GMS Contract 2017/18
CND 012W
National Clinical Priority A: Cancer

Requirement:

The Practice will complete Module 2 of the Macmillan Cancer Toolkit for General Practice in Wales as set out below.

Module Two: Prompt recognition and early referral

Introduction

Cancer is a leading cause of death and a major contributor to health inequalities across Wales. Cancer survival is a key measure of the effectiveness of healthcare systems. Five-year survival rates from cancer in Wales are lower than the rest of the UK and most other European countries. Differences in stage at diagnosis and access to optimal treatment are likely to be major contributing factors to cancer survival in Wales. Earlier diagnosis is crucial to improving survival in many cancers, as when cancer is diagnosed at an early stage, treatment options and chances of a full recovery are greater.

It should be recognized that living with active, progressive, recurrent cancer is a reality for over 2.5 million people in the UK. In Wales, there are over 120,000 people living with cancer and this number is expected to rise to 240,000 by 2030. In 2015, there were 19,088 new cases of cancer in Wales, an increase of 10% from 2006 (Welsh Cancer Intelligence and Surveillance Unit Data).

Macmillan Wales' Cancer Quality Toolkit (module two) for prompt recognition and early referral aims to support GPs to diagnose cancer early and it offers an exciting opportunity to improve overall outcomes for people affected by cancer in Wales and supports key elements of the Welsh Government's Cancer Delivery Plan to 2020 and the Primary Care Services Plan.

This module encourages Primary Care teams to review their current approach to identifying and diagnosing cancer, and develop strategies to improve recognition and early diagnosis.

By completing this module, you will:

1. **Review current data regarding cancer presentation, referral and incidence for your practice (and cluster).**
2. **Review and critique your current practice regarding recognition and referral of cancer, with particular reference to NICE suspected cancer referral guidance, at risk groups, and potential barriers to prompt referral.**
3. **Agree and carry out three actions/tests of change to enhance patient care, using quality improvement methods**

(This Module has been developed by Macmillan Cancer Support. It is part of "Cancer Care in Primary Care: A Quality Toolkit for General Practice". If you would like further information regarding this toolkit and other cancer care quality improvement modules, please contact you LHB Macmillan GP Cancer Lead for the Macmillan Framework for Cancer Programme.)

Module Questions:

A Background information, data collection and analysis

1 For your practice population, identify the proportion of patients diagnosed with cancer in the last 12 months:

- Who were referred urgently with a suspicion of cancer?

- Who presented as an emergency (A+E attendance or Emergency Admission by GP)?

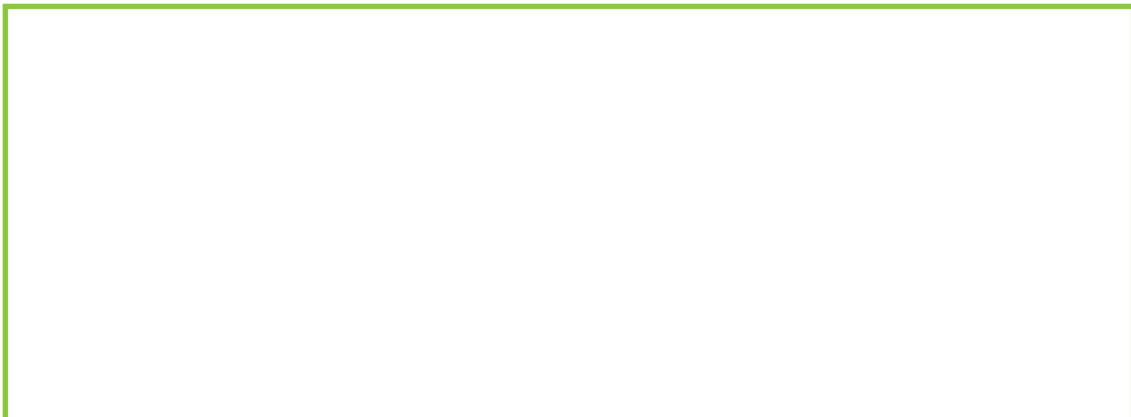
- Who were referred to a specialist clinic or diagnostic test as a routine/urgent (non-USC referral)?

