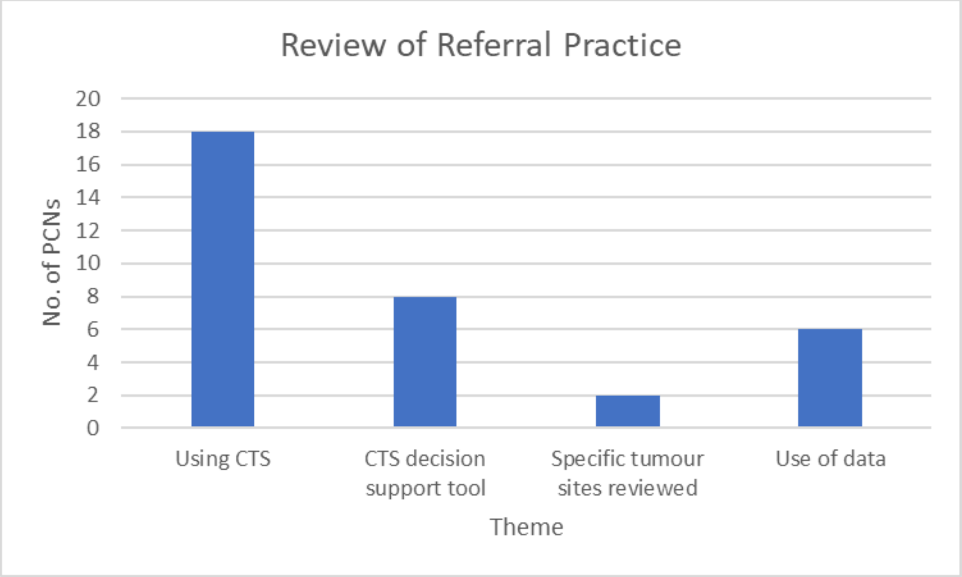
Requirement 1: Review referral practice for suspected and recurrent cancers, and work with its community of practice to identify and implement specific actions to improve referral practice, particularly among people from disadvantaged areas where early diagnosis rates are lower.

The chart below shows the four themes that came out from this requirement. All PCNs are using 'C The Signs' (CTS) with most PCNs and practices having fully embedded the software in their referral practice for suspected cancers and many PCNs highlighting the benefits of 'C The Signs'.

Eight PCNs specifically mentioned using the CTS risk assessment tool with ARRS roles and other clinicians.

Two of the PCNs chose to review specific tumour sites putting in place improvements to ensure that the pathway is effective and will pick up appropriate referrals to secondary care.

Six PCNs mentioned the data meetings led by WCA and DiiS data analysis.



Examples of PCN comments on their reviews are outlined below:

> *C The Signs now also used as the default for all clinicians doing suspected cancer referrals, instead of the previous ICB systmone template.*

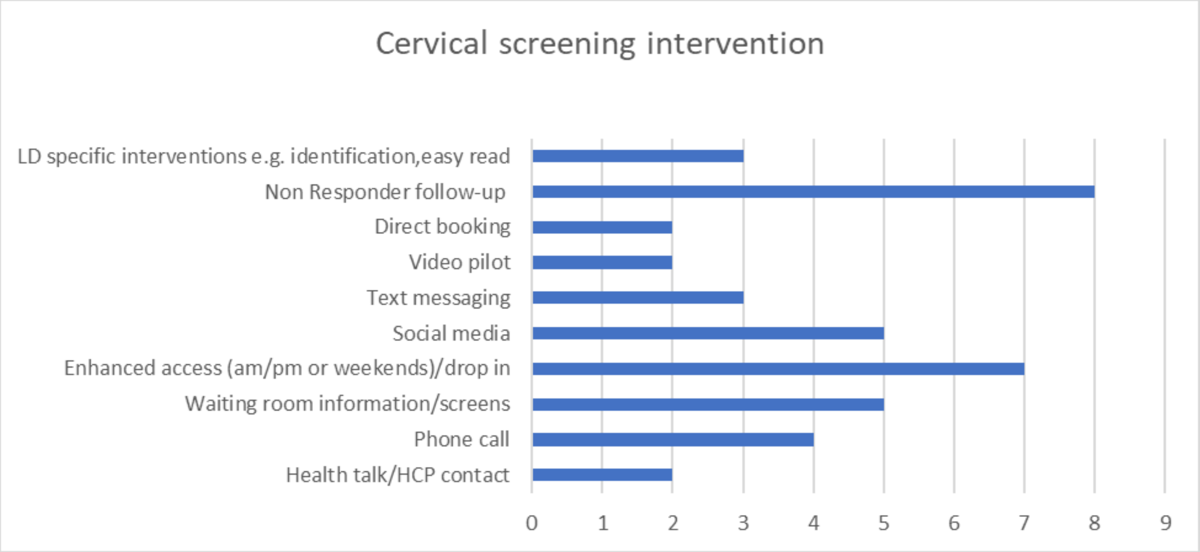
> *The cancer symptoms checker for c the signs has been useful aid tool especially for some of the ARRS role staff with their decision making and confidence to appropriately escalate referrals into the correct cancer referral pathways.*

> *All four surgeries make good use of the tools available during consultation on C the signs. GPs have also fed back they make good use of the Rapid Investigation Service which is valued within the teams. We use the information leaflets from C the signs to ensure patients have the correct information when it comes to signposting and their onward care.*

Improve uptake in cervical and bowel cancer screening

Requirement 2: work with local system partners – including the NHS England Regional Public Health Commissioning team and Cancer Alliance – to agree the PCN's contribution to local efforts to improve uptake in cervical and bowel NHS Cancer Screening Programmes and follow-up on non-responders to invitations. This must build on any existing actions across the PCN's Core Network Practices and include at least one specific action to engage a group with low participation locally.

