

# Improving diagnosis of cancer



## A TOOLKIT FOR GENERAL PRACTICE

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## Summary

**1.** This Toolkit has been developed as a resource for use when considering ways to improve the diagnosis of cancer in primary care.

**2.** In recent years, repeated studies have demonstrated poorer cancer outcomes in the UK than in comparable countries. The most recent of these ~ reported by the International Cancer Benchmarking Partnership ~ found that for colorectal, lung, breast and ovarian cancers, survival in the UK was consistently lower than in five comparator countries.<sup>1</sup> The authors concluded that the variations seen between countries were consistent with later diagnosis or differences in treatment, and that this was especially true for patients aged 65 or older.

**3.** As a result of the growing evidence in this area, there has been a great deal of interest in early diagnosis of cancer in the UK. Since encounters and activity in general practice are key to the pathway to diagnosis for many cancer patients, the spotlight has fallen on the contribution of primary care.<sup>2</sup>

**4.** Investment by the Department of Health in England ~ via the National Cancer Action Team to the cancer networks ~ has resulted in a number of projects being carried out in the last few years that focus on general practice. These have included:

- › **The National Audit of Cancer Diagnosis in Primary Care.** In collaboration with the Royal College of General Practitioners, a national quantitative baseline data collection exercise was conducted with 1,170 practices in 20 cancer networks.<sup>3</sup>
- › **Significant Event Audit (SEA) of Cancer Diagnosis.** Two rounds

of Cancer SEA were carried out in which reports relating to four specific cancer groups were provided by practices and analysed using systematic qualitative methods. The SEAs related to:

~ **lung cancer and cancers in teenagers and young adults:** carried out in collaboration with the Northern Cancer Network and local practices (2008/09).

~ **upper gastrointestinal and ovarian cancers:** carried out in collaboration with the South East London Cancer Network and local practices (2010/11)

- › **The GP Leadership / Practice Profiles project.** As part of the GP Leadership Project, cancer-related Practice Profiles (produced by the National Cancer Intelligence Network) have been distributed to general practices across England via the cancer networks. GP leads in the networks have since been visiting practices to discuss these profiles, and to engage with them in a process of developing action plans for early cancer diagnosis.

**5.** We have developed this Toolkit based on the insights of general practices participating in these initiatives, and on the data that they provided. We hope that it will present individual practitioners and practice teams with information and structures that will be of benefit to them when thinking about cancer diagnosis, and that it will be particularly useful in helping develop an action plan to improve this in their practice. The Toolkit is in three parts:

- **Part 1: Insights into cancer diagnosis.** Documents the lessons learned by practice teams following review and reflection on their most recent cancer diagnoses. The findings reported in this section are a synthesis of the data generated from the two rounds of Cancer SEA described above.

- **Part 2: Planning for improvement.** Suggests ways of identifying and reflecting on what needs to change in order to improve cancer diagnosis, by examining what is already happening within the practice.

- **Part 3: Moving forward.** Considers how to make progress towards those improvements by developing a strategy to target relevant areas for activity.

**6.** For the most part, the data presented in the Toolkit are drawn from GPs' consideration of symptomatic diagnosis, and as such the learning points and practice changes described in **Part 1** relate to this. However, the contribution that primary care makes to early cancer diagnosis also includes activity around prevention and screening. These aspects have been recognised in **Part 3**, where a template for developing an action plan for improvement is proposed.

## References

- 1.** Coleman MP, Forman D, Bryant H, Butler J, Rachet B, Maringe C, *et al.* Cancer survival in Australia, Canada, Denmark, Norway, Sweden, and the UK, 1995-2007 (the International Cancer Benchmarking Partnership): an analysis of population-based cancer registry data. *Lancet* 2011; 377: 127-138.
- 2.** Richards M. The size of the prize for earlier diagnosis of cancer in England. *British Journal of Cancer* 2009; 101: S125-S129.
- 3.** Royal College of General Practitioners. *National Audit of Cancer Diagnosis in Primary Care*. London: RCGP, 2011.

This Toolkit was developed by Dr Elizabeth Mitchell (*Senior Research Fellow, University of Dundee*), Professor Greg Rubin (*Professor of General Practice and Primary Care, Durham University*), and Professor Una Macleod (*Professor of Primary Care Medicine, Hull York Medical School*). Further information about the work on which it is based (including some summary reports) can be obtained from Una Macleod (*email: u.macleod@hyms.ac.uk*).

# Part 1: Insights into cancer diagnosis



Lessons from practice

## Background

**7.** Most cancers diagnosed in the UK present symptomatically to general practitioners, but the process to diagnosis in primary care is complex, varies for different cancers, and is poorly understood.<sup>1</sup>

**8.** As part of the Department of Health's Cancer Reform Strategy<sup>2</sup>, a National Awareness and Early Diagnosis Initiative was established to coordinate and provide support to activities and research that promote the earlier diagnosis of cancer<sup>3</sup>. It includes a programme of work led by the Royal College of General Practitioners, on cancer diagnosis in primary care.

**9.** Traditionally, Significant Event Audit (SEA) has been widely used as a tool for self-reflection and improvement within practice teams, but it has not been employed as a means of trying to understand and draw lessons from the process of care for a condition more generally.

**10.** As part of the RCGP programme, we analysed multiple Cancer SEA reports to gain a better understanding of the events that surround the diagnostic process in primary care. In early 2009, an analysis of SEAs for lung cancer and cancers in teenagers and young adults (TYA) was carried out using reports provided by practices from the North of England Cancer Network. In 2010, a further analysis of upper gastrointestinal (GI) and ovarian cancers was carried out with practices from the South East London Network.

**11.** GPs' reflections on the cases of cancer diagnosis that they presented provide important opportunities for learning. We have combined the findings from the four cancer groups, and have drawn together the learning points identified by GPs along with the changes that they made to their

practice. These lessons from practice may be transferable to other cancer groups, and to other practitioners looking to develop or improve cancer diagnosis.

## About our methods

**12.** The research on lung and TYA cancers was carried out in two PCTs from the North of England Cancer Network (NHS South of Tyne and Wear, and NHS County Durham). The network covers a population of over three million service users, and includes a range of urban, rural and semi-rural locations. A total of 202 practices were invited to participate.

**13.** The research on upper GI and ovarian cancers was carried out in six PCTs incorporated in the South East London Cancer Network (Bexley Care Trust, Bromley PCT, Greenwich Teaching PCT, Lambeth PCT, Lewisham PCT, and Southwark PCT). The network covers a population of approximately 1.5 million service users, and there are around 4,500 cancer related deaths each year. A total of 271 general practices were invited to participate.

**14.** Practices were contacted by the local NHS Cancer Leads, and asked to undertake two significant event audits, one for each of the two cancers being studied (either lung and TYA, or upper GI and ovarian). They were asked to complete the SEAs for the most recent diagnosis of each cancer in the practice, and to include patients who may since have died. If there was no diagnosis for one of the cancer groups within the history of the current partners, practices were asked to send SEA reports relating to the last *two* diagnoses in the other group (i.e. if no TYA diagnosis, then two lung SEAs).

**15.** SEAs were reported on an electronic template that was

provided to practices. This was based on the format recommended by the National Patient Safety Agency<sup>4</sup>, and comprises four sections asking practice teams to:

- document the process of the event
- reflect on what happened and why it happened
- identify the learning points (good and bad)
- consider changes to be made or actions to be taken

Typically, SEA templates are generic, so we produced a cancer-specific template, adding prompts for GPs to consider in each section. These were designed to build a richer and more complete account of the circumstances surrounding diagnosis of cancer specifically. The template also requested information about the practice.

**16.** Since each SEA report represents a narrative account of the diagnosis of a new cancer and the context surrounding it, we used a systematic qualitative method to analyse the data.

## Participating practices

**17.** Significant Event Audits were received from 171 practices, 36% of those invited to take part (92 returned lung and/or TYA cases; 79 returned upper GI and/or ovarian cases). Most practices had a list of more than 5,000 registered patients (69%), and almost half had training practice status (47%). The majority were teaching practices (57%).

## Cancer diagnoses

**18.** SEA reports for 313 cancer diagnoses were analysed. Year of diagnosis ranged from 1986 to 2010, with the majority of patients diagnosed between 2008 and 2010 (77%). More than two-thirds were alive at the time of SEA completion (Table 1).

**TABLE 1: DOCUMENTED DIAGNOSES**

Lung	Upper GI	Ovarian	TYA
<b>Patients (n)</b>			
132	78	68	35
<b>Sex (male)</b>			
49%	64%	—	51%
<b>Mean age (SD)</b>			
68 (11)	68 (14)	62 (15)	20 (3)
<b>Age range</b>			
30–93	33–89	27–89	15–25
<b>Status (alive)</b>			
64%	56%	75%	86%
<b>Year diagnosed</b>			
2003-09	2000-10	1999-10	1986-09

**The referral pathway**

**19. Presenting symptoms and referrals.** The cancer-SEA reports provided a great deal of information relating to patients’ symptoms on initial presentation, and we were able to identify the main patterns of presentation for each of the four cancer groups (Table 2A). In most of the cases described, the responses made by GPs to the initial presentation, and to any subsequent consultations, appeared to be appropriate, and there were many examples of good practice. Most patients were referred within one month of first presentation (68%); 40% were referred at or following the initial consultation (Table 2B).

**20. Understanding longer times to referral.** In order to better understand the factors that related to longer referrals, we undertook a detailed examination of those cases where the referral process took longer than one month (≥31 days). Although this timescale is at the lower end of the limits suggested in referral guidance, it was used in order to ensure that no opportunities for learning were missed. We found that where the process to referral took longer, there were often reasonable

explanations for this. These were similar across the cancer groups (Table 3) and largely related to:

- complexity of presentation
- patient-mediated factors
- the reassurance provided by investigations

There were also some cases in which there may have been opportunities for earlier referral.

