NHS
South East
Clinical Networks

Summary Audit Report 2015/16

Emergency Cancer Presentations in NHS Coastal West Sussex CCG and NHS Hasting and Rother CCG

Authors: Dr Tina George, Clinical Lead Awareness and Early Diagnosis SE Cancer CN, Julia Hugason-Briem, Interim Programme Manager AEDI, SE Cancer CN, Rebecca Matthews, Analyst, Quality Observatory
Email: england.secscns@nhs.net
Web: www.secscn.nhs.uk
Twitter: @SEClinNets

Table of Contents

Executive Summary

Introduction and background

It is widely accepted that patients who are diagnosed with cancer as a result of an emergency presentation to hospital have significantly lower survival rates than those who are diagnosed via a GP 2 week wait (2WW) referral. It is an objective of the South East Cancer Strategic Clinical Network to understand variations in the rates of emergency presentations across Kent, Sussex and Surrey and to support Primary Care colleagues in the quest to reduce avoidable emergency presentations of cancer. All GP practices within Coastal West Sussex CCG (CWS) and Hastings and Rother CCG (H&R) were invited to audit their 6 most recent hospital emergency presentations which led to a diagnosis of cancer. The practices were then asked to present their audit results at a practice meeting to share the overall lessons learnt. This paper summarises the results of both the CWS and the H&R audits to draw out similarities, differences and lessons learned.

Audit objectives

An objective of this audit was to give GPs the opportunity to reflect on their own clinical practice, to understand the events which may lead to an emergency presentation and whether these could have been avoided. It is hoped that the learning generated from these audits will reduce rates of emergency presentations, improve use of the 2WW referral system and promote earlier diagnoses of cancer.

Data Collection

GPs were invited to complete this audit using the RCGP Audit Template found within the 'National Audit of Cancer Diagnosis in Primary Care' (2009/2010). Analysis of the data obtained revealed (i) the demographics of patients presenting as an emergency (ii) the types of cancer which present as an emergency (iii) pathway timescales and (iv) any learning points generated by the audit and actions agreed at the practice meeting.

Audit completeness

25 of the 54 GP practices in CWS completed this audit. 14 of the participating practices audited the full number of 6 patients.

15 of the 33 GP practices in H&R completed this audit. 14 of the participating practices audited the full number of 6 patients.

Audit findings

Patient demographics

- In CWS 69% of patients presenting as an emergency were >65 years old, however in H&R this figure was only 36%
- Nearly 86% (CWS) and 76% (H&R) of patients presenting as an emergency were white/British
- Over 1/8th of patients who presented as an emergency were housebound in both CCGs.

Cancers which present as an emergency

- In CWS and H&R Lung cancer was the most common tumour to present as an emergency, accounting for 23% of presentations in both CCGs. This was followed in both CCGs by colorectal cancer (15% CWS and 16% H&R) and pancreatic cancer (8% CWS, 10% H&R),
- In CWS prostate cancer (6%) and neurological cancer (5%) followed as the next most common presentations whilst in H&R it was leukaemia (7%) and neurological, myeloma and urological cancers each accounting for 6% of presentations.
- Significantly, distant or regional metastases were present in 71% of audited cancers at the point of diagnosis in CWS and 52% in H&R.

Pathway Timescales

- In 22% (CWS) and 24% (H&R) of audited cases, the GPs felt there were definite or possible delays to diagnosis.
- 35% of patients did not present with any relevant symptoms to Primary Care prior to their emergency presentation in CWS, this figure was 28% in H&R.
- In CWS the number of days from 1st Primary Care Presentation to new cancer diagnosis was only available in 70 of the 111 audited cases and the median days to diagnosis was 48. In

H&R this information was available for 61 of the 88 audited cases and the median days to diagnosis was 36.

- In CWS the number of days from emergency presentation to cancer diagnosis was given in 102 of the 111 audited cases and the median days to diagnosis was 21.5. In H&R this information was available for 80 audited cases and the median days to diagnosis was 10.5.