The chart below highlights some of the actions that PCNs took to improve uptake of cervical screening. The majority improved access to cervical screening appointment by having weekend and/or evening appointments available. In doing so they stated they were actively trying to encourage working women to attend. Many opted to follow up non-responders with regular reminders with text messaging and phone calls mentioned. Four practices took part in a cervical screening video texting pilot and two PCNs have highlighted this in their reporting.



Examples of PCN comments on their initiatives are outlined below:

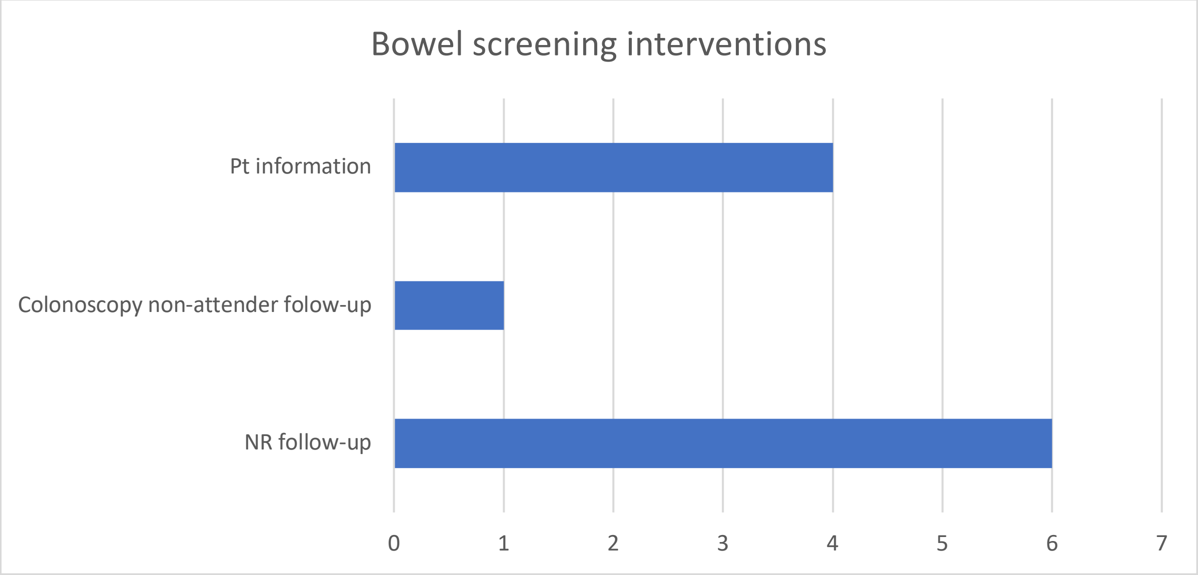
Cervical screening follow-ups were sent to patients who did not respond to third invitation letter and have never had a cervical screening on our records. The cervical information campaign coincided with a national campaign to maximise effectiveness.

Introduction of Saturday smear clinics at treatment centre. Hoping to capture working age group better, based in area of lower deprivation so may improve access.

Learning Disability Liaison Nurse (1 year role) helped to encourage and improve bowel, breast, and cervical screening amongst our Learning Disability population.

PCNs also shared the actions that they have taken to improve bowel screening uptake. The below graph shows that the majority followed up their non-responders. One PCN focused on follow-up of patients who had a positive bowel screening result but who had not attended their follow-up appointments.

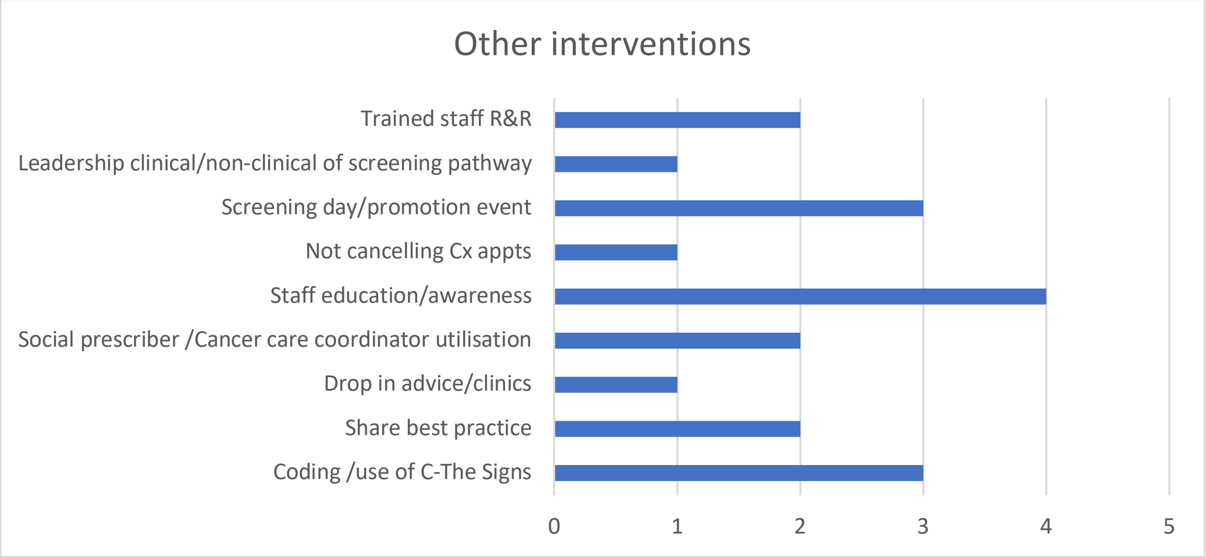
We appointed a Cancer Care Coordinator who has carried out significant projects to increase screening. We followed up non-responders to bowel screening invites. Letters to LD patients were sent in easy read.



The PCNs also shared more general information about responsibility and ownership of the screening pathway in practice. One practice highlighted the impact that staff shortages had on prioritisation of screening appointments and how they now try to avoid cancelling these.

