BMUS

GP Direct Access / Straight to Test Pathways

What does this mean for ultrasound departments / pathway design / issues and challenges ?

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Disclaimer

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Aims for this session:-

- What are GP Direct Access (GPDA) and Straight to Test Pathways (STT)?
- What are the primary drivers behind these pathways?
- What is the role of ultrasound departments in delivering these pathways?
- What are the benefits?
- What are the challenges faced by ultrasound managers in implementing these pathways?
- How does this affect the future?

What are GPDA and STT pathways?

- NHS Long Term Plan ambition is for 75% of people with cancer to be diagnosed at an earlier stage of cancer (stage 1 and 2)

- What do we know?
- There is a currently long waits to see a specialist in secondary care and diagnostics

- What are they trying to achieve?
- Improve access to diagnostics
- Opening access to GPs for a range of examinations which do not meet 2ww criteria
- Use of Community Diagnostic Centres
- Trying to reduce the number of appointments for patients.

DM01 Data – May 2026

Table 1: Total activity, by test – May 2025 and May 2026

	May-25	May-26	Average monthly growth
MRI	421,697	433,940	**0.2%**
CT	768,198	799,680	**0.3%**
Non-obstetric Ultrasound	743,762	735,992	**-0.1%**
Barium Enema	4,363	4,575	**0.4%**
Dexa Scan	50,378	48,468	**-0.3%**
Audiology Assessments	117,324	118,383	**0.1%**
Echocardiography	165,514	166,998	**0.1%**
Electrophysiology	109	295	**8.7%**
Peripheral Neurophysiology	20,802	19,477	**-0.5%**
Sleep Studies	19,967	21,307	**0.5%**
Urodynamics	5,852	6,482	**0.9%**
Colonoscopy	56,788	53,184	**-0.5%**
Flexi Sigmoidoscopy	16,378	15,087	**-0.7%**
Cystoscopy	31,129	31,317	**0.1%**
Gastroscopy	66,294	61,334	**-0.6%**
All Tests	**2,488,555**	**2,516,519**	**0.1%**

Table 5: Total number of patients waiting at month end, by test – May 2025 and May 2026

	May-25	May-26	Growth (%age)
MRI	323,353	378,142	**16.9%**
CT	179,962	197,330	**9.7%**
Non-obstetric Ultrasound	615,987	659,064	**7.0%**
Barium Enema	3,661	4,988	**36.2%**
Dexa Scan	55,014	64,683	**17.6%**
Audiology Assessments	112,715	127,928	**13.5%**
Echocardiography	159,868	165,412	**3.5%**
Electrophysiology	484	318	**-34.3%**
Peripheral Neurophysiology	36,934	42,244	**14.4%**
Sleep Studies	30,200	42,166	**39.6%**
Urodynamics	9,344	10,349	**10.8%**
Colonoscopy	67,485	80,162	**18.8%**
Flexi Sigmoidoscopy	22,384	24,750	**10.6%**
Cystoscopy	24,459	27,036	**10.5%**
Gastroscopy	68,283	79,302	**16.1%**
All Tests	**1,710,133**	**1,903,874**	**11.3%**

Note: Barium Enema is a test that should be replaced by Colonoscopy or CT Colonography, so the number of tests undertaken should be reducing.

Table 4: May 2026 Diagnostic Waiting Times and Activity by Regional Team*

Region	Number of patients waiting six weeks or more at month end	Percentage of patients waiting six weeks or more at month end	Total number of patients waiting at month end	Total activity undertaken in month	Median waiting time
London	79,589	23.4%	340,698	410,015	2.9
South West	28,323	17.6%	160,947	243,881	2.8
South East	62,311	22.5%	276,801	382,736	3.0
Midlands	116,896	29.9%	390,854	475,721	3.6
East of England	78,884	32.5%	242,771	288,404	3.9
North West	30,152	13.9%	217,503	341,217	2.6
North East and Yorkshire	59,113	22.0%	268,154	364,081	3.0
England	**456,089**	**24.0%**	**1,903,874**	**2,516,519**	**3.1**

4.2 Total Waiting List

4.2.1. At the end of May 2026 there was a total of 1,903,900 patients still waiting for a diagnostic test. This is an increase of 193,700 (11.3%) from May 2025.

