Cheshire & Merseyside Cancer Alliance

NHS

# Welcome

# To the Primary Care Webinar

# We will begin shortly

Please mute your mic during the meeting 

Please use the 'chat' function to comment and ask questions 

***Please note – the webinar is being recorded***

# Primary Care Webinar:

***'Early Diagnosis – Primary Care'***

Please mute your mic during the meeting

Please use the 'chat' function to comment and ask questions

# Welcome

- Virtual housekeeping rules:
  - Please keep your microphone muted/cameras off
  - Please use chat function to ask questions/comment

*Recording has now started*

# Welcome

**Dr Debbie Harvey**
CMCA GP Lead

**Louise Roberts**
Senior Quality Improvement Manager

**Ed Bourne**
Cancer Engagement Lead – North Mersey

**Nicola Williams**
Cancer Engagement Lead – Cheshire & Wirral

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# Key Developments/Horizon Scanning

## Cheshire and Merseyside

Dr Chris Warburton

CMCA Medical Director

Cheshire & Merseyside Cancer Alliance

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# The Data Picture - Key Cancer Statistics

## Cheshire and Merseyside

Jenny Hampson (November 2022)

# Summary

- Incidence:
  - Around 16,000 new cancer cases per year.
  - 592 new cases per 100,000 population vs 531 per 100,000 in England as a whole (2019/20).
- Mortality:
  - Around 7,000 deaths per year, of which around 6000 are in people aged over 65.
  - In people over 65 there were 1,102 per 100,000 deaths due to cancer vs 1,050 per 100,000 in England as a whole.
- Early stage diagnosis:
  - In 2017-2019 (three years pooled) 53.3% of cancers with a known stage were diagnosed at an early stage vs 54.2% in England.
  - Between 2017 and 2019, early stage diagnosis increased from 53.6% to 53.7% in 2019 (53.8% to 54.5% in England)
- 1 year survival:
  - 75.8% of people aged 15-99 years survive for at least 1 year following diagnosis, vs 74.6% n England as a whole.

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# Deprivation

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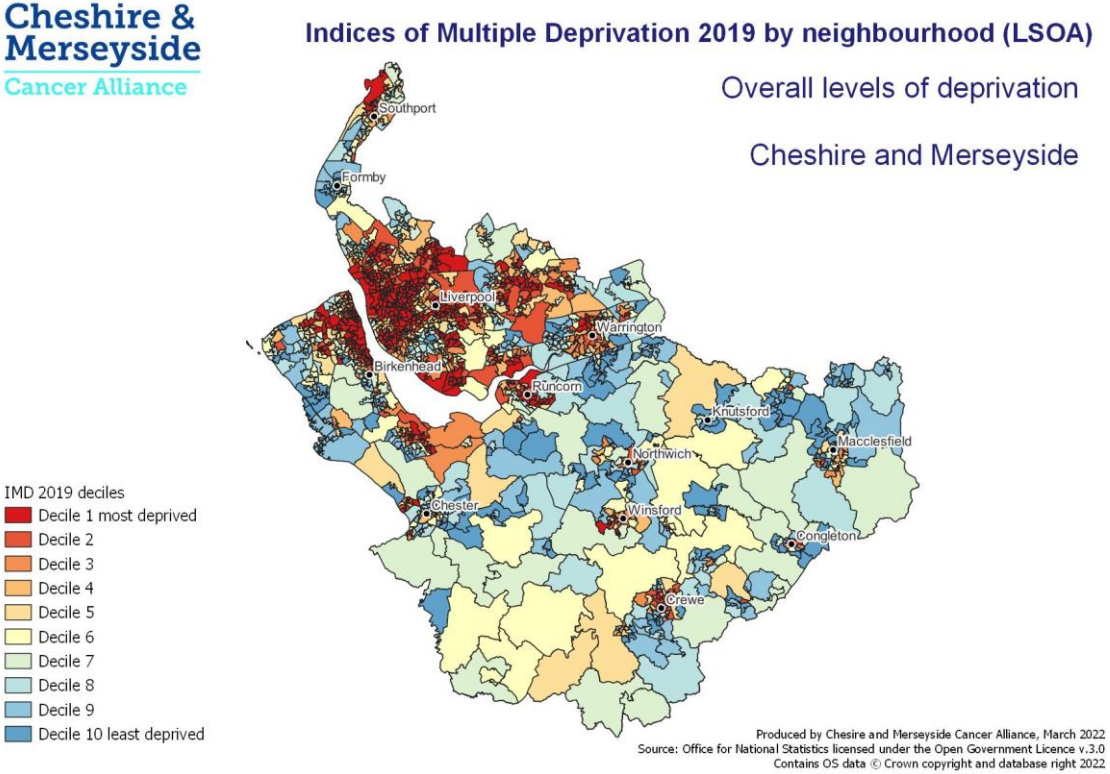
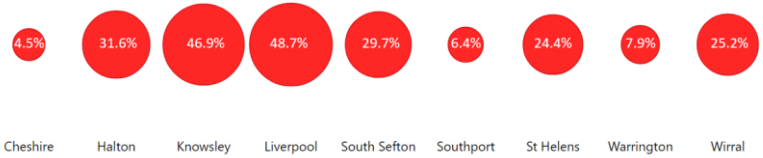


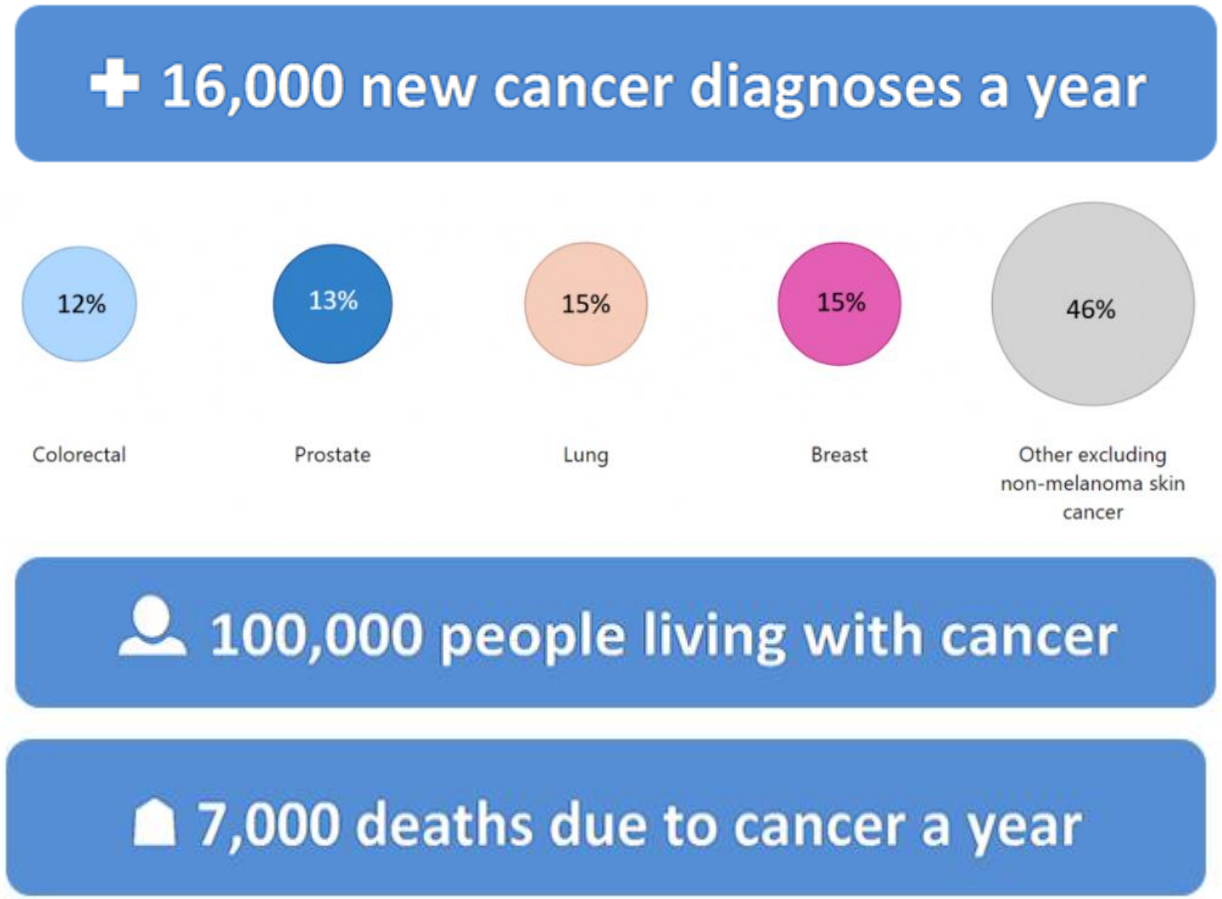

- Cheshire and Merseyside is:
  9 places
  14 hospital trusts*
  2.6 million residents
- Wide variation within CM, from 5% of neighbourhoods in Cheshire CCG in most deprived 10% nationally, to 49% in Liverpool CCG




Percentage of neighbourhoods in Decile 1 of the 2019 Indices of Multiple Deprivation – Clinical Commissioning Groups

*Providing cancer services

# Cheshire and Merseyside Cancer Headlines

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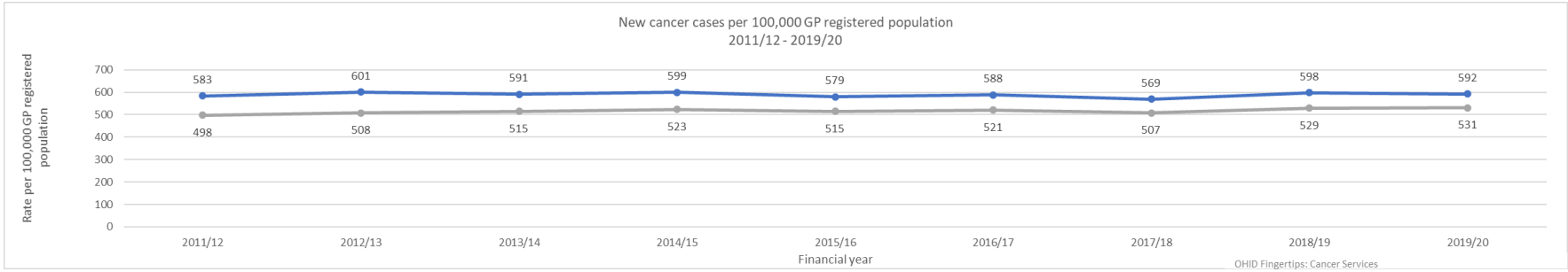
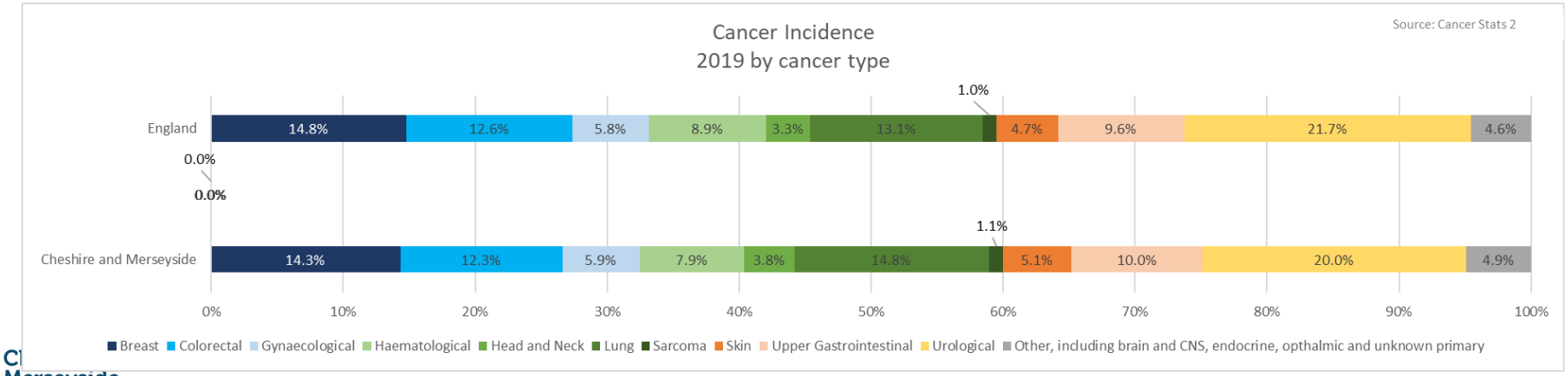
# Incidence

- Around 16,000 new cancer cases per year.
- 592 new cases per 100,000 population vs 531 per 100,000 in England as a whole (2019/20).

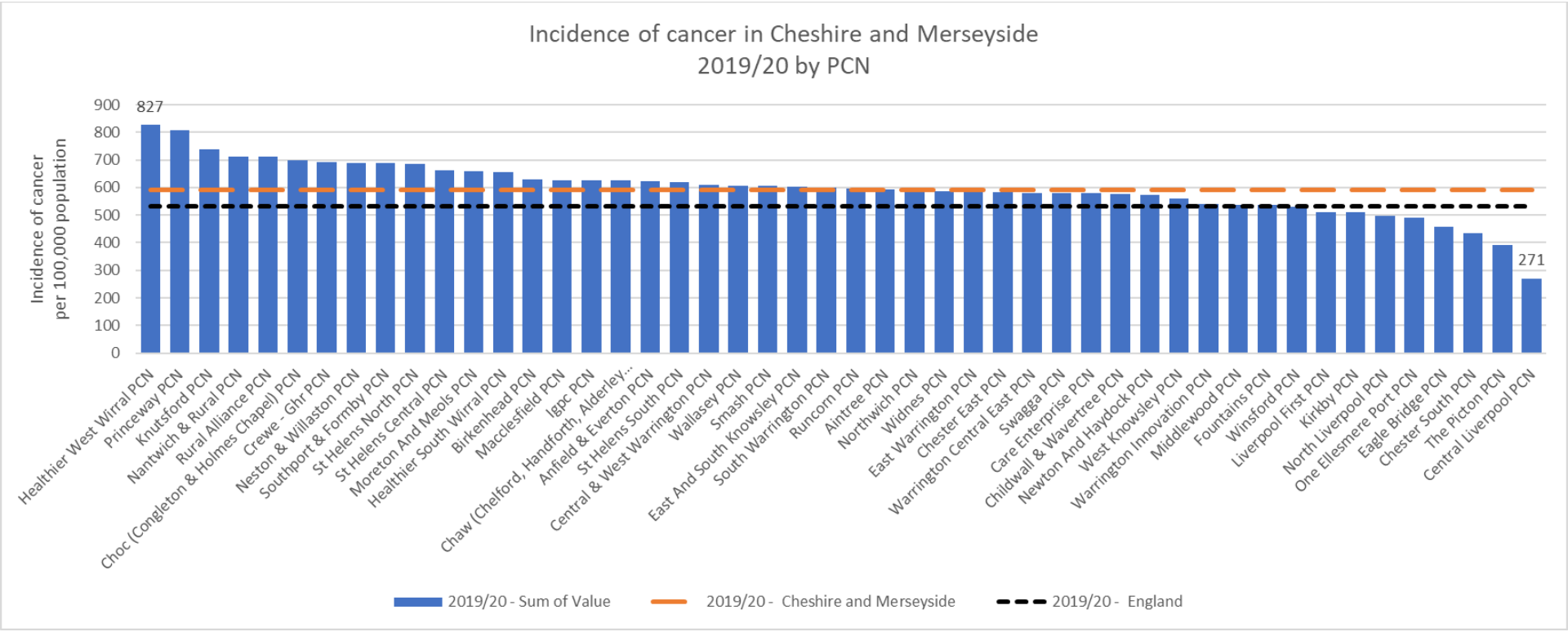



Merseyside Cancer Alliance

Source: PHE Fingertips, cancer Services

# PCN data: Incidence (2018/19)




- Incidence* ranges from 827 patients per 100,000 population (all ages) in Healthier West Wirral PCN to 271 patients per 100,000 population in Central Liverpool PCN.