**Lessons learned**

**21. Part of the SEA process** involves discussion of the particular event within a team meeting. This facilitates shared learning, and allows members of the team who may not have been directly involved in the care of the patient concerned to benefit from considering the issues involved. It was clear from the SEA reports that participating GPs and practices had learned lessons from the cases presented. The learning points that were identified cross-cut various aspects of the diagnostic process, and covered presentation and diagnosis, consultation-based activity, system issues and communication, patient factors, and guidelines.

**22. Presentation and diagnosis of cancer.** Lessons identified around presentation and diagnosis concerned the nature of presentation (often atypical), the need for vigilance in relation to potential cancer symptoms (even when symptoms might seem straightforward), and the usefulness and limitations of diagnostic tools. Issues arose around the importance of having a high index of suspicion when dealing with a range of patient groups (Table 4).

**23. Consultation-based activity.** Many of the learning points focused on consultation-based activities, including the importance of safety-

netting<sup>5</sup>, and the need to ensure that steps are taken to fully consider what is currently happening with the patient, and to plan for what will happen next. Various aspects of diagnosis and management were included in this such as history taking, patient examination, and follow-up of persistent symptoms and results (Table 5).

**TABLE 2A: PRESENTATION**

Patterns of presentation
<b>Lung</b>
▶ chest symptoms☉
▶ symptoms suggesting malignancy (not necessarily of lung origin)
▶ other symptoms not normally suggesting lung malignancy☹
▶ presentation outwith primary care
<b>Upper GI</b>
▶ alarm symptoms suggesting upper GI malignancy☉
▶ dyspeptic symptoms☹
▶ non-upper GI symptoms
▶ presentation outwith primary care
<b>Ovarian</b>
▶ gynaecological symptoms (with or without other symptoms)
▶ lower abdominal symptoms☉
▶ symptoms suggesting malignancy (not necessarily of ovarian origin)☹
▶ other symptoms not normally suggesting ovarian malignancy
▶ presentation outwith primary care
<b>TYA</b>
▶ symptoms varied by type of cancer
▶ included weight loss, flushing and sweats, visual field loss, changing mole, pain (back, shoulder, knee, groin, testis), lump or swelling (neck, cheek, thigh, calf, scrotum)
▶ presentation outwith primary care
☉ most common symptom type
☹ least common symptom type

**24. System issues and communication.** Learning points here centred on communication, both with secondary care and as a means of shared learning within the practice team. Many of the practices described examples of good communication between primary and secondary care, or



between primary care and family members or other care providers. In addition, there was an acknowledgement that continuity of care and information could facilitate faster diagnosis and referral. In some cases, practices thought that communication from secondary care could have been better (Table 6).

**25. Relevant patient factors.** These learning points related primarily to frequency of attendance, and lifestyle factors. Some consideration was also given to the difficulties involved in engaging with particular patient groups, as well as the need for continuing patient education about risk factors for cancer (Table 7).

**26. The role of referral guidelines.** Many practices had reviewed relevant referral guidelines as part of the SEA process. In many cases, practices identified that they had followed the guidance, and that the process was helpful. In others, while the usefulness of guidelines was acknowledged, their limitations were recognised (Table 8).

### Changes to practice

**27.** Practices documented a variety of suggestions for change based on their review and reflections on the diagnoses documented in the SEAs. Most related to organisational factors, and unsurprisingly appear to have been derived mainly from the learning points identified. Most changes were made at the level of the consultation (Figure 1), or at practice level (Figures 2), but there were also some at the level of the cancer network (Figure 3).

**28.** This analysis of cancer-specific SEAs has shown that cancer diagnosis in primary care can be complex and challenging. Combining the reviews of cancer diagnoses made by individual practices has generated useful insights into the circumstances surrounding diagnosis and referral. Participating practices have shown that reflecting on even one or two cancer diagnoses can help identify learning points, and suggest changes that can be made in order to improve diagnosis and referral in

the future. Many of these may be transferrable to cancer diagnosis in general, and may be of value to other practices interested in developing a strategy to improve cancer diagnosis.

**TABLE 2B: INITIAL REFERRAL**

Time to referral
<b>Following initial consultation</b>
▶ lung: 31%
▶ upper GI: 45%
▶ ovarian: 60%
▶ TYA: 30%
<b>Within one month (≤31 days)</b>
▶ lung: 58%
▶ upper GI: 71%
▶ ovarian: 86%
▶ TYA: 66%
<b>By presenting symptom</b>
▶ Lung: patients with non-respiratory symptoms referred earlier
▶ Upper GI: patients with alarm or multiple symptoms referred earlier
▶ Ovarian: no difference for vague abdominal or other symptom types
▶ TYA: melanoma, brain/nervous system, and haematological cancers referred earlier

Figures relate to patients for whom we were able to identify referral timescales within the SEA reports

**TABLE 3: FACTORS INFLUENCING THE REFERRAL PATHWAY**

Explanatory factor	Lung	Upper GI	Ovarian	TYA
<b>Complexity of presentation</b>				
Presence of co-existing morbidity	●	●	●	
Symptom suggests different initial diagnosis	●	●	●	●
Symptom suggests different malignancy	●	●		
<b>Patient-mediated factors</b>				
Time to re-present with ongoing symptoms	●	●	●	●
Time to re-present after initial treatment	●	●	●	
Declining investigation or examination		●	●	
Declining referral or admission	●			
Not attending for follow-up (GP or hospital)	●	●		
<b>Diagnostic process</b>				
Reassurance from negative investigation	●	●	●	
Investigation suggests benign cause	●			

### References

- Richards MA. The National Awareness and Early Diagnosis Initiative in England: assembling the evidence. *British Journal of Cancer* 2009; 101: S1-S4.
- Department of Health. *Cancer Reform Strategy*. London: DH; 2007.
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Further information about the work reported in this section can be obtained from Una Macleod (email: [u.macleod@hyms.ac.uk](mailto:u.macleod@hyms.ac.uk)), or Elizabeth Mitchell (email: [liz.mitchell2@gmail.com](mailto:liz.mitchell2@gmail.com)).

TABLE 4: LEARNING POINTS AROUND PRESENTATION AND DIAGNOSIS

Lung	Upper GI	Ovarian	TYA	KEY MESSAGE
<b>Patterns of presentation</b>				
Lung cancer does not always present typically, and there may be no immediate warning signs or 'red flags' on presentation	Upper GI malignancies can be asymptomatic and therefore difficult to diagnose	Be aware that ovarian cancer may be asymptomatic for a long time	Atypical presentation is not uncommon	▶ <b>Atypical cancer presentations are not uncommon</b>
Initial presentation may be with secondary signs of malignancy, which can obscure the issue and potentially delay diagnosis	Patients with dysphagia should be referred at first presentation	Ovarian malignancy can often present with non-gynaecological symptoms	Cancer is not always suggested by symptoms, or the most likely differential diagnosis in young people	
	Unexplained anaemia should always be investigated further	Post menstrual bleeding can also be caused by an ovarian tumour	Diagnosing cancer in low risk age groups is difficult	
	New onset dyspepsia in older patients should be treated with a high degree of suspicion, regardless of other possible diagnoses	Consider ovarian cancer in women with vague abdominal symptoms or long-term diarrhoea		
		Consider ovarian cancer in women with urinary frequency or bladder pressure problems		
		Consider ovarian malignancy as a differential diagnosis in women with shortness of breath and/or leg oedema		
<b>Index of suspicion</b>				
Do not always assume the most common cause for a problem	A high index of suspicion should be present as GI malignancies often present late, when they are at an advanced stage	A high index of suspicion is vital, given the non-specific nature of presenting symptoms in ovarian cancer	Symptoms of common illness should be investigated if they are persistent or show no improvement	▶ <b>Have a high index of suspicion, and a low threshold for investigating possible cancer symptoms, especially in older patients</b>
Malignancy should be considered as a possibility, even when symptoms sound innocuous	Always look for and pay heed to 'red flag' symptoms, whatever the age of the patient	Be aware of the diffuse presentation of ovarian cancer		
Have a high index of suspicion and low threshold for investigation in patients with persistent cough (both smokers and non-smokers)	There is a need for a high index of suspicion in patients with a history of GORD and ulcer disease	Maintain a low threshold for investigating possible malignancy in elderly patients		
Musculoskeletal sounding pain (neck or shoulder) can be a presenting symptom for lung cancer, and should have a low threshold for CXR				
<b>Co-existing morbidity</b>				
Co-existing disease can mask symptoms of malignancy	It can be difficult to diagnose cancer in patients with multiple morbidities	Other causes for symptoms should be kept in mind, rather than assuming that associated co-morbidities are to blame		▶ <b>Co-existing illness may mask the symptoms of cancer</b>  ▶ <b>It can be difficult to differentiate new, potentially malignant symptoms</b>
The possibility of a serious diagnosis should be considered in patients with known disease, either those with an existing respiratory condition (asthma, COPD) or other concurrent illness	Upper GI malignancies can present with relatively common symptoms, or be masked by another condition	It is very easy to attribute on-going symptoms to previous, benign diagnoses		
Have a heightened suspicion of lung cancer in patients with worsening COPD or new or persistent COPD symptoms	Consider other diagnoses in patients with co-existing disease, rather than assuming the symptom is due to the primary condition	The benign diagnosis of IBS and diverticulitis can make diagnosis of more sinister causes harder		
	It is important to consider a change in symptom origin in patients with existing disease	Multiple morbidities can lead to delayed diagnosis		

Investigations and results				
Rapid reporting of CXR results is of benefit	Previous normal investigation results can give false reassurance	Access to ultrasound is very useful in helping make a diagnosis	Early consideration should be given to further investigation and referral in persistent cases where no diagnosis is made	<p>▶ Initial normal investigations can give false reassurance to patients and GPs</p> <p>▶ Further investigation or referral should be considered in patients with non-resolving symptoms after initial negative investigation</p>
Immediate access to CT scan for sinister symptoms is important	Ultrasound results are not 100% accurate	Ultrasound for suspected cancer should be requested as urgent		
CXR reports can sometimes give false reassurance		Adnexal mass felt on exam requires urgent USS		
Lung cancer cannot be excluded even if a CXR is normal		Post-menopausal women with lower abdominal symptoms in the absence of bleeding should be urgently investigated with pelvic USS		
A normal CXR can become abnormal over a relatively short time period		Consider using CA125 in all urgent gynaecology referrals		
Be alert to referring people with continuing symptoms, even if CXR is negative				
Consider early and urgent referral where worrying symptoms are not matched by confirmatory investigation.				