4.2.2. The test with the largest waiting list was Non-obstetric Ultrasound, which accounted for 34.6% of the total waiting list, or 659,100 patients. The test with the smallest waiting list was Electrophysiology, which accounted for 0.02% of the total waiting list, or 300 patients (Table 5).

Table 5: Total number of patients waiting at month end, by test – May 2025 and May 2026

	May-25	May-26	Growth (%age)
MRI	323,353	378,142	**16.9%**
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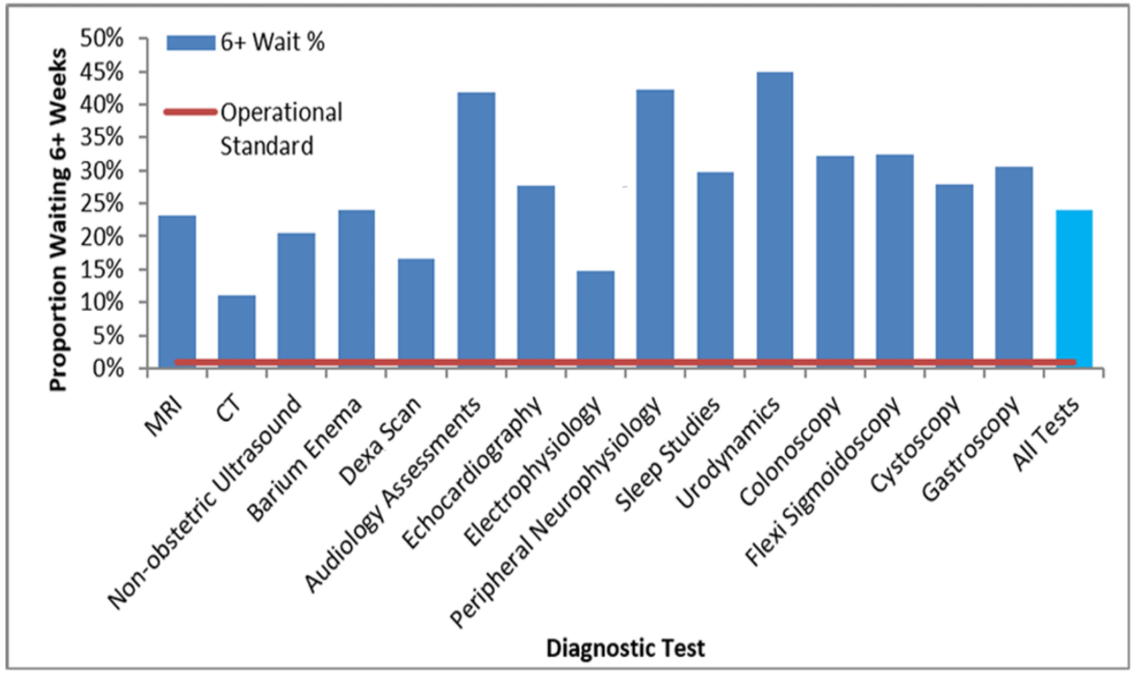
Chart 6: Percentage of patients waiting 6+ weeks, by test – May 2026



4.1.6. 128 of the 134 acute trusts that submitted data for May 2026 failed to meet the 1% operational standard.

4.1.7. All 37 Commissioners (ICBs) failed to meet the 1% operational standard.

GPDA

- GP direct access was identified in the NHS plan as a way of GPs accessing diagnostic pathways to look for cancer in patients with ‘vague’ symptoms which do not meet 2ww referral criteria within NICE guidelines.
- Phase One was launched in 2022 and allowed GPs to request a range of scans which included an US abdomen and pelvis and was supported by the introduction of funding for CDC’s to act as one stop assessment for patients with symptoms which could be cancer.
- Phase Two launched in 2023/4 and is being developed locally after discussion with GPs, Integrated Care Boards (ICB) and stakeholders.
- This has been supported in most cases but GPs have acknowledged the increasing burden on them to determine appropriate testing, reviewing and referring patients some of which would have been done in secondary care.