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* All reportable malignant cancers, excluding non-melanoma skin cancer,

Source: PHE Fingertips, cancer Services

# Early Stage Diagnosis

- In 2017-2019 (three years pooled) 53.3% of cancers with a known stage were diagnosed at an early stage vs 54.2% in England.
- Between 2017 and 2019, early stage diagnosis increased from 53.6% to 53.7% in 2019 (53.8% to 54.5% in England)
- The NHS Long Term Plan ambition for is for 75% of cancers to be diagnosed at an early stage (stage 1 or 2) by 2028
  - There are strong links between earlier diagnosis and better rates of survival
- Cheshire and Merseyside would need a sustained shift to reach 75%
  - Over a 2% increase every year would be needed
  - On average, each GP practice would need to diagnose 7 additional cancers at an early stage each year
- In Cheshire and Merseyside, early stage diagnosis varies from 56.8% of known stages in South Sefton to 49.4% in Knowsley(2019)
  - No significant differences

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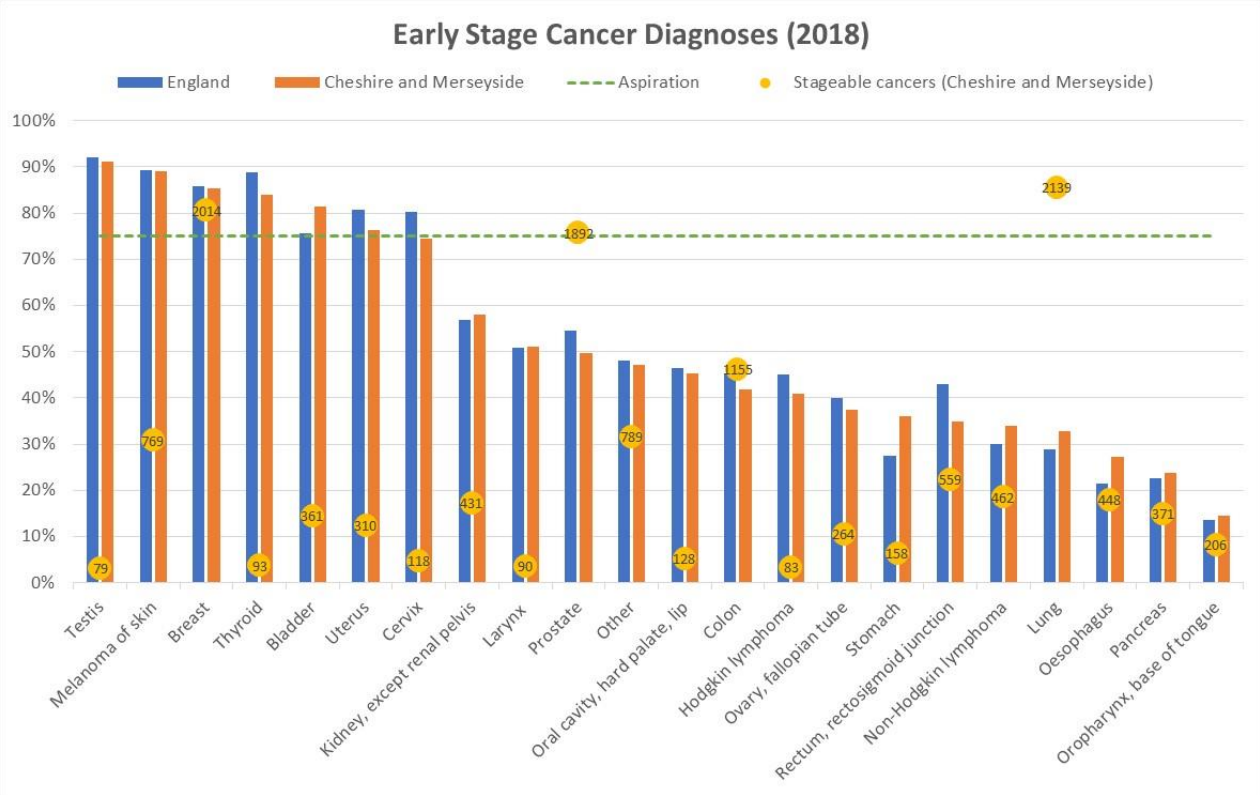
# Early Stage Diagnosis

- Of the largest tumours:
  - Breast 85%
  - **Prostate 50%**
  - Colorectal 40%
  - Lung 33%
- Tumours above England but still low
  - Stomach, oesophagus, lung, non-Hodgkin lymphoma
- Tumours with biggest gaps to best cancer alliance
  - Kidney, ovarian, prostate
  - All over 12% below best cancer alliance (data not shown)

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# One Year Survival (ONS survival index)

- 75.8% of people aged 15-99 years survive for at least 1 year following diagnosis, vs 74.6% n England as a whole.
- Cheshire and Merseyside survival rates were lower then England in 2013 but as of 2019 are higher than England.
- The range of One year survival rates in Cheshire and Merseyside historic CCGs has widened from 3.1 percentage points in 2013 to 4.1 percentage points in 2019.
- Knowsley CCG had the highest One Year Survival rate in Cheshire and Merseyside in 2013 (63.1%) but the lowest in 2019 (72.7%)
- Wirral CCG had the lowest One Year Survival rate in Cheshire and Merseyside in 2013 (60.0%) but the joint highest in 2019 (76.8%)

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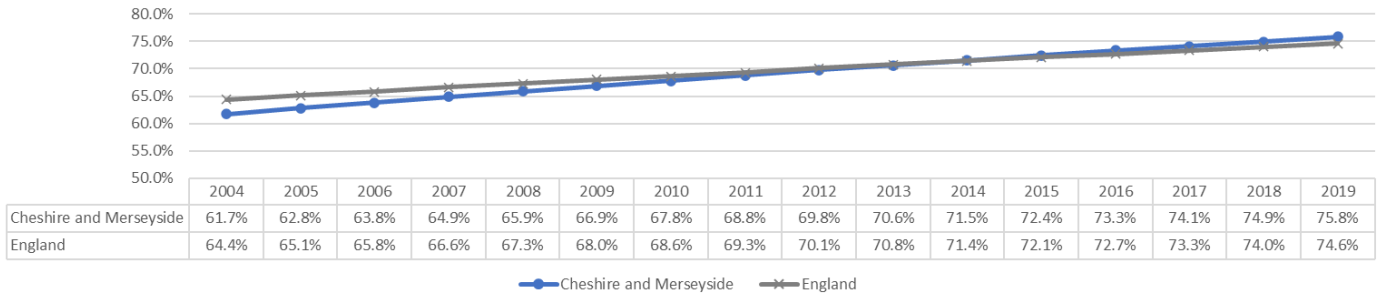
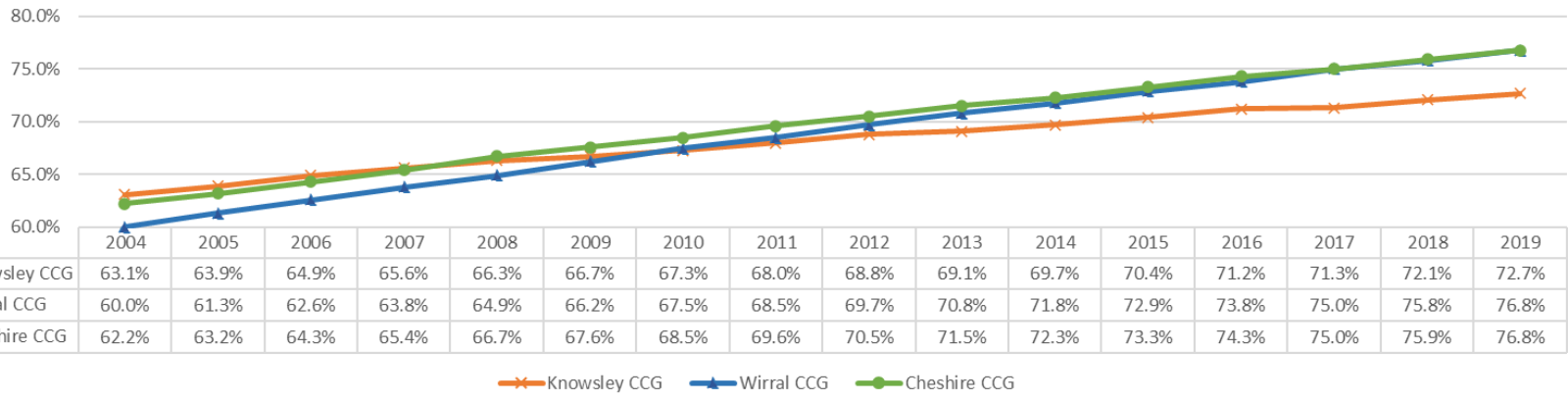
# One Year Survival (ONS survival index)

Percentage of people aged 15 to 99 surviving for at least 1 year following a diagnosis of cancer: All cancers




| | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cheshire and Merseyside | 61.7% | 62.8% | 63.8% | 64.9% | 65.9% | 66.9% | 67.8% | 68.8% | 69.8% | 70.6% | 71.5% | 72.4% | 73.3% | 74.1% | 74.9% | 75.8% |
| England | 64.4% | 65.1% | 65.8% | 66.6% | 67.3% | 68.0% | 68.6% | 69.3% | 70.1% | 70.8% | 71.4% | 72.1% | 72.7% | 73.3% | 74.0% | 74.6% |

Historic Clincal Commissioning Groups with the highest and lowest One Year Survival rates in Cheshire and Merseyside




| | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Knowsley CCG | 63.1% | 63.9% | 64.9% | 65.6% | 66.3% | 66.7% | 67.3% | 68.0% | 68.8% | 69.1% | 69.7% | 70.4% | 71.2% | 71.3% | 72.1% | 72.7% |
| Wirral CCG | 60.0% | 61.3% | 62.6% | 63.8% | 64.9% | 66.2% | 67.5% | 68.5% | 69.7% | 70.8% | 71.8% | 72.9% | 73.8% | 75.0% | 75.8% | 76.8% |
| Cheshire CCG | 62.2% | 63.2% | 64.3% | 65.4% | 66.7% | 67.6% | 68.5% | 69.6% | 70.5% | 71.5% | 72.3% | 73.3% | 74.3% | 75.0% | 75.9% | 76.8% |

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# Prevalence (QOF 2020/21)

- 3.6% of patients in Cheshire and Merseyside have a diagnosis of cancer recorded on GP Practice disease registers. This is higher than the 3.2% seen in England as a whole.
- In real terms, almost 100,000 people in Cheshire and Merseyside are living with and beyond cancer.
- Percentages range from 4.7% of people registered with GP practices in Southport and Formby (n=5,962), to 2.9% of people registered with GP practices in Liverpool (n=16,255).

| Area | Recent Trend | Count | Value |
|---|---|---|---|
| **England** | | 1,948,913 | 3.2 |
| Cheshire and Merseyside | | 97,176 | 3.6 |
| NHS Southport And Formby CCG | | 5,962 | 4.7 |
| NHS Cheshire CCG | | 31,348 | 4.0 |
| NHS Wirral CCG | | 13,465 | 4.0 |
| NHS South Sefton CCG | | 5,652 | 3.6 |
| NHS St Helens CCG | | 7,162 | 3.6 |
| NHS Halton CCG | | 4,692 | 3.5 |
| NHS Knowsley CCG | | 5,535 | 3.3 |
| NHS Warrington CCG | | 7,105 | 3.2 |
| NHS Liverpool CCG | | 16,255 | 2.9 |

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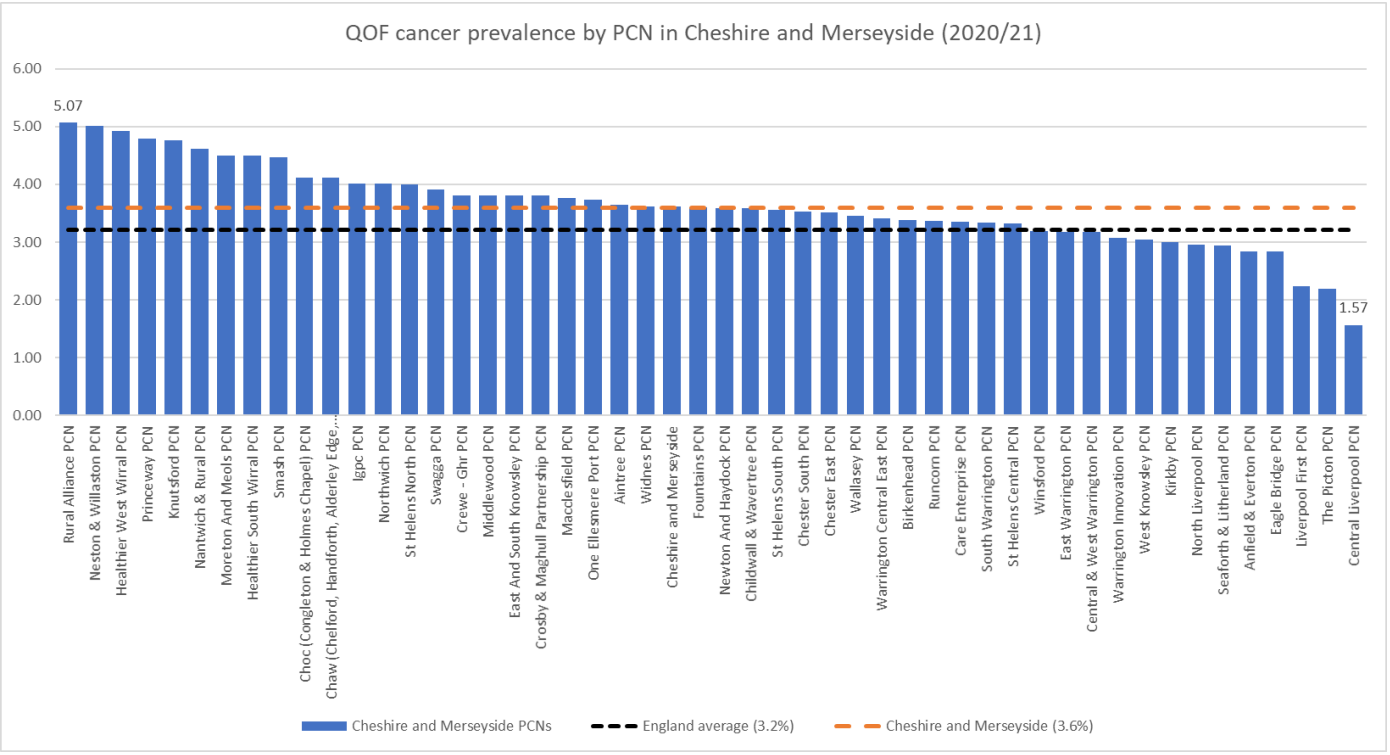
* Register of patients with a diagnosis of cancer excluding non-melanotic skin cancers

Source: PHE Fingertips, cancer Services

# PCN data: Prevalence (QOF 2020/21)




- QOF prevalence* ranges from 5.07% of patients registered with Rural Alliance PCN to 1.57% of patients registered with Central Liverpool PCN.
- This indicator set is not evidence-based but does represent good professional practice.