**TABLE 5: LEARNING POINTS AROUND CONSULTATION-BASED ACTIVITY**

Lung	Upper GI	Ovarian	TYA	KEY MESSAGE
<b>Patient history</b>				
It is important to review recent medical history (including hospital and GP appointments) when seeing a patient	It is important to review past consultations at new presentations, to determine if there is repetition of a problem	Ensure careful history taking in patients with multiple unexplained symptoms	It is important to review previous consultations and ask about previous symptoms where appropriate, even if patient is attending for another issue	<ul style="list-style-type: none"> <li>▶ Review recent contacts at each consultation</li> <li>▶ Take a careful history when there are multiple or unexplained symptoms</li> <li>▶ Consider the recent history of presentations, even if the patient presents symptoms as being separate episodes</li> </ul>
Be vigilant to warning symptoms even if these are brought up coincidentally when the patient attends for another reason or is discussing another issue	Be proactive in searching for information, as patients may not realize the importance of certain symptoms	Patients may not always correctly describe their symptoms due to anxiety, fear, education, or poor communication, especially if seeing a new doctor		
It is important to 'link' consultations, especially when continuity is an issue	Explore symptoms thoroughly, especially if the patient is presenting with other non-related conditions, or has no complaints	Pursue family history in detail, and consider expert advice when appropriate		
	It is possible that patients may not mention or be concerned about symptoms that they consider to be part of a previous or existing diagnosis	It is important to consider all possibilities, and not to go along with the patient's interpretation of the cause of symptoms		
	Patients may be anxious and may leave out information, so it is important to allow adequate time for history taking and assessment			
	The quality and reliability of patient history can be influenced by co-existing conditions (e.g. dementia, mental health problems).			
	Always enquire about number of episodes and duration of symptoms, as patients may delay in presenting			
	Patients often self-medicate for indigestion, and the history needs to include details of this			
<b>Examination</b>				
Examination is a key part of early diagnosis	Physical examination is important in identifying possible cancers	Clinical examination is important	Thorough clinical examination is important (e.g. for lymph nodes)	<ul style="list-style-type: none"> <li>▶ Examination is a key part of making or excluding the diagnosis</li> </ul>
	Patients presenting with respiratory symptoms should be assessed to consider possible GI signs	Women presenting with vague abdominal symptoms should be examined		
	It is important to take the time to assess patients fully, especially older patients	Examination of women with abdominal pain or bloating should include a pelvic exam		
	It is important to regularly check and record weight, as tracking this might facilitate earlier diagnosis	Examine thoroughly, even if the initial exam does not reveal any pathology		
		Regular checking of weight can be very useful		

Investigation				
	Be mindful of underlying causes behind presenting symptoms, and screen if significant but unclear	Persistent symptoms require re-assessment and further investigation		<ul style="list-style-type: none"> <li>▶ Persistent symptoms require investigation</li> <li>▶ FBC is useful in the initial patient assessment</li> </ul>
	Full blood count is important in the initial assessment of a patient	Where examination of obese patients is difficult, consider alternative investigations earlier than usual		
	Knowing when to reinvestigate a patient with ongoing symptoms after negative investigations			
Record keeping				
Detailed record keeping is important, including history taking and length of time with symptoms	Thorough history taking and record keeping are important (including duration of symptoms, family history of cancer, smoking status, and alcohol intake)	Duration of pain should be recorded	Be aware that over recording can obscure relevant clinical details	<ul style="list-style-type: none"> <li>▶ Detailed record keeping is important, and should include the duration of symptoms</li> <li>▶ Record negative findings</li> <li>▶ Safety netting details and advice should be documented</li> </ul>
Serially documenting patient weight is valuable	It is important to record physical examination, including weight	Record examination findings, even if negative, as well as the reasons for examinations not being done		
It would be useful to document when a patient was referred urgently if a possible diagnosis of cancer was discussed	It is important to record follow-up advice in patients' notes	Make sure to document referrals if done or planned		
	Patient refusal of investigations should be documented	Document safety-netting details in the patient record		
Safety-netting				
Safety-netting is an important part of the consultation	It is important to follow-up on abnormal blood results	Ask patients to return for review if symptoms do not settle, and record this in the notes	Safety-netting with adequate recording of information is important	<ul style="list-style-type: none"> <li>▶ Ask patients to return for review if symptoms do not resolve</li> <li>▶ It may be appropriate to give a follow-up appointment time rather than just advice to return</li> <li>▶ Actively follow-up abnormal blood results, rather than waiting for patients to make appointments</li> </ul>
There is a need to give robust safety-netting advice	It is important to make patients aware of the relevance of and urgency involved in attending appointments, including for diagnostic tests	Follow-up abnormal results, rather than relying on patients to make appointments to discuss	Specific safety-netting on time for representation and practitioner to be seen could be helpful	
It is important to prioritise clinical signs / symptoms rather than negative test results		Advise patients to contact the surgery if they do not receive an appointment for a planned investigation or referral within a specified time	It is important to ensure attendance for review following abnormal blood results	
Follow-up				
It is important to ask specific questions when patients report improvement on review	Patients requesting repeat PPIs should be reviewed to ensure appropriate management	If symptoms do not resolve or fail to be reasonably controlled, question the established diagnosis	It is important to maintain contact with the patient after referral and to follow-up the outcome	<ul style="list-style-type: none"> <li>▶ Follow-up patients after negative test results</li> <li>▶ Recurrent or non-resolving symptoms should be investigated further</li> </ul>
Recurrent or non-resolving complaints should be investigated further		It is important to evaluate new symptoms after previous negative investigations		
Follow-up is important with upper respiratory tract infections				
It is important to follow-up patients after negative test results				
Consider reviewing patients undergoing hospital investigations and follow-up, as this may prevent delays in the hospital system if GP can re-refer				

Referral				
Never be wary of re-referring to secondary care, even if the patient has been discharged	Earlier referral is required on the failure of treatment	Do not delay referral while waiting for investigations or results		<p>► <b>Have a low threshold for referring patients with symptoms suggestive of cancer</b></p>
		Do not be afraid to refer a patient if 'something does not feel right'		
		Do not be reticent about re-referring a patient, or about referring a patient to a different hospital		

**TABLE 6: LEARNING POINTS AROUND SYSTEM ISSUES AND COMMUNICATION**

Lung	Upper GI	Ovarian	TYA	KEY MESSAGE
<b>Continuity of care</b>				
Although there are difficulties related to this, it is important to try to ensure continuity within the practice so that patients with ongoing symptoms can be reviewed by the same GP	Continuity of care can be difficult to achieve, but is extremely important	Continuity of care is important in maintaining an overview, especially in patients with multiple pathologies	Continuity of care as far as possible is vital	<ul style="list-style-type: none"> <li>▶ <b>Continuity of care by the same GP for an illness episode is to be preferred</b></li> </ul>
	Try to encourage patients to see the same GP when they have ongoing problems	Continuity of care and knowledge of the patient can facilitate earlier referral	A lack of continuity of care makes it more difficult to recognise trends in patient symptoms or conditions	
<b>Continuity of information</b>				
Record keeping is important to ensure that other colleagues are aware of patients' previous complaints	GP concerns that require follow-up should be clearly recorded so that subsequent doctors are aware of these		Good record keeping is important in facilitating different doctors following a case	<ul style="list-style-type: none"> <li>▶ <b>In the absence of personal continuity, good record keeping is vital for ensuring continuity of information</b></li> </ul>
It is important to ensure that test results are passed to the practitioner who requested the test, for review			Continuity in those requesting and reviewing investigations aids earlier diagnosis	
<b>Practice systems</b>				
Review methods for follow-up of abnormal tests are important (i.e. would a telephone call be more appropriate than a letter).	Abnormal tests results should be forwarded to the practitioner who requested the test, or if more urgent, should be acted on immediately	It is important to have accurate patient summaries		<ul style="list-style-type: none"> <li>▶ <b>Ensure that practice systems for patient review, and for follow-up of abnormal results, are robust</b></li> </ul>
It is important to have up-to-date contact details for patients in case urgent contact is required	Patient notes should be reviewed prior to home visits, when records are not available	If women request a female to do a pelvic exam, this should be done by a female GP rather than a practice nurse, even if that means making another appointment		
Writing to patients who fail to attend appointments is effective	Maintaining a register of all patients referred under the 2WW would be useful for ensuring that a patient has been seen and dealt with	Ensure that referrals contain accurate patient address and contact details		<ul style="list-style-type: none"> <li>▶ <b>Accurate patient summaries are important</b></li> <li>▶ <b>Review patient records prior to home visits</b></li> </ul>
	It is important to ensure the transfer of records when patients register from another practice			
	Patient contact details should be kept up-to-date			
<b>Team work and communication</b>				
Effective communication and team working is key	Collaborative working between professional groups is important	Good teamwork is important before, during and after diagnosis	Effective communication and team working is key	<ul style="list-style-type: none"> <li>▶ <b>It is helpful to discuss potential cancer diagnoses with colleagues</b></li> <li>▶ <b>Reviewing new cancer diagnoses helps assess standards of care and determine whether things could be done differently</b></li> </ul>
	Poor communication between medical teams, within secondary care or from secondary to primary care, can result in delayed diagnosis	Good communication between professionals, and with patients, is essential		
	It is helpful to discuss cases and/or concerns with colleagues, and to ask for advice when the case is unclear	Discussion of complex cases with colleagues can be useful, and enables shared learning		
		It is useful to review cancer diagnoses to assess standards of care and determine whether anything could have been done differently		

