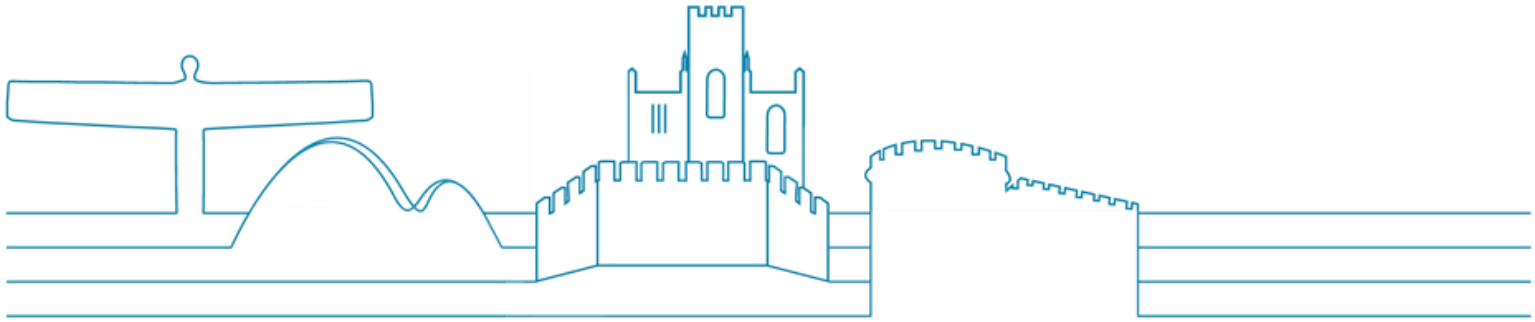
Early Cancer Diagnosis

Improving Early Cancer Diagnosis
&
PCN DES 2024/25

Dr Hassan Tahir
Clinical Lead for Primary Care
Northern Cancer Alliance



How to prevent Cancer?

Prevention

- Smoking
- Alcohol
- Obesity

Early Diagnosis in Cancer

- **Early detection**
  - Screening
  - Symptom awareness
  - Access to Primary Care appointments
- **Timely diagnosis**
  - Access to diagnostics / Direct access tests
    - radiology , endoscopy , pathology.
  - Access to Referral pathways (NSS etc)

What are the chances?...

- NHS Ambition Target...
- By 2030, 75% of ALL Cancers will be Diagnosed at Stage 1 & 2

What are the chances?...

- Currently in NENC ICB…
- Only 57% of ALL Cancers ARE Diagnosed at Stage 1 & 2

What are the chances?...

North East had the **highest age-standardised cancer incidence rate for males and females** at **717** and **603** per **100,000** people.

Nearly 1 in every 100 diagnosed with Cancer.

- For **Lung cancer**, the North East had the **highest rate for males and females** at **108** and **96** per 100,000 people.
  - *South East had the lowest rate for males at **74** per 100,000 people,*
  - *South West had the lowest rate for females at **53** per 100,000 people.*

- For **Colon and Rectum cancer**, the North East had the **highest rate for males** at **92** per 100,000 people
  - *East Midlands had the highest rate for females at 61 per 100,000 people.*
  - *London had the lowest rate for males and females at **77** and 53 per 100,000 people*

***2019 Data**

What are the chances?...

- Currently in N Cumbria (Worse in NENC)
- 65% of ALL Lung Cancers ARE Diagnosed at **Stage 4** (5% 5YS)
- TLHC's can flip this on its head:
  - **80% (vs 30%) stage 1&2 nationally**
  - 60% & 30% 5YS respectively

What are the chances?...

- 40% of Cancer Diagnosis happen via Emergency Presentations.
- Not via GP Referrals

What's Been happening in Primary Care?

PCN DES 2023/24 Early Diagnosis in Cancer:

Support from NCA:

- **Fiona Anderson**
  - Cancer Delivery Lead (Timely Presentation & Primary Care)
  - Fiona.Anderson@hwn.org.uk

- **Dr Shaun Lackey**
  - Clinical Lead, NCA (N Cumb & North)
  - shaunlackey@nhs.net

What's New for 2024/45 PCN DES

- **New PCN DES** has limited details regarding cancer in main document.

- Detail of the Cancer elements of the DES are in the supplementary document:
  - Part A: Clinical and Support Services (Section 8)

Full Guidance Here

- More emphasis on **working with Cancer Alliance** to identify areas of work and specific milestones and tackling health inequalities.

What's expected in Primary Care 2024/25?