* Register of patients with a diagnosis of cancer excluding non-melanotic skin cancers

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Source: PHE Fingertips, cancer Services

# Urgent GP Referral rates (2020/21)

- In 2021/22 there were 107,547 Urgent GP Referrals for suspected cancer in Cheshire and Merseyside. This equates to 4,008 referrals peer 100,000 people registered with GP practices.
- This is higher than the England average of 3,389 per 100,000.
- Referral rates in Cheshire and Merseyside historic CCGs range from 3,447 per 100,000 in Liverpool to 4,829 per 100,000 in Southport and formby.

| Area | Recent Trend | Count | Value |
|---|---|---|---|
| **England** | | 2,058,069 | 3,389 |
| Cheshire and Merseyside | | 107,547 | 4,008* |
| NHS Southport And Formby CCG | | 6,068 | 4,829 |
| NHS South Sefton CCG | | 7,285 | 4,675 |
| NHS St Helens CCG | | 8,957 | 4,492 |
| NHS Wirral CCG | | 14,699 | 4,347 |
| NHS Knowsley CCG | | 7,220 | 4,282 |
| NHS Warrington CCG | | 9,437 | 4,275 |
| NHS Halton CCG | | 5,281 | 3,937 |
| NHS Cheshire CCG | | 29,489 | 3,751 |
| NHS Liverpool CCG | | 19,111 | 3,447 |

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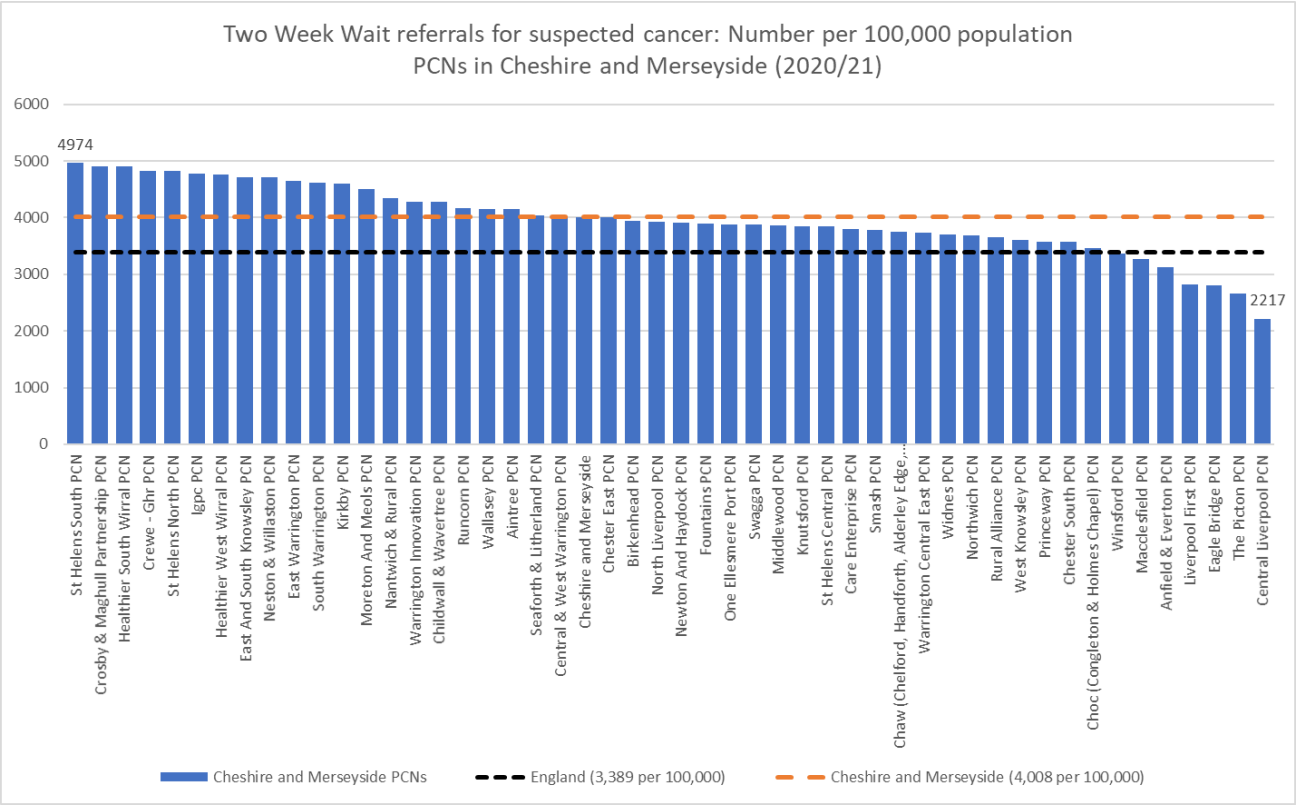
Source: PHE Fingertips, cancer Services

# PCN data: Urgent GP Referral rates (2020/21)




Referral rates* range from 4,974 per 100,000 population in IGPC PCN to 2,217 per 100,000 population in Central Liverpool PCN.

Both in Cheshire and Merseyside and England as a whole, referral rates were lower in 2020/21 than in 2019/20, due to the impact of Covid.

* All records with a 'Referral Priority Type' of '3' (Two Week Wait) were included, excluding patients referred for non-cancer breast symptoms (those with a 'Cancer Referral Type' of '16' (non-cancer breast symptoms)).

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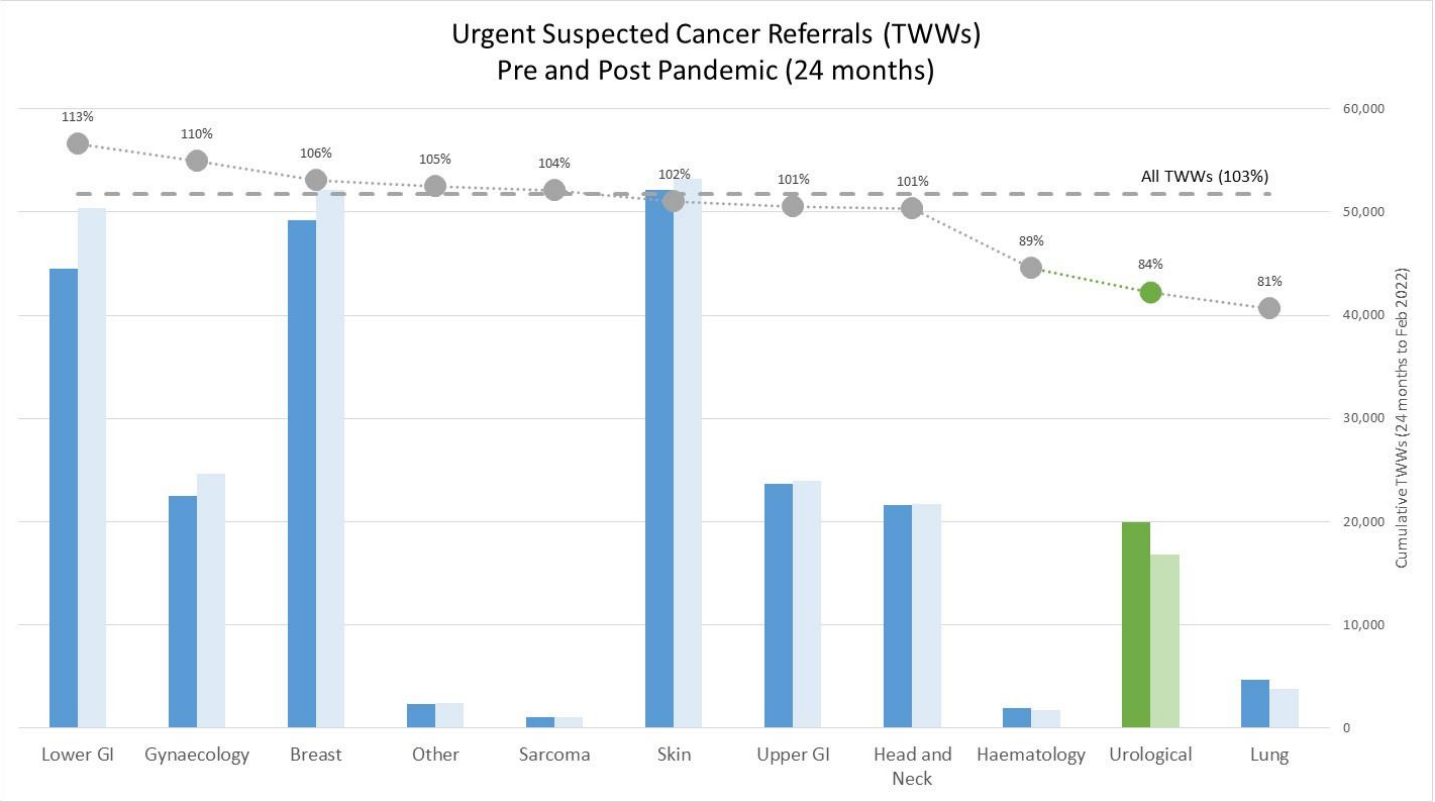
Source: PHE Fingertips, cancer Services

# Urgent Suspected Cancer Referrals

Overall, TWW referrals have recovered, with pandemic “shortfall” being met

However urology and lung* still have “missing” TWW referrals

*Haematology also have “missing” TWW referrals, however numbers are very small.

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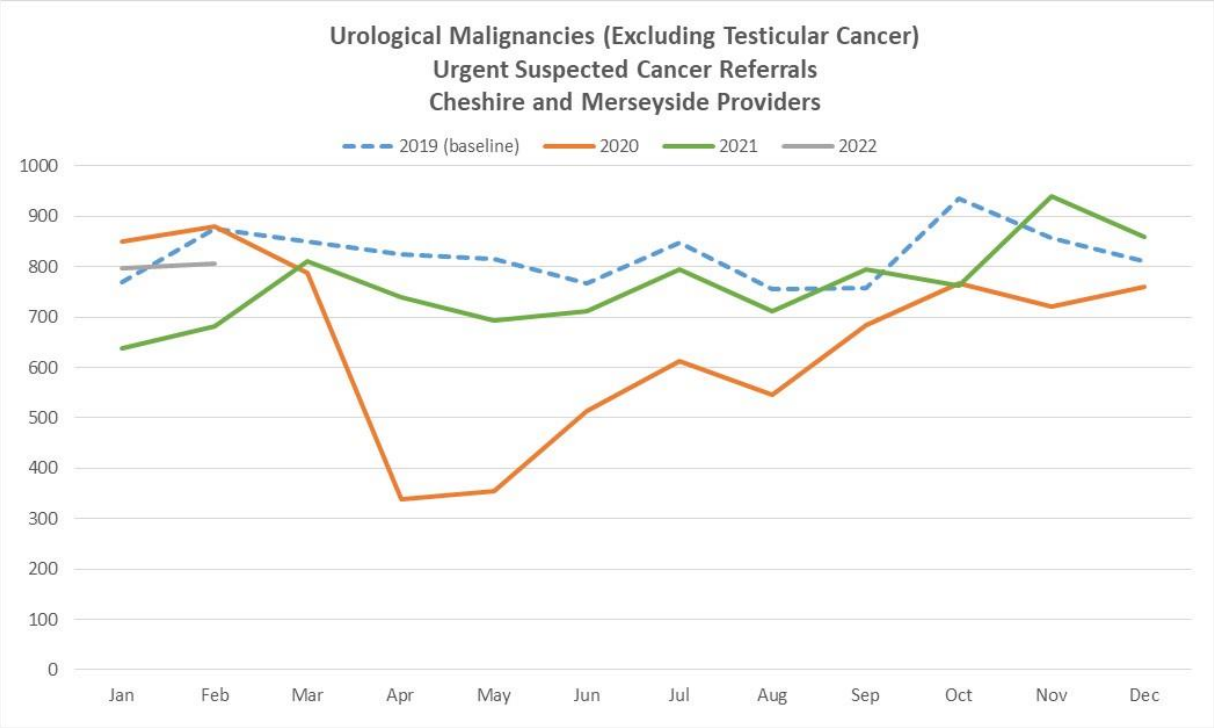
# Urology: Urgent Suspected Cancer Referrals

Potentially, just over 3,000 “missing” urology TWW referrals still

- Equivalent to almost 4 months of TWW referrals
- Only 2/24 months above pre-pandemic average
- Pre-pandemic also saw 5% growth in urology TWWs per annum

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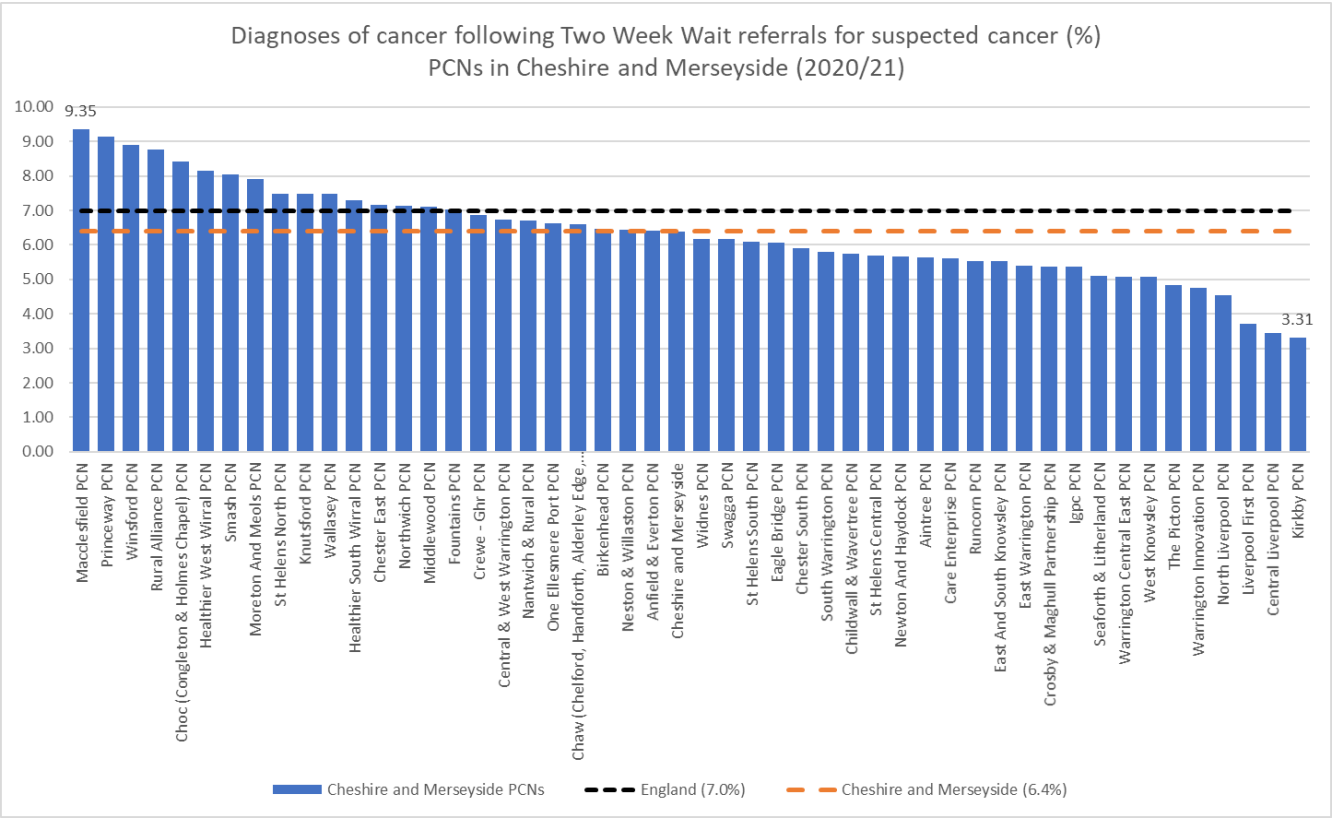
# PCN data: Urgent GP Referral conversion rates (2020/21)




- Conversion rates* range from 9.4% of urgent GP referrals in Macclesfield PCN to 3.3% on urgent GP referrals from Kirkby PCN.
- PCNs with the highest conversion rates were among the lowest referral rates.
  - Macclesfield PCN 5/50
  - Princeway PCN 10/50

* Referrals resulting in a diagnosis of cancer were identified as those TWW referrals which received a first treatment.