> Long term staff illness of smear-taking nurses, shortages of trained staff and resulting long waits for appointments or sometimes cancellation of these in favour of other urgent tasks and appointments for the nursing staff. This seems to have persisted past the post-Covid recovery phase.

> We send links to patients so they can book directly into these clinics themselves. We have added a "pop up" on S1 to all patients who are overdue a smear. This enables both the admin staff and clinicians to offer an appointment opportunistically at any point that the patient contacts the surgery.

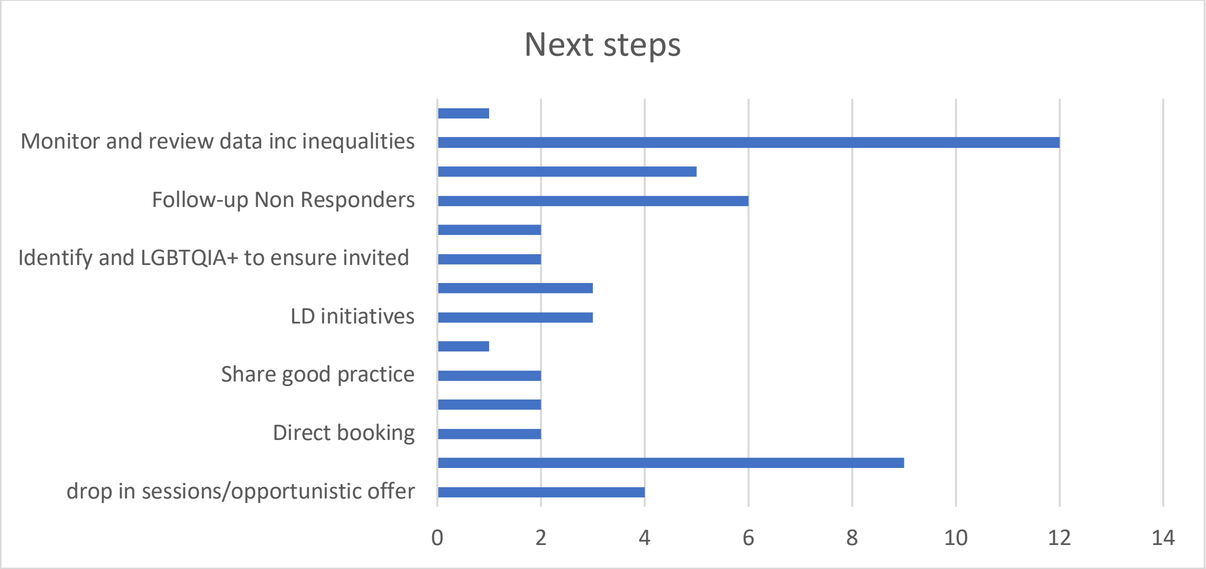


Finally, PCNs were asked how they plan to sustain activities in improving screening uptake and following up non-responders and several different suggestions were provided, as seen in the chart below. The main actions are planned around improving uptake in lower uptake groups such as patients with learning disabilities (LD) and serious mental illness (SMI). Other actions included sharing good practice, use of a wide range of staff, community engagement, direct booking, and improving engagement with anxious patients.

Ensure all eligible patients are invited for screening, including our transgender and veteran patients who may be missed depending on their circumstances.

One of the main things I would like to achieve, and now with the appointment of the new long term condition co-ordinators it will be possible, is to review the Practice Learning disability registers and look at the cervical screening uptake in those groups and actively promote and encourage those who are eligible to take up cervical screening. There may also be an opportunity to provide education to the carers of this cohort on why cervical screening is important so they can help encourage the person they look after to attend their cervical screening appointment.

Cancer care coordinator re-recruitment is in process and this role will be actively engaged with reviewing the DiiS dashboards – targeted support can be provided to surgeries where there is under performance. Data management has been written into the updated job description to support this part of the role.



Outcomes:

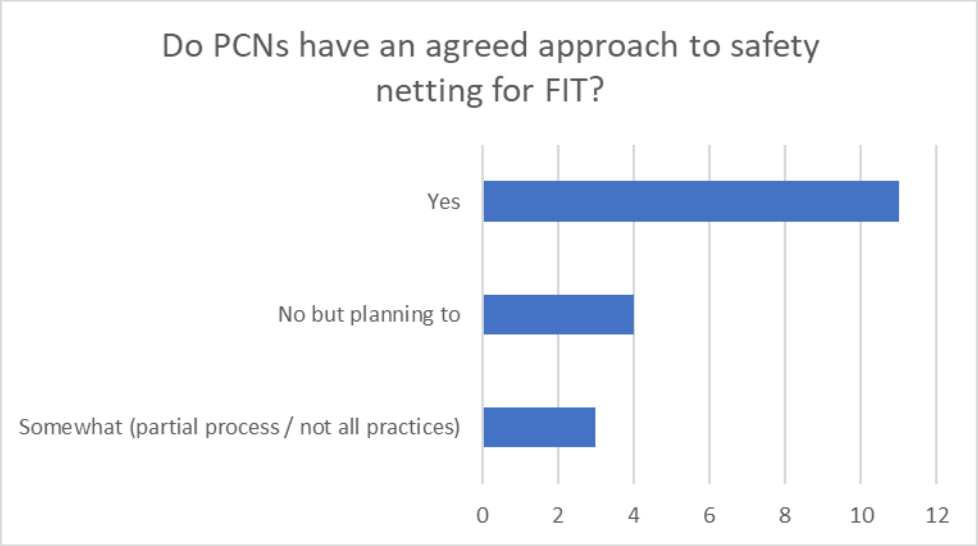
A number of PCNs reported that their cervical screening uptake had improved due to the initiatives introduced.

