PCN DES Webinar
26th April 2023

Dr Hassan Tahir
Personalised Care Lead for Primary Care

Northern Cancer Alliance

Collaborating to improve cancer care

NHS
Northern
Cancer Alliance

Agenda

- 12:30 - Introduction

Review of good practice

- 12:35 - Nicola Marlor
- 12:45 - Dawn Elliot
- 12:55 - Annabelle Ryan
- 13:05 - Angela Atkinson
- 13:15 - Hassan Tahir

PCN DES updates for 2023/24

- 13:25 – Shaun Lakey
- 13:40 – Katie Elliot
- 13:55 – Discussion

Housekeeping

- Microphones & cameras should be kept off please, to aid meeting quality.
- Questions can be added to the chat box throughout the presentation or left until the Q&A starts
- If the panel run out of time to answer all questions, the team will follow up on them as soon as possible.
- The webinar will be recorded and details of where to find it will be issued to registrants in due course.

Cancer and our ethnic minority communities - South Tyneside

Nicola Marlor

Senior Commissioning Support Officer

NECS

Background

In November 2021 Sunderland Bangladeshi International Centre (SBIC) released a report highlighting the experiences of patients & carers of their local BAME population

There were key recommendations in the report including;

- Educating the BAME community on the signs and symptoms of cancer as well as how it can be treated/eased
- Consideration of health literacy & language in the development of resources
- Improving interpreter services and increasing trust/confidence in them
- Increasing the cultural competence of professionals
- Improving/increasing access to peer support and community groups for patients
- Improving/increasing access to support for carers/families
- Generally improving the knowledge of what support is available and how to access it
- Personalised care plans that involve carers/family members

Following the report, SBIC were funded by Macmillan Cancer Support to develop a project in Sunderland with a view to;

- Educating the community about the importance of screening, and
- Supporting access into the health system and navigation through it

South Tyneside & Sunderland work closely together around cancer; we share the same Trust (STSFT) and we're in the process of developing a joint cancer strategy (the first time both areas have come together to do this)

In addition, we were keen in South Tyneside that we also acted on the recommendations of the Sunderland Bangladeshi International Centre (SBIC) report to improve the experiences of people in ethnic minority communities in relation to cancer

The group – who?

In the absence of any project funding, we have instead set up a group that is made up of representatives from across the system.

We have members from;

- NENC ICB – South Tyneside place
- South Tyneside Public Health team
- South Tyneside Council Liaison Officer for Carers
- Action Foundation
- CREST
- South Tyneside & Sunderland Foundation Trust
  - Targeted Lung Health Check programme
  - Cancer Lead Nurse
  - Personalised Care
- Gateshead Foundation Trust – Screening
- South Tyneside Health Collaboration – PCN Health Inequalities Lead
- Macmillan Cancer Support
- Northern Cancer Voices
- Apna Ghar
- Healthworks

The group – what?

The aim of the group and responsibility of group members is to;

- raise and discuss issues affecting ethnic minority communities in relation to cancer
- collaborate on developing solutions, informed by the communities themselves
- commit to action in areas of the system where they have the power to affect change
- build relationships, networks and collaborative working partnerships

We held our first meeting in January 2023 and meet every six-eight weeks, most recently just this morning!

Achievements to date

We've already achieved so much, in such a relatively short amount of time. That is testament to the enthusiasm and commitment from every partner around the table.

Highlights include;

- Raising awareness of services and support available for individuals from our ethnic minority communities across the group and instigation of a mapping exercise
- Connections made between;
    - our local carers organisations and those organisations working with ethnic minority communities and alignment to the South Tyneside Carers Strategy
    - the VCSE partners working with ethnic minority communities and the delivering partner of Cancer Awareness & Cancer Champion training
- Exploring…
    - the potential to procure Cultural Competence training for frontline staff
    - the potential to do a local "deep dive" of our National Cancer Patient Experience Survey results specifically around the experience of ethnic minority communities
    - how we support individuals from ethnic minority communities to understand the risks with using family members as interpreters

Achievements to date (there's more!)

- Multiple occasions of collaborative working including;
  - PCN representative and a community pharmacist attending a cultural integration session held by one of our VCSE partners to talk about accessing GP services and carried out a mini health check
  - Outreach to the Sikh temple to deliver a session on cancer awareness
  - Cancer colleague attendance at a Bollywood event for ethnic minorities young women and girls held for International Women's Day
- Coproduction of patient information leaflets between screening colleagues and members of our ethnic minority communities via VCSE representatives
- Retrospective audits in Primary Care to critique and learn from the routes to diagnosis for individuals from ethnic minority communities
- Scheduling a "health drop in" to take place in Primary Care aimed at ethnic minority communities

We also have the potential to receive some additional funding to support the project group from Macmillan which will help us push the work forward further and quicker

Questions/Discussion

Engaging ladies of ethnic minorities to a cancer screening drop in outreach clinic

Dr Dawn Elliot

General Practitioner

St George & Riverside Medical Centre

Collaborating to improve cancer care

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- Purpose was for the practice to try and engage with their Non-white ethnic female population by using a different approach to the standard way of engaging with cancer screening non responders
- The focus was to understand barriers experienced to non-responding to the cancer screening programmes and re-engage with the non responders for cervical and breast screening.
- Working closely from the offset with the Community Development Worker from CREST
- The staff who attended the session were; GP Dr Elliott, Practice nurse, practice manager, one member of admin support, two HCA's, two interpreters and Cancer Coordinator lead in Cancer and Inequalities.
- All ladies were offered group and some individual time with Dr Elliott and the practice nurse and a range of topics were discussed in both one to ones and group consultation
- Feedback and evaluation from staff and attendees