Positives and Negatives

- NICE does not publish a single “GPDA ultrasound” guideline, but it clearly endorses direct access diagnostics.
- 🔹 **NICE NG12 (Suspected Cancer)**
- Recommends **direct GP access to investigations** (e.g. imaging) in appropriate scenarios

- There is **NO single national ultrasound GPDA protocol** covering:
- Exact referral indications
- Examination scope
- Reporting standards
- Escalation pathways

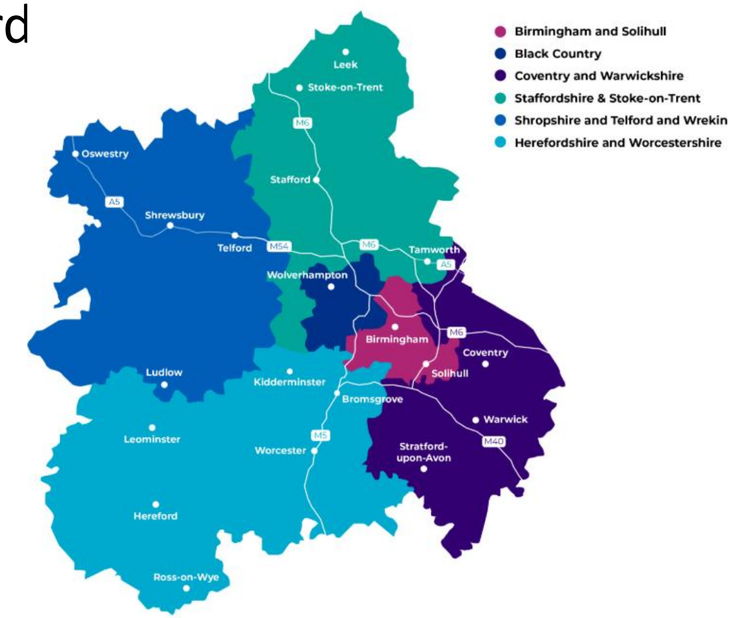
- Implementation is **locally defined**, especially for ultrasound
- This leads to variation in:
  - Referral criteria
  - Vetting
  - Sonographer responsibilities

GPDA – Unscheduled Bleeding on HRT

- West Midlands Cancer Alliance to develop a regional pathway for patients experiencing unscheduled bleeding on HRT.
- HRT was prescribed to 1.9million women in 2021/2022 – a 35% increase on the previous year.
- Alongside a rapid rise in referrals for women experiencing unscheduled bleeding on HRT on Urgent Suspected Cancer Pathways (USC) of 43% over the previous 3years (British Menopause Guideline - Management of unscheduled bleeding on hormone replacement therapy (HRT) – 2024)
- Bleeding on HRT is common (approx. 40% of women) and the risk of cancer is low in women with no major risk factors such as obesity, and hereditary conditions such as Lynch Syndrome.
- Purpose of the GPDA was to offer the GPs an alternative way to have women assessed outside of a 2ww referral by giving direct access to GPs for imaging with guidance of how to manage these cases.

WMCA approach

- Arranged regional meetings discuss the pathway including Primary care and Secondary Care clinicians.
- Improve performance against the headline 62-day cancer standard to 75% by March 2026.
- Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026.
- No involvement from radiology at the early implementation meetings. (Gynae Specialist Interest Grp)
- When radiology was included referral forms and pathways had already been developed.
- Sonographers and radiology managers had immediate concerns regard pathway for several reasons
  - Current position of US waiting times across the West Midlands
  - Current vacancy and recruitment issues across the region.
  - Differences in service implementation across the 15 NHS Trusts and 6 ICBs
  - Expectation of increase of referrals by 15-20% with no additional resource
  - KPIs linked to this pathway
  - The expectation for onward referral by sonographers if an abnormality is found.