The DES specification states that:

- *a PCN must seek to **improve health outcomes** for its population*

- *Actively seek to **reduce health inequalities***

- ***Use data-driven approach and population health management** in line with guidance and the CORE20PLUS5 approach.*

REDUCING HEALTHCARE INEQUALITIES

The **Core20PLUS5** approach is designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement

CORE20
The most deprived **20%** of the national population as identified by the Index of Multiple Deprivation

PLUS
ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups

Target population

CORE20 PLUS 5

Key clinical areas of health inequalities

1. **MATERNITY**
ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups

2. **SEVERE MENTAL ILLNESS (SMI)**
ensure annual Physical Health Checks for people with SMI to at least, nationally set targets

3. **CHRONIC RESPIRATORY DISEASE**
a clear focus on Chronic Obstructive Pulmonary Disease (COPD), driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations

4. **EARLY CANCER DIAGNOSIS**
75% of cases diagnosed at stage 1 or 2 by 2028

5. **HYPERTENSION CASE-FINDING**
and optimal management and lipid optimal management

SMOKING CESSATION
positively impacts all 5 key clinical areas

What's expected in Primary Care 2024/25?

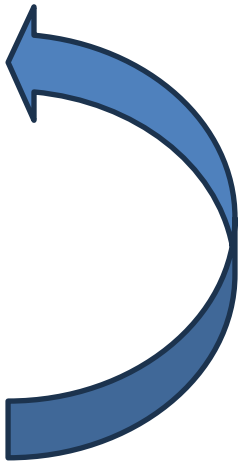
- NCA will provide supporting documents and templates by Q2

- PCN Engagement Workers, Community Cancer Awareness Workers (CCAW) and NCA Team will support PCNs as required, depending on need.

PCN DES Planning 2024/25

- **In support NCA to share planning template**
  (format word/excel). With Hints and Tips
  - Hints and Tips to be released aligned to the newer element of specific tumour work – to be confirmed and released by Q2

- **PCN Engagement Workers – Support with elements**
  - Assist with kick start planning meetings across the PCN
  - Data
  - Work with practice GP Leads for cancer
  - QI plans and projects
  - Examples of practice
  - Support materials and resources



- **NCA Planning and Support Cycle**
  - Share and Learn Event
  - Share Cancer ED DES Plans
  - Share End of Year Reflections

Utilising Data / Analytics

- **Data** - PCN Engagement Worker can provide:
  - ED cancer data packs – OHID Fingertips , plus
  - FIT – Quarterly Lab data

- **PCN Dashboard** – IIF & Safety Netting access to PCN Dashboard

- **Other sources of data** and tracking
  - RAIDR
  - Primus (North Cumbria)
  - System Searches
    - via CDRC reports in EMIS/SystmOne
    - also searches in Ardens

PCN DES 2024/25

Improving Early Diagnosis in Cancer

Specific Details

PCN DES 2024/25

- **2.1.13 Improving Referral Practice**
  - **Improve referral practice for Colorectal / Lung / Head & Neck**
- **2.1.14 Improving Cancer Referrals**
  - **Review NICE NG12 and ensure practice reflects this**
  - **Audit options to inform improvements.**
- **2.1.15 Support and Streamline Diagnosis and Referral**
  - **Promote direct access test, FIT, NSS & Telederm**
- **2.1.16 Increase Screening Uptake / Health Inequalities**
  - **Fingertips | Audit non responders | Every contact counts**