Analysis of the coverage data showed that for Q4 2023/24 7 out of 69 practices exceed the national target of 80% coverage for age 24-49 and 32 practices in total had an increase in coverage between Q1 and Q4. For the age 50-64 17 practices met or exceeded the national target of 80% and 23 practices had an increase in coverage between Q1 and Q4. However, for the ICB there was no change in coverage for age 24-49 between Q1 and Q4 (70.9%) and there was a drop in coverage of 0.3% (76.2%) for age 50-64. A full breakdown of data can be found in appendix A.

FIT testing for colorectal cancer referrals

Requirement 3i: Work with its Core Network Practices to adopt and embed the requesting of FIT tests where appropriate for patients being referred for suspected colorectal cancer.

Dorset PCNs have been consolidating their work from previous years to embed FIT testing into the Lower gastrointestinal suspected cancer referral pathway. The majority of PCNs (14) reported that they had a robust process in place, in either all or some of their practices, to ensure FITs are completed and the test results followed up. The remaining practices were still developing their approaches.



PCN reported activity to support embedding of FIT

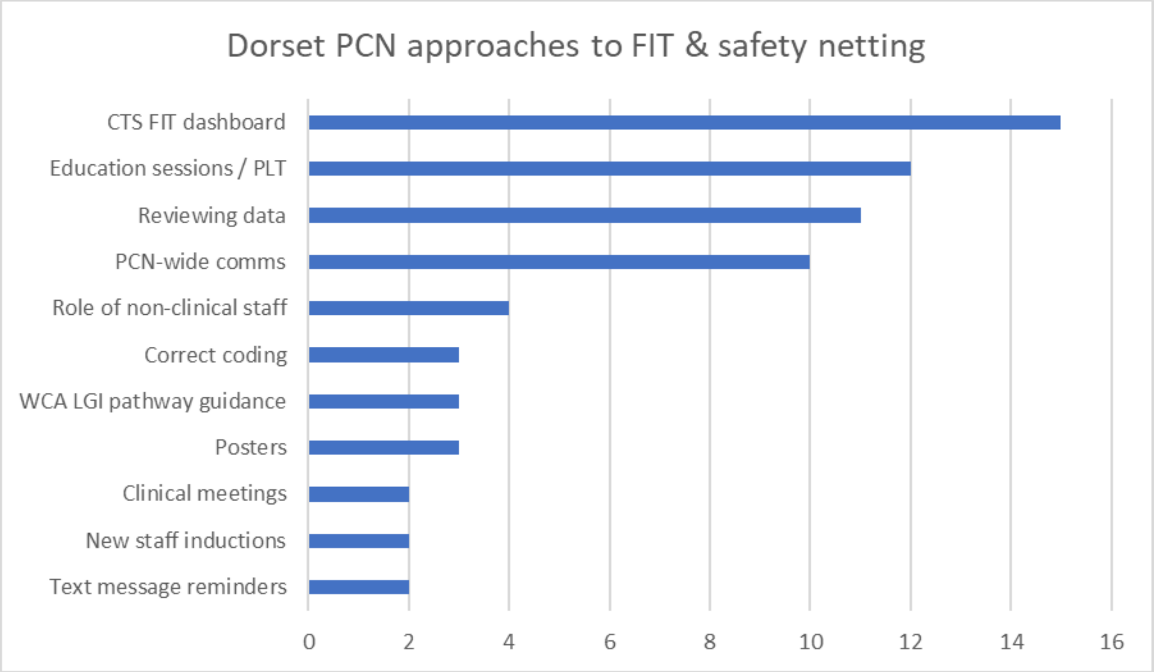
Use of C the Signs (CTS)

The introduction of CTS has had a significant impact on PCN approaches to supporting the use of FIT. 15/18 practices mentioned they were already using the CTS FIT Dashboard to safety net FIT tests, or were in the process of embedding this, for example tasking non-clinical staff with proactively checking the dashboard at agreed intervals throughout the week. Most PCNs reported that using CTS was effective and had simplified the safety netting process, however a couple noted it was "cumbersome" and preferred to use their own established systems.

Other activity

Outside of the CTS dashboard, the most common activities reported were running education sessions (or utilising Protected Learning Time), sharing FIT data and reviewing progress, and disseminating communications around FIT to both clinical and non-clinical PCN staff. From reviewing their data, one PCN found that locum GPs and junior doctors were least likely to wait for the FIT result to refer and are now able to develop some targeted comms or education.

The role of non-clinical and administrative staff was also highlighted by PCNs, as well as the importance of ensuring the correct FIT codes were recorded. Some highlighted the LGI pathway guidance produced by WCA and circulated this or printed off to use as posters in clinical rooms.



Some good practice examples:

> *We have developed safety netting pathways in the PCN which include use of the C the Signs FIT dashboard which a member of the team, checks regularly during the week, and if after SMS to patient a FIT is not returned then the Social Prescribing team will call the patient with a reminder to hand in the FIT test, and address any barriers/ problems with the return of the sample.*

> *We have planned data focused learning events throughout the year for clinicians. This is to raise awareness of how the PCN and each surgery are performing on their DES and IIF indicators.*

Teledermatology

DES requirement 3ii: work with its Core Network Practices to adopt and embed where available and appropriate, the use of teledermatology to support skin cancer referrals.

Teledermatology takes place in the acute trusts in Dorset for patients referred with suspected skin cancer. Therefore, image capture in primary care is not required for fast track referrals and a PCN report on this section of the DES was not required.