- 105 ladies got letters (non responders to the breast & cervical cancer screening programmes)
- 142 ladies got a text as they were coded as Bengali aged between 25-65.
- Some ladies will have overlapped and received both.
- 105 ladies were invited by letter (Double sided pink paper in Bengali translated and English)
- A total of 142 ladies were text the invitation in English (some ladies would be included twice through the letters not in addition to)
- 22 ladies attended on the day (2 of these ladies were from another GP practice as they were encouraged to attend following a family member attending earlier in the day)
- 22 Health checks were completed on the day (BP, weight, height, BMI and a mini-ECG undertaken)

Reflections ….

- Firstly, maybe most importantly in establishing trust and starting to break down barriers in accessing healthcare with this group. Four cervical screening appointments were made following the event
- To obtain 22 health checks completed on all the ladies attending which identified the need for further follow up for four ladies was a huge success
- Due to the success of the group sessions that naturally formed during the event could this 'group consultation' option be explored further?
- Demonstrated the need for a different approach to engage with ladies of non-white ethnicity which challenges the current provision of healthcare
- What could we learn anything from the 'outreach' aspect of this model and share?
- Cost implications for this type of intervention need careful consideration not only for sustainability but to demonstrate a worthwhile benefit to general practice. However, by upscaling this intervention from one Practice to include all or several more practices in the PCN would be beneficial.

Questions/Discussion

Cervical Screening at West Road

Anabelle Ryan

Practice Nurse

West Road Medical Centre

Our socioeconomic status and population.

- Our practice is located within a deprived area of West Newcastle

- 21% of our patient's do not have English as their first language.

Let's talk about cervical cancer

Our achievements.

- This year we reached our 80% target earlier than last year in the older ladies.

- In the younger ladies our figures were at 67.9% with 1 week to go. Last year we finished the year at 64.2%.

- It has taken a lot of time and effort but our figures are finally starting to improve.

Achievements continued…

- We have had lots of success stories – in particular 2 ladies that attended their first smear aged 39 & 52 had lots of abnormalities picked up at first tests.

- They were able to receive there diagnosis quickly and they have gone on to have necessary treatment.

- Many of these ladies attended due to Admin Ashleigh's patient & persistent approach, she has now been given the role of cervical cancer champion.

How did we achieve this?

- **We have done the following to improve our uptake:**
- Assigned an admin lead who has allocated time to book people in.
- We sent out a new year, new you text asking ladies to make time for themselves and book a smear.
- We keep an action plan as evidence and to monitor progress.
- We have offered 2 Saturday clinics to offer ladies more choice.
- We have done 2 Saturday walk in clinics, we got 16 patients at the first clinic and 6 patients at the 2nd clinic (these were very close together). We have plans to offer quarterly.
- We have 7am appointments for those that want it!
- We are allocating appointments to cervical screening to ensure there are enough appointments on offer.

Questions/Discussion

Quality Improvement initiatives in a Tees Valley PCN

Angela Atkinson

Primary Care Cancer Facilitator

Tees Valley ICP

Background

PCN population statistics

Column1	Pop. % >65yrs	IMD score	Smoking QoF prevalence	Obesity QoF prevalence
England	18.4	21.7	15.2	9.7
PCN	19.0		18.6	13.6
Practice A	22.1	31.9	16.8	14.5
Practice B	19.1	35.6	19.2	13.3
Practice C	12.9	40.5	20.6	12.7

PCN Requirements

- NHS Long Term Plan ambition to diagnose 75% of cancers at stages 1 and 2 by 2028
- PCN DES 8.4.1 (a) Review referral practice for suspected cancers, including recurrent cancers
- PCN DES 8.4.1 (a)(ii) Review of Safety Netting Procedure
- **PCN DES 8.4.1 (b) Contribute to improving local uptake of the national cancer screening programmes**
- PCN DES 8.4.1 Establish a community of practice between practice level clinical staff
- DES 9.5.1 - A PCN must provide a social prescribing service to their collective patients.
- **IIF CAN-01 LGI Referral with FIT -21 days to +14 days**
- QOF CANOO4 & CAN005 3 months & 12 months Cancer care reviews

Initiative 1

Cervical Screening

Project: aim to improve uptake in younger women

- Target population - 3 time non responders aged 25 - 49
- Staff involvement: SPLW (Cancer) and Cancer Care Coordinator
- Actions:
  - Search for target patients
  - Contacted patients by text – self book link
  - Contacted by phone to discuss any barriers/book appt.
  - Sent letter to capture any with incorrect phone details
  - Offer of a nurse to discuss the test

  The purpose of a direct approach was to identify and help to overcome any barriers for the patient.

Outcomes

Non-responders/DNA – text messages sent out		
Practice 1	76/98	78%
Practice 2	15/20	75%
Practice 3	57/75	76%
Appointment attended or booked		
Practice 1	22/98	22%
Practice 2	5/20	25%
Practice 3	18/75	24%

12% uptake on first contact, 32% uptake on second contact.
22% uptake on 3rd contact.