GP Learning and agreed actions were elicited by inviting practices to answer the following 4 questions (i) What happened / were there any delays or problems which resulted in the emergency presentation? (ii) Why did this occur? (iii) What learning has been generated? and (iv) What has changed / what actions have been taken as a result of undertaking the audit? There was significant variation in how GP practices chose to answer this final section of the audit. However,

- In response. to the question *'Were there any delays or problems which resulted in the emergency presentation?',* the 3 most commonly occurring themes in response to this question are listed in order of how frequently they were reported;

  CWS: (1) the patient did not attend (2) the patient was asymptomatic and (3) the patients' symptoms were missed / they should have been called back for a review

  H&R: (1) the patient presented late or with no relevant symptoms (2) there were delays in access to diagnostics and (3) the patient DNA'd

- In response to the question *'Why did this occur?'* the 3 most commonly occurring themes in response to this question were;

  CWS: (1) patient choice (2) the patient had no symptoms and (3) initial test results were normal

  H&R: (1) problems in following up patients (2) delays encountered in secondary care and (3) no relevant symptoms reported

- The final 2 questions in this section explored what actions would be taken as a result of the learning generated by the audit. Practices highlighted a range of activities to reduce emergency presentations including;

  CWS : improving patient awareness of the signs / symptoms of cancer, appropriate safety-netting (e.g. by calling patients back for a review), using aids to diagnosis (e.g. the Macmillan 'electronic clinical decision support tool'), performing in-house reviews of 2WW referrals & guidelines, attending educational events and improving standards of medical record keeping.

  H&R: appropriate safety netting (e.g. by calling patients back for review), using aids to diagnosis (e.g. Q-risk tool), performing in house reviews of new cancer diagnoses and emergency presentations, attending educational events and improving patient awareness of the signs and symptoms of cancer.

Conclusions

Some caution has to be exercised in the interpretation of these results due to the modest response rate from GP practices. There are many similarities in the results from the two CCGs:

- Being housebound is a significant risk factor for emergency presentations.
- Lung cancer was the most common tumour to present as an emergency, followed by colorectal cancer and pancreatic cancer.
- Distant or regional metastases were present in the majority of audited cancers at the point of diagnosis.
- In just under one quarter of audited cases, GPs were able to identify definite or possible delays to diagnosis.
- GPs were aware that the complexity of clinical presentations to Primary Care renders cancer a difficult diagnosis to make at the earliest stages.
- Between one quarter and one third of audited patients did not present to Primary Care with any relevant symptoms prior to the emergency presentation.
- Practices identified similar actions which may reduce emergency presentations in the future. Examples include; calling patients back for a review of their symptoms, not being falsely reassured by initial normal test results, improving patient education and increasing the standards of medical record keeping.

However, there were also some striking differences:

- The majority of patients who are diagnosed with cancer via an emergency presentation to hospital are aged 65 or over in CWS but in H&R the majority are under the age of 65.
- The median number of days from emergency presentation to cancer diagnosis in CWS was double that of H&R.
- Distant metastases were present in half of audited cancers at the point of diagnosis in CWS and two fifths in H&R.

The reasons for the differences in the results between the two CCGs were not investigated as part of this project, and are likely to be complex and multifactorial. However, the two CCGs do have differences in their patient demography which is likely to be an influencing factor.

CCG background

The two CCGs that took part in this audit are NHS Coastal West Sussex CCG (CWS) and NHS Hastings and Rother CCG (H&R).

CWS, with a registered population of 498,740 [1], is significantly larger than H&R which has a registered population of 183,709 [2]. Both CCGs have an older age profile than England, with 25% (CWS) and 23% (H&R) of the population over the age of 65; the England average is (17%). Each CCG has 4% of their population over 85 years and approximately 26% aged 24 and under.

Both CCGs have approximately 8% [3,4,] of residents of an ethnic group other than White British and Northern Irish, which is below the England and Wales average (19.5%). The largest of these groups is Other White 3.4% (CWS) and 2.8% (H&R).

In CWS life expectancy at birth is 80.2 (males) and 83.7 (females) and life expectancy at age 65 is an additional 19.2 (Male) and 21.7 (female) years [5]. In H&R life expectancy at birth is 78.9 (males) and 82.7% (females) and life expectancy at age 65 is an additional 18.8 (Male) and 21.3 (female) years [5].

CWS has pockets of deprivation, with 1.3% of the Lower-layer Super Output Areas (LSOAs) in most deprived 10% nationally; the CCGs IMD average score is 15.8 and is ranked number 153 of 209 CCGs in England [6]. H&R, on the other hand, has a higher deprivation profile, with an IMD score of 25.8 and a ranking of 69 of 209 CCGs. 15% of the LSOAs in H&R are in the most deprived 10% nationally [6].