2.1.13 Improving Referral Practice

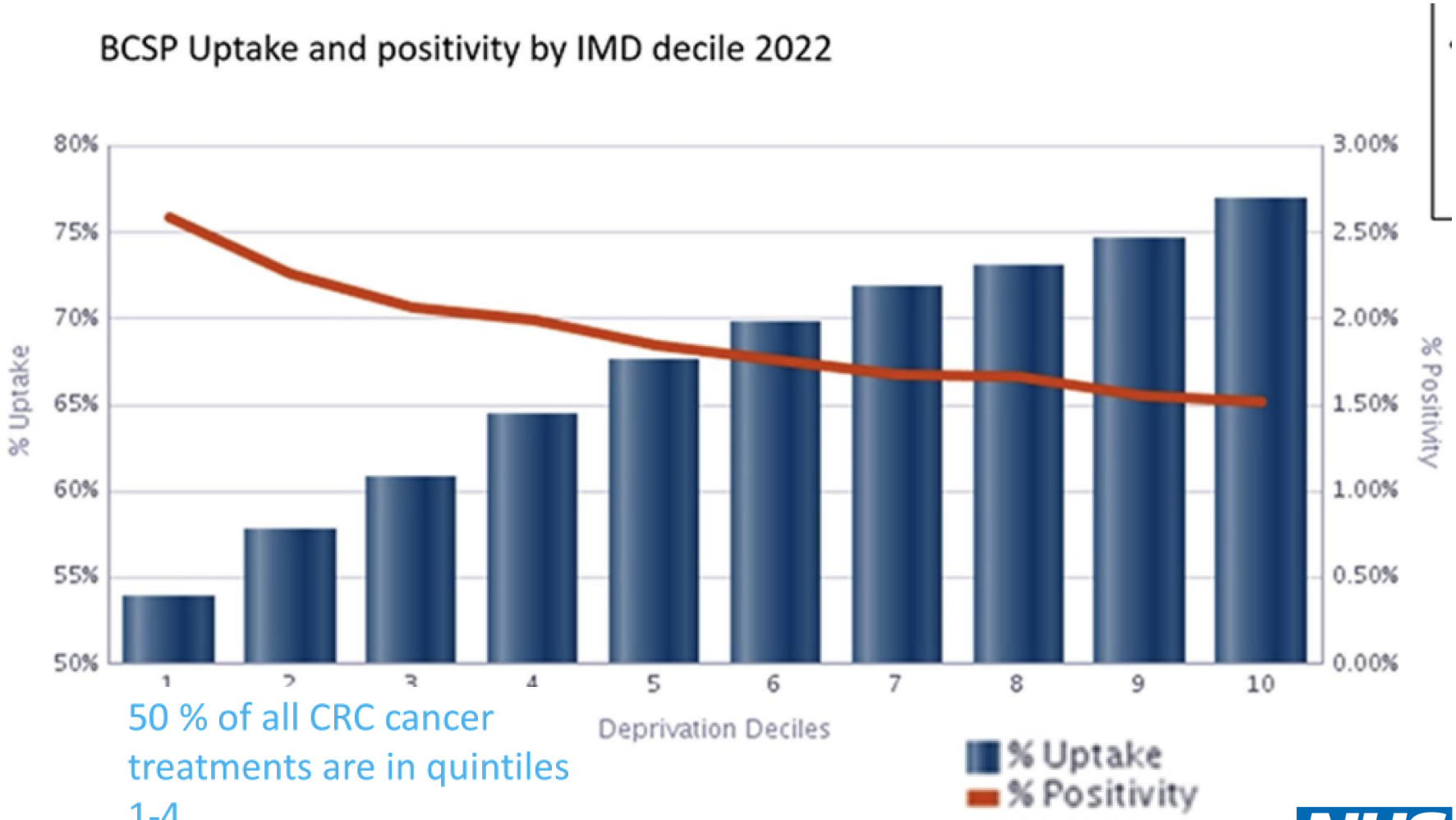
- PCNs and Cancer Alliance develop a clear set of actions to improve referral practice for:
  - **Colorectal and Lung Cancer** account for nearly 40% of all late-stage cancer diagnoses
  - **One other** cancer type determined by the Alliance ***Head and Neck*** *Cancer based on burden of late stage diagnosis.*

2.1.13 Improving Referral Practice

- Colorectal
  - Review FIT use and Data:
    - Request rates
    - Return rates
    - Average time from request to result (turn a round)
  - Link to IIF Target (>80% FIT result with referral)
  - Knowledge of NEW NICE guidelines
    - Updated referrals forms coming soon.

2.1.13 Improving Referral Practice

Strong link between late-stage bowel cancer diagnosis and deprivation.



50 % of all CRC cancer treatments are in quintiles 1-4

Collaborating to improve cancer care

NHS Northern Cancer Alliance

2.1.13 Improving Referral Practice

- Colorectal

PCNs should target variation in the completion of FIT tests linked to deprivation

Identify areas for improvement

- **focus on inequalities to ensure FIT is not a barrier to onward referral**
- Identify Patient groups more at risk
- Patient information during consultations
  - in different formats / Languages
  - extra time to explain if required
- best practice AccuRx SMS reminders
- Safety netting,
- Telephone follow-up.

2.1.13 Improving Referral Practice

- Lung
  - Focus on Year of Care reviews
    - Questions regarding symptoms such as Cough etc
    - Making Every Contact Count
    - Smoking Cessation
    - Low threshold for CXR etc
  - Looking to incorporate Direct Access to CXR in places of need.

2.1.13 Improving Referral Practice

- Lung
  - Smoking status accuracy
    - Accurate + up to date
    - TLHC eligibility
    - Ever smokers
  - Red Flag Criteria

    Age >40, ever smokers who have any of

    cough > 3 weeks
    chest wall pain
    shortness of breath, fatigue, weight loss
  - Smoking Cessation
    - All patient facing staff should be trained in 'Very Brief Advice'
    - Ask – Advise – Act

2.1.13 Improving Referral Practice

- Head and Neck
  - High burden of late-stage diagnosis & Strong links to deprivation
  - Prevalence of risk factors smoking and problematic alcohol use.
  - Lack of community awareness of range of symptoms

2.1.13 Improving Referral Practice

- Head and Neck
  - Targeted work in most at need populations
    - CCAW providing increased awareness in Communities based on “Nudge Theory”
    - Behavioural Science
    - Poster Campaigns – Highly Visual, Bright, Fun.
  - Increasing Knowledge of Clinicians
  - Letter / SMS awareness campaign targeted to at risk patient population within the practice

2.1.14 Improving Cancer Referrals

- **Ensure local referral practice reflects NICE NG12** i.e.
  - Ensure practices are up to date with pathway changes/referral form changes e.g. breast pain pathway, combined lower/upper GI
  - Encourage use of clinical decision tools
  - Access pathway/clinical training

- **Audit referrals for diagnosed patients**, review learning and identify any improvements.
  - Link to specific tumours - **Lung and Bowel**