Initiative 2

IIF CAN-01 - % of LGI 2ww cancer referrals accompanied by FIT result, with result recorded within 21 days leading to the referral or in the 14 days after

Project: to improve the return of the FIT kit in a timely manner

- **Target:** Referrals into PCN cancer team (CCC/SPLW) from September 22 – Jan 23
- **Action:** Pts tracked by the CCC and contacted if the kit was not returned after 14 days.
- Number of referrals to the team: Sept 22- Jan 23
  - Practice 1 – 85
  - Practice 2 – 51
  - Practice 3 – 110
- **Outcomes:** **81.8% returned within target range**

Summary

Achieving success

1. Develop an action plan supported by the PCN data packs to determine key areas of activity in each given year
2. Regular monthly meetings with key staff (e.g. SPLW, CCC, Clinical Lead, PCN Manager, Primary Care Facilitator)
3. Work together with other key staff in the practices (e.g. PMs, IT, Cancer Champions, GPs) to develop systems and processes that can be sustained
4. Provide education sessions to all staff

Questions/Discussion

Prostate Cancer Mosque Engagement Work

Dr Hassan Tahir

MacMillan Clinical Advisor

Tees Valley ICP

Introduction

- Tees Valley Prostate Case Finding
  - 22.5%
  - 389
- Ramadhan
  - Opportunistic
  - Increased attendance
  - Hard to reach/engage population

Objectives

- 9pm – midnight
- Raise prostate cancer awareness
- Presentation
  - English + Urdu/Punjabi
- 1-to-1 discussion opportunities
- Leaflets

Prostate Cancer Case Finding Project

Patient Name:

DOB:

F.A.O. GP Surgery

Your patient has been identified as part of a Macmillan Cancer Support prostate cancer case finding initiative due to:

- ☐ **Aged 50 or over and not had a PSA Blood test or chronic disease review in the last 12 months**
- ☐ **Aged 45 or over and registered as black African/Afro-Caribbean**
- ☐ **Aged 45 or over with a family history or 1st degree relative with prostate cancer**

PSA testing can be arranged without clinical involvement as your patient has been provided with a shared decision-making leaflet and an international prostate screening score sheet.

PSA testing can be arranged regardless of symptoms as most early prostate cancers do not have symptoms.

Please kindly arrange a PSA blood test for your patient.

Kindest regards

Northern Cancer Alliance


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Outcomes

- Attended 6 x mosques
- 1 x Radio presentation
- 90 x face to face interactions

- Future opportunities for community engagement work
- Collaborative multi-site cancer awareness work in near future

Questions/Discussion

PCN DES UPDATE 2023 - 2024

Dr Shaun Lackey
Clinical Lead for Primary Care

Dr Katie Elliot
Primary Care Clinical Director

Questions/Discussion

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Thank you for attending

Slides will be shared

PCN DES Update

Shaun Lackey

April 2023

Primary Care Networks Cancer DES

https://www.england.nhs.uk/wp-content/uploads/2022/03/B1357_PCN-ECD-Guidance-SUPPORT-PACK-FINAL_March-2022.pdf

Early Diagnosis of Cancer*

- improve referral practice
- Improve screening uptake through network level activity
- Adopt and embed FIT
- Adopt and embed Teledermatology
- Focus on Prostate Cancer Case Finding
- Review and use Non-Specific Symptom cancer pathways.

**NHS Long Term Plan ambition to diagnose 75% of cancers at stages 1 and 2 by 2028.*

Primary Care Networks Cancer DES

Tackling Neighbourhood Health Inequalities

- Health Inequalities (HIs) impact every part of the cancer pathway including:
  - Prevalence of cancer risk factors.
  - Screening uptake.
  - Stage of disease at diagnosis.
  - Access to and experience of treatment.
- HIs contribute to stark differences in incidence and outcomes.
- Cancer prevention and cancer screening are areas where action could have a significant impact.

Referral Quality Improvement Work

Review referral practice for suspected and recurrent cancers, and work with their **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.

- A PCN may reflect on their referral practice using a number of approaches:
  - **Audits of routes to diagnosis** for people who have received a diagnosis of cancer
  - **Learning event analysis** of cases where a diagnosis was an emergency presentation or diagnosed at a late stage (Stage 3 or 4).
  - A PCN can use data from Office for Health Improvement and Disparities (OHID) Fingertips, which provides data on cancer services at practice and PCN-level, to **reflect on referral practice to identify where improvements can be made.**

Referral Quality Improvement Work

There are **various aspects of referral** a PCN may decide to **focus on**, including:

- The **interval** between patient first presenting to a clinician with symptoms and when the Two Week Wait (2ww) referral is made, and the number of appointments they attended prior to referral;
- **Referrals resulting in a cancer** diagnosis (e.g. by tumour type, to identify variation in management of referrals or where a change in pathway has occurred);
- **Routes of presentation** to diagnosis (2ww or Emergency Presentation);
- Availability and use of **clinical decision support tools**;
- Building on current practice to ensure a **consistent approach in monitoring patients who have been referred urgently**; and
- Ensuring that all patients are **signposted** to, or **receive information** on, their referral including:
  - **why they are being referred**;
  - **the importance of attending** appointments, and;
  - where they can **access further support**.