In both CCGs the main cause of premature mortality (under 75 years) is cancer (47% CWS and 43% H&R) followed by circulatory diseases (22% CWS and 21% H&R) [1,2].

Smoking prevalence in adults in West Sussex (17%) and East Sussex (17.4%) are below the England average (18%) as are smoking attributable to mortality and smoking attributable to hospital admissions [7].

The proportion of people who are overweight or obese has been steadily increasing nationally over the last few years. For adults over 16 in CWS 35.3.5% were classified as a healthy weight with 22% as obese an 63.7% as having excess weight. In H&R 34.5% were a healthy weight, 23.5% obese and 64.5% excess weight [8].

References

1. West Sussex JSNA CWS Data pack 2014 (revised October 2015)
2. Hastings and Rother CCG business Plan 2015-16
3. CWS data back JSNA 2014 revised 2015
4. H&R CCG area summary based on JSNAA scorecards 2015
5. ONS life expectancy at birth and age 65 by CCG 2010-12
6. English Indices of Deprivation 2015, File 13 CCG Summaries, Department for communities and Government
7. Tobacco Profiles
8. Local Authority Adult Excess Weight Prevalence Data, 2012-14, PHE)

Introduction and background to the audit

All GP practices within Coastal West Sussex CCG and Hastings and Rother CCG were asked to audit the 6 most recent emergency presentations (in hospitals) which led to a diagnosis of cancer for patients from their surgery. Practices were then asked to present the audit results at a practice meeting and complete paperwork around the specific details of each patient and also overall lessons learned.

This audit was highlighted as being important for a number of reasons:

- Most patients who are diagnosed with cancer via emergency presentations have significantly worse survival rates compared with those who are diagnosed via a 2-week rule referral.
- By performing this audit, GPs will have an opportunity to reflect on their own practice, understanding the events which may lead to an emergency presentation and whether these could have been avoided. It is hoped that this will reduce the rates of emergency presentations and improve the use of the 2-week rule referral pathway.
- Quality improvement activities such as emergency presentation audits are an important aspect of GP appraisal and revalidation.

Data completeness

All GP Practices in the CCGs were asked to complete an audit. In CWS, audit forms were returned by 25 practices, with 14 of those practices auditing the full number of 6 patients. In H&R audit forms were returned by 15 practices with 14 of those auditing the full number of 6 patients.

Demographics

Information was collected on age, gender and ethnicity of the patients. Practices also noted if patients had communication problems or were housebound.

In CWS the majority of patients audited were over 65, 77 of the 111 patients audited (69%) were over 65. In H&R 56 of the 88 patients audited were under 65.

In CWS there were roughly equal numbers of male and female patients with 54 male patients and 56 female patients being audited. The gender of 1 patient was not noted. In H&R there were more female than male patients audited with 49 female and 39 male.

In CWS the majority of patients audited were noted as being Caucasian or White British. 95 patients audited (85.6%) fell into this category. 3.6% of patients were recorded as being Mixed British and the ethnicity of the remaining 12 patients was not noted. In H&R the majority of patients were noted as being White or White British. 67 patients audited (76.1%) fell into this category. A further 20.5% of patients were recorded as being British and the ethnicity of the remaining 3 patients was recorded as 1 Eastern European, 1 Indian and 1 Irish.

In CWS and H&R CCGs only 4 patients were highlighted as having communication problems

In CWS 14 patients were housebound and in H&R 12 were housebound.

The patient demographics are summarised in the table below:

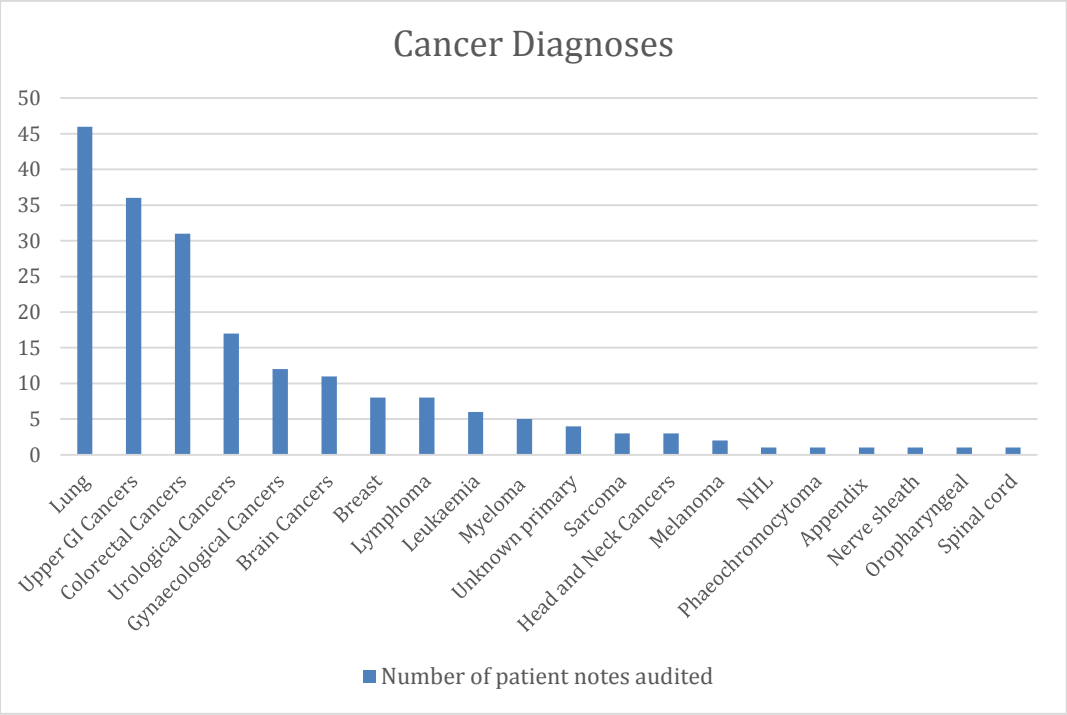
	Coastal West Sussex	Hastings and Rother
Percentage where patient was over 65	69%	36.4%
Percentage where patient was male	48.65%	44.3%
Percentage where patient was female	50.45%	55.7%
Percentage where patient was British	89.65%	96.59%
Of which, percentage (of all patients) specified as White British	85.65%	76.10%
Percentage where patient had communication problems	3.6%	4.5%
Percentage where patient was housebound	12.61%	13.6%

Cancer specific details

Information was collected on the diagnosis (type of cancer) and the stage of cancer at presentation.

Cancer diagnoses

The chart below summarises the total diagnoses for both CWS and H&R.



The table below shows a more detailed breakdown by CCG and total of the types of cancer diagnosed, with those occurring most frequently across both CCGs at the top of the table.

	Coastal West Sussex		Hastings and Rother		Total	
		% of total		% of total		% of total
Lung	26	23%	20	23%	46	23%
Upper GI Cancers	22	20%	14	16%	36	18%
Pancreatic	*9*	*8%*	*9*	*10%*	*18*	*9%*
Oesophageal	*2*	*2%*	*3*	*3%*	*5*	*3%*
Stomach	*4*	*4%*	*1*	*1%*	*5*	*3%*
Cholangiocarcinoma	*4*	*4%*	*1*	*1%*	*5*	*3%*
Liver	*3*	*3%*			*3*	*2%*
Colorectal Cancers	17	15%	14	16%	31	16%
Urological Cancers	12	11%	5	5%	17	9%
Prostate	*7*	*6%*	*1*	*1%*	*8*	*4%*
Kidney	*3*	*3%*	*2*	*2%*	*5*	*3%*
bladder	*2*	*2%*	*2*	*2%*	*4*	*2%*
Testicular			*1*	*1%*	*1*	*1%*
Gynaecological Cancers	8	7%	4	5%	12	6%
Ovarian	*4*	*4%*	*4*	*5%*	*8*	*4%*
Gynaecological	*2*	*2%*			*2*	*1%*
Cervical	*1*	*1%*			*1*	*1%*
Endometrial	*1*	*1%*			*1*	*1%*