Primary-secondary care interface				
Be aware of those patients who are under the care of several specialties, as key questions can be missed even when there is ongoing and regular communication	More informative referral letters (e.g. inclusion of a differential diagnosis or reason for urgent referral) can expedite investigation and facilitate earlier diagnosis	Prompt communication between primary and secondary care can help avoid delay	Communication from secondary care can sometimes be infrequent	<ul style="list-style-type: none"> <li>▶ <b>Always provide informative referral letters when cancer is suspected</b></li> <li>▶ <b>Be mindful of patients under the care of several specialties</b></li> <li>▶ <b>Do not assume that results will always be reported to requesting practitioner</b></li> </ul>
Be prepared to question discharges from secondary care	Telephone communication between primary and secondary care would be useful in the event of patients not attending for appointments	Do not always assume that referrals have been received	There is sometimes a need to 'break into' the hospital pathway in order to find out about delays in appointments, delays in diagnosis, or lack of information on treatment plans	
Do not assume that results will automatically be reported or that they will automatically be reported to the requesting practitioner		Robust organisation is important, and there should be a failsafe process for transmitting results from secondary to primary care		
		Sometimes the process to diagnosis in secondary care is slow		

**TABLE 7: LEARNING POINTS AROUND RELEVANT PATIENT FACTORS**

Lung	Upper GI	Ovarian	TYA	KEY MESSAGE
<b>Patient attendance</b>				
Consider serious diagnosis in patients who present only infrequently or who are not typical candidates for lung cancer (usual good health, younger age, non-smokers)	There should be a high index of suspicion with patients who are infrequent attenders	Consider regular health screening in patients who only attend annually for flu vaccination etc.	It can be difficult to determine if initial symptoms are relevant to a diagnosis in young patients who may be infrequent attenders	<ul style="list-style-type: none"> <li>▶ An infrequent attender who consults may be significant in itself</li> </ul>
<b>Patient history</b>				
	Patients with mental health issues and/or multiple morbidities can slip through safety nets	A positive family history is of relevance		<ul style="list-style-type: none"> <li>▶ Remember family history</li> </ul>
		Patients who have mental health problems can be difficult to follow-up		<ul style="list-style-type: none"> <li>▶ Take a careful history in patients with mental health issues or multiple morbidities</li> </ul>
		Patients with depression can harbour serious disease		
<b>Lifestyle factors</b>				
It is important to have a record of a patient's smoking status and smoking history	It is important to have a record of relevant patient factors (including family history of cancer, smoking status, and alcohol intake)			<ul style="list-style-type: none"> <li>▶ Awareness of smoking history is important</li> </ul>
There is a need to always remain suspicious of symptoms in patients who are smokers	Have a high index of suspicion in patients with poor lifestyle factors (i.e. history of heavy smoking and alcohol)			<ul style="list-style-type: none"> <li>▶ A high index of suspicion is needed in patients with lifestyle risk factors</li> </ul>
Lung cancer can occur in patients who are non-smokers				
<b>Engaging with patients</b>				
	Particular care needs to be taken when obtaining history from patients who do not speak English or who need an interpreter	Creative ways to remind patients about appointments etc. need to be employed for patients with problems that impact on their memory	It is important to have an appropriate consulting style that would allow young people to feel comfortable enough to explain their symptoms	<ul style="list-style-type: none"> <li>▶ Establish systems for communicating with patients who do not speak English (for consultation and communicating results)</li> </ul>
	Use an independent interpreter when discussing important health issues	GPs should ensure that the patient is in the best position to provide a complete history (e.g. suggest female patient attends with female translator when discussing gynaecological issues)	If a young person is reluctant to be examined at the time of initial consultation, for whatever reason, they should be seen again	<ul style="list-style-type: none"> <li>▶ Consider the most appropriate consulting style, and adapt for specific groups of patients (e.g. teenagers) to ensure that they are comfortable enough to report symptoms</li> </ul>
	It should not be assumed that patients will call for results; this is particularly important in patients who do not speak English	Serious consideration should be given to symptoms mentioned by translators who attend with patients who do not speak English	Communication with particular groups of people may require additional training	
	It is important to maintain communication with patients who DNA			
<b>Patient education</b>				
Although it is often difficult to influence patient behaviour in relation to smoking, practitioners should keep trying	Ensure that patients with existing risk factors are aware of 'red flag' symptoms, and the importance of reporting these			<ul style="list-style-type: none"> <li>▶ Persist with smoking cessation advice and interventions</li> </ul>
There is a need for patient education in relation to longstanding new or vague symptoms, so that delay can be reduced				<ul style="list-style-type: none"> <li>▶ Ensure patients with existing risk factors are aware of red flags</li> </ul>



Patient choice				
Patient autonomy during diagnostic, treatment and palliative phases needs to be respected	There can sometimes be delay due to patient autonomy (e.g. self-medication, refusing investigations)	It can be difficult to persuade elderly patients to have investigations		▶ Respect patient autonomy (and record patient led decisions)

**TABLE 8: LEARNING POINTS AROUND THE ROLE OF REFERRAL GUIDELINES**

Lung	Upper GI	Ovarian	TYA	KEY MESSAGE
<b>General usefulness</b>				
[Raised] awareness of the 2WW and that it is very beneficial in ensuring rapid access to secondary care	[Raised] awareness of the value of the 2WW referral system			<ul style="list-style-type: none"> <li>Guidelines are useful in making sense of potential cancer symptoms</li> </ul>
	[Highlighted] importance of the 2WW in getting prompt treatment			
	Guidelines are a useful aid in being vigilant for potential cancer symptoms			
<b>Referral criteria / pathway</b>				
Raised awareness of the criteria for urgent or 2WW referrals for suspected cancer	Reminder of the indications for urgent referral	Reminder of the criteria for urgent referral	[Raised] awareness of the 2WW and referral pathways	<ul style="list-style-type: none"> <li>Use the 2WW referral pathway whenever appropriate</li> <li>Raise awareness of the criteria for 2WW referral among the practice team</li> </ul>
	Reminder that patients over the age of 55 with new onset, persistent dyspepsia should be referred urgently for endoscopy	Reminder of the need to follow established referral pathways	Raised awareness of the criteria for urgent or 2WW referral for suspected cancer	
		Reminder that women over the age of 45 with persistent abdominal pain are indicated for early referral		
		If there is some suspicion of malignancy, use the 2WW system		
<b>Inclusion of investigations</b>				
Reminder that the NICE guidelines for COPD suggest CXR as part of initial assessment		Reminder of how to use investigations appropriately		
It is not necessary to have a CXR result to refer under the 2WW				
<b>Limitations</b>				
NICE guidelines do not always reflect local suspected cancer referral protocols	Guidelines are very useful, but they are not always applicable	While extremely useful, referral guidelines will not necessarily cover all patients early in their disease	Guidelines are less helpful when a suspicion for malignancy is not apparent	<ul style="list-style-type: none"> <li>Remember, guidelines may not always apply</li> <li>Not all cancer presentations meet the 2WW criteria</li> </ul>
		Not all cancer presentations meet the 2WW criteria	2WW referral is not necessarily best for all patients	
		The 2WW system does not always perform to target		
<b>Autonomy</b>				
Guidelines are useful, but there is still a need for practitioners to be vigilant and to be suspicious of potentially serious symptoms	Guidelines are useful for signposting, but sometimes a high index of suspicion is still required in order to refer a patient	Although NICE guidelines are usually helpful, clinical skill and knowledge are essential		<ul style="list-style-type: none"> <li>Practitioners need to be vigilant, and suspicious of symptom patterns that do not fit with guidelines</li> <li>Instinct, clinical skill, and experience are still important</li> </ul>
'Gut instinct' and experience are also important				
There is a need to remain patient centred, and at times to negotiate a referral pathway that is acceptable to the patient				

## FIGURE 1: CHANGES MADE AT CONSULTATION LEVEL

### SYMPTOMS

- Careful safety-netting of patients to ensure follow-up if still unwell.
- Patients with wheeze of more than three weeks duration to have further investigation, including spirometry and peak flow.
- Haemoptysis to be referred for CXR, even if minor.
- Increased vigilance when dealing with presentations for neck and shoulder pain.
- Patients presenting with any dysphagic symptom should be referred at first consultation.
- To always look for weight loss when patients give a history of reflux and dysphagia. If the history is not clear, review the patient the following week or so.
- All were reminded about the possibility of abdominal conditions presenting as back pain.
- We will use the “Ovarian Cancer Action” symptom diary<sup>1</sup> for appropriate women.
- Use stronger safety-netting for patients presenting with neck lumps, “if lump still present in x weeks then to return here to see GP”.
- All moles, if changing with possible malignant features, should be referred under the 2WW.