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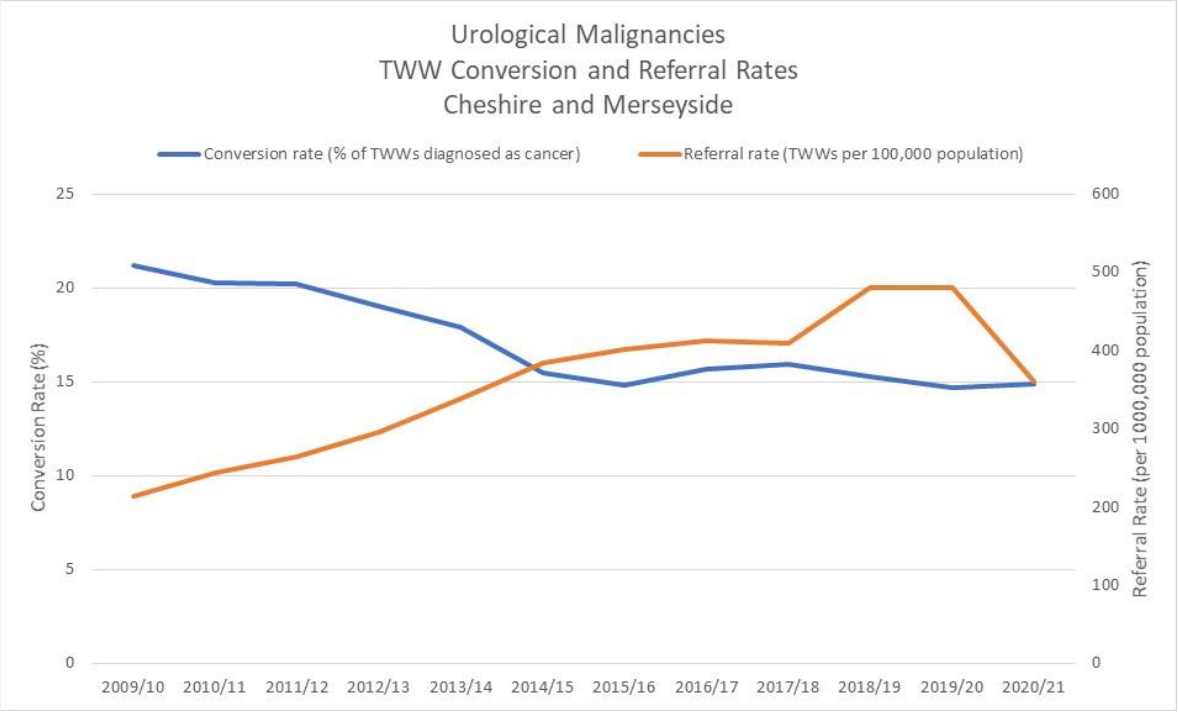
Source: PHE Fingertips, cancer Services

# Urological: Referral and Conversion Rates

Whilst the TWW referral rate fell during the pandemic (2020/21), the conversion rate remained similar

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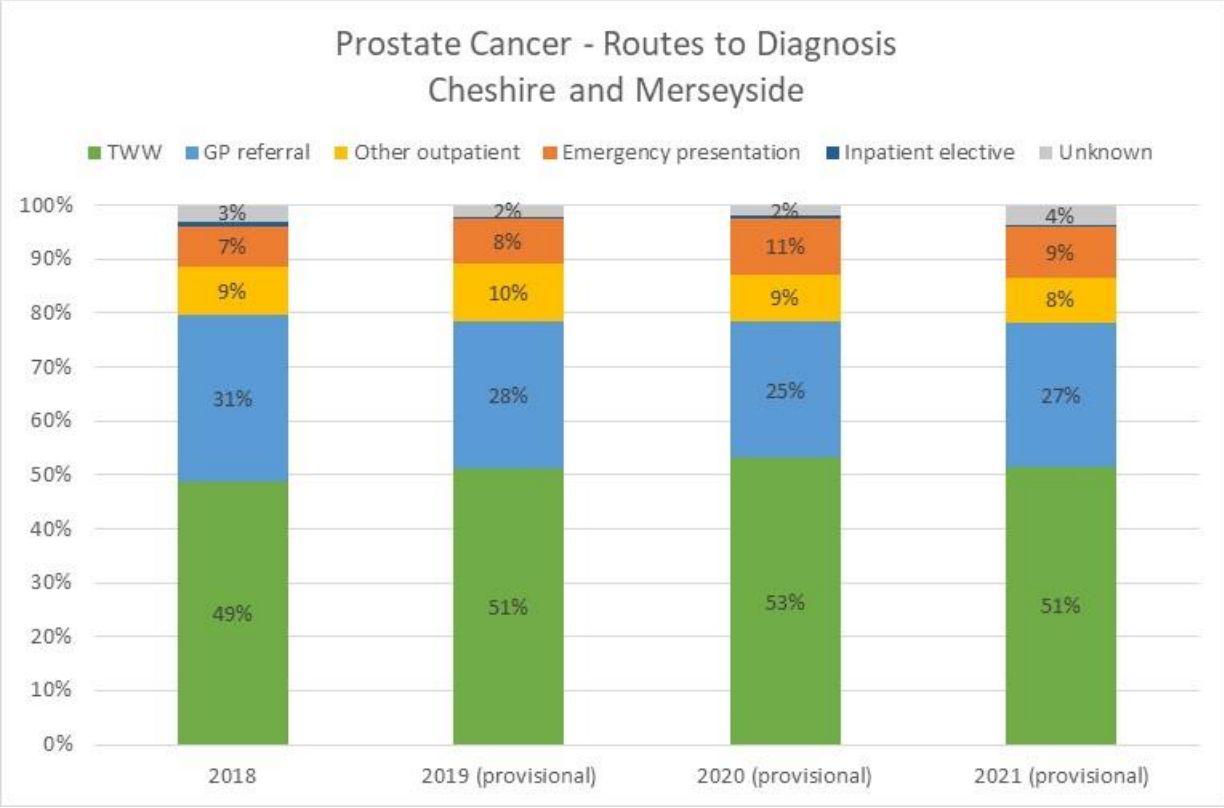
# Prostate: Routes to Diagnosis

Around half of prostate cancers are found via TWWs

- 30% via routine GP referral

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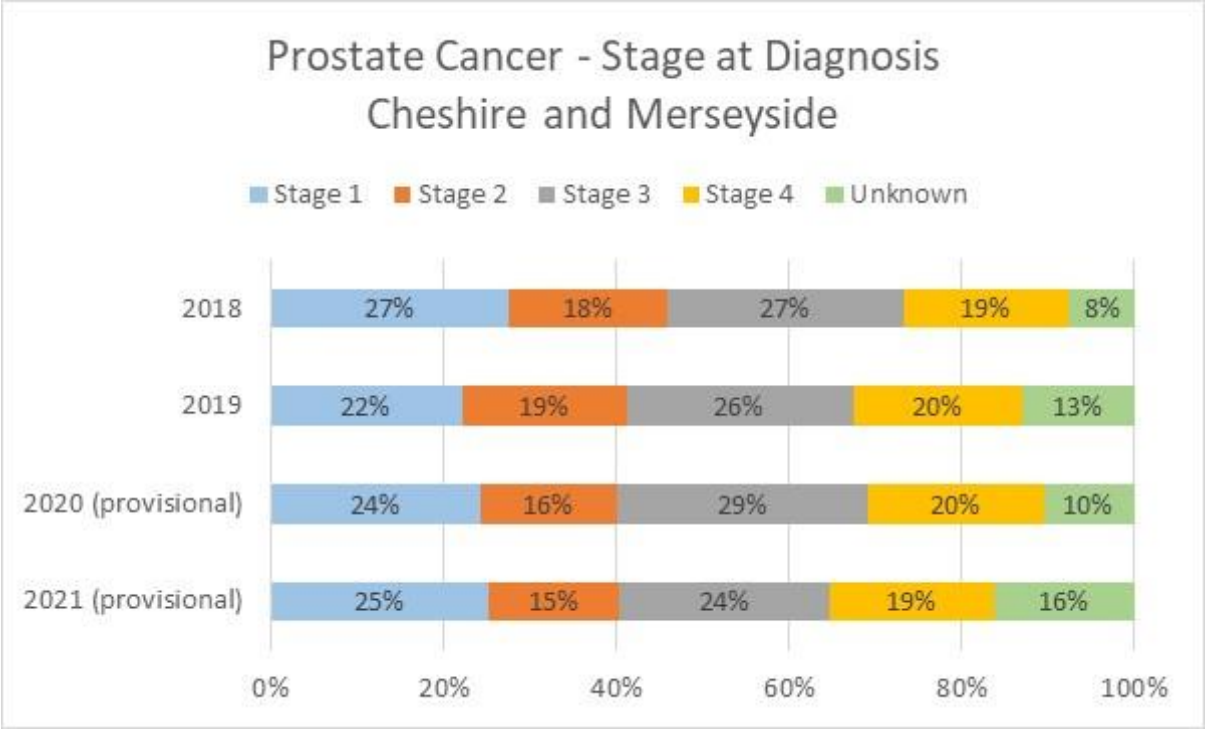
# Prostate: Stage at Diagnosis

Pandemic has not seen a shift to later diagnosis

- But could be amongst those not yet come forward
- Slight increase in “unknown” stage in 2021 (likely to be update with time)




*Please note – not comparable with previous early diagnosis slide which excluded the Unknown category.

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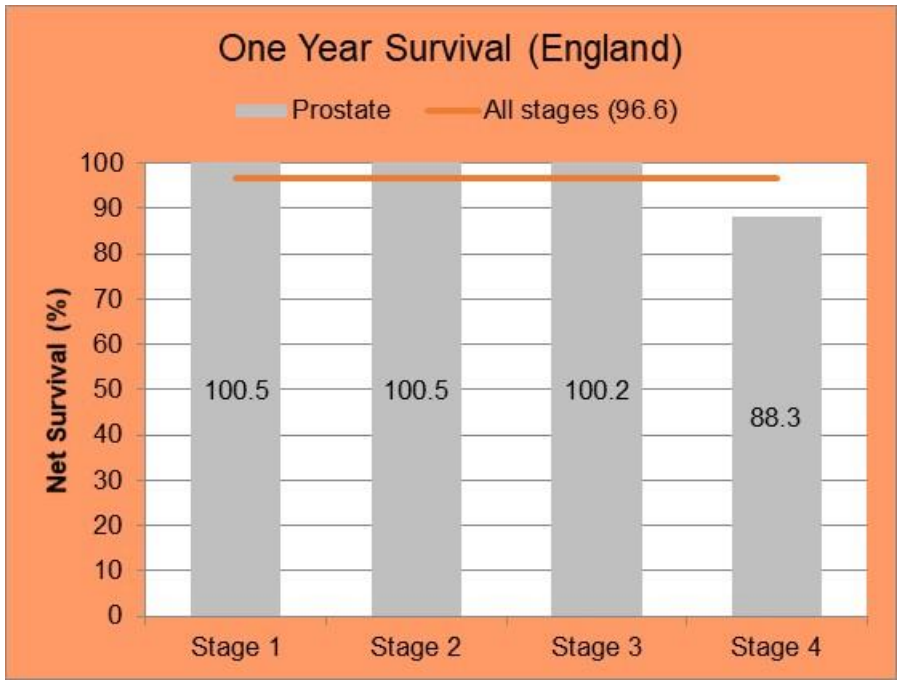
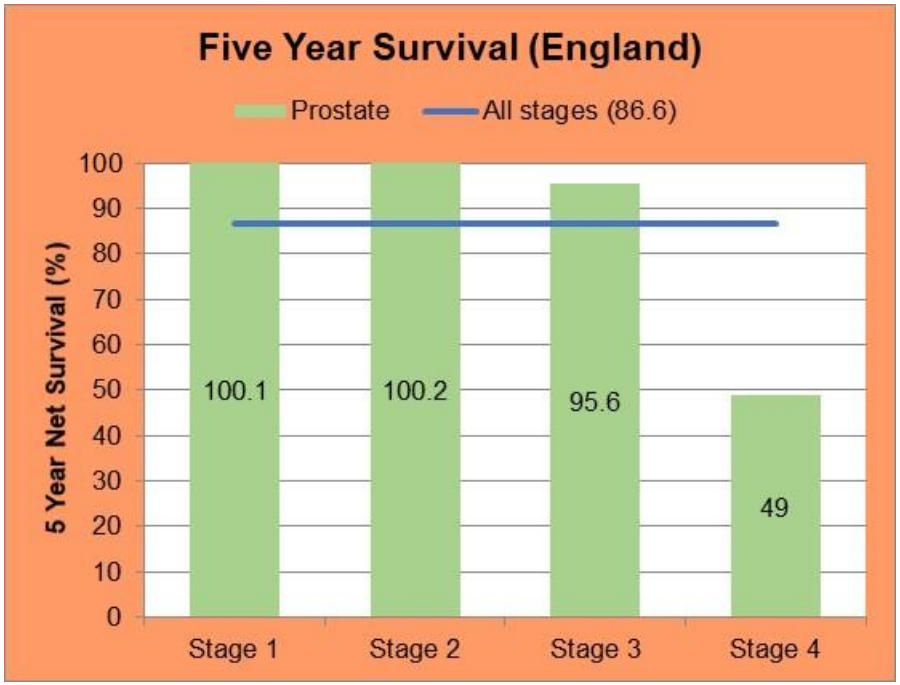
# Staging and Survival

Prostate cancer survival at one and five years is much lower for those diagnosed at stage 4 (England level data)



# PCN data: source

PCN level data within this slide set are taken from the Public Health England Fingertips tool for Cancer Services.

https://fingertips.phe.org.uk/profile/cancerservices

Data can be viewed for individual PCNs or downloaded to view multiple PCNs simultaneously.

Other levels of reporting are also available, eg CCG or Alliance level.

Full methodology and definitions of the datasets used within this report are available on the website.