Referral Forms

- Paper based / electronic referrals (eRS)
- Very detailed including co-morbidities / risk factors (6 pages)
- Most radiology departments were only accepting referrals via systems such as ICE.
- Challenges behind the depth of information
- Most information was not useful in regards to the US exam
- Intention was for the form to follow the patient if referrered

- Direct-access tests should ideally be **completed and reported within ~4 weeks**
- Systems should support **digital referral + result flow back to GP**

HRT Information – please provide the patient's current regime or attach completed patient questionnaire

HRT Regime	Medication 1	Medication 2 (Taken with Medication 1)
Name of the HRT Preparation i.e. Evorel sequi patch		
Dose of HRT e.g. 25mcg, 50mcg		
Frequency (how often do they take it) i.e. daily, once a week or once a month.		
Route e.g. vaginally, patch, orally, spray or gel		
Number of months / years on this HRT regime		
Previous HRTs used and duration		

Menstrual History

Information	
Date of last period (LMP)	
What is the patient's menopause status?	Perimenopausal ☐ Postmenopausal ☐
Age of menopause, if relevant	
Has the patient been previously investigated for unscheduled bleeding on HRT within the last 12 months?	Yes ☐ No ☐
If yes, please provide details i.e. date of Pelvic USS / TVUSS	

Unscheduled Bleeding History or attach completed patient questionnaire

Information	
When did the unscheduled bleeding start?	
How many episodes has the patient experienced of unscheduled bleeding?	
Please describe nature of bleeding	Light Bleeding ☐ Moderate Bleeding ☐ Heavy Bleeding ☐
Does the patient have any associated symptoms?	Pain or discomfort ☐ Pelvic Pressure ☐ Other symptoms ☐
How long does the bleeding last?	Less than 1 day ☐ 1 – 3 days ☐ More than 3 days ☐ After sexual intercourse ☐

Sonographer Concerns

- Lack of understanding of sonographer role
- Expectations of the Sonographer – what was within scope of practice?
- Medico-legal aspects of onward referral
- Where does the clinical responsibility for the patient fall?
- Time taken to make onward referral
- Not all sonographers were willing to take on the additional tasks.
- Differences in departmental set up – in-house Gynae Sonos, Radiology Sonos, CDC's and scans being performed in primary care.
- Lack of structure regionally for Women's Health Hubs, HRT specialist nurses, Gynae Triaging etc.
- Potential for further pathways all requiring additional resource / referral to be managed by sonographer and radiology teams.

Worcestershire Approach

- Herefordshire and Worcestershire form one ICB and worked together to find a local solution although there were still some variations between the 2 Trusts (Wye Valley and Worcestershire Acute)
- Patients will be assessed against risk factors for endometrial cancer and will undergo adjustments in HRT initially.
- Plan is for low-risk patients with unscheduled bleeding on HRT to now be referred by GP for an urgent scan (within 4-6 weeks) if altering HRT does not improve symptoms
- Worcestershire has opted for all reports to go back to referring clinician for onwards management.

2. Unscheduled bleeding on HRT with **1 major or 3 minor risk factors**

Major risk factors for endometrial cancer

☐ BMI ≥40

☐ Genetic predisposition (Lynch / Cowden syndrome)

☐ Unopposed oestrogen for ≥6months in women with a uterus

☐ Tricycling HRT (quarterly progesterone) for ≥12months

☐ Prolonged (sHRT) regimen: use for >5years when started in women aged ≥45

☐ ≥12months of using norethisterone of medroxyprogesterone acetate for <10days / per month or, micronized progesterone for <12 days / per month, as part of a sequential regimen

Minor risk factors for endometrial cancer

☐ BMI 30-39

☐ Unopposed oestrogen >3months but <6months in women with a uterus

☐ Tricycling HRT (quarterly progesterone) for >6months but <12months

☐ >6months but <12months of using norethisterone or medroxyprogesterone acetate for <10days/month or, micronized progesterone for <12days/per month, as part of a sequential regimen