Referral Quality Improvement Work

- Once a PCN has decided which aspects to focus on, it would **be expected to identify and implement specific actions** to support the increased effectiveness of referral practice and ensure that systems are in place so that continuous improvement can be made.
- Early diagnosis rates in the most disadvantaged 20% of areas are around 8% points lower than in the most affluent areas.
- In delivering these requirements, a PCN should consider options to **provide particular support to practices in disadvantaged areas** so that they can maximise the impact in those areas. Local level data on deprivation is available through the Health Inequalities Improvement Dashboard, and OHID Fingertips. A PCN can also contact their Cancer Alliance for further support.
- Funding will be available for Cancer Alliances in 2022/23 to establish universal coverage of clinical decision support tools. NCA have provided training to PCNs regarding these tools:
- https://northerncanceralliance.nhs.uk/pathway/early-diagnosis/supporting-primary-care/cancer-decision-support-cds-tools/

Referral QI – Digital Dermatology example

- This will be coordinated by PCN but likely PCN GP practices will have different issues
- Appoint PCN lead for the project to coordinate
- Ensure that each practice has a Clinical and Non-Clinical champion.
- Review 20 to 25, 2WW skin referrals in each practice within the PCN.
  - On Review:
    - *Does referral **contain Digital Images** (Three appropriate images OR appropriate reason why missing)*
    - *Is there **appropriate narrative** describing the history of the lesion (CLINICAL REVIEW)*
    - *Did the patient have the **2WW Patient information leaflet** (READ CODE)*
    - *Was any referral **safety netting** in place (READ CODE)*
    - *Was the **referral accepted***
    - *Was the **outcome Skin Cancer** Diagnosis*
    - *Was **Cancer Care review** process instigated appropriately*

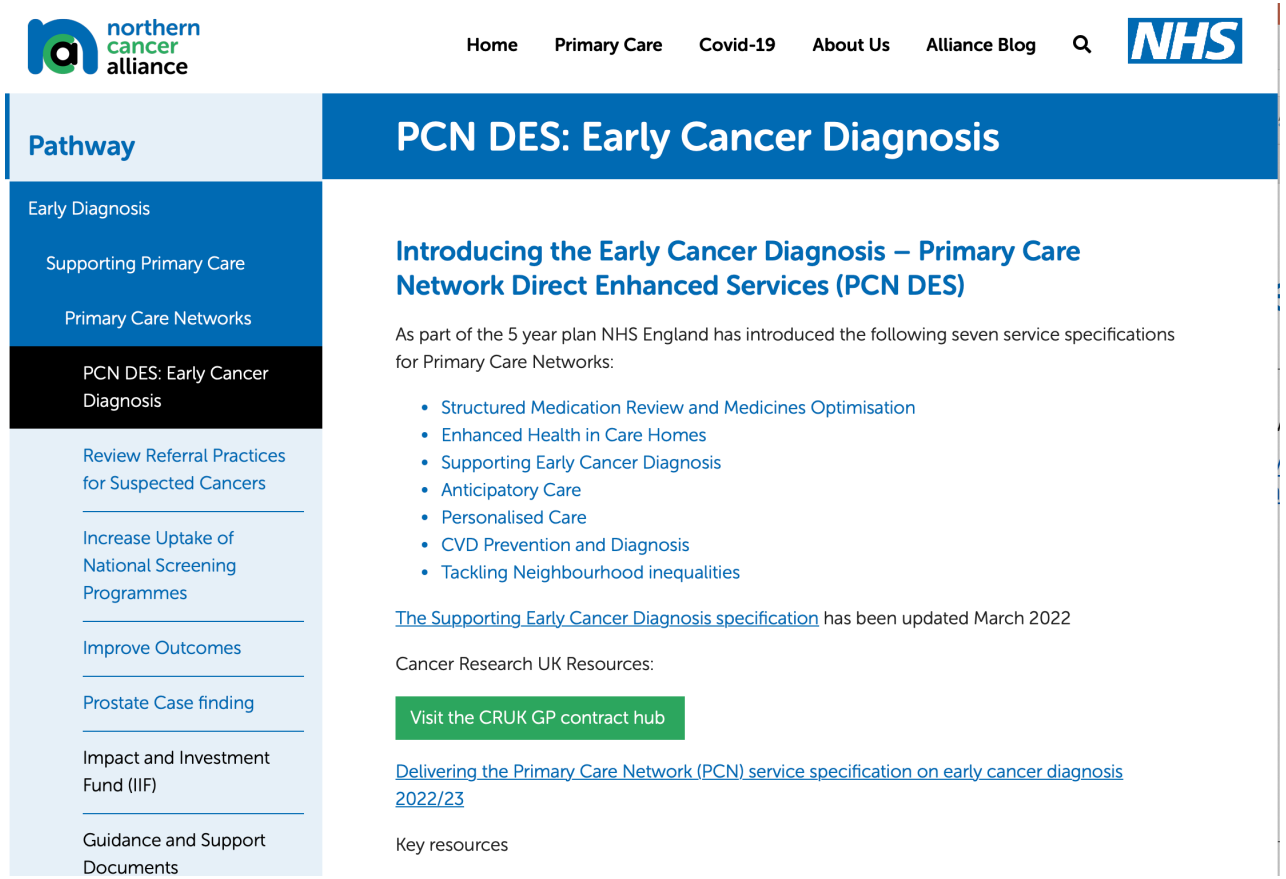
Referral QI – Digital Dermatology example