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Source: PHE Fingertips, cancer Services

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# CMCA Primary Care Programme

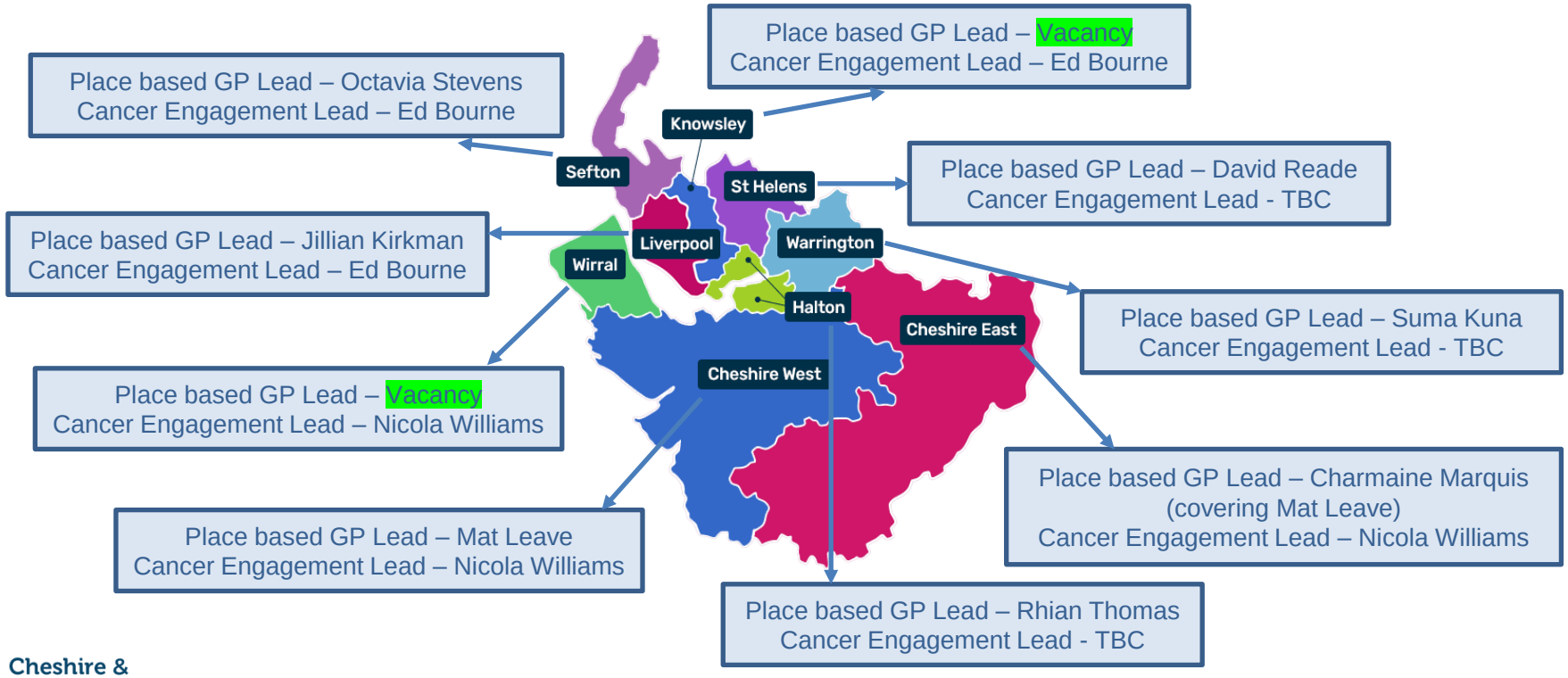
Dr Debbie Harvey

CRUK GP and Primary Care Lead CMCA

# CMCA Primary Care Programme Team

**Primary Care Clinical Lead** – Debbie Harvey

**Senior Quality Improvement Manager** – Louise Roberts

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# Aim of the Team

***To improve CMCA visibility, comms, support and collaboration with primary care***

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# CMCA Primary Care Programme Main Objectives

**PCN DES**
Support Primary Care Networks (PCNs) with the cancer element of the PCN DES and QOF; facilitating and providing practical support with implementing evidence-based interventions to achieve cancer-related objectives

**Cancer Communities of Practice**
Lead the development and implementation of three structured cancer communities of practice across Cheshire and Merseyside

**Cancer Academy**
Develop and deliver the primary care components of the new Cancer Academy which will act as a C&M repository and delivery arm for cancer education in C&M

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# CMCA GPs

Funded for 12 months

**Not** a replacement for the historic CCG GP Cancer Leads – roles are different

**Not** involved in pathway development or implementation or TLHC etc

**Not** involved in interface meetings with secondary care etc

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# Safety Netting

**The Safety Netting 2020 template created with local GPs, CMCA and iMersey has been updated and renamed**

**‘Cheshire & Merseyside Safety Netting Template’ will be available to download on the Cancer Academy website along with accompanying information**

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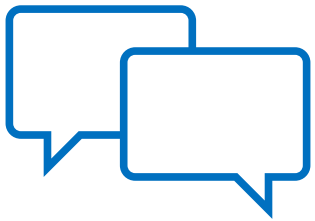
# CMCA Primary Care Programme



Get in touch via:

ccf-tr.cmcaprimarycareengagement@nhs.net

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# CMCA Cancer Academy

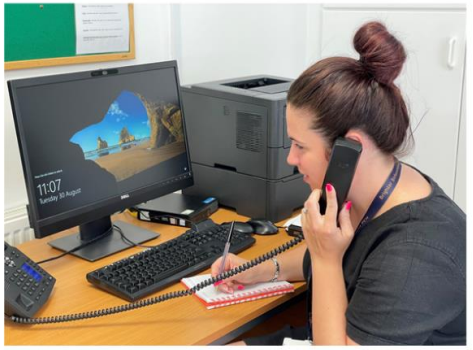
Lucy Irwin
Workforce Project Manager

The Cancer Academy

Excellence in cancer care

**For all Healthcare Professionals**

- Customised dashboard
- 60+ resources
- Digital notebook
- Events & Latest News
- Accurate information in one central place
- DES guidance, QOF & useful local pathway information



Jen Owen
Cancer Care Coordinator in Primary Care

**For Cancer Support Workers/Navigators (inc. ARRS Roles)**

**Principles in Cancer Care Programme (PCCP)**

**Access to eLearning**

**Learn & Share Forum**

We want to hear from you...
Email: ccf-tr.canceracademy@nhs.net
Or via 'contact us' page

https://www.canceracademy.nhs.uk/

Cancer_Academy

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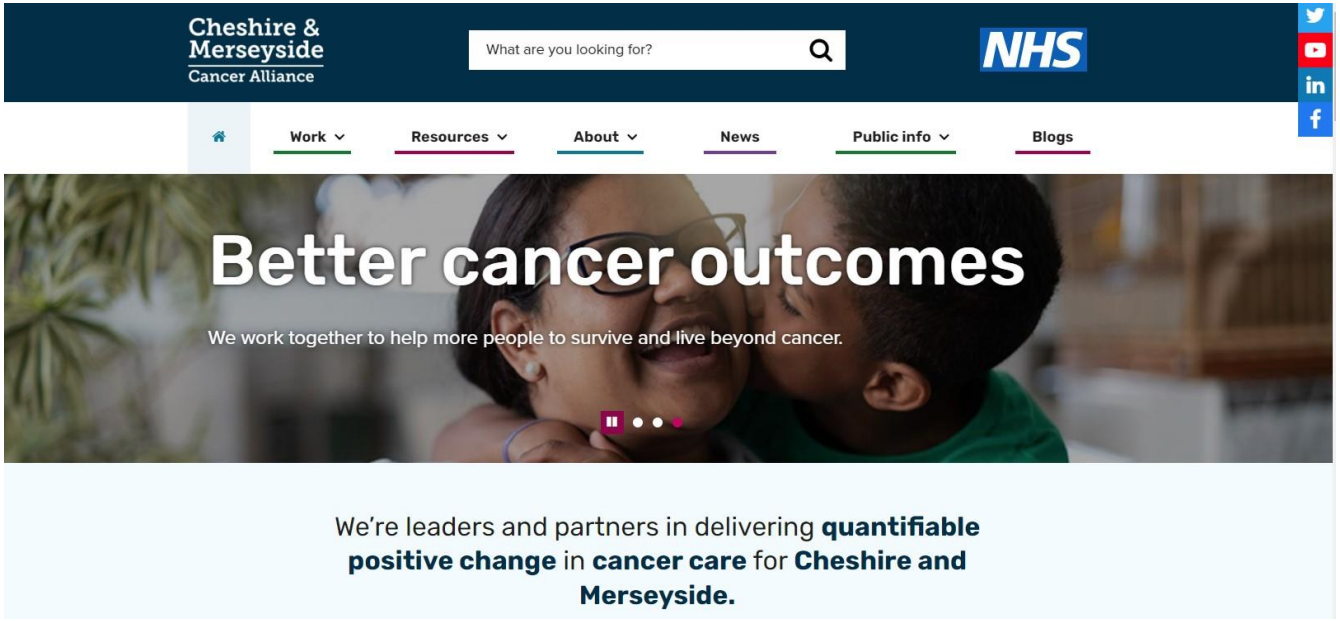
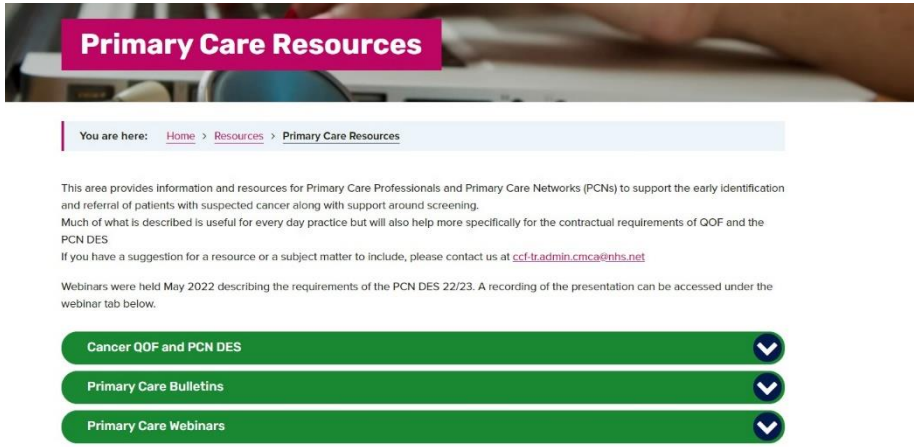
# CMCA Website

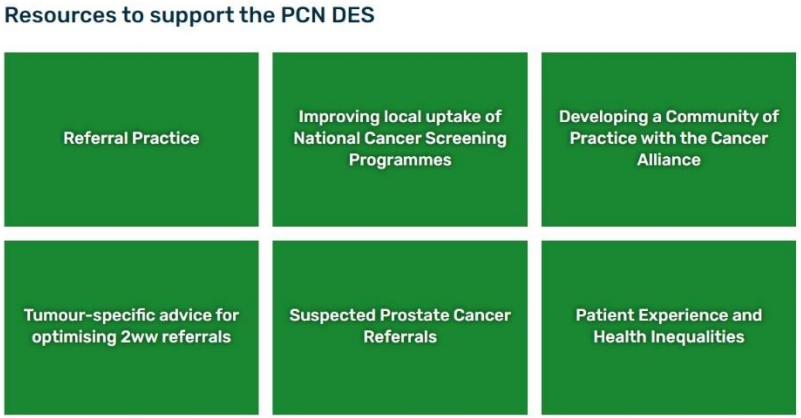
Paul Ogden

Communications Manager

# CMCA website and Primary Care resources



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# Health Inequalities & Patient Engagement (HIPE)

Jenny Brazier

Programme Admin Assistant & Patient Engagement Lead

# Making Health Inequality and Patient Experience (HIPE) Everybody's Business

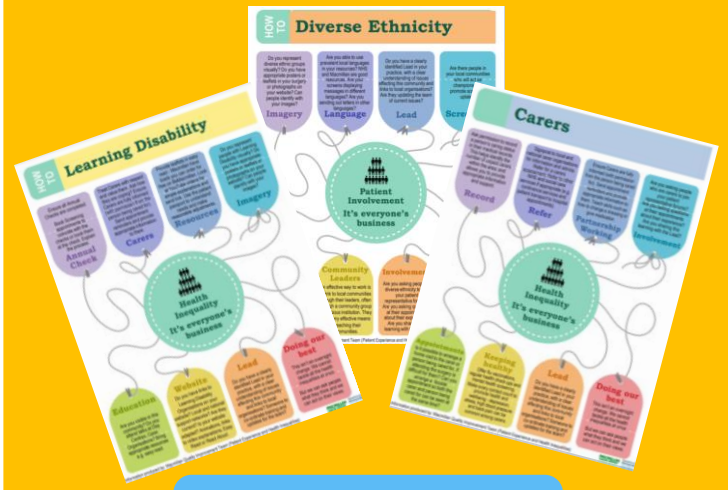
Cheshire & Merseyside Cancer Alliance

MACMILLAN CANCER SUPPORT

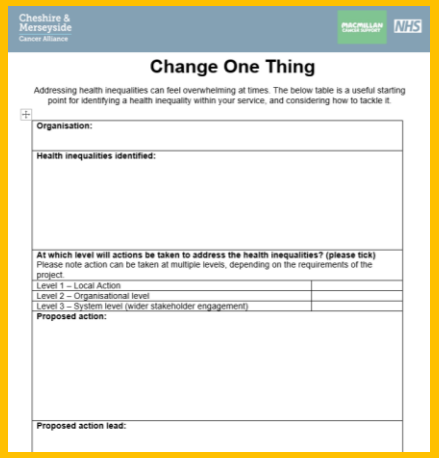
# Tools and Resources

**PCNs are required to nominate a Health Inequalities Lead**

We have created materials of an extremely high standard, to support colleagues, and to infiltrate the project management process with gateways relating to patient engagement and health inequality.




1,700+ downloads during 2021/22


Cheshire & Merseyside Cancer Alliance

MACMILLAN CANCER SUPPORT

# Health Inequalities Staff Network

## 20+ members across Cheshire & Merseyside, and growing

- Primary Care
- Hospital Trusts
- Integrated Care Boards
- Women's Health and Maternity Programme

**HIPE team**

ccf-tr.hipe@nhs.net

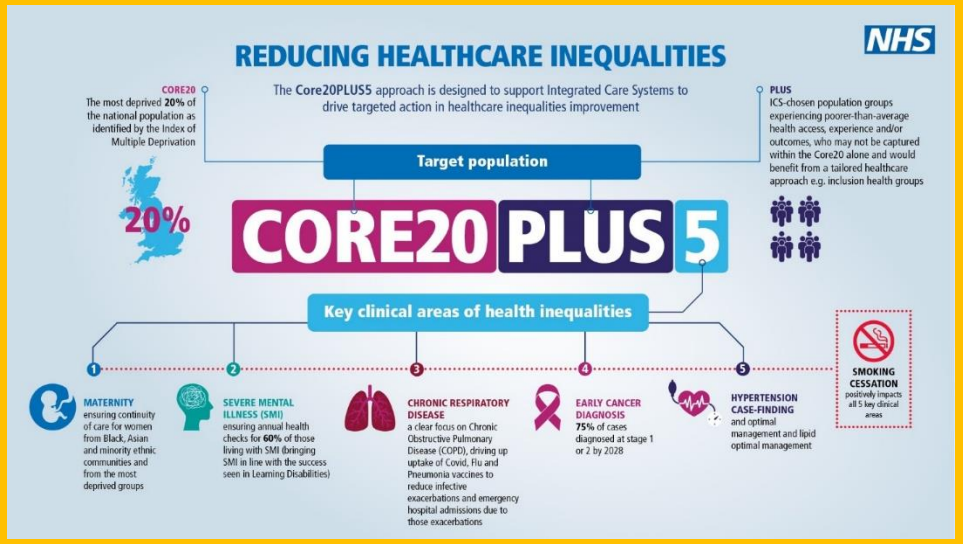
- Brings together NHS colleagues from across Cheshire and Merseyside who have an interest in tackling health inequalities.
- Provides a platform to share updates and best practice in addressing health inequalities and improving patient experience within cancer services.
- Offers support from the Cheshire & Merseyside Cancer Alliance, and enables colleagues to seek feedback from others.