☐ Where the progesterone dose is not in proportion to the oestrogen dose for >12months (including expired 52mg LNG-IUD)

☐ Anovulatory cycles, such as polycystic ovarian syndrome

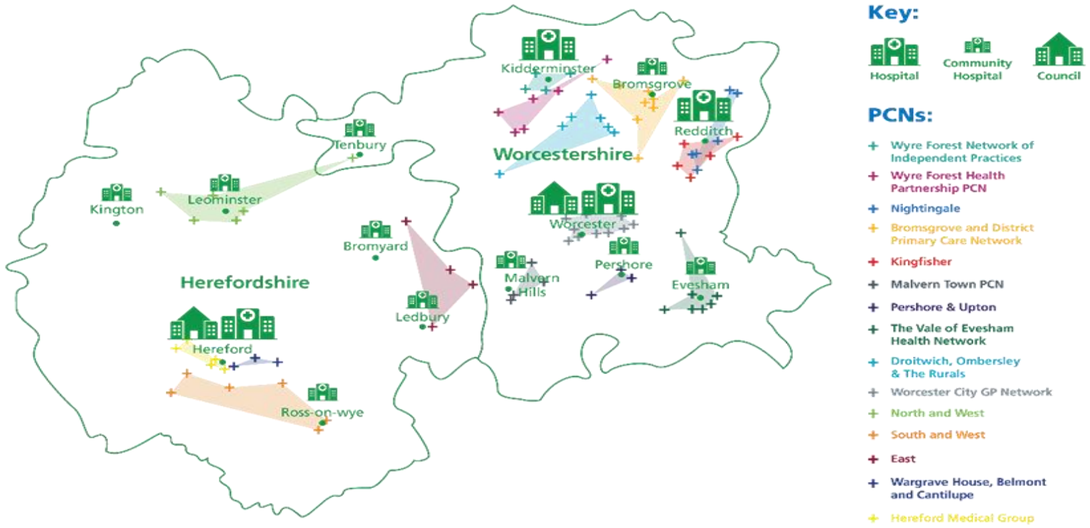
☐ Diabetes

Event Comment

Required on 11 September 2025 at 1456
MANDATORY ELIGIBILITY: Eligibility confirmed
BMI: <30
GPDA PMB ON HRT: >45 years on HRT with unscheduled bleeding
REFERRAL REASON: Heavy/persistent bleeding (>3months),Secondary Care Request
HRT REGIMEN: Continuous combined HRT
CATEGORY: N
ENTEREDBY: Goldby

Worcestershire Approach

- All GPDA referrals to be returned to GP (unpopular with GPs)
- Hereford obtained funding for pathway navigator (non-recurrent)
- Short codes for reporting
- Electronic flagging of any significant findings.
- Work still ongoing to standardise



The endometrium measures XX mm (Normal range ≤ 4 mm with ccHRT or ≤ 7 mm with sHRT): This result is considered reassuring but should be interpreted by the referring clinician in the context of the patient's individual risk factors for endometrial cancer and bleeding pattern