2 Look at your referrals for the last 10 patients with a final diagnosis, who were **NOT** referred as a USC referral. What proportion of these had symptoms that would have warranted USC referral or urgent direct access investigation / discussion with a specialist (as per current **NICE** suspected cancer referral guidance)?

3 How are referral guidelines for cancer displayed and used in your practice? What tools or systems do you have in place to promote the use of cancer referral guidance?

4 Review your practice's (or Cluster/Local Authority) cancer incidence compared to LHB and national rates. For common cancers (lung, colorectal etc) also consider reviewing data on stage at diagnosis.

5 What are the key features of your practice population (or the population of your cluster/Local Authority Area) that may impact on the incidence, type and presentation of cancers in you practice? Review relevant data (age distribution, smoking rates, ethnicity, obesity, chronic disease, screening uptake rates) and compare to national averages.



B Reflective practice

GPs are sometimes criticised for their referral behavior, particularly when a diagnosis of cancer is involved. It can be a difficult task to achieve the fine balance between over-referring and causing anxiety in patients, overwhelming the system with unnecessary referrals for investigations or specialist opinion and ensuring, amongst the array of presentations seen, that the worrying symptoms and signs are recognised and acted upon.

Use the following questions to facilitate a discussion within your practice about your suspected cancer referrals.

You have been provided with a summary of themes from the SEA work carried out as part of the previous National Clinical Priority for the Early Diagnosis of Cancer. You may wish to refer to this during your discussion.

1 Take a fresh look at the **NICE Suspected Cancer: Recognition and Referral Guidance (NG12)**

Write down any learning points from reviewing the guidelines. You may wish to focus your discussions on cancers with poor outcomes. Consider using one of the available referral aids (CRUK interactive desk easel or Macmillan Rapid Referral guidelines) to assist your review of the NICE guidance.

2 How aware are you about the 'at risk' groups? Look at the suspected cancer referral guidelines and consider the groups of people most at risk of particular cancers. What learning have you gained?

3 How does/could your practice encourage those in at risk groups to recognise what could be a serious symptom and to come along at an early stage to discuss e.g. patient information leaflets?

4 Consider the factors which can make you more reluctant to refer. How can you address these?

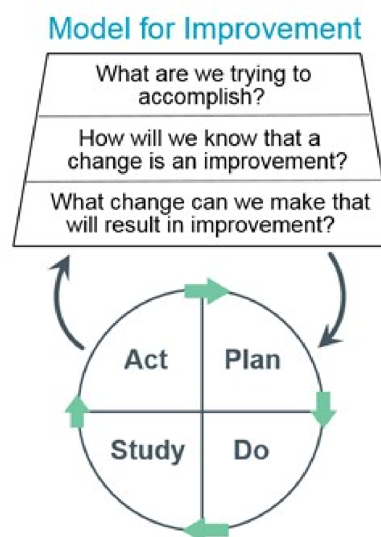
5 If you have a niggling concern about a patient, but don't feel you need to refer or are unsure about the most appropriate course of action, describe how you would obtain advice or a second opinion from within your practice or specialists in secondary care.

6 What open access or direct to test investigations are available in your area, how often do you make use of them?

C Action Plan

Once you have reviewed the relevant data, reflected on your current practice, and discussed these issues as a team you will need to decide what steps to take next.

You will need to specify three changes you will make. Consider what actions are most relevant to your practice and patient population and the 'Model for Improvement'.



Listed below are some suggestions you may wish to choose, or you can come up with your own. When deciding on which changes you will make, consider what you want to achieve and how you will demonstrate the impact of the changes you have made.

Considerations:

ACTION: How do you ensure that, as a practice, you keep up to date with referral guidance and pathways? How do you review the quality and consistency of your referrals for suspected cancer? Nominate a practice Cancer Lead (and lead administrator/nurse) to support cancer clinical governance and quality improvement within the practice. Implement a system of peer review of new cancer diagnoses, with particular reference to referral route. Minutes of meetings/reviews will include feedback to clinicians to improve practice.

ACTION: The NICE guidelines (NG12) advocate a reduction in the threshold for referral of suspected cancer. Specify one change that your practice will make regarding suspected cancer referral following your review of the guidance. Review referrals after 2 months to assess impact of change (e.g. % compliance with NICE referral guidance).