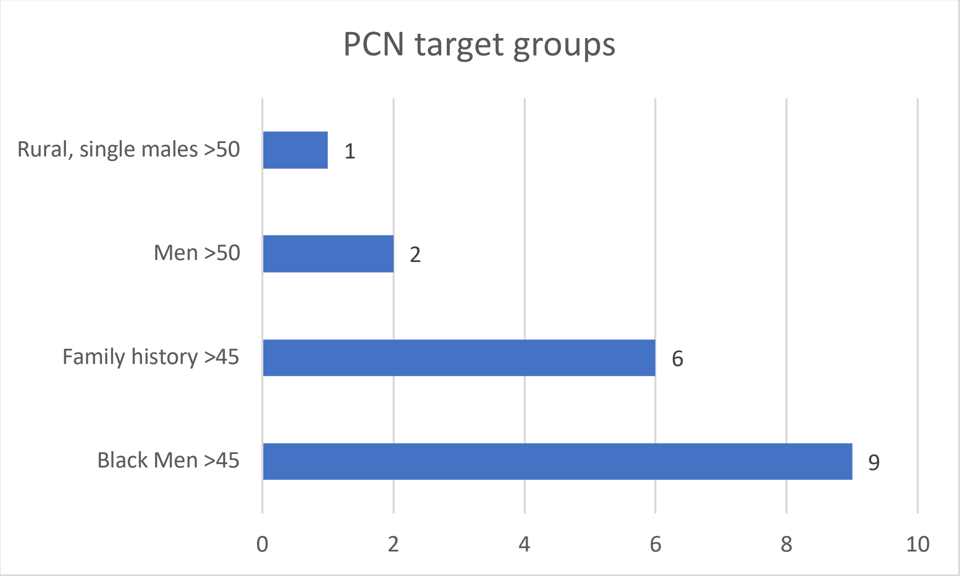
Prostate Cancer

Requirement 4: Focusing on prostate cancer, and informed by data provided by the local Cancer Alliance, develop and implement a plan to increase the proactive and opportunistic assessment of

patients for a potential cancer diagnosis in population cohorts where referral rates have not recovered to their pre-pandemic baseline

It was recommended that PCNs focus on men who are most at risk - those aged 50 or older, those aged over 45 with a family history of prostate cancer and black men aged over 45.

11 PCNs did targeted awareness work with specific groups:

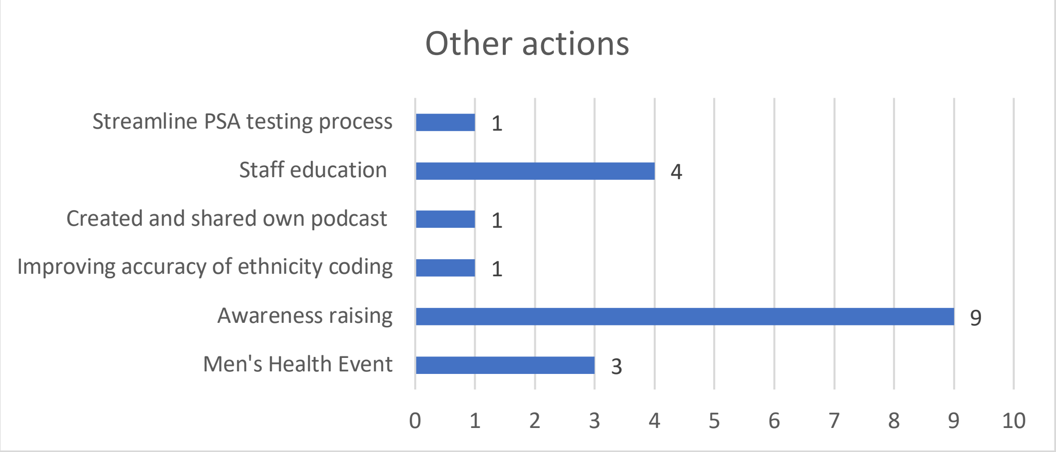


This targeted work involved directly contacting high risk patients with information about prostate cancer and/ or PSA testing and in many cases inviting them directly for a PSA test or discussion.

An example:

'Text message sent out to all patients with a recorded ethnicity of black/Afro-Caribbean/mixed highlighting increased risk and offering prostate screening discussion'

Other actions included:



Some examples:

‘Our Clinical Cancer Lead created a Prostate Cancer podcast for patients to listen to and a smart phone friendly text attachment that can be sent to men, which contained links to more information and the number that patients can ring for advice.’

‘A men only health event is being planned to spotlight prostate cancer. With new Care Coordinators, our PCN can now focus on high-risk groups. Our pharmacy team is also working to signpost the test.’

For some PCNs they felt that there was already a high awareness and demand for PSA testing in their PCNs, either through previous work or due to publicity of prostate cancer in the media, so their efforts focused more on raising awareness of symptoms and staff education.

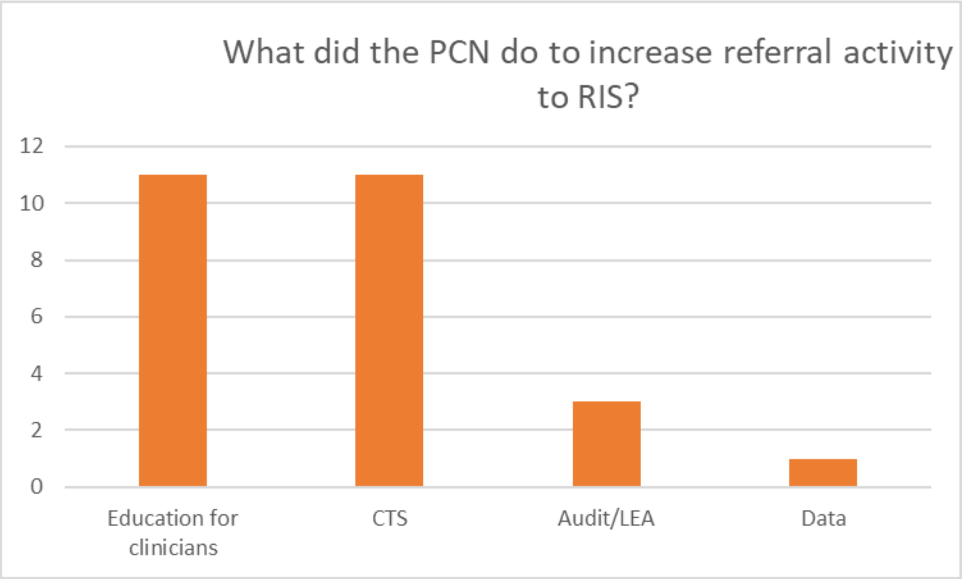
For one PCN there was difficulty getting a PCN level approach on action to take due to concerns by some that asymptomatic PSA testing is effectively screening which has the potential to cause more harm than good. Therefore, there was a more general approach to raising awareness of symptoms and opportunistic discussion of PSA testing where appropriate.