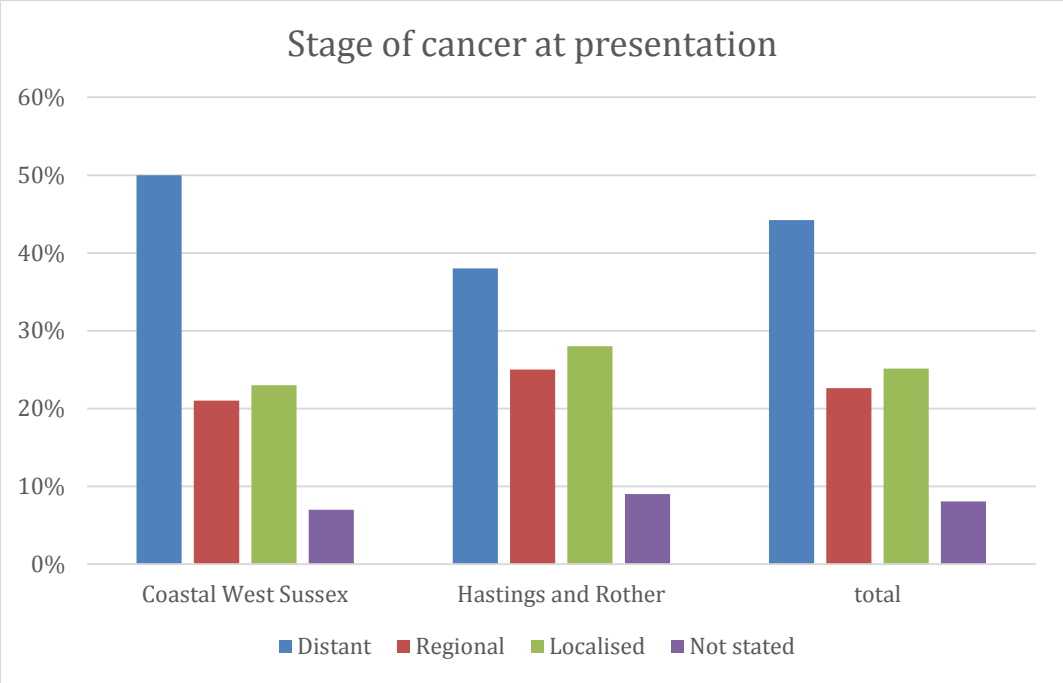
	Coastal West Sussex		Hastings and Rother		Total	
		% of total		% of total		% of total
Brain Cancers	6	5%	5	5%	11	6%
Breast	4	4%	4	5%	8	4%
Lymphoma	4	4%	4	5%	8	4%
Leukaemia			6	7%	6	3%
Myeloma			5	5%	5	3%
Unknown primary	2	2%	2	2%	4	2%
Sarcoma	3	3%			3	2%
Head and Neck Cancers	3	3%			3	2%
Tonsillar	*2*	*2%*			*2*	*1%*
Laryngeal	*1*	*1%*			*1*	*1%*
Melanoma	2	2%			2	2%
NHL	1	1%			1	1%
Phaeochromocytoma	1	1%			1	1%
Appendix			1	1%	1	1%
Nerve sheath			1	1%	1	1%

	Coastal West Sussex		Hastings and Rother		Total	
		% of total		% of total		% of total
Oropharyngeal			1	1%	1	1%
Spinal cord			1	1%	1	1%

Stage of cancer at presentation

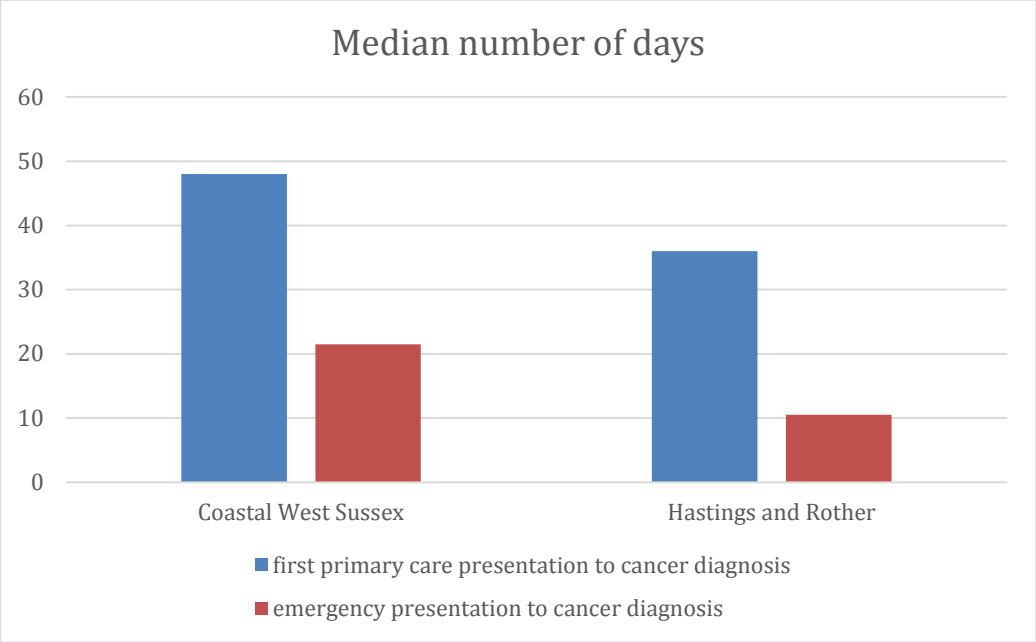
GP practices were asked to categorise the stage of cancer at presentation as 'localised', 'regional' or 'distant'. A summary of this is given below.