### INVESTIGATIONS

- Discuss investigations with patients who refuse them, to ensure that they understand the nature of the investigation and its importance.
- All patients over 55 with new onset back pain to have blood tests.
- Patients with persistent dyspepsia to have FBC checked.
- Be alert to changes in haemoglobin, even if small.
- If haemoglobin suddenly drops, then to do further tests / investigations.
- Clinicians will investigate all anaemia, and if the haemoglobin is <9.5 will refer patients for further investigation under the 2WW.
- If gastroscopy for anaemia or haematemesis was normal, it would be worth repeating after 3 years if the condition has not resolved.
- Consider a lower threshold for CXR in patients with pre-existing chest disease.
- If abdominal and pelvic examination is normal, but the GP is still worried about the possibility of ovarian cancer, pelvic USS rather than CA125 alone will be arranged.

<sup>1</sup> [www.ovarian.org.uk/media/8812/symptom\\_diary.pdf](http://www.ovarian.org.uk/media/8812/symptom_diary.pdf)

- Consider USS or tumour markers as relevant investigations where ovarian cancer is suspected, where this does not delay referral.
- Act on rising ESR, as this is more relevant than a single raised ESR.
- Increased use of CA125 as a screening tool in women with a reasonable index of suspicion, but not to be used as a screening tool for everyone.
- Consider use of x-rays for persistent groin strain.

### PATIENT FACTORS

- Reflect on what patients are saying rather than just taking this for granted.
- Enquire about patients’ general health and follow-up on symptoms, especially if vague.
- To employ a new policy of a higher index of suspicion for patients who are infrequent attenders.
- Patients who attend frequently, but are anxious of the doctor or reluctant to undergo full examination, should be requested to re-attend within a short period with a trusted family member so that a detailed collateral history can be obtained.
- Allow more time for patients with mental health problems.
- Consider obtaining collateral histories, particularly in patients with dementia.
- Any strong family history of cancer should be prominent on the computer so that it is immediately seen when a patient is in consultation.
- Clinicians to remember to take a family history, particularly in patients with abdominal symptoms, IBS diagnosis, or types of possibly malignancy-related symptoms.
- Be more vigilant of patients who are smokers aged >50 years.

### RECORD KEEPING & CONTINUITY

- Document symptom duration at initial presentation.
- Individual doctors to review their approach to reviewing clinical notes for previously unresolved issues, especially if the patient consults with different GPs.
- Engage in an active policy of recording smoking history.
- Advise patients that if a chest symptom does not resolve a CXR would be helpful, and make a record of this.

- Before going on a home visit, GPs will review recent consultations had with the patient to ensure that emerging / new issues are not ignored.
- Record all concerns directly into the patient record.
- Record weight at all GI symptom consultations.
- GPs should make more use of the medical record screen to see active and past problems, and not rely on patients' memories when taking a history.
- Patient's correct address will be checked when issuing a prescription or referring.
- Advice given to patients must be fully documented, particularly in relation to follow-up and recurrence or deterioration of their symptoms.
- Careful review of records when patients attend with anxiety, as there may be a reason in the notes that the patient is not discussing.
- Use clearer language in patient notes.
- In future cases, follow-up is to be discussed with patients and documented. Their agreement or dissent is to be recorded.
- Make sure that other staff, including practice nurses, are carefully documenting any symptoms described to them, even on routine visits such as smoking cessation.

## GENERAL SYSTEMS

- Review methods of patient recall and how patients are informed after abnormal CXR results.
- Record the date when a blood test should be performed when requesting this from the district nurse.
- Certain administrative tasks such as urgent scans, referrals, blood tests should be undertaken personally by the GP to prevent delays.
- Use cervical smear encounters opportunistically to ask about any health problems or concerns.
- Patients to continue to be safety-netted to call back if they have not received their referral in the stipulated expected time.

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## GUIDELINE-RELATED

- Cervical radiculopathy 'red flag' guidance has been made accessible to all clinicians on their computer desktops.
- Patients with dyspepsia that does not respond to the therapeutic options detailed in the NICE guidance will be referred for gastroenterology opinion sooner.
- Patients with iron deficiency anaemia of <10 (women and non-menstruating) and <11 (men) must be referred to secondary care under the 2WW system.
- Continue to follow NICE guidelines for management of dyspepsia.

**FIGURE 2: CHANGES MADE AT PRACTICE LEVEL**

**CLINICAL CARE**

- Appointment of a lead clinician, responsible for delivering care, for every seriously ill patient in the practice, to encourage continuity and better communication with secondary care; this person will also liaise with all ancillary staff involved.
- Need to monitor weight in housebound patients more closely; investigating use of portable scales for that purpose.
- Increased vigilance in the practice of all doctors to not allow patients to 'fall between specialties'.
- As far as possible, patients should see the same GP for an ongoing problem.
- Urgent results to be passed on the same day to the doctor dealing with a case, or in their absence, to the doctor on call.
- Prescribing policy has been amended to include ensuring that monitoring bloods are kept up-to-date where needed.
- More slots have been made available within the phlebotomy service.
- Continue to manage 'vulnerable' groups as pro-actively as we can.
- The practice plans to start a process to follow-up for dementia patients, and has a protocol in place.
- Regular recording of patient weight added to the COPD template.
- CXR for all newly diagnosed COPD patients added to the COPD template.
- Smokers who attend for chronic disease review to be asked about respiratory symptoms; if these are present, the patient will be referred to a GP.
- GPs to be available to practice nurses during COPD clinics for discussion of spirometry results and to review new or deteriorating chest signs.
- Heightened awareness at the practice level, of the importance of dysphagia as a marker of referral.
- Patients receiving regular PPI drugs must have regular clinical review; the clinician responsible for authorizing repeats must insist on clinical review.
- We have revisited the practice level protocol for infertility investigations in females, and have educated all clinicians to ensure that the protocol is followed.

**PATIENT CONTACT**

- Patients will be contacted after DNA letters are received from hospital.
- Validation of patient addresses and phone numbers.

- Each time a patient has a blood or other test they have to provide an up-to-date phone number.
- Code added to clinical records to indicate whether a patient has been told results (to facilitate follow-up).
- Cancer symptom related leaflet displays have been installed outside the consulting rooms.
- Poster placed in waiting room to raise awareness of ovarian cancer among patients.

**TEAM WORKING**

- Minutes will be circulated to all team members not available to attend meetings where cases are discussed.
- Discussion of patients at the monthly cancer care review meeting will include access to notes, in order to highlight outstanding letters etc. (these can then be requested).
- All new cancer diagnoses discussed at regular practice meetings.
- Partners reminded of the need to spend time to meet each day to discuss difficult cases.
- To talk to locums about the patients they are seeing.
- GPs agree to send task messages, using the internal message system, on all abnormal results. Messages are sent to the doctor who requested the test, and the doctor to whom the result has been passed is documented in the patient's notes.
- Issues of serious non-concordance by patients will be brought to clinical meetings so that all GPs are aware of this. This should enable those who have knowledge of the patient's family network to consider actions to improve concordance.
- Minutes of cancer significant events meeting were distributed to all clinicians.
- The non-clinical members of staff who have got to know the patients over years are encouraged to inform the GPs of any concerns that they have about patients' / families' wellbeing.
- Nurses who see patients with suspicious symptoms are asked to refer patients to the GP within 2 days, or at least discuss the patient straight away.
- If other colleagues are involved with a patient prior to diagnosis, ensure they are informed. This can be made part of the integrated team review.

**AUDIT**

- Reviewed scanned hospital information to ensure that this is stored in order and date.
- Regular cancer death audits will be held.

- Annual review of all cancers presenting in the practice in that year.
- Development of a practice policy to be followed when patients present with any persistent condition lasting more than three months, including consideration for further investigation; practice to audit process after six months by identifying all entries for 'cough' to make sure that multiple entries have been reviewed by a GP.
- Conduct a search for all patients with Barrett's Oesophagus to ensure that they are compliant with their PPI medication, and that they are reviewed regularly for red flag symptoms.

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### EDUCATION / TRAINING

- GP trainer will use tutorial when a new GP registrar joins the practice to review NICE referral guidance for suspected cancer. They will also review the urgent cancer referral pathway using the local cancer network referral forms.
- Incorporating these cases into the teaching and development of trainees. Allowing them to read these cases will reinforce learning objectives around the clinical presentation, investigation and management of ovarian cancer.
- The practice has implemented two weekly clinical education meetings, enabling all clinical staff to attend and have the opportunity to discuss problems or referrals etc.
- Doctors to attend regular courses to keep up to date with trends in gynaecology.

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### GUIDELINES & THE 2 WEEK WAIT

- Practitioners are more aware of guidelines and criteria for review.
- Planning a new system to ensure that all NICE guidance relevant to primary care is considered and implemented in the practice.

- All practitioners to receive a copy of the NICE guidelines on diagnosis.
- The practice now follows NICE and 2WW guidelines. Relevant information is on the shared drive and clinicians can access this freely when in doubt.
- 2WW guidelines are displayed on the clinical notice board and in a folder for the attention of locum clinicians.
- Be pro-active in chasing patients who DNA 2WW appointments, and if necessary, follow-up with telephone calls and a home visit; a letter is not enough.
- Secretarial protocol for 2WW referrals will be reviewed to ensure that the referral is received promptly, and that dates of appointments are received and communicated and checked with the patient.
- Patients are routinely asked to book follow-up appointment with a GP for 7-14 days after their 2WW appointment, and GP follow-up will continue until cancer is confirmed or excluded.
- Initiated a review of cancer referral protocols and identification of investigations that can be arranged simultaneously with the 2WW. Early availability of results may improve subsequent management of cases.
- We will be more alert to shortcomings of the 2 week wait system.....and will ensure all system failures are in future notified to the cancer lead.
- Awareness of where and when to consult guidance on criteria for urgent x-ray.
- Raised awareness of 2WW referrals in the elderly with anaemia and weight loss.
- Refreshed knowledge of the 2WW referral guidelines for gastrointestinal symptoms.