- Could then look at individual practices processes for Digital Dermatoscope equipment
  - Practice survey to assess knowledge, competence and training needs.
    - *Does everyone know what they should be doing and how to do it?*
  - Practice systems or specific practice issues.
    - *e.g. Wifi or Mobile Signal, access to dermatoscope etc*
- Then GP practices meet to review, generate themes and create an **improvement plan for practices** to implement.
  - This maybe **shared best practice** from other GP practices within the PCN that are doing well.eg
    - *Clinician training on 2WW Skin pathway & equipment*
      - *GATEWAY C - Skin Cancer Module: https://www.gatewayc.org.uk/our-courses/*
      - *Dermoscopy Features: https://egplearning.co.uk/introduction-to-dermoscopy-for-gps/*
    - *Improve readcode adoption for Patient 2WW leaflet – use of templates etc*
    - *Improve Safety net processes – cancer care coordinator role ?*
    - *Improved Equipment process – e.g. Sign in / out register, Case/Box to protect equipment, Portable battery to ensure that charge throughout the day.*
- Then **Re-audit** after 6 months to assess impact of changes in all practices.

Referral Quality Improvement Work

NCA website offers resources that PCNs can use:

- PCN DES: Early Cancer Diagnosis
- Macmillan has a useful QI toolkit
- Look at CRUK GP Top Tips for PCNs
- PCN action plan 22/23 (Word Download)



Digital Dermatology

PCNs will work with its Core Network Practices to adopt and embed where available and appropriate, the use of teledermatology to support skin cancer referrals (teledermatology is not mandatory for all referrals)

- Dermatoscope uses polarised and non-polarised light for its images.
  - Polarised light allows for visualisation of deeper skin structures, while non-polarised light provide information about the superficial skin.
  - These images are useful to identifiy or rule out sinister features of skin cancer.
  - Images can be viewed remotely by Dermatologists (Can utilise evening working and WLIs)
- Very good at excluding Seb. Warts from 2WW pathways
- Very good at upgrading SCC referred on BCC pathway

Digital Dermatology

- Issues for General Practice:
  - Takes extra time & resource
  - Needs Processes and organisation:
    - Locate the equipment (where is it kept & is it brought back)
    - Make sure equipment is working and charged.
  - Taking images takes extra time
    - Uploading the images
  - IT and Mobile Signal Strength can cause issues:
    - Needs Mobile Reception or Wifi
    - SMS used to upload images via *accurx©* in many places
  - Quality of images can be inconsistent
    - as Clinicians don't always know what they are looking for the images might not show this.
- NCA will continue to support the roll out and share best practice (Live in All areas now)

Digital Dermatology

To deliver this requirement, and supported by local partners (i.e. Cancer Alliances, commissioners, local hospital dermatology services), a PCN may:

- **increase awareness** among practices of the pathway for teledermatology 2ww referrals in their area.
- where available and appropriate, identify and deliver specific actions to encourage consistent use of teledermatology. These actions may include:
  - Working with Cancer Alliances to develop and/or distribute training materials to support staff in using teledermatology services;
    - GP Teamnet Digital Dermatology Resources.
  - Awareness raising for PCN clinical staff in practices.

Prostate Cancer (Case Finding)

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.