- Assess different stages for **pathway improvement** i.e. time interval presentation to referral, clinical assessment, safety netting

- **Setup PCN Learning Event Analysis to review audit** outcomes - to **develop improvement plans**

2.1.15 Support and Streamline Diagnosis and Referral

Review and promote the use of :

- **Direct access to diagnostics tests**
- **Faecal Immunochemical Testing (FIT)** to patients with signs and symptoms of colorectal - requiring a Lower GI Urgent Suspected Cancer referral.
- **Non-Specific Symptom (NSS) pathways** for pts. with symptoms that could indicate cancer but don't fit a single USC pathway.
- **Teledermatology** to support faster skin cancer referrals

Recommendations Direct Access to Test

- Discuss / use and availability
- Understand turn around times

Recommendations FIT

- Review Data – Reach 80% IIF Target
- Effective Coding & safety netting
- Adopt best practice to address inequalities in access/compliance – see section 2.1.13

Recommendations NSSP

- Easy access to pathway overview/criteria

Recommendations Teledermatology

- Adopt robust shared SOP across PCN
- Monitor & Improve returned image rate/delays

Core Activity : Access training and education – NCA Webinars, Gateway C

2.1.16 Increase Screening Uptake / Health Inequalities

- Work with partners & Identify and understand variation across all 3 screening programs to develop plans
  - Biggest challenges/lowest coverage
  - Use data, intelligence
  - Adopt interventions that try to address Health Inequalities
- Review non-responders
  - Linked to Health Inequalities & Population Groups
  - non-responder follow-up processes

2.1.16 Increase Screening Uptake / Health Inequalities

- **Consider access –** how can practices work together to improve access and pt. choice for cervical screening
  - eg Choice of Location +/- Appt time & Direct Booking options.

- **'Every contact counts' -** Check screening uptake at every appointment. E.g. Is it embedded in Year of Care work

- **Learn from Case Studies / Examples of Practice** – PCN Worker

- **Discuss and Identify - QI projects across practices.**
  PCN Engagement Worker can support

Other Resources

- Northern Cancer Alliance Website / Primary Care
- CRUK Primary Care Good Practice Guides for screening: Cervical Screening
- Screening Saves Lives which can be delivered locally.
- Head and Neck Cancer Symptom Awareness Materials
- FIT Lab Data from PCN Worker
- Help Us Help You cancer screening campaigns
- Planning Template with hints and tips (Q2 2024)

Next Steps…

- **PLT SESSIONS**
- Working now to finalise **PCN DES Planning Template/Resources** – Available Q2 2024
- PCN Engagement Workers working with NCA are **developing useful data and support resources** for the PCN DES
- NCA DES webpages to be updated
- Submit **Draft plans in October 2024** to NCA
- Submit **Reports, Due May 2025**
- Annual Share and Learn Event in June 2025.

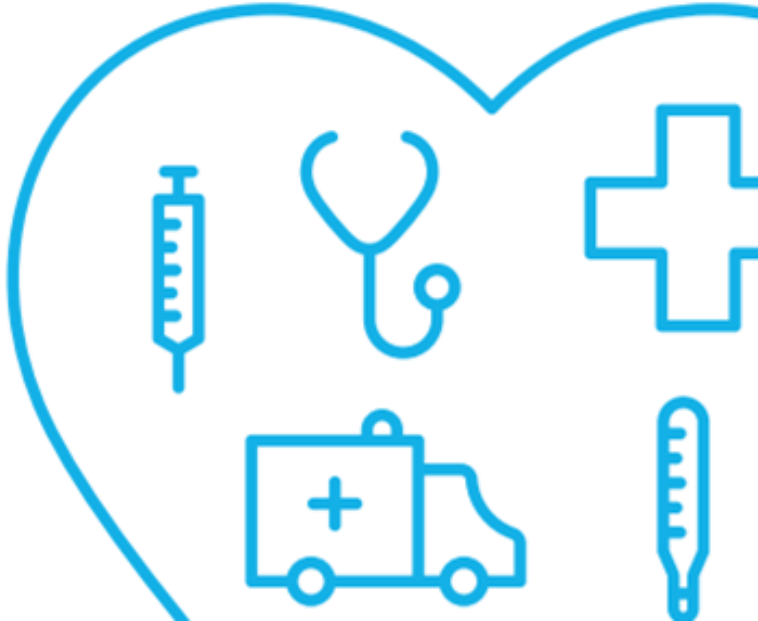
Thank you

Questions and Feedback

DURHAM DALES HEALTH FEDERATION

Early Engagement for Cervical Screening within Durham Dales

Emma Sarsfield &
Elaine Patterson



Introduction

Highlight a project undertaken within Durham Dales which is to enhance cervical screening uptakes for first time screeners

DURHAM DALES HEALTH FEDERATION

Purpose

PCN DES Requirements

As part of a broader social prescribing service, the PCN must review its targeted programme to proactively offer and improve access to social prescribing to an identified cohort with unmet needs

CORE20PLUS5

Clinical Area of Focus number 4 - Early Cancer Diagnosis

75% of cases diagnosed at stage 1 or 2 by 2030

The targeting of small cohorts with unmet needs is likely to be an ongoing DES requirement in conjunction with health inequalities and the CORE20PLUS5 model.