### FIGURE 3: CHANGES MADE AT NETWORK LEVEL

- Clearer documentation of GP concerns in admission letters to ensure that these are not missed.
- When using the 2WW system, the code for reason for referral should be added to the referral letter.
- All cancer patients are now run through the practice Keep Improving the Experience (KITE) system.
- Administrative staff to continue to follow-up 2WW referrals; if no appointment is offered to a patient within 24 hours they will follow this up with the appropriate speciality.
- Audit of results received to measure length of time to reporting for radiology reports, as there can be lengthy delays.
- Use of a 'forward diary' by individual GPs and by the practice as a whole to pick up on reports that have not been sent to primary care.
- All practice doctors to complete a 2WW unless it is absolutely clear that someone in hospital has taken care of the onward referral.

- Continue to encourage hospital administration to confirm receipt of our referral letters, especially 2WW letters.
- To use the urgent referral pathway for USS in suspected ovarian cancer, using the local cancer network referral form.
- Audit of numbers of patients who fail to attend for CXR, along with the indication for CXR.
- Consider sharing guidelines, and possibly embed future NICE guidance in the working of the clinical team, through education meetings both in-house and outside the practice.
- Be more questioning of secondary care if there are still concerns about a patient.
- Raised awareness of the extended second opinions and anti-cancer trials offered by local hospital.

# Part 2: Planning for improvement



Examining the current situation

### Why review cancer?

**29.** One of the key messages arising from the data presented in **Part 1** of this Toolkit, is that cancer diagnosis in primary care is complex. Patients infrequently present with classic red-flag symptoms, but they often present their symptoms in the context of other illnesses.

**30.** That being the case, the process of reflecting on cancer diagnosis is useful in enabling practice teams to consider and discuss patterns of presentation, along with the processes within the practice that facilitate diagnosis.

**31.** Such reflection is undoubtedly valuable for shared, experiential learning within the practice team, as well as being useful in the continued professional development of individual clinicians.

**32.** It is also likely that practice changes enacted as a result of reflection and discussion, along with any subsequent action planning, will be of benefit to patients beyond those with a potential cancer diagnosis, and will help improve quality of care across the practice population as a whole.

### Quality assessment

**33.** In areas where we are unable to benchmark quality in a clear quantitative manner ~ as is possible for many of the QOF domains ~ quality improvement requires different methods of collecting data and assessing activity. So for early cancer diagnosis, where it is difficult to determine standards for many aspects of the diagnostic and referral process, it is useful to consider quality improvement at its most fundamental:

- What is the existing situation?
- What works well?

- What processes would benefit from change?

### The current situation

**34.** Two methods of reviewing the current situation with a view to establishing a basis from which to consider the processes and activities that work well or that might benefit from change are **quantitative audit** and **significant event review**. As a result of projects outlined in the **Summary** and in **Part 1**, there are now tools available that have been produced specifically for considering cancer diagnosis in general practice. These are the RCGP-NCAT **Cancer Diagnosis Audit Tool**, and the **Cancer SEA Template**.

### Cancer diagnosis audit

**35.** The RCGP-NCAT audit template (Cancer Diagnosis Audit Tool) was produced in response to the Cancer Reform Strategy.<sup>1</sup> It was developed and tested by a group made up of service and academic GPs ~ including primary care cancer leads ~ using knowledge and experience gained from previous local audits related to cancer diagnosis.<sup>2</sup>

**36.** The Audit Tool facilitates the collection of the key items of data that are relevant when assessing cancer diagnosis. This includes patient demographics, relevant communication factors, and co-existing disease, as well as data related to symptom assessment, investigation, and the process of referral in primary care (**Table 9**).

**37.** The data fields are contained in a Microsoft Excel workbook, which includes guidance on data entry (outlined at the top of each field) as well as detailed notes about much of the information required (via a *Notes* tab at the bottom of the worksheet). To make data entry as straightforward as possible, the tool

uses a combination of drop-down lists of predetermined responses (for diagnosis, stage, investigations etc.) and free text entries (for dates, symptoms etc.).

**TABLE 9: CANCER AUDIT DATA**

Key cancer data fields
<b>Demographics</b>
▶ date of birth
▶ gender
▶ ethnicity
<b>Communication &amp; social</b>
▶ language barrier / speech impaired
▶ poor hearing / poor vision
▶ mental health
▶ learning difficulty
▶ dementia
▶ housebound
<b>Co-morbidity</b>
▶ hypertension
▶ cardiovascular disease
▶ diabetes
▶ cerebrovascular disease
▶ chronic respiratory disease
▶ arthritis
<b>Diagnosis</b>
▶ cancer site
▶ date of diagnosis
▶ stage at diagnosis
<b>Presentation &amp; investigation</b>
▶ location of first presentation
▶ date of first presentation
▶ main presenting symptom
▶ number of visits before referral
▶ investigations used
<b>Referral</b>
▶ date of referral
▶ speciality
▶ type of referral
▶ date first seen by specialist
▶ presence of delay
<b>Outcomes</b>
▶ date of death (if deceased)

**38.** By using this tool to collect and collate relevant information, practices will be able to review diagnostic and referral intervals over a specified period of time. This in turn will allow them to identify and reflect on a variety of factors where lessons may be learned in relation to areas where improvement is possible. This includes:

- symptom patterns related to particular cancers/patient groups
- length of time between presentation and referral
- patient factors associated with earlier or later referral
- the urgency of referrals
- any delays around diagnosis and/or communication

**39.** Some key steps to follow when undertaking an audit of cancer diagnosis are:

**Step 1: agree who will be responsible** for completing the audit. This should be a clinician, but a lead member of the administrative staff should also be identified.

**Step 2: decide on the period of time** to be used when identifying cases. This is usually 12 months, but can be less. On average, eight new cancers will be diagnosed per full time GP in a 12 month period.

**Step 3: decide on the data to be collected** and identify the sources that will be used for this. This will primarily involve reviewing the patient's record, but may include some discussion with colleagues ~ for example when considering factors related to management of the case, or possible delays in the patient's journey.

**Step 4: identify all relevant patients.** Assuming that all cancer diagnoses have been correctly coded, and the data entered for QOF purposes, the QOF cancer

register is a useful starting point in identifying relevant cases for audit. However, it will not include patients who have recently died or left the practice, and it may be necessary to run a separate search using Read codes (codes for malignant neoplasms have a B root: B0..., B1..., B2..., etc.).

**Step 5: include only confirmed malignancies.** Ensure that cases of carcinoma in situ and non-malignant melanoma are excluded from the audit.

**The Audit Tool is available for download [here](#).**

### Cancer diagnosis SEA

**40.** Significant Event Audit as a quality improvement technique is already widely used in primary care practice. It provides a structured narrative analysis of the circumstances surrounding an event of interest,<sup>3</sup> and although it can be applied to any aspect of care, it is perhaps most often used for events where something went wrong or almost went wrong ~ most SEA topics suggested by QOF relate to adverse events such as medication errors or harm to patients, sudden death, admissions under the Mental Health Act, or child protection issues.<sup>4</sup>

**41.** Diagnosing cancer in primary care is complex, and GPs have to distinguish between those patients whose symptoms may be due to cancer and the much larger number whose symptoms are attributable to existing morbidity, or to self-limiting illness. Given the relative infrequency with which individual GPs encounter a cancer diagnosis, considering and reviewing each one as a significant event is a valuable way of learning from the strengths and weaknesses in the processes involved.

**42.** The Cancer SEA Template that we have produced adapts the generic SEA format (as recommended by the NPSA) to facilitate reflection and learning around the key elements surrounding the process of cancer diagnosis in primary care. This includes symptoms on initial presentation, the patient's recent presenting history, practitioner assessment of symptoms, use of diagnostic services, use of safety-netting and follow-up, speed of referral, and use of cancer referral guidelines.

**43.** By using this template to collect information and structure discussion, primary care teams will be able to reflect on the specific factors that are relevant to cancer diagnosis in their practice, to identify learning points and learning needs related to this, and to highlight and implement any changes necessary to improve on the existing situation. In addition, SEA reports from individual practices could be provided to the cancer network for combined analysis, and the synthesised findings used to improve local pathways to diagnosis.

**44.** The key steps involved in undertaking an SEA of a cancer diagnosis are:

**Step 1: decide on the cancer sites and number of cases** to be reviewed. For maximum points, QOF expects a minimum of three SEAs in a 12 month period. You should agree whether it would be most useful to consider a range of cancers, or to review the most recent diagnoses for a single site.

**Step 2: agree who will be responsible** for carrying out the SEA(s). Although completion of the report may involve discussion with colleagues, a co-ordinator should be identified who has responsibility for undertaking the SEA.

This might be the clinician who was most involved with the patient prior to the diagnosis being made.

**Step 3: collect as much relevant information as possible** before completing the SEA report. This is likely to involve reviewing the patient's record, and discussing the event with colleagues who may have been involved with the patient before diagnosis. Where possible this should include information on the initial presentation (including date, presenting symptom(s), duration of symptoms), GP response to initial and any ongoing symptoms, use of examination and diagnostic services, the key consultation at which the diagnosis was made, the patient's recent presenting history, and the referral (date, type and speciality).