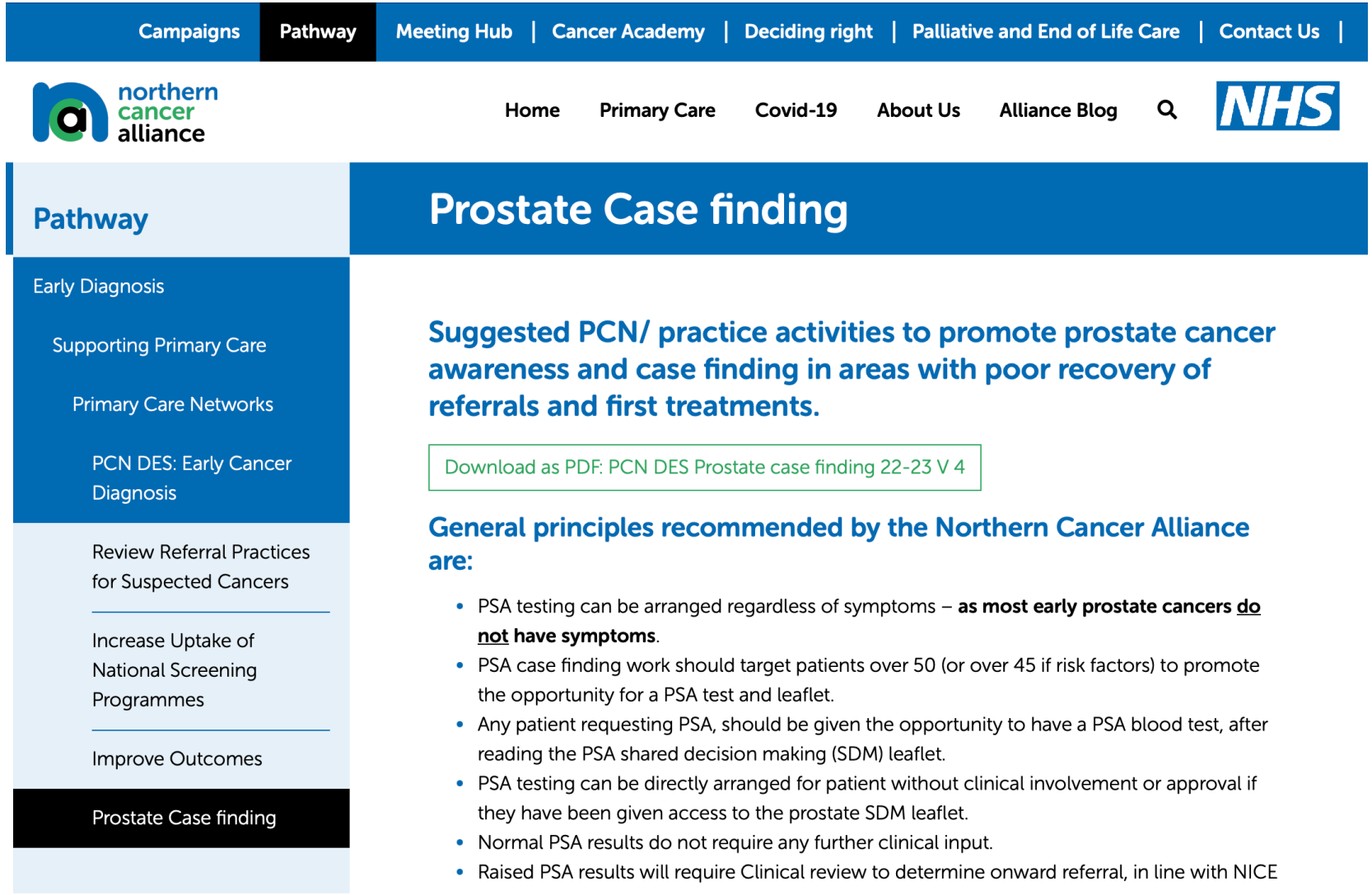
- NCA have developed a traffic light action plan available on the website:
- https://northerncanceralliance.nhs.uk/pathway/early-diagnosis/supporting-primary-care/gp-contracts-primary-care-networks/introducing-the-early-cancer-diagnosis-direct-enhanced-services-des/prostate-case-finding/
- PCNs focus on men who are most at risk (target cohort):
  - those aged 50 or older; *(NB Poor evidence for asymptomatic screening in 70+)*
  - those with a family history of prostate cancer aged over 45
  - black men aged over 45
- This remains contentious as conflicts exist between screening and use of PSA in asymptomatic patients isn't agreed in UK as yet, however PCUK recognise that many early prostate cancer will NOT have symptoms and developments in investigation pathway reduces the harm from prior baseline.

Prostate Cancer (Case Finding)

CCGs ranked by deficit in urology referrals and first treatments. Biggest deficit first:

		% treatments	number of people
1.	Tees Valley	-22.5%	-389
2.	North Cumbria	-24.5%	-266
3.	South Tyneside	-9.6%	-54
4.	Newcastle Gateshead	-4.8%	-54
5.	Northumberland	-6.2%	-70
6.	Co Durham	-1.4%	-22
7.	North Tyneside	-0.0%	0.0
8.	Sunderland	-1.0%	+8.

Prostate Cancer (Case Finding)



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Pathway

- Early Diagnosis
- Supporting Primary Care
- Primary Care Networks
- PCN DES: Early Cancer Diagnosis
- Review Referral Practices for Suspected Cancers
- Increase Uptake of National Screening Programmes
- Improve Outcomes
- Prostate Case finding

Prostate Case finding

Suggested PCN/ practice activities to promote prostate cancer awareness and case finding in areas with poor recovery of referrals and first treatments.

Download as PDF: PCN DES Prostate case finding 22-23 V 4

General principles recommended by the Northern Cancer Alliance are:

- PSA testing can be arranged regardless of symptoms – **as most early prostate cancers do not have symptoms**.
- PSA case finding work should target patients over 50 (or over 45 if risk factors) to promote the opportunity for a PSA test and leaflet.
- Any patient requesting PSA, should be given the opportunity to have a PSA blood test, after reading the PSA shared decision making (SDM) leaflet.
- PSA testing can be directly arranged for patient without clinical involvement or approval if they have been given access to the prostate SDM leaflet.
- Normal PSA results do not require any further clinical input.
- Raised PSA results will require Clinical review to determine onward referral, in line with NICE

Questions?

“Improving cancer outcomes through transformation.”

PCN DES and IIF
FIT and Non-Specific Symptoms

Dr Katie Elliott
Clinical Director (Primary Care)
CRUK GP
Northern Cancer Alliance

Join our Journey

FIT and IIF

- Embed use of FIT in colorectal pathways
  - Fast track colorectal referrals
  - NSS
  - Symptoms that could be caused by colorectal cancer
  - NICE endorsed BSG FIT guidance explained

- IIF FIT
  - FIT result recorded in the GP notes up to 21 days before fast track colorectal referral.
  - At least 80% (Payment thresholds 65%. - 80%)