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Objective

- Within Durham Dales our screening rates for cervical screening are good with an average of 79% across our 3 PCN and across ages 25-49.

- NHS England, ICBs and many organisations, including Jo's Cervical Cancer Trust, advised that 25 year olds who are due their first screening test should be targeted to raise awareness and provide support due to the current low uptake nationally

- To further improve these rates the aim is to target and improve cervical screening in 25 year olds. Patients will have received their initial invitation for screening and our project aimed to reduce the cycle of intergenerational DNA's as well as overcome perceived barriers towards the screening.

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Project Setup

- Retrieved data on eligible patients who were 25 at the time of the cohort start

- Engaged with the practices to discuss current processes and pathways, make them aware of the planned work and the potential additional appointments which may be generated

- Provided a training session to all Social & Wellbeing team detailing the process, with telephone scripts to start the engagement, highlighting potential barriers and identifying signposting for any GP practices undertaking evening clinics or alternatively the CASH clinic

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Challenges encountered

Initial teething problems were:

- Text messages signposting to practice websites for online booking - did not realise patients had to be pre-registered to book online
- Inconsistent coding on system
- Data Searches - unable to differentiate reasons for not being eligible - eg. appointment booked, pregnancies, recent birth

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Training and Preparation

Training provided to the Social and Wellbeing Team included:

- In depth understanding of the screening and HPV
- In depth understanding of the screening invitation process (from the initial contact from the screening unit to primary care)
- What reasonable adjustments can be made in primary care
- Some barriers for having the cervical screening such as embarrassment, pain, fear of results, judgement and trauma

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Patient Evaluations - Qualitative

“Saved time, very grateful for call / help to arrange appointment”

“Forgot about reminder letter to book smear/ reluctant to book due to calling surgery/ waiting in queue to get in touch with reception to book appointment “
“felt more confident to attend and how to book appointments in the future”

“Knew her smear was due and our discussion was the push she needed to pick up the phone”

“Happy to discuss the procedure and assured me that she would make an appointment”

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Patient Evaluations - Qualitative

“Extremely nervous to go for first smear due to history of domestic violence Appreciated conversation with SPLW about concerns. Would not have booked smear herself due to anxiety and fear of unknown”

“Felt better about going for smear after conversation with myself around concerns however did not feel confident enough to go through with procedure”.

“This meant a lot to her, even though she couldn’t think about her smear appointment as it raised anxiety levels, she did thankfully realise the importance of the procedure being carried out”.

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Staff Evaluations - Qualitative

“Help to book appointment improves patient experience and gave opportunity for patient to ask questions/ explain concerns before appointment

“Most patients who answered the phone were grateful for call and were able to book their appointment easily, saving them time”

“I assisted with booking a smear counselling appointment with the nurse which the patient appreciated”

“I suggested a chat with the practitioner prior to her appointment so the patient could make her feelings known and hopefully put her mind at ease.

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Results - Quantitative

294	**Number of eligible patients**	Reports ran via DDHF admin lead on SystmOne for overall eligibility of patients aged 25 at the time of the report who had not had a test in the previous year	
158	**Engagement**	Engagement via telephone contact from either Social Prescriber or Care Coordinator with relevant reassurance, support and signposting	**54%**
56	**Cervical Screening completed**	Report ran for tests between January 2024 and April 2024	**35%**

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Contact Details

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DURHAM DALES HEALTH FEDERATION

Increasing uptake in bowel screening in South Tyneside

Cohort; eligible males aged 50-59 years who are first-time non-responders to bowel screening invitations.

SOUTH TYNESIDE HEALTH COLLABORATION

Background

Bowel cancer is the 4th most common cancer in the UK, accounting for 11% of all new cancer cases. Of these, 44% of bowel cancer cases are in females, and 56% are in males. According to Cancer Data, in 2020, colorectal cancers (which incorporates bowel cancer) were South Tyneside's third most prevalent cancer, with 871 cases. Of these, 500 were in men (57%).

Data from the bowel cancer screening programme North East hub shows that in South Tyneside only 58.81% of eligible males aged 50-59 years were screened in 2022/23. This was lower than the number of women of the same age who took up screening (63.91%).

Out of 1923 men invited to participate in 2022/23, 792 of those, by not participating in bowel cancer screening programme, have missed the opportunity of cancer, or abnormalities that could lead to cancer, being detected.

SOUTH TYNESIDE HEALTH COLLABORATION

National Context

Major Conditions Strategy

Published in August 2023, the strategy clearly identifies the early diagnosis of cancer as a priority, stating that "early diagnosis is good for the NHS, good for communities and, above all, good for patients".