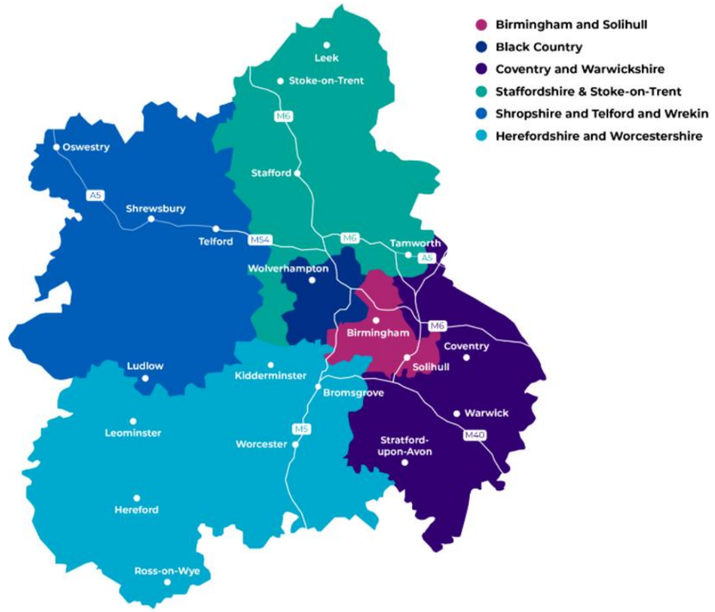
The endometrium is thickened and measures XX mm (Normal range ≤ 4 mm with ccHRT or ≤ 7 mm with sHRT): malignancy should be excluded and referral to the gynaecology urgent suspicion of cancer pathway is advised

The endometrium cannot be assessed in its entirety because of the presence of XXXXXX, therefore endometrial pathology cannot be excluded; the visualised portion measures XX mm. Referral to the gynaecology urgent suspicion of cancer pathway, for endometrial assessment, is advised if the visualised portion is thickened (> 4 mm for ccHRT and >7 mm if sHRT) or on an urgent pathway (within 6 weeks) if the visualised portion is within normal limit

- The endometrium cannot be visualised therefore endometrial pathology cannot be excluded. Referral to the gynaecology urgent suspicion of cancer pathway for endometrial assessment is advised

Regional Approach

- Extended and staggered implementation
- Pathway design tailored by individual ICBs
- Scans being done in CDCs and Acute Depts



- Regional variation with some sonographers making referrals
- Codes for electronic flagging to automatically email teams
- Pathway Navigators – some funding available
- Admin Support

- Joint working with WMCA has allowed many issues to be overcome even if this looks differently across the region.
- Discussions now held earlier with Radiology / Imaging Teams involved from the start

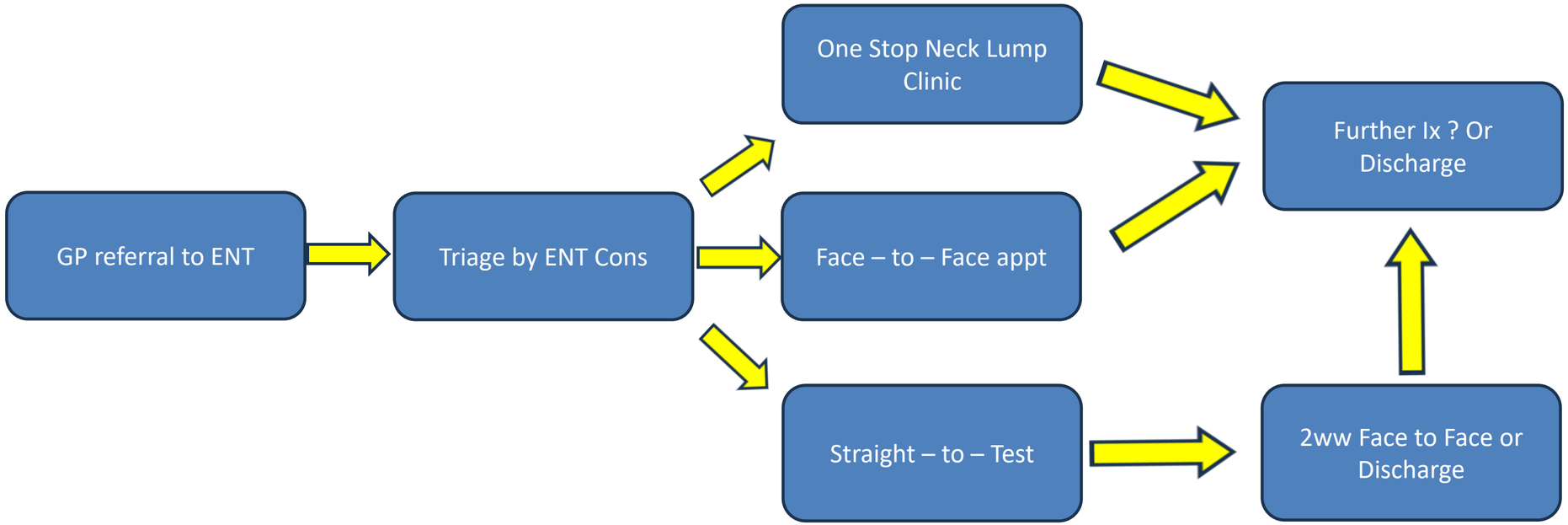
- Work being done with SoR / RCR / GIRFT teams to define scope of practice for Sonographers in GPDA pathways.