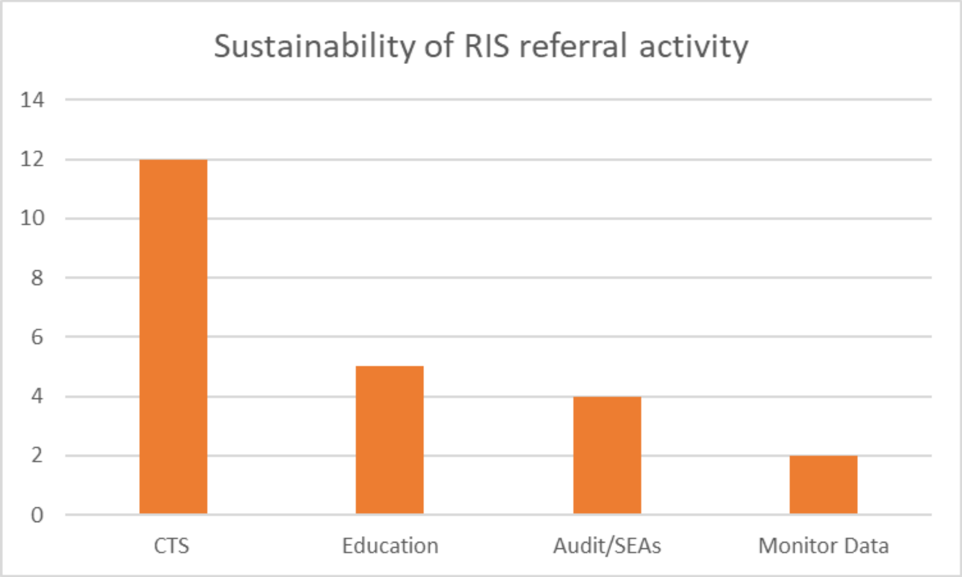
PCNs were asked to share any outcomes of the work they had done. For most this was difficult to achieve as there had not been long enough between the action they took and reporting to show any impact. For those who did targeted work and contacted patients in high-risk groups they were sometimes able to give data, however, this often showed very small numbers and, in many cases, low uptake, particularly for black men.

Rapid Investigation Service (RIS) pathway review

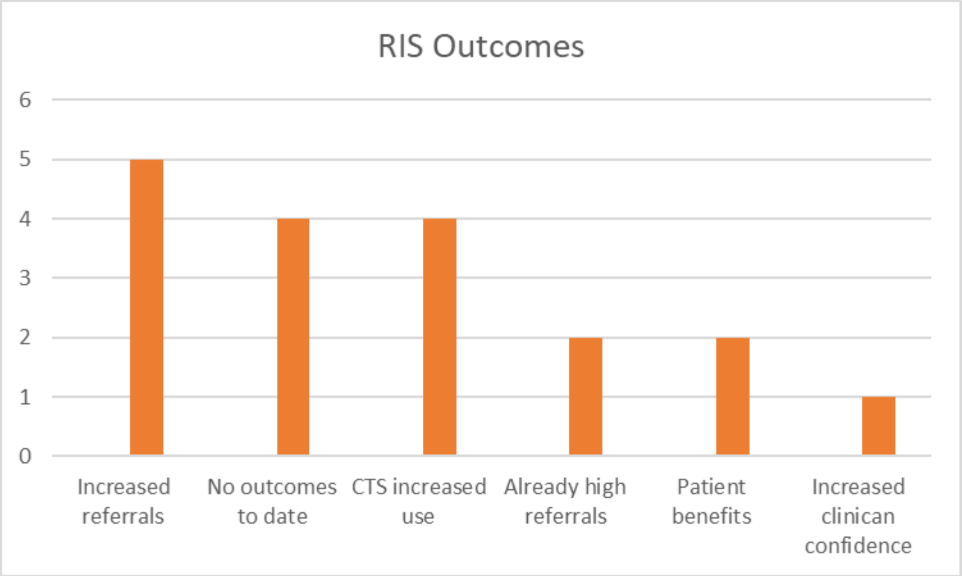
Requirement 5: Review use of their non-specific symptom pathways, identifying opportunities and taking appropriate actions to increase referral activity.

The PCNs were asked what actions they took to increase referral activity to the RIS. The majority opted to provide education for their clinicians to ensure that everyone was aware of the RIS service. In addition, most practices highlighted the use of C the Signs (CTS) as a tool that has helped to support them in increasing their referrals to the RIS service. This is attributed to the Risk Assessment Tool built into CTS that suggests to the clinician when a RIS referral may be appropriate. A small number of PCNs audited and discussed their referrals to the RIS service and one reviewed the referral data to understand where improvements could be made. The graph below demonstrates the action that PCNs took to increase referral activity to the RIS.