**Step 4: organise a team meeting** to discuss the case(s). This should be a facilitated meeting for the purposes of shared reflection and learning. It should be structured, with basic ground rules to ensure that all opinions are valid, and that no 'blame' is directed at any individual(s) during the discussion. Minutes of the meeting should be taken including the key issues identified along with any related action points. These can then be circulated to all team members, including those who were not present at the meeting.

**Step 5: discuss the case using the four questions in the SEA report** ~ "What happened?", "Why did it happen?", "What has been learned?", "What has been changed"? The discussion should involve careful reflection of why events occurred as they did, as well as identification of any good aspects of care, learning needs, or changes required.

**Step 6: agree and implement any changes** to be made. This should include identifying and agreeing on

someone to oversee the changes, and to monitor these over a specified time period. This will help ensure that any alterations to practice systems and procedures are sustained beyond the short term.

**Step 7: complete the SEA report** documentation. The report template can now be completed using the factual information collected about the case, the discussion and minutes from the team meeting, and knowledge of the implemented changes. This can then be used for QOF and/or personal appraisal. In addition, SEA reports could be shared locally.

General information on undertaking SEA ~ produced by NPSA ~ can be found [here](#).

**The Cancer SEA Template has been provided as part of this Toolkit.**

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Greg Rubin was Project Lead for the National Cancer Diagnosis Audit. For further information about this ~ or about the audit tool ~ *email* [g.p.rubin@durham.ac.uk](mailto:g.p.rubin@durham.ac.uk).

The Cancer SEA Template was developed by Elizabeth Mitchell and Una Macleod as part of the SEA of Cancer Diagnosis project. For further information about this, *email* [una.macleod@hyms.ac.uk](mailto:una.macleod@hyms.ac.uk), or [liz.mitchell2@gmail.com](mailto:liz.mitchell2@gmail.com).

## SIGNIFICANT EVENT AUDIT OF CANCER DIAGNOSIS

### Cancer SEA Report Template

<b>Diagnosis:</b>	
<b>Date of diagnosis:</b>	
<b>Age of patient at diagnosis:</b>	
<b>Sex of patient:</b>	
<b>Is the patient currently alive (Y/N):</b>	
<b>If deceased, please give date of death:</b>	
<b>Date of meeting where SEA discussed:</b>	

N.B.: Please DO NOT include the patient's name in any narrative

#### 1. WHAT HAPPENED?

Describe the process to diagnosis for this patient in detail, including dates of consultations, referral and diagnosis. Consider for instance:

- The initial presentation and presenting symptoms (including where if outwith primary care).
- The key consultation at which the diagnosis was made.
- Consultations in the year prior to diagnosis and referral (how often the patient had been seen by the practice and for what reasons).
- Whether s/he had been seen by the Out of Hours service, at A&E, or in secondary care clinics.
- If there appears to be delay on the part of the patient in presenting with their symptoms.



## 2. WHY DID IT HAPPEN?

Reflect on the process of diagnosis for the patient. Consider for instance:

- If this was as good as it could have been (and if so, the factors that contributed to speedy and/or appropriate diagnosis in primary care).
- How often / over what time period the patient was seen before a referral was made (and the urgency of referral).
- Whether safety-netting / follow-up was used (and if so, whether this was appropriate).
- Whether there was any delay in diagnosis (and if so, the underlying factors that contributed to this).
- Whether appropriate diagnostic services were used (and whether there was adequate access to or availability of these, and whether the reason for any delay was acceptable or appropriate).

## 3. WHAT HAS BEEN LEARNED?

Describe the discussion at the team meeting, and demonstrate that reflection and learning have taken place, and that team members have been involved in considering the process of cancer diagnosis. Consider, for instance:

- Education and training needs around cancer diagnosis and/or referral.
- The need for protocols and/or specified procedures within the practice for cancer diagnosis and/or referral.
- The robustness of follow-up systems within in the practice.
- The importance and effectiveness of team working and communication (internally and with secondary care).
- The role of the NICE referral guidelines for suspected cancer, and their usefulness to primary care teams.

Learning point 1:

Learning point 2:

Learning point 3:

Learning point 4:

#### 4. WHAT HAS BEEN CHANGED?

Outline the action(s) agreed and/or implemented. Consider, for instance:

- If a protocol has been introduced, updated or amended, how this was done, who it will involve, and how the related changes will be monitored.
- If there are things that individuals or the practice as a whole will do differently (detail the level at which changes are being made and how are they being monitored).
- Whether the changes will bring improvements to the diagnosis of a specific cancer group, or whether the impact will be broader.
- Consider both clinical and administrative issues.

#### WHAT WAS EFFECTIVE ABOUT THIS SEA?

Consider how carrying out this SEA has been valuable to individuals, to the practice team and/or to patients.

#### SOME INFORMATION ABOUT YOUR PRACTICE \*

How many registered patients are there?						
How many F.T.E. GPs are there (inc. principals, salaried GPs, trainees etc.)?						
Is your practice a training practice?				Yes		No
Does your practice teach medical students				Yes		No
What were your QOF points last year?		Clinical		Organisation		Total
OUT OF:		650		167.5		1000

\* This information is useful when collating results across practices and/or localities

# Part 3: Moving forward



Developing a strategy for improvement

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## Making a change

**45.** The earlier sections of this document have been focused on gaining an understanding of the current situation surrounding cancer diagnosis in primary care practice. **Part 1** presents the lessons that were learned by practices reflecting on recent cancer diagnoses, and highlights some of the changes that were implemented in response to those lessons. **Part 2** presents tools that may be useful to practices when thinking about reviewing and improving on the existing care that they provide in this area.

**46.** This final section contains a **Cancer Action Plan** that we have designed for use in primary care. We hope that practices will find it a valuable tool when reviewing cancer diagnosis, and outlining the steps that need to be taken in order to bring about change.

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## Cancer Action Plan

**47.** The Cancer Action Plan is divided into two parts:

- the first records key items of data related to current activity and helps to establish targets for the future
- the second details the key tasks to be undertaken in order to improve cancer-related activities across a range of areas

**48.** The Action Plan template has been designed to be as comprehensive as possible, and as such, provides direction for a wide range of action points

across a variety of areas. The basic template can be modified according to individual practice circumstances and requirements, and specific areas and/or action points excluded or additional ones added where necessary. Practices may also choose to focus on some areas or actions in a given year, then review progress and opt to focus on further activities in the following year(s).

**49.** The contribution that primary care makes to early cancer diagnosis goes beyond assessment and referral of symptomatic patients, and also involves activity around prevention and screening. As such, these aspects have been included in the template.

**50.** The Cancer Action Plan is intended to be a “live” document that is revisited periodically by the practice throughout the year to assess progress. It contains pointers to where practices can obtain useful data, as well as options for more detailed analysis and review of care.

**51.** We anticipate that the plan template will be used in conjunction with the audit and SEA tools described earlier in this document. However, practices that have already carried out cancer-related audits will be able to utilize the Cancer Action Plan template in combination with those, as they will nonetheless provide a useful basis from which to plan for improvement.

If you have any feedback about the Cancer Action Plan ~ or about any other part of this Toolkit ~ please send it to Elizabeth Mitchell (*email: liz.mitchell2@gmail.com*).

## CANCER ACTION PLAN FOR GENERAL PRACTICE

### Facilitating earlier diagnosis

<b>Practice:</b>		<b>Identifier:</b>	
<b>Date plan initiated:</b>		<b>Plan completed by:</b>	
<b>Frequency of review:</b>	3 / 6 / 12 monthly	<b>Date of next review:</b>	
<b>Monitoring:</b>	Review of Plan progress and discussion of updates and amendments to take place at practice-based learning sessions.		

The purpose of this template is to:

- Provide a framework for developing an Action Plan to improve early detection of cancer.
- Enable review of activities and performance related to cancer screening, prevention and diagnosis.
- Enable review of the systems used to facilitate screening, prevention and diagnosis.
- Help identify current good practice, and areas for change.
- Encourage shared-learning around diagnosis of cancer.
- Facilitate improvements in patient care.

The first part involves documenting the key data that will help in assessing current activity and establishing future targets. It can be completed using a combination of practice-run searches, the National Cancer Intelligence Network Practice Cancer Profiles, and clinical audit.

The second part involves detailing the key tasks that may help to improve cancer-related activity across a range of areas.

The Cancer Action Plan template has been designed to be comprehensive, and it provides direction for a wide range of action points across a number of areas. Specific areas and/or action points can be excluded ~ or additional actions added ~ in response to individual practice circumstances and requirements. It is anticipated that practices may choose to focus on some areas or actions in a given year, then review progress and opt to focus on further activities in the following year(s).

This template does not cover activities related to end of life care, as these are covered well elsewhere [see the Gold Standards Framework at <http://www.goldstandardsframework.org.uk/>].

#### Useful data and tools <sup>1</sup>

Cancer Research UK	<a href="#">Cancer statistics</a>
National Awareness & Early Detection Initiative	<a href="#">Information and updates on activity</a>
National Cancer Action Team	<a href="#">Early diagnosis resources for GPs</a>
National Cancer Intelligence Network	<a href="#">GP Practice Profiles</a>
National Institute of Clinical Excellence	<a href="#">Cancer referral guidelines</a>
Public Health Observatories	<a href="#">National General Practice Profiles</a>
RCGP Cancer Diagnosis Audit Tool	<a href="#">Audit template</a>
Cancer Significant Event Audit Template	From the <i>Improving Cancer Diagnosis Toolkit</i>
National Patient Safety Agency	<a href="#">Significant Event Audit guidance</a>

<sup>1</sup> Click on the hyperlink to be taken to the relevant website.

## PART 1: ACTIVITY DATA

The following data are required in order to facilitate monitoring of cancer related activity within the practice, and to contribute to the development of a Cancer Action Plan to aid early diagnosis.