	Coastal West Sussex		Hastings and Rother	
Stage	**Number of Audits**	**Percentage of Audits**	**Number of Audits**	**Percentage of Audits**
Distant	55	50%	33	38%
Regional	23	21%	22	25%
Localised	25	23%	25	28%
Not stated	8	7%	8	9%


Stage of cancer at presentation
60%
50%
40%
30%
20%
10%
0%
Coastal West Sussex
Hastings and Rother
total
Distant
Regional
Localised
Not stated

Pathway timescales

Information was collected on key dates in the patient pathway, namely the date of the emergency presentation to secondary care, date on which the cancer diagnosis was confirmed by secondary care and date the patient first reported relevant signs/symptoms to primary care. This is summarised in the chart below.



First primary care presentation to cancer diagnosis

In CWS the median number of days from first primary care presentation to cancer diagnosis was 48 days. This is based on data for provided for 70 patients. This data was not available for 41 of the patients audited.

In H&R the median number of days from first primary care presentation to cancer diagnosis was 36 days. This is based on data for provided for 61 patients. This data was not available for 27 of the patients audited.

Emergency presentation to cancer diagnosis

In CWS the median number of days from emergency presentation to cancer diagnosis was 21.5 days. This data was not available for 9 of the patients audited.

In H&R the median number of days from emergency presentation to cancer diagnosis was 10.5 days. This data was not available for 8 of the patients audited.

GP Learning

GP practices were asked to consider if there were any avoidable delays in the patient pathway for each of the patients audited. In CWS for 24 of the 111 patients (22%), it was felt that there were definite or possible delays. In H&R for 24 of the 88 patients (27%) it was felt that there were definite or possible delays.

Most commonly cited reasons for delays in the patient pathway

	Coastal West Sussex CCG	Hastings and Rother CCG
Possible delays in diagnostics or other secondary care appointments	5 cases (4.5%)	11 cases (12.5%)
Possible missed symptoms/Test results not acted upon/tumour not picked up after diagnostics	2 cases (1.8%)	7 cases (7.9%)
Patient declined investigations/ did not return in case of worsening symptoms/Patient DNA or delay/patient did not report symptoms fully	3 cases (2.7%)	6 cases (6.8%)
Direct access CT would have been helpful	1 case (0.9%)	
Should have been referred as 2 week rule	2 cases (1.8%)	
further investigations could have been carried out, although this would not necessarily have changed the outcome	7 cases (6.3%)	
Other not noted	4 cases (3.6%)	

GP practices were also asked to reflect on the cases audited overall and consider the following 4 questions:

- What happened (i.e. were there any delays or problems which resulted in the emergency presentation)?
- Why did this occur?
- What learning has been generated as a result of this audit and the subsequent discussions at your practice meeting?
- What has been changed/ what actions have been taken?

There is some variation in how practices have answered this section of the audit – some completed this for each patient, some one form for all audited patients. Common themes and comments have been highlighted.

Question 1 – what happened (i.e. were there any delays or problems which resulted in the emergency presentations)?