Cheshire & Merseyside Cancer Alliance

MACMILLAN CANCER SUPPORT

# OUR WORK

- Patient and Public Involvement Policy – NEW!
- HIPE champions within CMCA
- Embedding HIPE into our projects from the beginning
- Training the health inequalities staff network on our HI workshop
- Roadshows
- Healthwatch
- Core20PLUS5 – Jo is 1 of 100 ambassadors

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# Useful Links

**RCGP Training Course -** Summary of Health Inequalities (rcgp.org.uk)

**HIPE Tools and Resources -** https://www.cmcanceralliance.nhs.uk/resources/introduction/primary-care-resources/patient-experience-and-health-inequalities

**Core20PLUS5 -** NHS England » Core20PLUS5 – An approach to reducing health inequalities

**NHS DES requirements -** B1366-tackling-neighbourhood-health-inequalities-supplementary-guidance-v1.1.pdf (england.nhs.uk)

**HIPE team**

Jo Trask, Nicola Shaw and Jenny Brazier

ccf-tr.hipe@nhs.net

Cheshire & Merseyside Cancer Alliance

NHS

# Symptomatic FIT

Anna Murray

Senior Programme Manager

Cheshire & Merseyside Cancer Alliance

NHS

# Supporting LGI Urgent Suspected Cancer Referrals and patient diagnosis:

## Symptomatic FIT and other key points for change

Version 0.2 28th October 2022

***FIT is superior to symptoms in predicting pathology in patients with suspected colorectal cancer symptoms'***

**De'Souza et al., 2021**

# Why is FIT testing changing?

Joint guidance from British Society of Gastroenterology (BSG) and Association of Coloproctology of Great Britain & Ireland (ACPGBI) published May 2022.

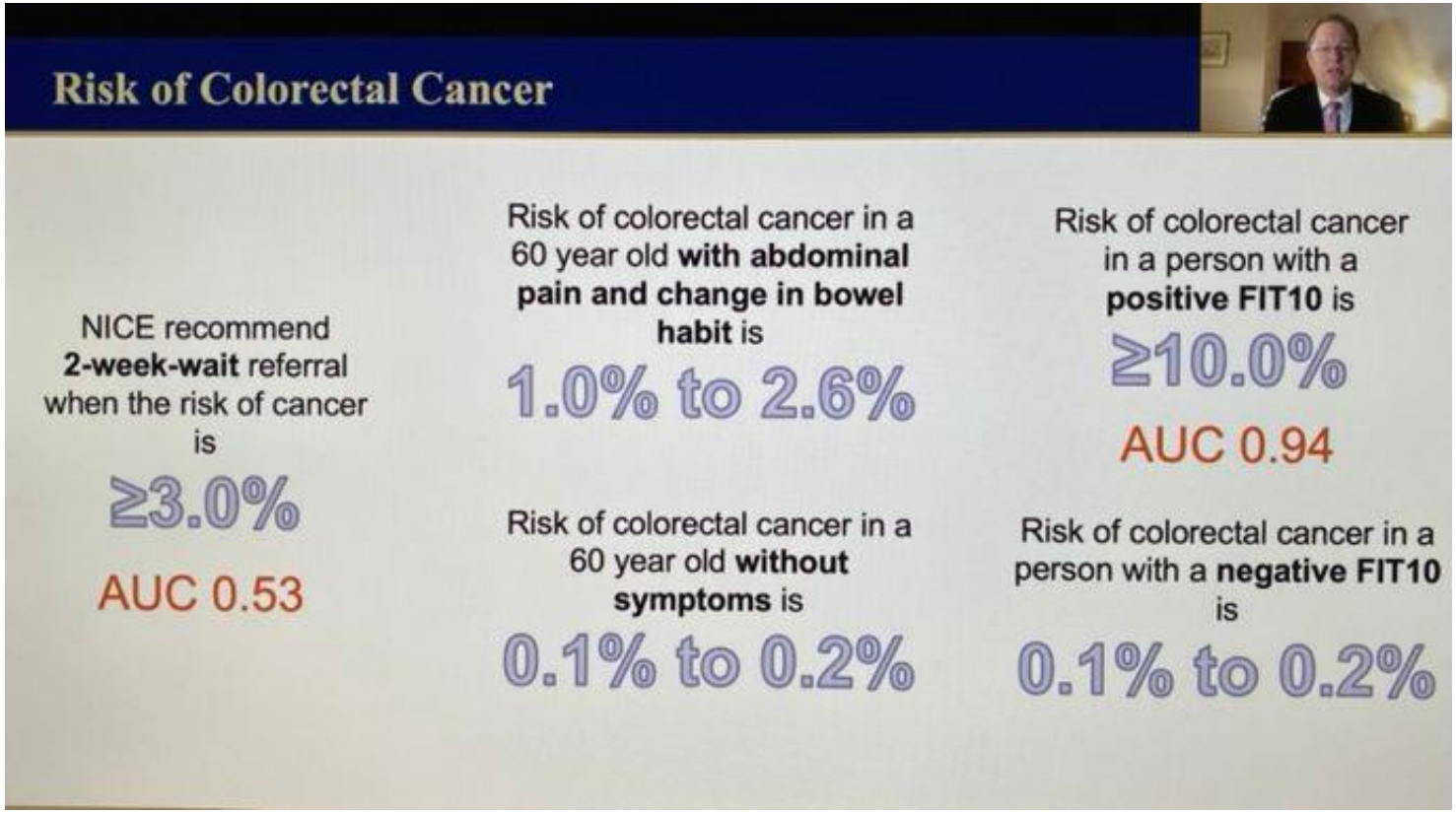
- FIT should be used for adults aged 18 years or over who present with symptoms of a suspected colorectal cancer.
- FIT should be used by primary care clinicians to prioritise patients with clinical features of colorectal cancer for referral for urgent investigation.
- A FIT threshold of fHb ≥10µg Hb/g **EXCEPT** in the case of patients with unexplained IDA where an urgent referral is recommended, and FIT test requested simultaneously.
- Patients with persistent/recurrent anorectal bleeding should be referred on an urgent suspected LGI cancer referral (LGI TWW) for flexible sigmoidoscopy if fHb <10µg Hb/g.
- Patients with a fHb <10µg Hb/g but with persistent and unexplained symptoms for whom the GP has ongoing clinical concern should be referred to secondary care for evaluation.
- Where no FIT result can be obtained, clinicians should use existing national and local guidelines to assess risk of colorectal cancer.
- Patients who decline to return a FIT test should be counselled that evaluation of their symptoms is incomplete and be encouraged to complete their test.
- Clinicians should follow up patients with no FIT result to encourage them to return a sample or, where the kit has been lost or inadequately submitted, offer a further test.

# Why is FIT testing changing?

- NHS England and North West NHS Regional Team letters – Supporting changes to FIT; superseding NG12 guidance.


- Learning from evaluations in Cheshire & Merseyside and further evidence for FIT for Iron Deficiency Anaemia (IDA).
- Key points:
  - The negative predictive (NPV) value of FIT is 99.7% at a cut-off of 10µg.
  - FIT testing provides a high level of assurance to patients with negative results AND no IDA**.**
  - A study showed that 90% of patients found it easy to complete and over two thirds of patients preferred it to colonoscopy
  - C&M will continue to use unexplained IDA as a key risk factor for patients with a FIT <10µg. A study by Hunt et al. (2022) showed ALL 7 of 18,000 patients with CRC had IDA.
  - People with FIT <10mcg/g threshold, without IDA or weight loss or abnormal abdominal/ rectal examination, have a risk of colorectal cancer less than the background population risk.
  - Colonoscopy has a miss rate of approximately 7.5% and is an invasive procedure for patients. FIT will support efforts to ensure only those who really need a colonoscopy, have one.

# Why is FIT testing changing?

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# What is happening in C&M?

We fully recognise the challenges that Primary Care are experiencing and there is no expectation that individual practices will implement the required changes in isolation and indeed we would advise against doing this.

Cancer Alliances are coordinating implementation and working collaboratively with stakeholders:

- Criteria and pathway guidance for FIT testing
- Information concerning safety netting by clinicians and clinical teams.
- Provision of standardised patient information and advice materials
- Provision of guidance where patients have not returned a FIT AND there is ongoing clinical concern.
- Provision of Two Week Wait referral forms
- Ensuring continued adherence to Cancer Waiting Times Guidance (section 2.5), which states if a consultant thinks the two week wait referral is inappropriate this should be discussed with the referrer. Only the referrer can downgrade or withdraw a referral. **A TWW referral must not be rejected**.

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# What areas are beginning to implement now?

**Areas are based on Trust catchments:**

**Phase 1:**

- St Helens & Knowsley Teaching Hospitals NHS Foundation Trust – 03/04/2023
- Warrington & Halton NHS Foundation Trust – 03/04/2023
- East Cheshire NHS Trust – TBC estimate March
- Mid Cheshire Hospitals NHS Foundation Trust – TBC estimate March
- Wirral University Teaching Hospital NHS Foundation Trust – TBC estimate March

**Improvement Trusts:**

- Liverpool University Hospitals NHS Foundation Trust
- Southport & Ormskirk NHS Trust
- Countess of Chester NHS Foundation Trust

**This will REPLACE the current NG12 and DG30 guidance in your area and affects all patients aged 18 years and above with suspected LGI cancers.**

Cheshire & Merseyside Cancer Alliance

# References

**This presentation and the Symptomatic FIT Pathway have been informed by the following guidance and key evidence:**


ACPGBI, BSG and BSGAR 10th April 2020 Joint ACPGBI, BSG and BSGAR considerations for adapting the rapid access colorectal cancer pathway during COVID-19 pandemic

Bailey, S.E.R., Abel, G.A.; Byford, R.; Davies, S-J; Mays, J.; McDonald, T.J.; Neck, C.; Renninson, J.; Thomas, P; Walter, F.M.; Warren, S. & Hamilton, W. (2021) Diagnostic performance of a faecal immunochemical test for patients with low-risk symptoms of colorectal cancer in primary care: an evaluation in the South West of England. *British Journal of Cancer* **volume 124**, pages1231–1236

British Society of Gastroenterology Updated on: 03 Mar 2021 First published on 10 Apr 2020. Joint ACPGBI, BSG and BSGAR considerations for adapting the rapid access colorectal cancer pathway during COVID-19 pandemic

British Society of Gastroenterology 3rd April 2020; last updated 6th April 2020. Endoscopy activity and COVID-19: BSG and JAG guidance – update

British Society of Gastroenterology updated 3rd April 2020. GI Endoscopy Activity and COVID-19: Next steps

British Society of Gastroenterology updated 17th April 2020. Service Recovery Documents: The What, When and How

Chapman, C.; Bunce, J.; Oliver, S.; Ng, O.; Tangri, A.; Rogers, R.; Logan, R.; Humes, D. and Banerjea, A. (2019) Service evaluation of faecal immunochemical testing and anaemia for risk stratification in the 2-week-wait pathway for colorectal cancer. *BJS Open, 3(3): 395-402, doi: 10.1002/bjs5.50131. eCollection 2019 Jun.*

Chen, Y.; Chen, L.; Deng, Q.; Zhang, G.; Wu, K; Ni, L; Yang, Y.; Liu, B.; Wei, C.; Yang, J.; Ye, G. and Cheng, Z. (2020) The presence of SARS-Cov-2 RNA in the feces of COVID-19 patients. *Journal of Medical Virology,* DOI: 10.1002/jmv.25825

Cheshire & Merseyside Cancer Alliance (2022) High-Risk FIT in Cheshire & Merseyside: Prioritising Lower GI Two-Week Wait Patients

D'Souza, N.; Delisle, T.G.; Chen, M.; Benton, S and Abulafi, M. (2021) Faecal immunochemical test is superior to symptoms in predicting pathology in patients with suspected colorectal cancer symptoms referred on a 2WW pathway: a diagnostic accuracy study. *Gut Published Online First: 21 October 2020. doi: 10.1136/gutjnl-2020-321956*

Health and Safety Executive (2020) Rapid Evidence Review: Review of personal protective equipment provided in health care setting to manage risk during the coronavirus outbreak.

Hunt N, Rao C, Logan R, Chandrabalan, V.; Oakey, J.; Ainsworth, C.; Smith, N.; Banjaree, S & Myers, M. (2022) A cohort study of duplicate faecal immunochemical testing in patients at risk of colorectal cancer from North-West England *BMJ Open*;**12:**e059940. doi: 10.1136/bmjopen-2021-059940


Cheshire & Merseyside Cancer Alliance

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Lazlo, H.E.; Seward, E; Ayling, R.M.; Lake, J.; Malhi, A.; Stephens, C.; Pritchard-Jones, K.; Chung, D.; Hackshaw, A & Machesney, M. (2022) Faecal immunochemical test for patients with 'high-risk' bowel symptoms: a large prospective cohort study and updated literature review. *Br J Cancer* **126,** 736–743 (2022). https://doi.org/10.1038/s41416-021-01653-x

Mole, G.; Withington, J. and Logan, R. (2019) *Clinical Medicine, Conference Report, 19(3):196-9ast, J.E.; Kleijnen, J.; Machensney, M.; Pettman, M.; Pipe, J.; Saker, L.; Stephenson, J. & Steele, R.J.C.*

Monahan, K.J.; Davies, M.M.; Abulafi, M.; Banerjea, A.; Nicholson, B.; Arasaradnam, R.; Barker, N.; Benton, S.; Booth, R.; Burling, D.; Carten, R.; D'Souza, N.; East, J.; Kleijnen, J.; Machesney, M.; Pettman, M.; Pipe, J.; Saker, L.; Sharp, L.; Stephenson, J. and Steele, R. (2022) Faecal Immunochemical Testing (FIT) in patients with signs or symptoms of suspected colorectal cancer (CRC): A joint guideline from the Association of Coloproctology of Great Britain & Ireland (ACPGBI) and the British Society of Gastroenterology (BSG): Executive Summary.

Monahan, K.J.; Davies, M.M.; Abulafi, M.; Banerjea, A.; Nicholson, B.; Arasaradnam, R.; Barker, N.; Benton, S.; Booth, R.; Burling, D.; Carten, R. V.; D'Souza, N.; East, J. E.; Kleijnen, J.; Machesney, M.; Pettman, M.; Pipe, J.; Saker, L.; Sharp, L.; Stephenson, J. and Steele, R. (2022). Faecal immunochemical testing (FIT) in patients with signs or symptoms of suspected colorectal cancer (CRC): a joint guideline from the Association of Coloproctology of Great Britain and Ireland (ACPGBI) and the British Society of Gastroenterology (BSG). 0:1–24. doi:10.1136/gutjnl-2022-327985

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National Institute of Clinical Excellence (NICE), DG30, published 26th July 2017. Quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care

NHS England and NHS Improvement. 2020. Letter to Cancer Alliance. 19th March 2020

NHS England 23 March 2020 Version 2 Speciality guides for patient management during the coronavirus pandemic: Clinical guide for the management of non-coronavirus patients requiring acute treatment: Cancer. Publications approval reference: 001559.

NHS England 02 April 2020 Version 1 Speciality guides for patient management during the coronavirus pandemic: Clinical guide for the management of patients requiring endoscopy during the coronavirus pandemic. Publications approval reference: 001559.

NHS England 24 April 2020 Version 1 Speciality guides for patient management during the coronavirus pandemic: Clinical guide for triaging patients with suspected colorectal cancer. Publications approval reference: 001559


Cheshire & Merseyside Cancer Alliance

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NHS England 04 June 2020 Version 1 Speciality guides for patient management during the coronavirus pandemic: Clinical guide for triaging patients with suspected colorectal cancer. Publications approval reference: 001559

NHS England 22nd February 2022 Version 3. 2022/23 priorities and operational planning guidance. Publication approval reference: BPAR1160.