Straight – to – Test (STT)

- Initially, seen as a way for GPs to be able to request imaging prior to referral
- Now STT is being implemented in secondary care as a way of reducing the number of appointments for patient / protecting OP appointment capacity
- US is requested by the secondary care team after referral from the GP but prior to the clinic appointment
- Used as a way to triage requests and streamline specialist pathway

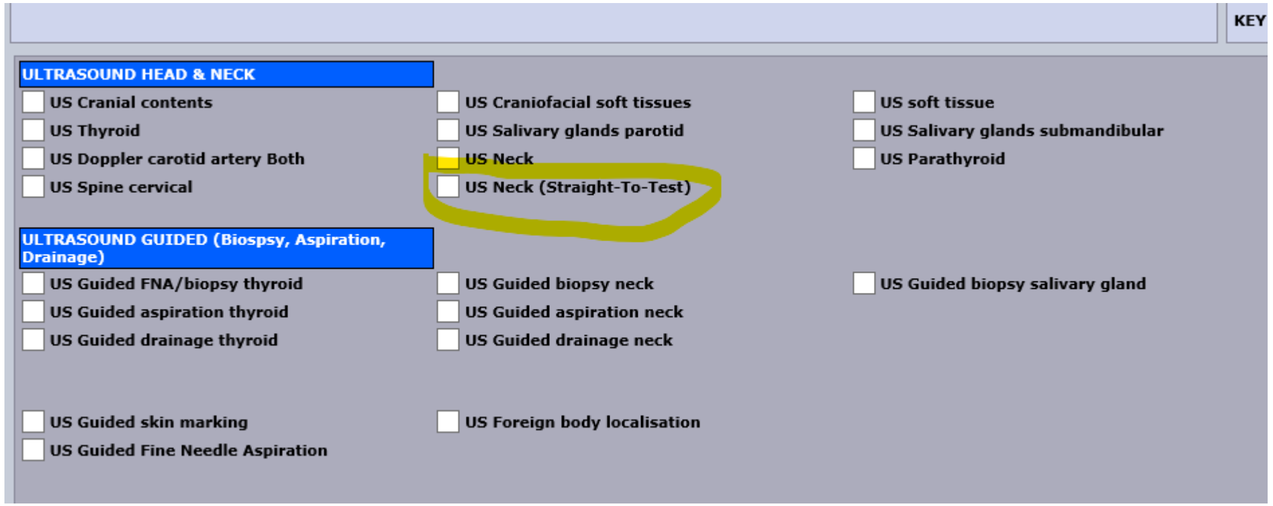
Neck Lumps STT Pathway

- Increasing numbers of 2ww requests for ‘neck lumps’
- Regional audits suggest that around 20% of patients have no ‘lump’ on ultrasound scan.
- STT pathway implemented to protect OP capacity and support cancer waiting times and standards.



Things to consider

- Triage to be done by ENT consultants to one of 3 pathways.
- How were scans going to be requested?
- How would the scans be vetted and booked?
- Who was going to do the scans?
- Was there a level of training?
- Can the scans be done anywhere ?
- How would urgent results be flagged?
- Could an onward referral be made by the sonographers?
- Patient to remain on cancer tracking till scan reviewed.