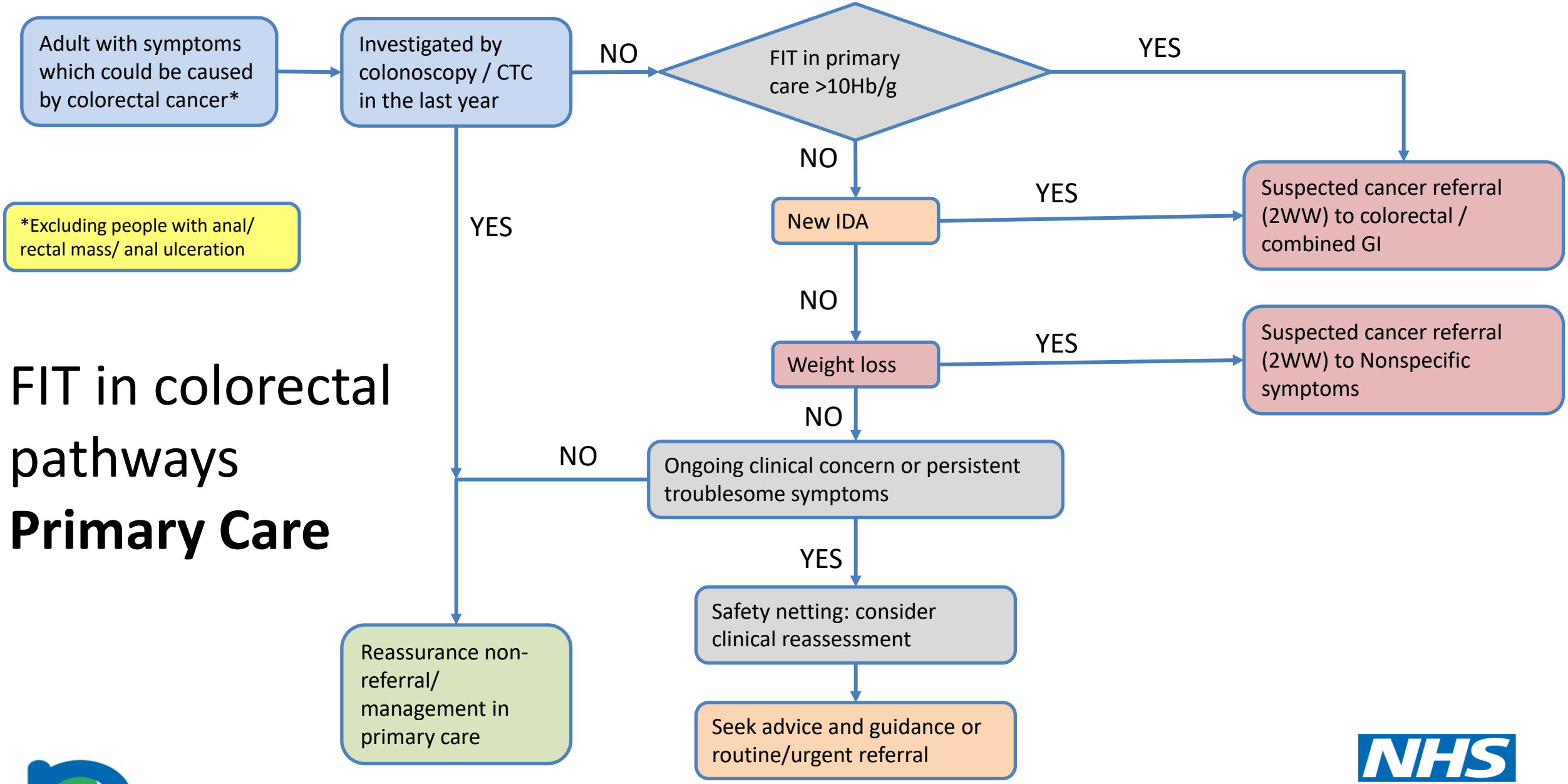
FIT and IIF

Offer FIT if not previously investigated

Wait for the result

Use the result to decide about referral

FIT in colorectal pathways **Primary Care**



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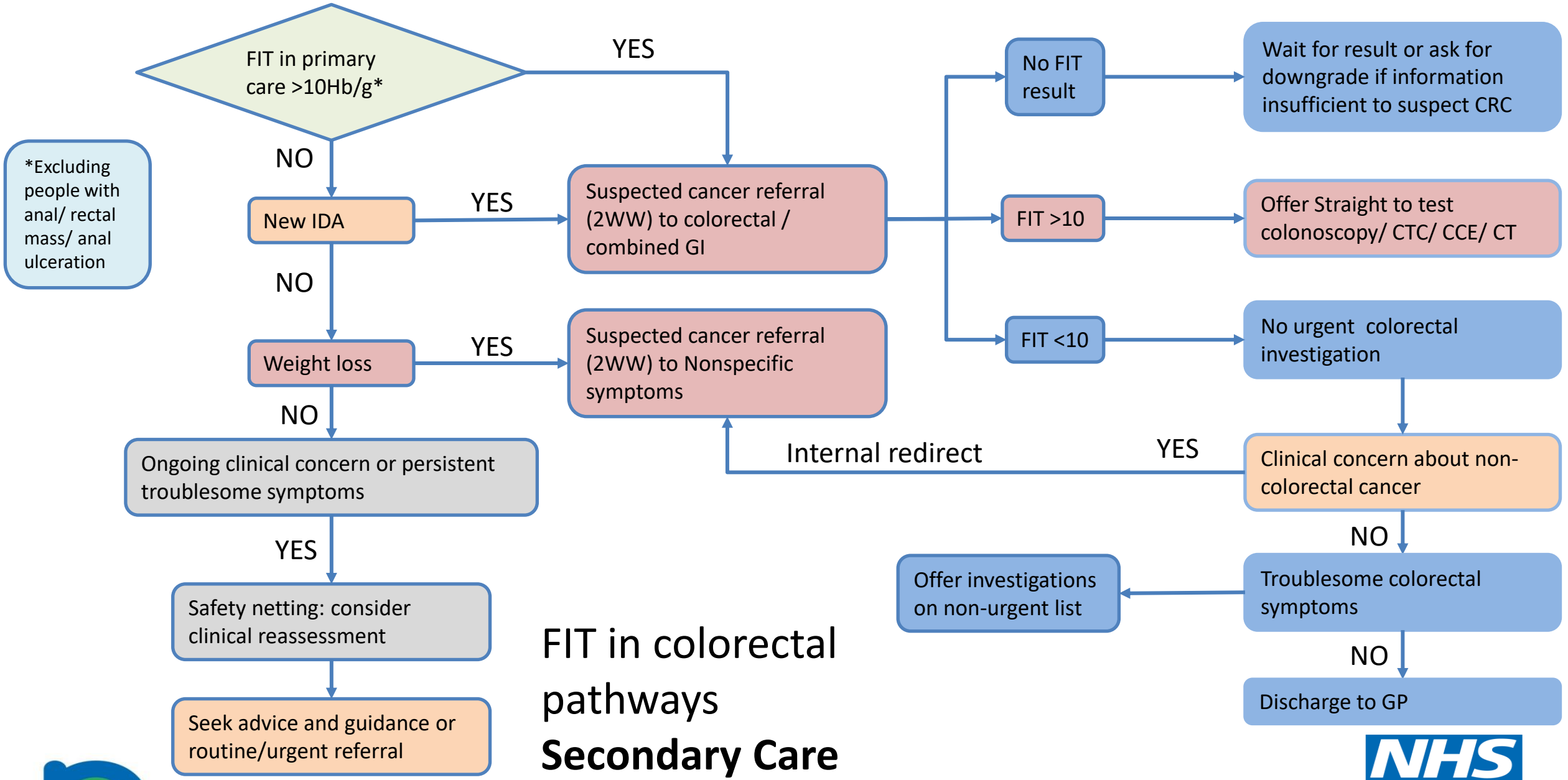

FIT in colorectal pathways

Secondary Care

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Data for FIT

- Lab data
  - Practice level
  - FIT return rates – aim for > 85%more is better
    - Consider: language/ explanation/ support for patients when asking them to do the test
  - FIT request rates relative target
    - Consider : screening rate/ incidence/ mortality/ detection rate for 2ww pathway

- Practice level data will be the most up to date
  - Reports in SystmOne/ EMIS / Ardens

Lab Data for FIT

J2 | fx | No. FIT returned

	A	D	K	L	M	N	O
2	Place	Registered Patients		Requests Total	Requests per 100,000 population	% returned tests	Percentile Rank of Column M
7	NHS TEES VALLEY CCG	3,842		24	624.67	91.67%	0.05
9	NHS TEES VALLEY CCG	6,645		44	662.15	88.64%	0.08
10	NHS TEES VALLEY CCG	10,093		72	713.37	87.50%	0.09
15	NHS TEES VALLEY CCG	5,225		41	784.69	100.00%	0.15
24	NHS TEES VALLEY CCG	11,130		104	934.41	99.04%	0.27
28	NHS TEES VALLEY CCG	8,007		80	999.13	82.50%	0.32
37	NHS TEES VALLEY CCG	9,141		97	1061.15	81.44%	0.44
69	NHS TEES VALLEY CCG	9,035		129	1427.78	82.17%	0.85
82							

Lab Data for FIT

	A	D	K	L	M	N	O
1							
2	Place	Registered Patients	Requests Total	Requests per 100,000 population	% returned tests	Percentile Rank of Colum	IIF from PCN dashboard