NHS England, Letter to all GP Practices in England and Primary Care Network Clinical Directors, 1st March 2022. General practice contract arrangements in 2022/23

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Penman, I; Rees, C. (2020) British Society of Gastroenterology guidance on recommencing gastrointestinal endoscopy in the deceleration and early recovery phases of COVID-19 pandemic. Guidance developed by: BSG Endoscopy Committee, BSG Endoscopy Quality Improvement Programme, Endorsed by the BSG Executive

Souza, N.D.; Delisle, T.G.; Benton, S.; Chen, M.; Abulafi, M.; NICE FIT Study Investigators (2020) FIT can rule out colorectal cancer in patients with high risk symptoms? Diagnostic Accuracy Results of the Faecal Immunochemical Test in 9822 patients in the NICE FIT study. Colorectal Disease; BJS Prize Session; https://doi.org/10.1111/codi.15167

Westwood, M.; Lang, S.; Armstrong, N.; van Turenhout, S.; Cubiella, J.; Stirk, L.; Corro Ramos, I.; Luyendijk, M.; Zaim, R.; Kleijnen, J. and Fraser, C. (2017) Faecal immunochemical tests (FIT) can help to rule out colorectal cancer in patients presenting in primary care with lower abdominal symptoms: a systematic review conducted to inform new NICE DG30 diagnostic guidance. *BMC Medicine, 15:189, DOI 10.1186/s12916-017-0944-z*

Cheshire & Merseyside Cancer Alliance

NHS

# Non-Specific RDS

Sarah Griffiths

Senior Project Manager

# Eastern Sector Rapid Diagnostic Pathway (ESRDP):

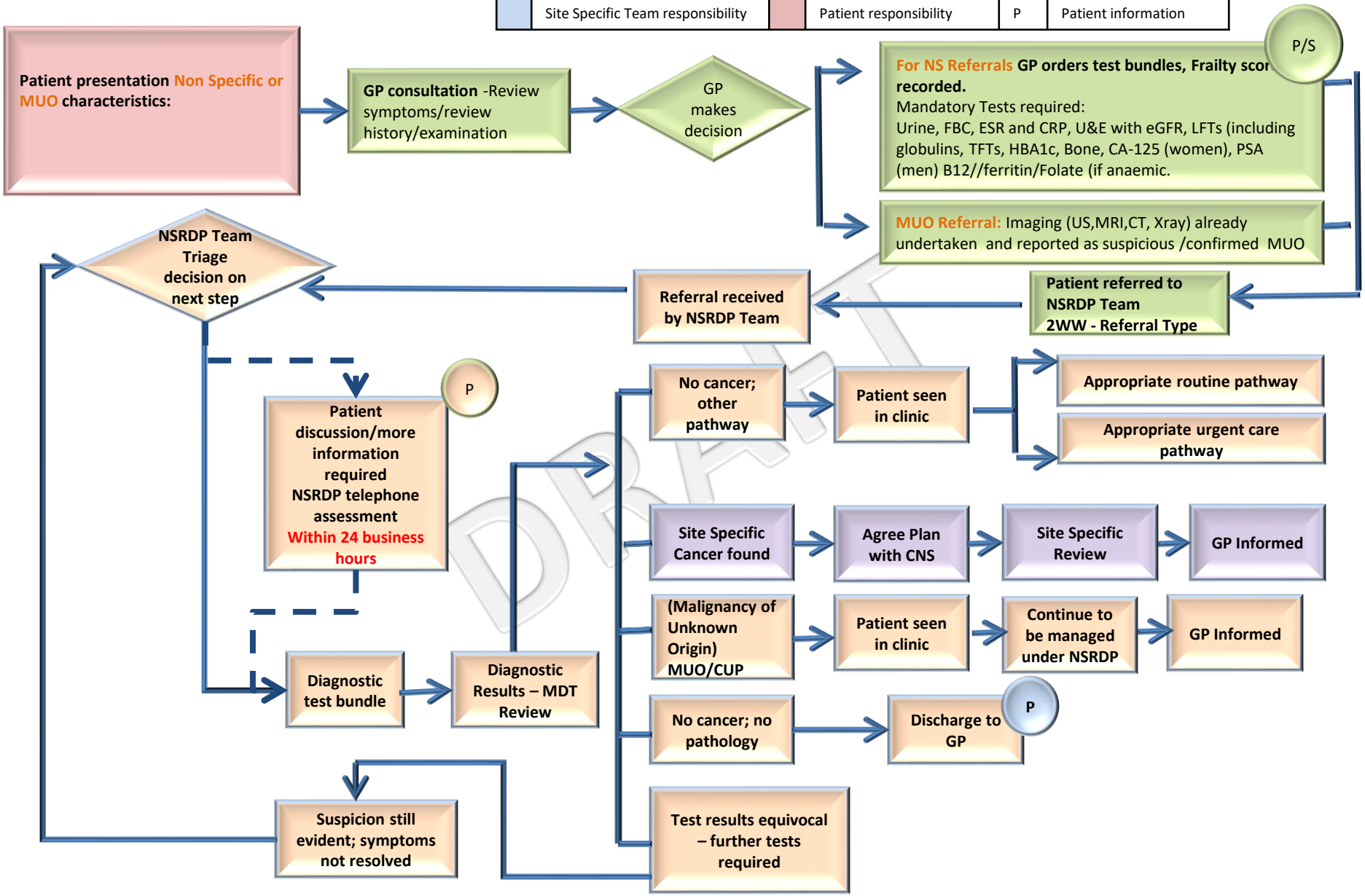
## Non-specific Symptoms & MUO Pathway

### Version 0.6 May 2020

Cheshire & Merseyside Cancer Alliance

NHS St Helens and Knowsley Teaching Hospitals NHS Trust

| | | | | | |
|---|---|---|---|---|---|
| | Primary care responsibility | | NSRDP responsibility | S | Safety netting |
| | Site Specific Team responsibility | | Patient responsibility | P | Patient information |



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NHS

# Suspected Cancer Templates

Dr Cathy Hubbert

# Cheshire and Merseyside Suspected Cancer Templates

Cathy Hubbert Oct 22

# Suspected Cancer Referral Forms

- Update suspected cancer (2ww) referral forms in consultation with Tumour Specific CQGs and 1ry Care CQG
- Standard information requested – though each Place can add an extra line if local pathways differ *e.g. Southport offer to screen men with suspected Penile cancer so they don't need to travel to specialist centre in Arrowe Park*
- In process of being made EMIS friendly by Informatics Merseyside, then will be offered to other IT providers including System One areas
- Final check with each Place Cancer Lead that will work for their area

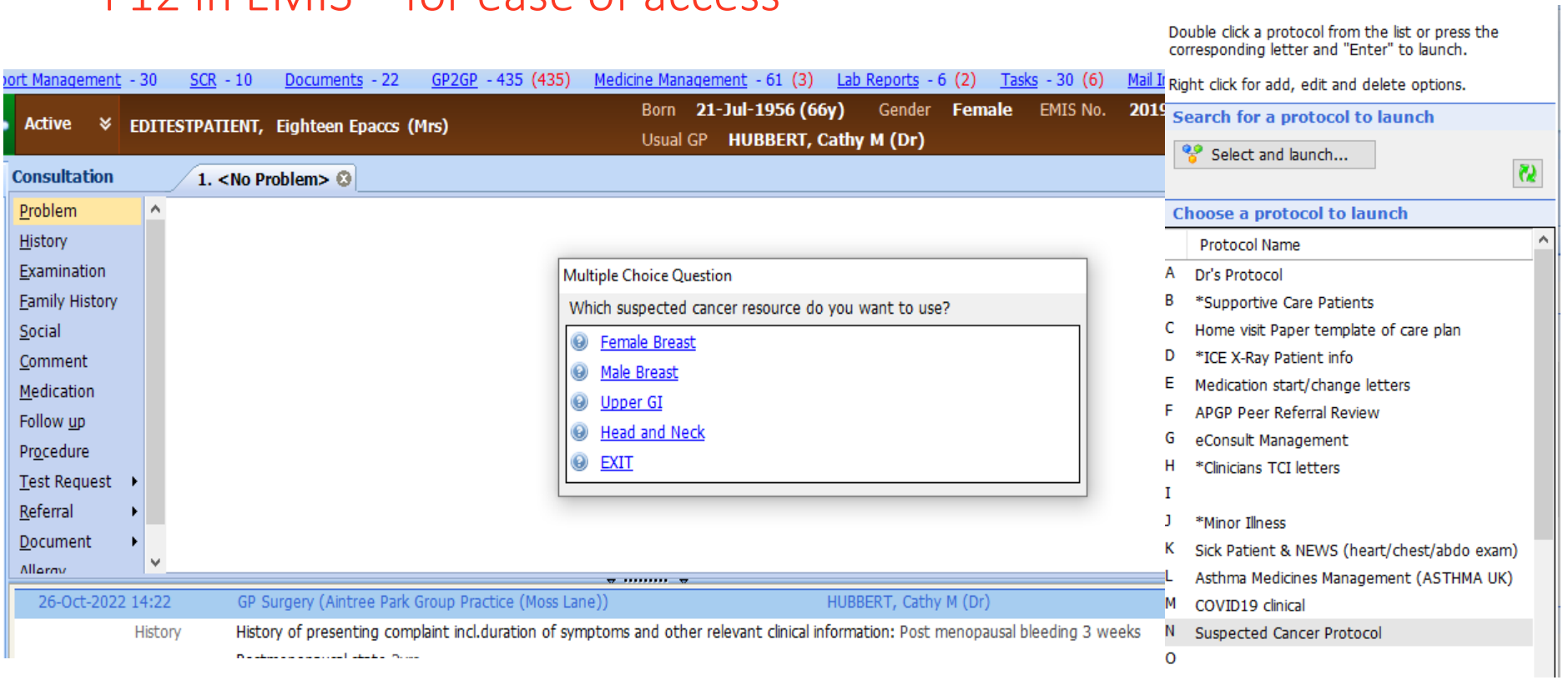
# Templates

- Developed in EMIS with Primary Care IT
- Can be used in consultation  to check if symptoms/signs meet NG12 criteria
- Prompts to include information required to enable patient journey is as smooth as possible
- Wherever possible information is coded so as much of the referral form as possible  is complete
- Templates will be offered to  all GP practices via IT  providers and can be adapted for System One

# Challenges …… IT!!

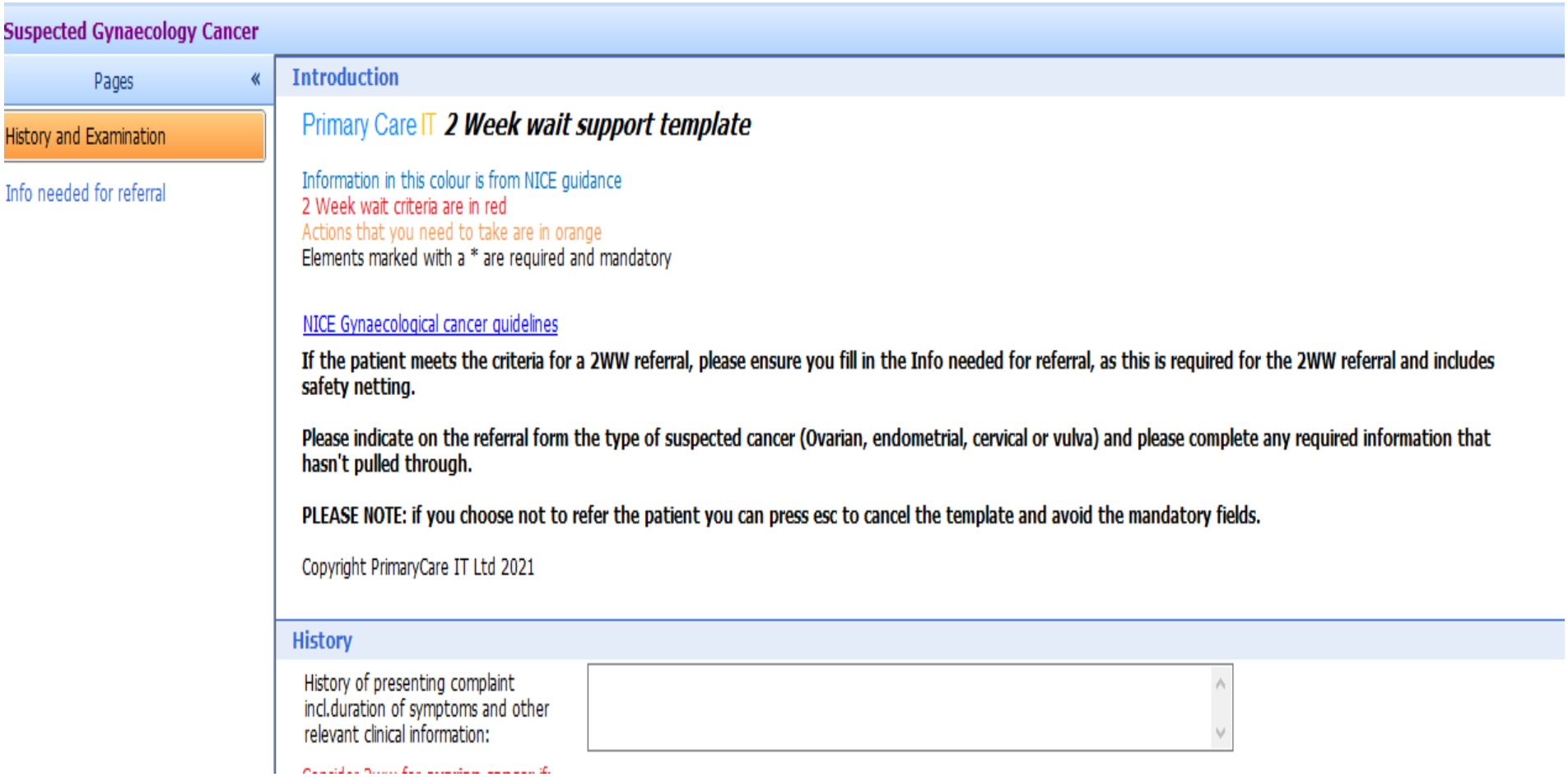
- Not everything we wish to capture has a Snomed code – so still some blanks to fill
- Not everyone in C and M on EMIS - System One lends itself more readily to templates so focus has been on developing in EMIS
- Some areas use Accenda/Gateway where forms are completed in ERS, using templates may not avoid duplication, but forms will be updated in line with C &M
- Delay in "Resource Publisher" roll out – so that forms and templates will need to be imported into each Practice's system. Protocols which link the form to the template have to be built in each Practice's system.
- Not everyone will use templates so forms have to work as stand alone documents too

# F12 in EMIS – for ease of access




All tumour sites' templates can be added

# e.g. Gynae cancer a possibility  choose suspected gynae cancer  template



NG12

Consider 2ww for **ovarian cancer** if:

- Ascites +/- pelvic or abdominal mass (which is not obviously uterine fibroids)
- Patient has ultrasound suggestive of ovarian cancer and results are attached

Please perform CA125 urgently if not already done.