Themes relating to this question:

Coastal West Sussex	Hastings and Rother
Patient presented late or did not visit their GP or refused further investigation	Delays in secondary care/ diagnostics
No symptoms suggestive of cancer	Existing conditions were explored first
Possible missed symptom	Lack of symptoms for pancreatic cancer
Already under consultant care	Patient did not attend
No direct access to scans	Patient presented late or had no relevant symptoms
Lung and pancreatic cancers present late	Symptoms were not followed up
Patient gave GP incorrect information	
Patient should have been called in for review	
Rare symptoms	

Question 2 – why did this occur?

Themes relating to this question:

Coastal West Sussex	Hastings and Rother
Patient choice – patient did not visit GP or declined further investigations	Poor performance with diagnosing lung cancer
No symptoms	Communication problems (on part of patient)
Initial diagnostics tests were normal	Complex case
Delay in test results	Existing conditions contributing to delayed cancer diagnosis
Limited investigations during hospital stay	False reassurance from previous referral
NHS capacity	Limited time in primary care to check results and look back at past treatments
Other pathology masking cancer symptoms	No pathway for urgent outpatient review if 2WR guidelines not met
Paramedics reluctant to take patient to A&E	No relevant symptoms reported
Patient did not see same GP for all visits	Pancreatic cancer presents late
Patient housebound so assessment progressed through A&E	Patient choice/ DNA
Lack of rapport between locum and patient	Delays in patient follow up
Presented with minor ailment only so no extensive physical examination	Poor communication between primary and secondary care
Radiology reports need to clarify when a 2WR to	Secondary care delays

be used	
Secondary care did not initiate a 2WR pathway	Brain cancer presents late
Tumour did not show in investigations	Weight loss is a common theme and awareness needs to be raised for this

Question 3 – What learning has been generated as a result of this audit and the subsequent discussions at your practice meeting?

The most commonly reported themes are tabulated below;

Coastal West Sussex	Hastings and Rother
Public awareness of cancer signs / symptoms needs to improve	Patient follow-up and safety-netting are essential
It is important to make better use of the 2WW pathway	Ensure timely referrals for diagnostics in Primary Care (including CXRs and screening blood tests)
It is important to ensure continuity of care to detect evolving symptoms in patients	Some delays were caused by patients DNA'ing diagnostic appointments (highlighting the need to counsel patients about the importance of attending)
Be wary of patients who present more than once with the same (undiagnosed) problem	The audit highlighted the need for patient education
Ensure a better handover of vulnerable patients	Be wary of patients who have pre-existing medical conditions that may be masking cancer
Be wary of patients who minimise their symptoms / present infrequently / have co-morbidities which may mask cancer (e.g. worsening shortness of breath in a COPD patient may represent lung cancer)	Ensure good communication
Have a lower threshold for performing chest X-rays and beware a normal CXR result when you have a high index of clinical suspicion	Ensure good record keeping
Mindfulness of specific risk factors for cancer will	Improved access to health care / GP

help (e.g. H. pylori infection for gastric cancer)	appointments is important for early presentations and diagnosis
Mindfulness of key warning symptoms is essential to early detection (e.g. the red flags for headache and persistent hoarseness of voice)	Take care to document the family history
It is important to make better use of tumour markers (e.g. CA-125), when appropriate	Beware of diagnostic delays within secondary care
Delays in secondary care investigations may be avoided by giving Primary Care more direct access to diagnostics	
It would be helpful if the pressure on GPs NOT to refer symptomatic patients was reduced	

4. What has been changed / what actions have been taken?

A selection of notable and frequently reported actions taken, as a result of the audit, is tabulated below;

Coastal West Sussex	Hastings and Rother
Discuss and review the new NICE 2WW guidance	Perform more in-house / practice discussions about clinical cases (including discussions about any new cancer diagnosis and emergency presentations)
Start a drive to improve patient awareness by; (i) placing posters in the practice waiting room and toilets (ii) including information on the practice's website (iii) Making better use of the TV screen in the waiting area to educate patients about the risks and benefits of PSA testing in males (iv) Making women more 'breast aware' during appointments for cervical screening	Ensure timely referrals for diagnostics in Primary Care (including CXRs and screening blood tests)
Safety-netting as clearly as possible by booking follow-up appointments with patients, when necessary	Ensure that CXRs are requested earlier to diagnose lung cancers (especially in patients with COPD)
Making greater use of cancer risk assessment tools (including the Macmillan e-CDS) to aid early diagnosis of cancer	Try to safety-net more rigorously and ensure follow-up for patients