What did the PCN do to increase referral activity to RIS?
12
10
8
6
4
2
0
Education for clinicians
CTS
Audit/LEA
Data


Sustainability of RIS referral activity
14
12
10
8
6
4
2
0
CTS
Education
Audit/SEAs
Monitor Data

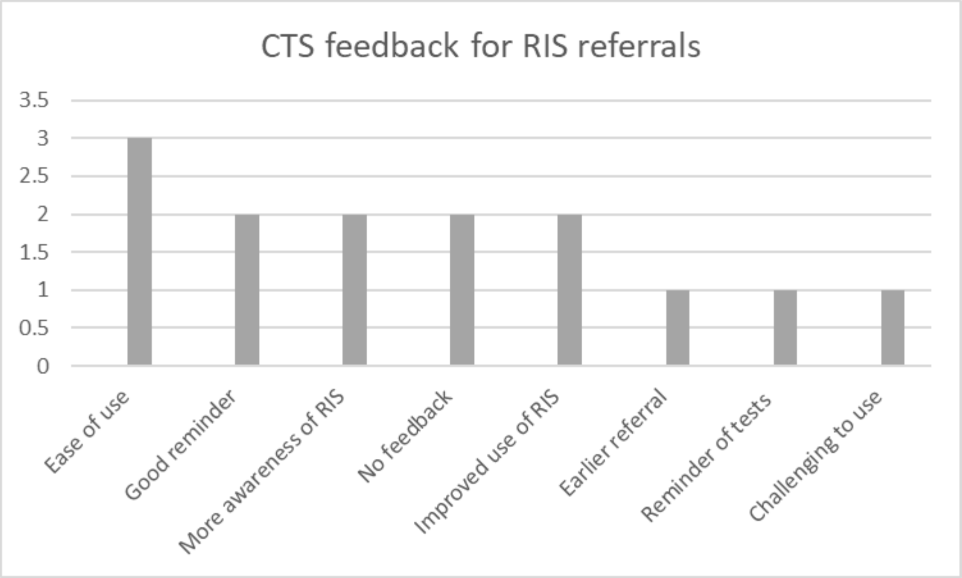
PCNs were asked whether there were any outcomes as a result of these actions. Several reported an increase in referrals to the RIS service whereas some have reported that it is too early to tell whether the actions have impacted on referral rates. A couple of PCNs already had high referral rates to the RIS service to did not expect a change. Several reported that the increased use of the CTS platform has increased their referrals to the RIS service and a couple of PCNs demonstrated how this work has directly impacted patients. Finally, one mentioned that it has increased clinician confidence in referral to the service.



‘As a PCN we utilise C the Signs for all cancer referrals we have received feedback the RIS referral process is now much easier. The portal looks good, and they like how you can see all other referrals available which makes it much more accessible.’

‘We discussed the RIS Service and people were surprised at how quickly patients were seen and impressed by the outcome measures/other chronic health conditions that have been discovered when using this.’

PCNs were asked to share their feedback specifically regarding the use of CTS risk assessment tool with regards to utilising the RIS service. The below responses show several positives for using the tool including: ease of use, good reminder of the pathway and tests, improved awareness, and use of the RIS and one response referred to earlier referrals because of the tool. A couple of PCNs provided no feedback and one reported ‘challenge of use,’ which was referring to the frequency that the risk assessment tool triggers a RIS referral.



When asked for specific feedback/suggestions of improvement to the RIS service, the majority were positive about the service and did not suggest improvements. Two of the PCNs suggested that it would be useful for there to be an ICE panel with all the filter tests required for the RIS for ease of test requests.

Next Steps & Recommendations:

Referral practice

- Continued awareness raising of C the Signs, in particular use of the Risk Assessment tool. Development work is also underway to improve user experience of the safety netting dashboard following feedback from the PCNs.
- WCA will have another local improvement scheme for PCNs in 2024/25, this will include a PCN level audit to capture quantitative data around the primary care pathway for certain tumour types.

Screening

- WCA are reviewing cervical coverage data for 2023/24 to understand if the data demonstrates any impact of work undertaken by PCNs.
- WCA will provide updated data packs to PCNs in January 2025, these will include cervical screening exception reporting data.
- The 24/25 WCA Early Diagnosis LIS will also encourage PCNs to look at how they are engaging with their communities around cancer symptoms and screening, including use of social media.
- There will be an extension of the video text messaging pilot to look at engagement of 'never attenders' for cervical screening.

FIT

- There are significant differences for some PCNs between the self-reported IIF CAN-02 data and the national data, suggesting there may still be some coding issues. WCA will work with these PCNs and the ICB to identify any issues and support where needed.

Rapid Investigation Service

- Feedback on actions taken around the Rapid Investigation Service demonstrate a continued need for education. There are plans for an LMC-wide webinar to continue to promote this service.