NHS Long Term Plan

Published in 2019, the NHS Long Term Plan sets an ambition to diagnose 75% of cancer at stage 1 or 2 by 2028. The plan identifies that "one of the biggest actions the NHS can take to improve cancer survival is to diagnose cancer earlier" and makes a commitment to take action to improve uptake of screening.

Core20PLUS5 Approach

Core20PLUS5 is NHS England's approach to reducing healthcare inequalities. The approach defines a target population and identifies 5 focus clinical areas requiring accelerated improvement, including the early diagnosis of cancer.

SOUTH TYNESIDE
HEALTH COLLABORATION

Current State In South Tyneside

When an individual does not engage with the bowel screening programme a notification is sent to their Primary Care record. In South Tyneside, there is an inconsistent approach to responding to this notification, with some practices sending a text message or letter to prompt the patient, and others not doing anything.

Offer from local delivery provider not taken up by all practices

There continues to be an inconsistent and inequitable approach to the engagement of non-responders to bowel screening in South Tyneside.

SOUTH TYNESIDE HEALTH COLLABORATION

The proposed intervention

The intervention proposed would, in the first instance, be aimed at the cohort most at risk, which as identified , is **eligible males aged 50-59 years who are first-time non-responders** to bowel screening invitations. The initiative would look to engage these individuals on a one-to-one basis through a phone call. The purpose of the call would be to:

- deliver education on the importance of engaging in bowel cancer screening - this will look to amplify national and local promotion and messaging, not duplicate it

- gain a better understanding of the specific barriers preventing patients engaging in bowel cancer screening - the learning from these one-to-one conversations will be recorded

- use a microgrants process to support patients to overcome financial barriers to engaging in the bowel cancer screening programme, recording how funds are utilised

- evaluate the project, using intelligence gathered to produce recommendations that will inform the improvement and development of screening pathways

SOUTH TYNESIDE HEALTH COLLABORATION

Evaluation

We would look to evaluate the efficacy of this approach, collating, analysing and sharing the learning from the:

- Baseline number of male first-time bowel screening non responders aged 50-59 years
- Number of male first-time bowel screening non responders aged 50-59 years contacted through this initiative
- Reasons given for non-engagement in bowel screening, identifying themes and commonalities
- Where financial support is provided, what funds are utilised on and how much is accessed
- Number of male first-time bowel cancer screening non responders aged 50-59 who, following contact return their test kit
- Demographic data for all above, including postcode (to map against IMD), again identifying themes and commonalities
- Results of bowel cancer screening for those who engage in this pilot, including number of abnormalities and cancers diagnosed

SOUTH TYNESIDE HEALTH COLLABORATION

Finances & Contracts

£16,000 of non-recurrent monies in a financial envelope issued to South Tyneside place. The purpose of these funds is to support early diagnosis of cancer and improve access to Primary Care.

Based upon the data we have available we anticipate around 800 eligible individuals in the first cohort (males aged 50-59 years who are first-time non-responders). We anticipate around half of the financial envelope will be used to fund practitioner capacity. The remaining financial envelope will be used to fund the microgrants process to support patients to overcome financial barriers.

SOUTH TYNESIDE
HEALTH COLLABORATION

Results so far

Following contact with the cohort 205

10% declined,
29% ask for new kit or will sent current kit,
60% struggled to make contact with.
No barriers raised and no microgrants issued to support patients to overcome financial barriers.

Reasons for declining to take part

Not always disclosed, but reasons noted are recently did one through another pathway, choice (seems wrong, rather not know, doesn't want to), medical reasons.

Next steps are to ascertain how many of those that asked for a new kit or said that they would complete the kit have done so and demographic details and any follow up required

SOUTH TYNESIDE HEALTH COLLABORATION

Primary Care Services
North Cumbria

Operational Improvements

(PCN DES – ED Cancer FIT & Fast Track Standardisation)

Samantha Gargett – Primary Care Services North Cumbria

PCN DES – ED Cancer

- Led by Primary Care Services North Cumbria, specifically by Project Manager & PCN Cancer Engagement Lead
- Cross over of required deliverables in respect of improvements
- Working with: NCIC Contact Centre (referral), NCIC lab (FIT test pathway), PRIMIS (data & upload of referral forms) GP Practice teams
- Granular level work right at the heart of operational delivery with feedback from those undertaking the work

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North C

PCN DES/IIF – ED Cancer

The DES specification states that PCNs should support early diagnosis by:

"Reviewing cancer referral practice in collaboration with partners and making efforts to improve support of early diagnosis"

"PCNs should target action to address variation in completion of FIT tests in symptomatic patients by deprivation and develop patient education and safety netting approaches to follow up with those who have not returned their FIT test"

"CAN-02: Percentage of lower gastrointestinal urgent suspected cancer referrals accompanied by a faecal immunochemical test result, with the result recorded in the twenty-one days leading up to the referral" (2)

Don’t assume

ASK!