Don't be falsely reassured by negative test results (especially CXRs)	Attend a cancer educational event
Be extra vigilant when patients with chronic conditions experience a sudden deterioration in their symptoms	Better liaison is needed with secondary care (especially for patients who do not meet the 2WW criteria)
Practice staff to start checking whether patients attended their 2WW appointments (and auditing the outcomes of 2WW referrals)	Request a CA-125 whenever a female is referred on a 2WW pathway to Digestive Diseases
Be more mindful of pain as a potential symptoms of cancer, even in the absence of other symptoms	Increase patient awareness of cancer
Lower the threshold for referring and investigating certain patients (for example, if a woman with a history of breast cancer presents with new-onset musculoskeletal pain, have a low index of suspicion for bony metastasis)	Ensure family histories are recorded
Encourage all doctors to attend educational events on cancer, to keep their knowledge up-to-date and to support earlier diagnosis	Encourage screening uptake
Improve standards of medical record keeping and documentation	Ensure careful history taking
Take regular opportunities to discuss complex clinical presentations at Drs' meetings	Improved access to diagnostics required
	Improved access to urgent outpatient clinics required
	Improved GP access

Recommendations and Next Steps

At a GP Practice Level

The GP Learning section of this report identifies the learning and actions that GP practices who took part in the audit identified. It is recommended that these are widely shared with primary care colleagues. The actions include:

- Improve patient awareness of the signs / symptoms of cancer
- Review and implement appropriate safety-netting (e.g. by calling patients back for a review)
- Use aids to diagnosis (e.g. the Macmillan 'electronic clinical decision support tool', Q-risk tool)
- Perform in-house reviews of 2WW referrals, new cancer diagnoses and emergency presentations
- Attend cancer educational events
- Improve standards of medical record keeping.

At CCG Level

There are a number of actions that CCGs can take following this audit report. Here are some suggestions:

- Share the report with GPs, or highlight key findings and actions that GPs can consider implementing in their practice in a primary care cancer communication, or a cancer focussed primary care education event.
- Use the report as evidence to inform Cancer plans – 'where are we now' and 'what does excellent care look like.'
- Encourage practices to regularly review new cancer diagnoses, two week wait referrals and undertake emergency presentation audits to review their quality of care, liaising with Primary Care Development Colleagues to see if there may be ways in the future in which these can be promoted or incentivised.
- Share best practice examples of safety netting/ ask CRUK facilitators about running their safety netting training package for a group of practices.
- Liaise with the Communications teams to consider how the CCG can support increased patient awareness as local initiatives or to tie in with national initiatives such as Be Clear on Cancer.

- Review CCG and practice data on the local AEDI dashboard, national cancer dashboard and practice profiles to identify any areas of focus.

At a Clinial Network Level

- Publish this report on the CN website
- Use this report as evidence to support the CN's position in seeking to offer targeted cancer education to primary care.
- Publish the template proformas and guidance used by CWS and H&R CCG on the Clinical Network's website, so that they are available to download.
- Consider development of the audit to consider the interface between primary and secondary care.

Further reading, useful documentation and guidance:

- Improving diagnosis of cancer; A Toolkit for General Practice, E Mitchell, G Rubin, U Macleod, January 2012, available on the RCGP website
- Safety netting recommendations for primary care, CRUK, http://www.cancerresearchuk.org/health-professional/learning-and-development-tools/safety-netting-recommendations-for-primary-care
- Safety netting training for primary care, CRUK – access via CRUK Facilitators
- Macmillan 10 Top tips for safety netting http://www.macmillan.org.uk/Documents/AboutUs/Health_professionals/PrimaryCare/safetynetting.pdf
- Nice Guideline NG12 Suspected cancer: recognition and referral, recommendations on patient support, safety netting and the diagnostic process (1.14-1.16)
- National cancer diagnosis audit in primary care 2016: http://www.cancerresearchuk.org/health-professional/early-diagnosis-activities/national-cancer-diagnosis-audit
- 'National Audit of Cancer Diagnosis in Primary Care' (2011), available at http://www.rcgp.org.uk/news/2011/november/~/media/Files/News/National_Audit_of_Cancer_Diagnosis_in_Primary-Care.ashx