Appendix A: Cervical screening coverage data 2023/24 Q4

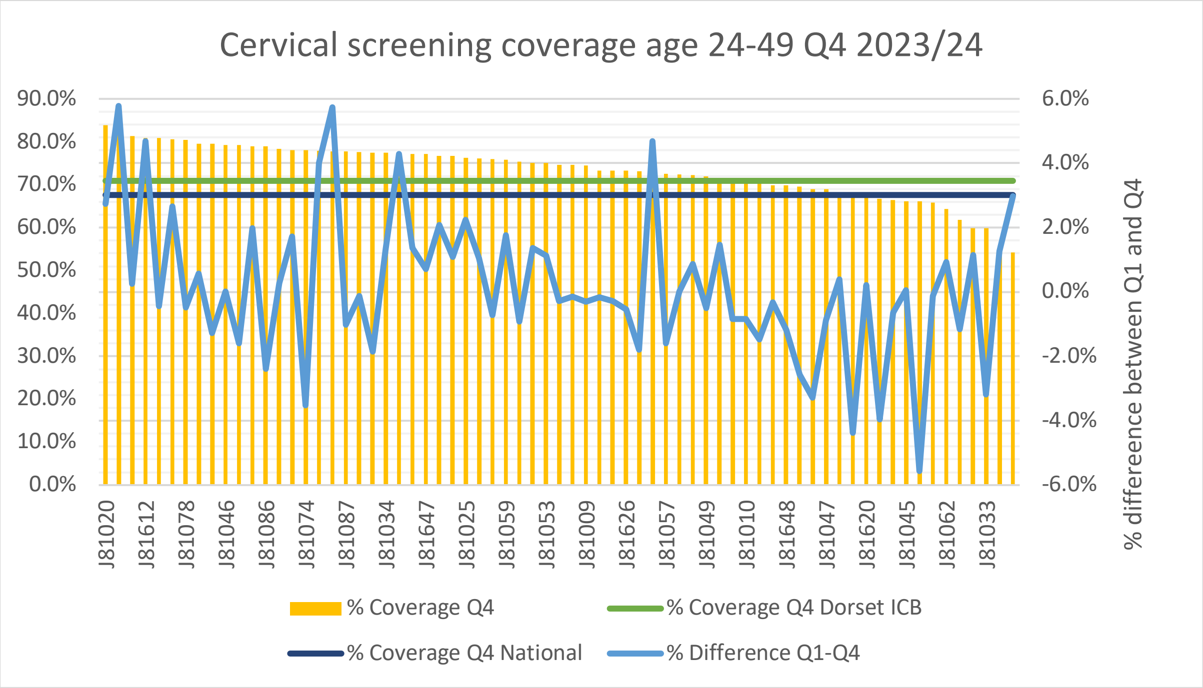
Cervical screening coverage age 24-49

In Q4:

- 7/69 practices met or exceeded the national target of 80% coverage.
  - 5/7 had an increase in coverage from Q1to Q4
- 19/69 practices had less than 70% coverage.
  - 7/19 had an increase in coverage from Q1 to Q4

In total

- 32/69 practices had increase in coverage from Q1 to Q4.
  - Range 0.1% to 5.8% increase.
  - 23/32 practices had an increase in coverage of 1% or greater, and 7 of these practices had an increase of 3% or greater.
- 35/69 practices had a decrease in coverage between Q1 and Q4.
  - Range -0.1% to -5.6% decrease.
  - 8/35 practices had a decrease of 2% or greater.
- 4 practices had data supressed due to small numbers.



Cervical screening coverage age 50-64

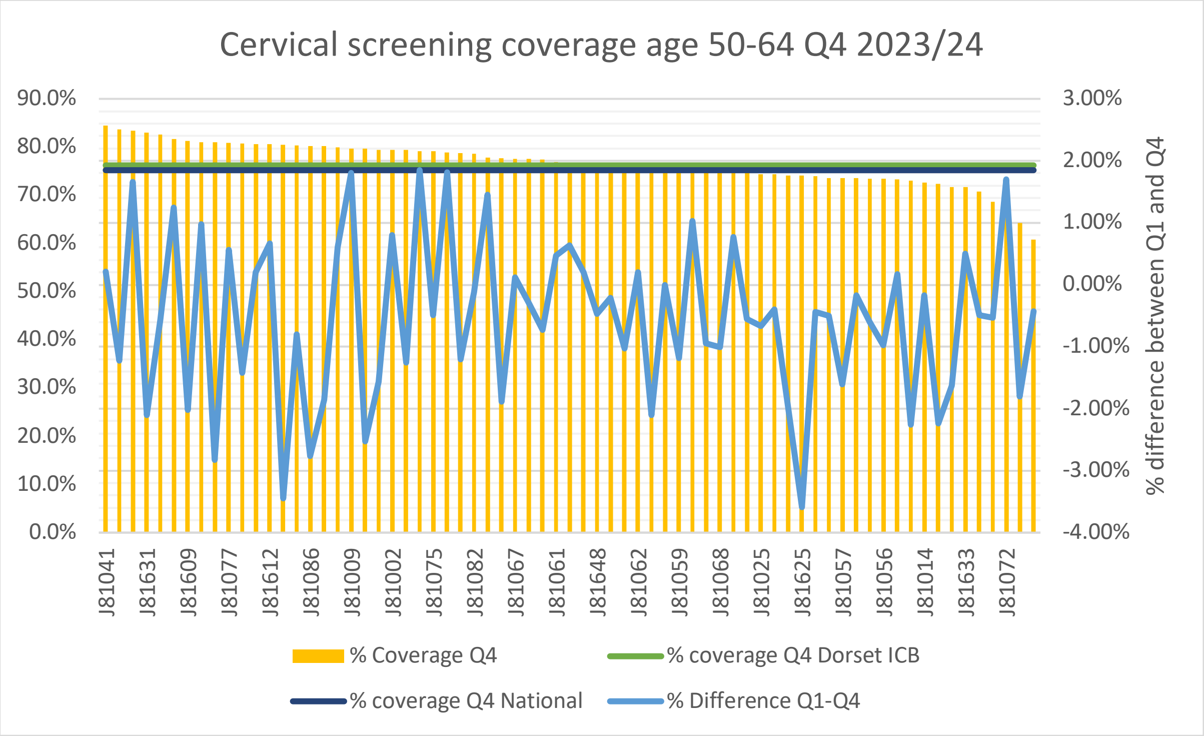
In Q4

- 17/69 practices met or exceeded the national target of 80% coverage.
  - 7/17 had an increase in coverage from Q1to Q4
- 4/69 practices had less than 70% coverage.
  - 1/4 had an increase in coverage from Q1 to Q4

In total

- 23/69 practices had increase in coverage from Q1 to Q4.
    - Range 0.12% to 1.85% increase.
    - 8/23 practices had an increase in coverage of 1% or greater.
- 46/69 practices had a decrease in coverage between Q1 and Q4.
    - Range -0.01% to - 3.59% decrease.
    - 10/46 practices had a decrease of 2% or greater.
- 4 practices had data supressed due to small numbers.

There was a drop in coverage between Q1 and Q4 overall of 0.3% for the ICB (76.2%) against a national increase of 0.2% (75.2%).


Cervical screening coverage age 50-64 Q4 2023/24

Work needs to continue in low coverage practices to support engagement and uptake of screening across both cohorts.

Practices with a high student/transient population may benefit from regular practice list cleansing.