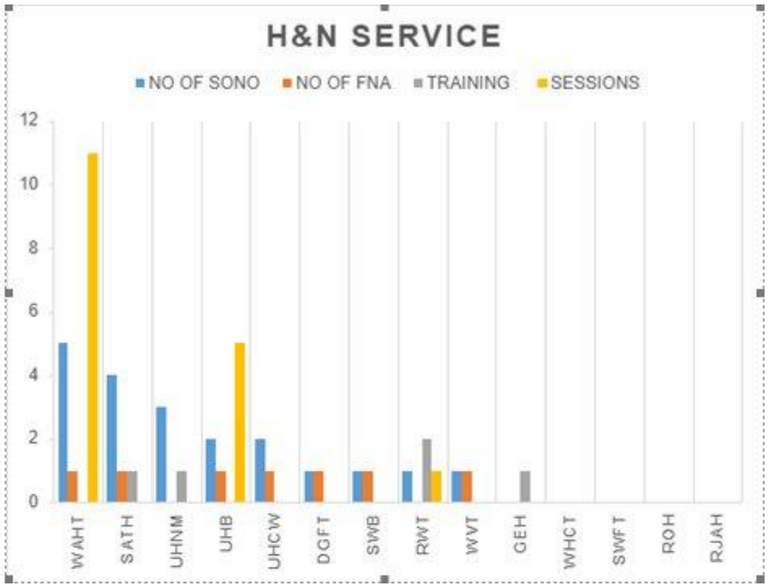
Regional Approach

- West Midlands Imaging Network were included from initial discussions with link into NOUS SIG
- Proposal:
- Sonographer ultrasound service
- To be done in CDC
- Sonographer fast track of results

- Concerns :-
- Lack of H&N trained sonographers in West Mids – Survey 2025
- Sonographer vacancy rate
- Limitations to training
- Lack of funding for development of roles
- Poor referrals
- Insufficient CDCs
- Many scans in CDCs being done by insourcing companies

Total number of Sonographers employed within WM(245.56WTE)
Sonographer = 187.02 WTE
AdvP Sonographer = 48.35WTE
Cons Sonographer = 10.19 WTE

Vacancy (53.05WTE)
Sonographer = 40.46WTE
Cons/ AdvP = 12.59 WTE



What should managers consider?

- What is the impact of this new pathway?
- Will this add any additional time to the scan?
- Is there any additional requirements of the sonographer?
- Who is clinically responsible for the patient?
- Who do reports go back to?
- How are reports sent back?
- What are considered significant findings in this pathway?
- How are these flagged to the referrer? Electronic / manual / email
- Are there any additional resources required?
- How much will they cost?
- Is there funding available to support implementation? How much and for how long?

- How is the referral made? If via radiology system such as ICE. Who builds this? Are certain questions needed? Is there a way it can be limited?
- Sonographer training – is anything new required? Do reports need to be changed?
- Is there anything specific to this pathway which needs to be considered?
- Is training needed for referrers? In primary care to be able to implement this pathway?
- How is this going to be disseminated?
- What are the governance implications? Do radiology have a responsibility for parts of the pathway?
- Update of SOPs and Protocols to reflect change
- Are there any vetting changes?
- When will this service be reviewed? What is the process for review?
- What audit requirements are needed? Who will do this?
- Where does this information need to be shared?

Summary

- GPDA and STT pathways are supported by NICE, NHSE and other organisations as a way to see more patients as quickly as possible
- Both are used to improve and support FDS and pathway targets
- There is a risk that the admin burden for radiology depts could increase, and this could be compounded as more pathways are introduced.
- We need to be aware that many pathway discussions do not include radiology at the early stages
- There is a lack of understanding around the role of the sonographer and expectations within a 20min scan
- There is little understanding of the national picture of sonographer workforce, skill mix, role design and vacancy rates which could impact the implementation of the pathways.
- We need to take every opportunity to be involved in discussions to share the workforce issues and the role of the sonographer !

Thankyou for listening !

GOOD LUCK ☺