Consider 2ww for **endometrial cancer** if:

- Post menopausal bleeding (>12 months amenorrhoea)
- USS indicates possible endometrial cancer (any age)
- CT indicates possible endometrial cancer (any age)

Consider 2ww for **cervical cancer** if:

- Appearance of their cervix on examination is consistent with cervical cancer. Take a smear if due but do not delay referral if concerned

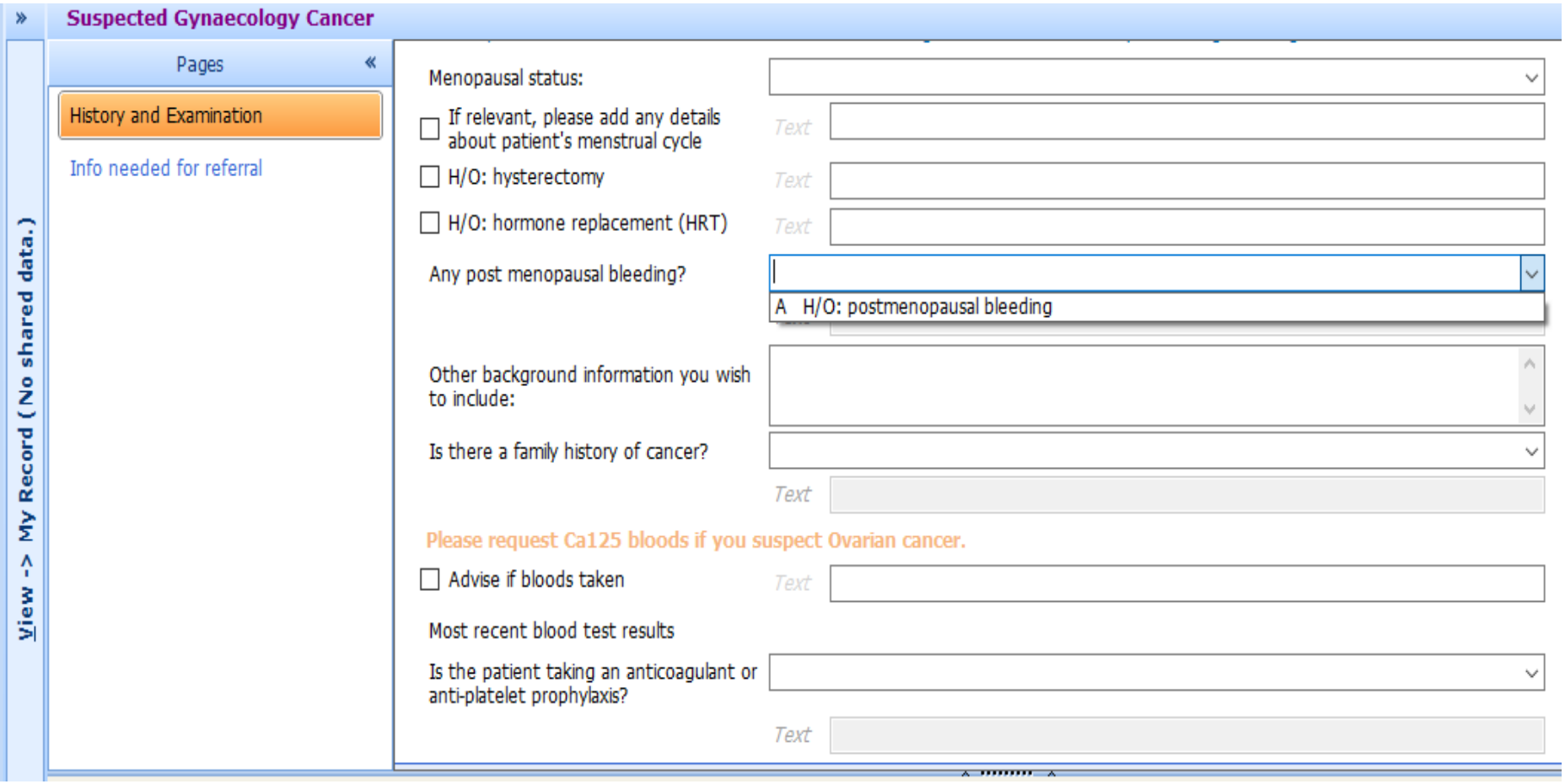
Consider 2ww for **vulva/vagina** cancer if:

- Unexplained vulval lump, ulceration or bleeding
- Unexplained palpable mass in or at the entrance to the vagina

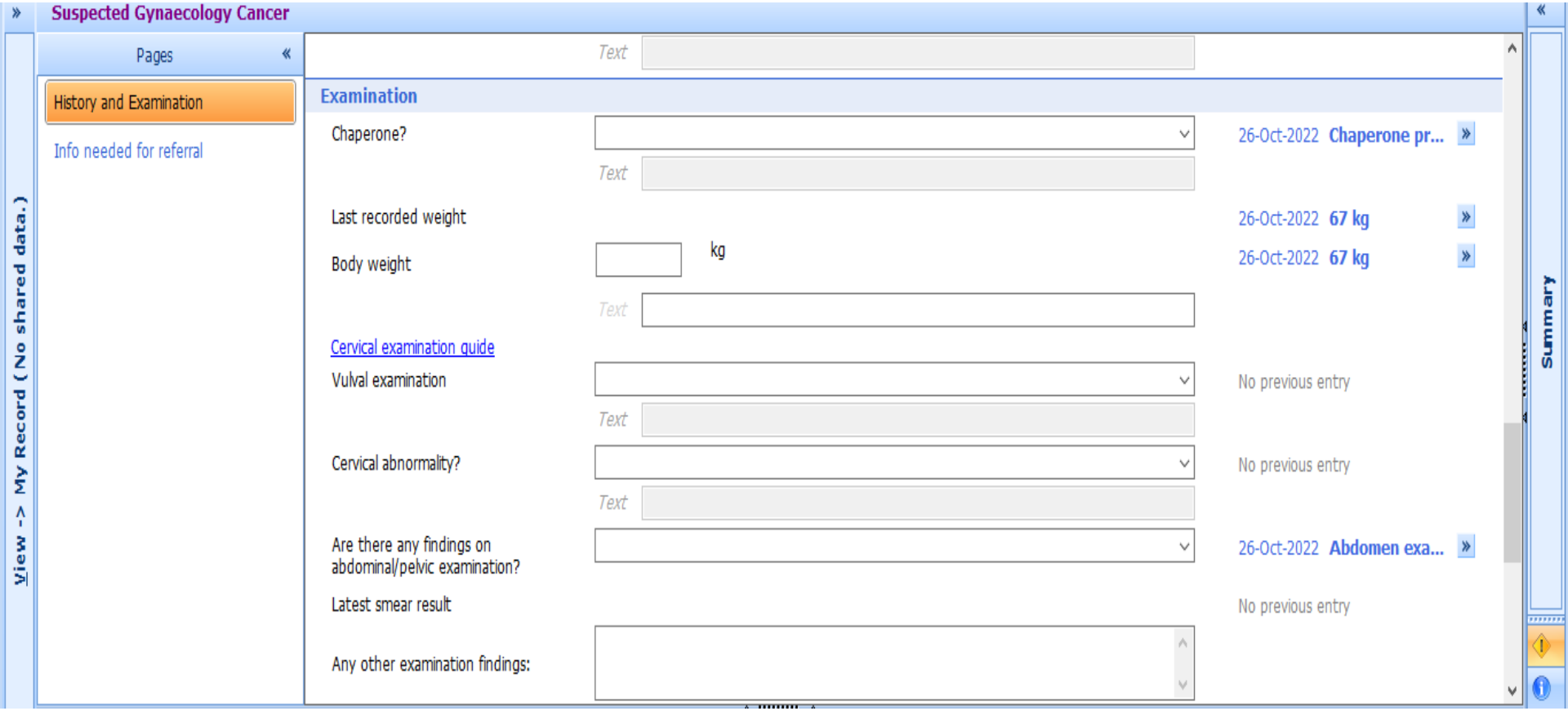
Organise a trans-vaginal scan for patients > 55 years with unexplained symptoms of vaginal discharge who:

- are presenting with these symptoms for the first time or
- have thrombocytosis or
- report haematuria or visable haematuria and low haemoglobin levels or thrombocytosis or high blood glucose levels

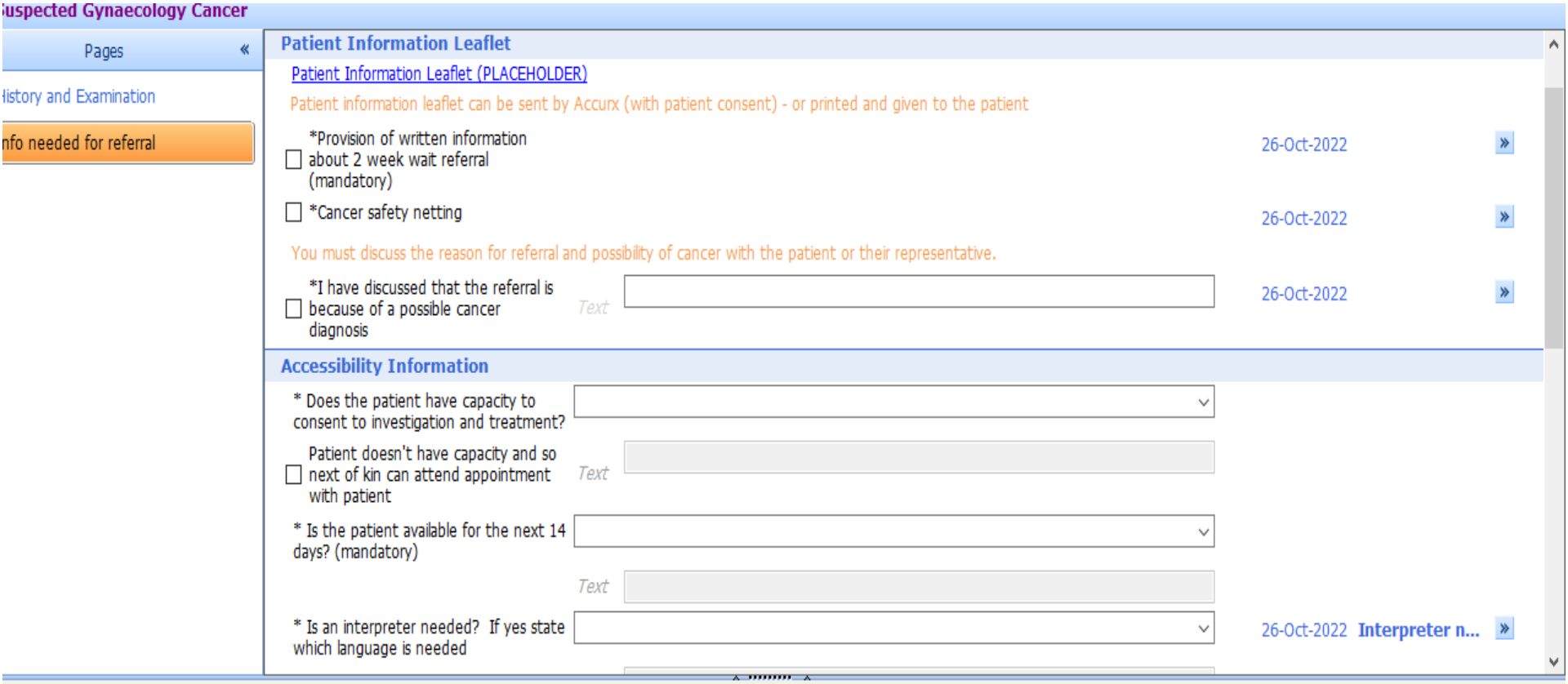
If there's a code – it' s captured from the pick list



Examination : If already coded in notes (e.g weight) it pulls through, links to guidance e.g cervical appearance chart



Decide to refer?? Go to page to gather required info – Has reason for referral been discussed? Patient available? Etc. Any assistance required e.g. interpreter? Safety netting codes



If Protocol imported clinician will be offered referral form to open, and much of the form will be completed or info included in consultation section

Cheshire & Merseyside Cancer Alliance

**URGENT SUSPECTED CANCER (2WW) REFERRAL FORM FOR**
**SUSPECTED GYNAECOLOGICAL CANCERS**
(Including Ovarian, Endometrial, Cervical, Vulval and Vaginal).

*Advice and Guidance should be considered if there is uncertainty about the interpretation of symptoms and signs, and whether a referral is needed. This may also enable the primary healthcare professional to communicate their concerns and a sense of urgency to secondary healthcare professionals when symptoms are not classical*

| **PATIENT ENGAGEMENT – THIS IS A MANDATORY FIELD** | |
|---|---|
| Has the patient been counselled they are being referred to a suspected cancer service and the reason for referral? NICE ng12 guidance/ patient support | Yes ☐ No ☐ **Informed of reason for referral** |
| Has the patient been given relevant written information about this referral? 02-Nov-2022 **Provision of written information about 2 week wait referral** - | Yes ☐ No ☐ |
| Is the patient available within the next 14 days? If no, please explain why? | Yes ☐ No ☐ |
| Have you checked all contact details are correct and informed the patient that the initial appointment may be by telephone? | Yes ☐ No ☐ |
| **REFERRER DETAILS** | |

Using the template , most of key information is captured in consultation

| Date | Consultation Text |
|---|---|
| 02-Nov-2022 | GP Surgery (Aintree Park Group Practice (Moss Lane)) |
| 17:10 | HUBBERT, Cathy M (Dr) |
| History | History of presenting complaint incl.duration of symptoms and other relevant clinical information: Post menopausal bleeding . Been on combined HRT 3 yrs no bleeding recent PMB 6 weeks Postmenopausal state H/O: hormone replacement (HRT) 12m combined therapy H/O: postmenopausal bleeding • Referred by member of Primary Health Care Team |
| Examination | CSHA (Canadian Study of Health and Aging) Clinical Frailty Scale score 1 |
| Comment | Abdomen examined - NAD • Informed of reason for referral • Patient CAN consent to investigation and treatment • The patient IS available for the next 14 days • Interpreter not needed • No known disability |
| Additional | Chaperone present Receptionist Mrs Jones Provision of written information about 2 week wait referral • Cancer safety netting • Ex-smoker |

Forms also need to work as usual referral forms and Additional info mostly easy to add and crosses

## REFERRAL INFORMATION

**Main Reason for referral (please enter free text):**
PMB 3months , been on HRT 3 yrs

**Family History:**
26-Oct-2022 **No family history of malignancy** -

**Please select type of cancer suspected** NICE NG12 suspected cancer referral guidance/Gynae

Ovarian ☐ Endometrial ☒ Cervical ☐ Vulval ☐ Vaginal ☐

**Menopausal status**

Pre-menopausal ☐ Post-menopausal ☐
02-Nov-2022 **H/O: postmenopausal bleeding** -

**Hysterectomy** Yes ☐ No ☒

**HRT** Yes ☐ No ☐
02-Nov-2022 **H/O: hormone replacement (HRT)** - 12m combined

| **Endometrial Cancer** | |
|---|---|
| • Any age with post-menopausal bleeding (unexplained vaginal bleeding more than 12 months after menstruation has stopped because of the menopause) | ☐ 02-Nov-2022 **H/O: postmenopausal bleeding** - |
| • USS indicates possible endometrial cancer (any age) – *with report attached*<br>*Refer to NICE guidance for indications for direct access USS investigation (PV discharge, visible haematuria etc.)* | ☐ |
| • CT indicates possible endometrial cancer (any age) – *with report* | ☐ |

# BENEFITS

- Information on referral criteria for suspected cancer easily available to help clinicians decide if referral required

- Gathering as much information automatically from a consultation to auto populate forms

- Prompting clinicians to gather and record all the information required for a referral

- Helping our patients with suspected cancer get to the right test or appointment soonest, so they can be reassured or receive treatment without delay


Q&A

# Moving Forward:

We will:

- Share these slides and recording (which will also be hosted on the CMCA & Cancer Academy website)

This is your resource - please feedback on future topics/content. Contact details can be found on final slide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Ccf-tr.primarycareengagement@nhs.net

Ccf-tr.canceracademy@nhs.net