Data related to current activity levels should be reviewed and updated every 12 months. Target levels and associated Action Plan activities can then be revised or removed as required. Levels set may be based on existing national targets (e.g. screening or smoking), locally set targets (e.g. cancer referrals), or targets that you aspire to as a practice (e.g. cases of avoidable delay).

Screening data (previous 12 months) <sup>2</sup>	Current	Target
Uptake of cervical screening (women aged 25-64)	%	%
Uptake of breast screening (women aged 50-70)	%	%
Uptake of bowel screening (persons aged 60-69)	%	%

Risk factor data <sup>3</sup>	Current	Target
Registered patients with smoking status recorded	%	%
Current smokers offered smoking cessation	%	%
Uptake of smoking cessation in known smokers	%	%
Registered patients with weight recorded	%	%
Patients classed as obese offered diet / exercise therapy	%	%
Uptake of diet / exercise therapy in patients classed as obese	%	%

Cancer referrals audit (previous 12 months) <sup>4</sup>	Current	Target
Total number of new cancer diagnoses		—
Two-week-wait referrals	%	—
Two-week referrals with cancer (conversion rate)	%	%
Cancer diagnosed as a result of emergency presentation	%	%
Diagnoses where avoidable patient or practice delay was present	%	—

SEA data (for diagnoses in previous 12 months) <sup>5</sup>	Number
Total number of Cancer SEAs undertaken (QOF expects ≥3 completed SEAs)	
Key actions identified (e.g. relating to use and follow-up of investigations, or to use of safety-netting):	
Action 1:	
Action 2:	
Action 3:	
Action 4:	
Action 5:	

<sup>2</sup> Complete using data from practice-run searches, and NCIN General Practice Profiles etc.

<sup>3</sup> Complete using data from practice-run searches.

<sup>4</sup> Complete using data from practice register and completed RCGP-NCAT audit template.

<sup>5</sup> Complete using data from significant event analysis undertaken.



## PART 2: ACTION PLAN TEMPLATE

AREA OF ACTIVITY	KEY ACTIONS	RESPONSIBILITY	DUE DATE	CURRENT STATUS	COMPLETE
<b>A: Screening</b>					
Maximise uptake of cervical, breast and bowel screening among practice patients	Identify screening uptake rates for the target populations in the previous 12 months				<input type="checkbox"/>
	Implement processes to target defaulters <sup>6</sup>				<input type="checkbox"/>
	<sup>7</sup> Method(s):				
<b>B: Prevention</b>					
Improve recording of smoking status	Identify existing level of recording for smoking status data				<input type="checkbox"/>
	Review current methods of recording among practitioners				<input type="checkbox"/>
	Implement processes to increase recording of smoking status (e.g. computer alert messages)				<input type="checkbox"/>
	<sup>7</sup> Method(s):				
Increase smoking cessation among known smokers <sup>8</sup>	Identify current prevalence of smoking				<input type="checkbox"/>
	Review smoking cessation uptake rates				<input type="checkbox"/>
	Implement processes to target patients and increase uptake of smoking cessation <sup>6</sup>				<input type="checkbox"/>
	<sup>7</sup> Method(s):				
Improve recording of weight in adult patients	Identify existing level of recording for weight				<input type="checkbox"/>
	Review current methods of recording				<input type="checkbox"/>
	Implement processes to increase recording of weight (e.g. computer alert messages)				<input type="checkbox"/>
	<sup>7</sup> Method(s):				

<sup>6</sup> This may vary for each type of screening, and could involve multiple methods such as: computer alert messages, text messages, telephone calls, targeted letters, posters and/or flyers in the waiting area, “open-days” similar to flu clinics for cervical screening etc.

<sup>7</sup> Document the methods to be used for targeting defaulters and/or increasing recording.

<sup>8</sup> Similar action points related to targeting other risk factors – e.g. alcohol consumption, sun-bed use – could be added.

AREA OF ACTIVITY	KEY ACTIONS	RESPONSIBILITY	DUE DATE	CURRENT STATUS	COMPLETE
Increase uptake of diet and/or exercise among patients classed as obese	Identify current level of obesity in adult patients				<input type="checkbox"/>
	Review uptake of diet and/or exercise therapy				<input type="checkbox"/>
	Implement processes to target patients and increase uptake of diet and/or exercise <sup>6</sup>				<input type="checkbox"/>
	<sup>7</sup> Method(s):				
<b>C: Audit</b>					
Quantitative audit of all new cancer diagnoses in the previous 12 months	Download Cancer Diagnosis Audit Tool and complete for each new diagnosis <sup>9</sup>				<input type="checkbox"/>
	Review audit results to identify key issues				<input type="checkbox"/>
SEA of new cancer diagnoses in the previous 12 months (QOF expects ≥3 completed SEAs)	Complete a Cancer SEA Template for each individual diagnosis				<input type="checkbox"/>
	Review SEA reports to identify key messages and learning points (inc. what is done well)				<input type="checkbox"/>
Organised learning session for practice team (protected time)	Discuss findings from the quantitative audit and SEA analysis, and agree necessary changes				<input type="checkbox"/>
	Incorporate key actions related to the agreed changes into the Cancer Action Plan <sup>10</sup>				<input type="checkbox"/>
<b>D: Presentation and diagnosis</b>					
Raise awareness of cancer symptoms among patients	Display cancer symptom awareness leaflets / posters in the waiting room				<input type="checkbox"/>
Raise practitioner awareness of the importance of comprehensive history taking and record keeping	Reinforce the need to document length of time with symptoms <sup>10</sup>				<input type="checkbox"/>
	Ensure recent presenting history is reviewed before all consultations, including home visits <sup>10</sup>				<input type="checkbox"/>
	Ensure that negative findings are recorded in the patient's record <sup>10</sup>				<input type="checkbox"/>

<sup>9</sup> RCGP-NCAT Cancer Diagnosis Audit Tool is available from: [http://www.dur.ac.uk/school.health/erdu/cancer\\_audit/cancerdiagnosisaudittool/](http://www.dur.ac.uk/school.health/erdu/cancer_audit/cancerdiagnosisaudittool/)

<sup>10</sup> It may be useful to conduct internal audits of key action points to ensure successful implementation and uptake within the practice

AREA OF ACTIVITY	KEY ACTIONS	RESPONSIBILITY	DUE DATE	CURRENT STATUS	COMPLETE
Continuity during diagnosis of suspected cancer	Implement process to ensure continuity of care for individual illness episodes where possible <sup>10</sup>				<input type="checkbox"/>
	Ensure that safety-netting details and advice are documented in the patient notes <sup>10</sup>				<input type="checkbox"/>
Review and revise practice safety-netting procedures	Develop procedures for review of patients with non-resolving symptoms (may involve providing dated return appointment) <sup>10</sup>				<input type="checkbox"/>
	Develop procedures for review / re-investigation of patients following negative test results <sup>10</sup>				<input type="checkbox"/>
	Reassess practice system for review and communication of abnormal results (there should always be a clear action for follow-up) <sup>10</sup>				<input type="checkbox"/>
	Consider protocol for follow-up of two-week referrals and receipt of appointment <sup>10</sup>				<input type="checkbox"/>
	Implement a process to follow-up patients who DNA investigations or referral appointments <sup>10</sup>				<input type="checkbox"/>
<b>E: Referral</b>					
Raise awareness of two-week wait referral criteria	Ensure that all clinical staff (including locums) have ready access to cancer referral guidelines during consultations				<input type="checkbox"/>
	Arrange learning session to raise awareness of the criteria for urgent referral among clinicians				<input type="checkbox"/>
Provision of information to secondary care	Agree data to be included in all suspected cancer referrals (e.g. previous investigations, differential diagnosis, reason for referral code)				<input type="checkbox"/>
<b>F: Patient care post-diagnosis</b>					
Ensure minimum data set for all cancer diagnoses	Review data entry for all cancer diagnoses in the previous 12 months				<input type="checkbox"/>
	Develop protocol to ensure complete and consistent coding and recording of cancer data				<input type="checkbox"/>
	Implement process to ensure entry of all key information related to dates, diagnosis, stage, treatments etc.				<input type="checkbox"/>
Follow-up care during cancer treatment	Insert computer alert messages for all patients undergoing chemotherapy				<input type="checkbox"/>

AREA OF ACTIVITY	KEY ACTIONS	RESPONSIBILITY	DUE DATE	CURRENT STATUS	COMPLETE
<b>G: Team work and communication</b>					
Quarterly clinical learning sessions for practice (projected time)	Develop timetable for the forthcoming year				<input type="checkbox"/>
	Agenda to include new or complex cases, referrals, and sharing of knowledge gained from courses attended or research				<input type="checkbox"/>
	Circulate timetable to all team members				<input type="checkbox"/>

# Glossary of terms



2WW	2 week wait
A&E	Accident and emergency
CA125	Cancer antigen 125 (ovarian)
COPD	Chronic obstructive pulmonary disease
CT	Computerised tomography
CXR	Chest x-ray
DNA	Did not attend
ESR	Erythrocyte sedimentation rate
FBC	Full blood count
FTE	Full time equivalent
GI	Gastrointestinal
GORD	Gastro-oesophageal reflux disease
IBS	Irritable bowel syndrome
NAEDI	National Awareness and Early Diagnosis Initiative
NCAT	National Cancer Action Team
NCIN	National Cancer Intelligence Network
NICE	National Institute of Clinical Excellence
NPSA	National Patient Safety Agency
PCT	Primary care trust
PPI	Proton pump inhibitor
QOF	Quality and Outcomes Framework
RCGP	Royal College of General Practitioners
SEA	Significant Event Audit
TYA	Teenager and young adult
USS	Ultrasound scan