4	NHS TEES VALLEY CCG	7,647	40	523.08	77.50%	0.01	87
12	NHS TEES VALLEY CCG	2,488	19	763.67	57.89%	0.12	100
16	NHS TEES VALLEY CCG	7,187	58	807.01	53.45%	0.17	77
31	NHS TEES VALLEY CCG	10,879	111	1020.31	85.59%	0.36	82
41	NHS TEES VALLEY CCG	7,390	80	1082.54	70.00%	0.49	72
44	NHS TEES VALLEY CCG	8,552	97	1134.24	70.10%	0.53	87
71	NHS TEES VALLEY CCG	8,079	116	1435.82	79.31%	0.87	83
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Non-Specific Symptoms Pathway

- Concern about cancer and not meeting criteria for other site specific pathway
- Improve earlier and faster diagnosis
- Existing range of 4.5-12% conversion to cancer diagnosis in NENC
- Other precancerous and serious non-cancer diagnoses
- All trusts should be offering a pathway

Non-Specific Symptoms Pathway

- Promote use of pathway
  - Suspected cancer with symptoms not matching criteria for a specific pathway
  - Significant weight loss and FIT negative
  - Significant constitutional symptoms
    - Fatigue/ loss of appetite
  - New severe, abdominal pain not previously investigated
  - Severe unexplained pain

Non-Specific Symptoms Pathway

- Filter tests, complete and good quality referrals
- Dovetail with GI/ combined pathway
- Ongoing work to develop single referral form

- **Work for PCN**
- Local data – trust level
- Practices not using the pathway
  - Education for clinicians

- New Snomed code coming in for fast track NSS referral. - code not live yet

PCN engagement team

PCN engagement posts (Cancer)

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