Ask those who undertake the work at practice level: GP’s, Nurses, HCA’s, Cancer Care Co-Ordinators, Coders, Medical Secretaries

Our main findings:

- *FIT instructions not matching pathway eg ICE forms in packs, lack of language checks*
- *Differentials in process between F2F & Telephone consultation & process used by clinicians/admin – including forms & safety netting on returns/fails*
- *Lack of standardisation in respect of when blood results available & patient availability on referral (fast track)*
- *Lack of up to date local data around fail rates and appropriate referrals, fast track*

Resources:

Access to up to date data is key and we are working to ensure we are able to monitor and review at the earliest possible opportunity

Equitable service:

We currently have different processes running across practices therefore we are working to standardise, thus leading to equitable service.

Primary Care Services
North Cumbria

WHY?

Quality Control & Process:

WHY – do we have a 10% fail rate compared to 1% at Gateshead lab?

WHY – Do we have so many differentials in delivery, across North Cumbria, across PCN's and within practices?

WHY – do we have so many different uncontrolled forms and patient leaflets in use?

WHY – have we not updated ways of working & processes to take into account telephone consultations/multi site working

TIME is a huge factor

Asking operational people to take time out to review and implement change is not easy, they have the day job to do and not enough hours in the day

Practice/PCN Buy in is crucial

We have only been able to begin making real improvements thanks to the willingness of our PCN & practice teams, not least those our pilot practices and Cancer Care Co-Ordinator at Carlisle Healthcare

Primary Care Services
North Cumbria

Working in isolation will not lead to improvements

It takes many people & many areas of focus BUT they must not be worked on in isolation

PCN Cancer Engagement Lead

Valuable role, already seeing benefits and bringing together of PCN's/Practices to embed long term improvements

Cancer Care Co-ordinators

Focus on specific area of patient care – data already shows improvement, for example at Carlisle Healthcare

Standardisation

Survey showed standard written practice process required, variable use of ACCURX with standard templates

Pilot Practices

All new and updated ways of working are being piloted by several practices across North Cumbria

Working in isolation will not lead to improvements

It takes many people & many areas of focus BUT they must not be worked in isolation

Local Digital Dashboard

Working with PRIMIS to bring together up to date cancer contract and service delivery data

Sharing best practice

NENC information via PCN Cancer Engagement, best practice sharing by Primary Care Services North Cumbria & Cancer Conference/PLTs

Reviews/Quality Control

QC control patient information leaflets/letters/referral forms, working with ICB & NCA Clinical leads for clinical safety

Equitable Patient Care

All of this work should and can, with a sustained effort, lead to both improvement and equitable patient care

Working example of standardisation & Good Practice

Cancer Care Co-Ordinator
Carlisle Healthcare PCN

2 Practice PCN

41’403 Patients

Developed working relationships

Macmillan welfare & benefits teams, counselling, hospice & specialist palliative care teams. In house practice team relationship building operational & clinical

Supporting FIT

Supporting patients to correctly undertake test, follow up any failed tests. Follow up fast track non attendance, work to standardise process, shares good practice

Equitable Patient Care

All of this work ensures there is a person within the PCN who is a key contact across teams & woks to ensure equitable service delivery for all patients.

Have we included the right people at the right time?

Simply - Have we reviewed the small stuff to improve the big stuff – with the right people?

ICB/NCA Clinical Leads

Practice Clinical & Operational Teams

Labs/Contact Centre

PCN Ops/CD's

PRIMIS & Data providers

INCLUDE, EMPOWER, IMPROVE

Primary Care Services
North Cumbria

Thank You

Information sources

1) https://coreprescribingsolutions.co.uk/blog/pcn-des/
2) Network Contract DES 2024/25 (england.nhs.uk)
3) Network contract directed enhanced service (england.nhs.uk)
4) Network contract directed enhanced service (england.nhs.uk)

Targeted Lung Health Check Programme
Tees Valley

Angela Atkinson
Primary Care Cancer Facilitator

The Lung Cancer Picture

- Lung cancer deaths account for 20% of total cancer mortality worldwide
- Survival is poor in both developed and low/middle income countries
- Only 15% patients with lung cancer are alive at 5 years
- In the UK 50% of patients have stage 4 disease at diagnosis
- One third of patients present as emergency

- **The Tees Picture**
- Lung cancer accounts for 18% of all cancers in South Tees and the most common cancer overall.
- South Tees ranks 14/191 (CCG boundaries) for lung cancer incidence - South Tees is ranked 8/191 for female and 26/191 for male incidence
- South Tees ranks 10/191 for lung cancer mortality and significantly higher than England

- **Treatment options for lung cancer are improving**
- **Early diagnosis offers the best chance of improving survival**

Targeted Lung Health Check Patient Pathway

- Participants aged between 55-74
- Current and ex-smokers
- Lung Health Check – high risk / low risk of lung cancer
- Smoking Cessation advice/referral
- High Risk Lung Cancer – Low Dose CT Scan of the Chest
- Suspicion of Cancer or serious incidental finding – Screening Review Meeting and referral into secondary care

Implementation in Tees – Initial Response

Key Learning from the Implementation

- Positives:
  - Significant improvement in patient outcomes immediately seen
  - Positive patient feedback
  - True system working across the three hospital Trusts, the ICB, Primary Care and Public Health
  - Partnership working with private providers InHealth and Heart Lung Health
  - Ability for organisations to work at pace to achieve a common objective
  - Ability to locate service at heart of patient population
- Challenges
  - Information Governance processes across GP Practices, Trusts, ICB and private providers
  - Integration of IT systems across mobile CT scanner, external Radiology reporting company, Trust RIS/PACS
  - Ongoing management of the incidental findings' pathways both in secondary and primary care
  - Ongoing sustainability and further roll out of the service

The Numbers So Far…

Tees Valley Targeted Lung Health Check Programme
Update: August 2022 to March 2024

49
GP Practices Involved - Scanner located at place

40,190
Invitations sent

27,547
Telephone lung health checks completed

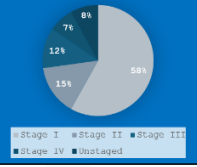
70%
Uptake rates

11,682 first CT Scans completed

5916 Patients referred to Stop smoking services

136 Lung Cancers diagnosed

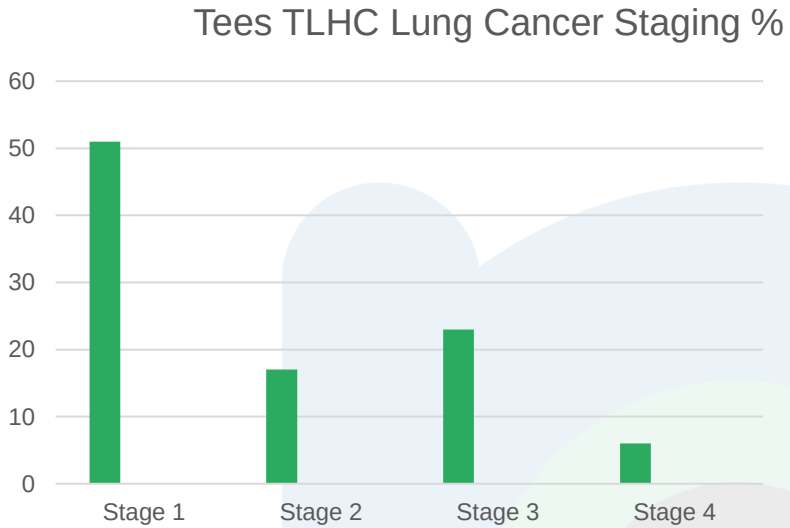
% Cancers found by staging
Total number found = 136



6129
Other healthcare needs found, including other cancers

Thank you to everyone who has made this programme a success!

InHealth | Intelligence



Thank you to all the PCN teams, GPs and administration staff for their hard work, input and support.

Sunderland
GP Alliance

Promoting Engagement in Cervical Screening

Introduction

Sunderland GP Alliance

The idea – create a digital solution to increase uptake of Cervical Screening

With the support of Practice Nurses across Sunderland the suggestion was made to create an information video that could be shared in place of a third invitation or for anyone who failed to attend their cervical screening appointment.

The video would be shared via AccuRx message with a request to contact your practice to make an appointment, speak to your Practice Nurses if you have any questions or to opt out of the screening programme.

It is hoped the video will address and concerns a patient may have and bust any cervical cancer beliefs which may be preventing them attending their appointment.

Video Content

Sunderland GP Alliance

The Practice Nurses thought it important to not only highlight the importance of cervical screening but also to reassure patients who were feeling nervous or embarrassed, or finding the timing of an appointment challenging.

Together a script was created to ensure all messages the Practice Nurses would want to say in person were included in the short video. This included the following;

- The importance of screening for women and people with a cervix
- Availability of weekend and evening appointments
- What happens during your appointment including the intrsuments used
- What we look for when screening
- Follow up and outcomes
- Next steps

Video Content

Sunderland GP Alliance

Please follow the link below to watch the video in full;

Video link - https://vimeo.com/949132958?share=copy

Example of video clips

Sunderland GP Alliance

This video has been created by Sunderland Practice Nurses...

What do I do next?

Next Steps

Sunderland GP Alliance

The video has now gone live for use across all Sunderland GP Practices. Baseline data has been collected from the ICB and will be monitored at 3 and then 6 months to see if we quantify any improvements. The video has been shared on all Sunderland GP Practice waiting room screens and on their social media channels.

For those patients not signed up to digital communications a letter has been created from the video script for sharing. This letter has been approved by the Health Literacy team at STSFT.

Next steps for this quality improvement is to have the letter translated and to monitor its success. Our Practice Nurses are also planning to gather anecdotal feedback where they can. One PCN has agreed to survey patients who received the video for feedback.

Any Questions?

Sunderland GP Alliance

Contact Details

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