ACTION: How can you improve recognition and referral in 'at risk' groups (patients with chronic disease/co-morbidities; Mental Health; Learning Disabilities; Frail/Elderly)? Incorporate discussion of cancer risk into annual reviews for these patient groups (e.g. discussion of symptoms of lung cancer in COPD reviews) and identify appropriate supporting information (patient information leaflets etc). Review records of chronic disease annual reviews to assess impact, and consider other measures of impact for specific disease areas (e.g. Chest X-ray referral rates).

ACTION: Are all the practice team aware of how to seek advice and support regarding investigation and referral when there is suspicion of serious illness/cancer, but USC criteria are not met? Develop a directory of local resources (electronic guidance; email advice lines; contact numbers for specialists etc) – this could be done in conjunction with other practices in your cluster. Review rates of USC referrals and use of email advice to assess impact.

ACTION: Does your practice team include multiple professionals as the first point of contact for patients, depending on their presenting problem? What systems do you have in place to ensure that all health professionals working in your practice are aware of the signs and symptoms of cancer, and when to investigate or refer for suspected cancer?

List your three actions below:

1.   2.   3.

Please return this module to ………………………………………………………………….

Please ensure no patient identifiable information is included.

Further reading / Useful resources

Cancer Delivery Plan 2016- 2020
http://gov.wales/docs/dhss/publications/161114cancerplanen.pdf

National Institute for Clinical Excellence: Suspected cancer: recognition and referral (NG12) https://www.nice.org.uk/guidance/ng12

Macmillan Rapid Referral Guidance Toolkit
http://www.macmillan.org.uk/documents/aboutus/health_professionals/pccl/rapidreferralguidelines.pdf

Cancer Research UK: Suspected Cancer Recognition and Referral – Symptom Desk Easel
http://www.cancerresearchuk.org/sites/default/files/nice_desk_easel_final_interactive_version.pdf

Macmillan Ten Top Tips: multiple or vague symptoms
http://www.macmillan.org.uk/documents/aboutus/health_professionals/primarycare/10toptips/10toptipsvaguesymptoms.pdf

Royal College of General Practitioners SEA Template
http://www.rcgp.org.uk/clinical-and-research/our-programmes/quality-improvement/significant-event-audit.aspx

Welsh Cancer Intelligence and Surveillance Unit
http://www.wcisu.wales.nhs.uk/home

Institute for Healthcare Improvement: How to Improve
http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx

Summary of National Clinical Priority for Early Diagnosis of Cancer findings, 2015 and 2016

The Cluster collated reports of the SEA work have been reviewed and collated by each LHB's Macmillan GP Cancer Lead. The common and important themes from these LHB summaries are listed below. These issues listed below have all been identified by multiple clusters and LHBs.

Primary Care Issues:

- Need to ensure awareness and adherence to NICE Cancer referral guidance
- Recognise, record and READ code 'red flag' symptoms
- There is increasing awareness of the importance of 'vague symptoms', but there is no corresponding referral pathway
- All USC referrals should be made by WCCG, and all referral pathways should allow WCCG referral
- Practices are instigating systems to monitor progress of USC referrals, due to increasing delays in referral to appointment times
- Threshold for referral and investigation:
    - Need to be aware that some investigations generate false negatives – investigations should continue if there is a high index of suspicion
    - Threshold for investigation needs to be lowered to correspond to changes in NICE guidelines
    - Lower threshold advisable for vulnerable groups (LD, MH) and carers
    - Be aware of possibility of cancer where there is clinical deterioration in patients with chronic conditions (COPD, DM)
- Lack of continuity of care may detrimentally impact on referral times. Good record keeping and READ coding is required to compensate for this
- Increased awareness needed of risk factors other than smoking (occupational exposure, alcohol, obesity etc)

Secondary Care Issues

- Diagnostics:
    - Delays in reports (in particular, Chest X rays)
    - Issues with access to urgent CT or US scans and endoscopy
    - No USC referral option for radiology in all LHBs
    - Lack of clear clinical pathways (e.g. IDA, vague symptoms etc)
    - Primary Care need pathways to pursue investigation even if initial test negative (eg normal chest x ray, or normal Ca 125)
    - Significant discrepancy between USC and 'Urgent' waiting times introduces delay if worrying presentation but no clear 'red flags'
- Communications:
    - Delayed Discharge Summaries
    - Delayed Clinic Letters
    - Inconsistent approach to communicating abnormal results
    - WCCG not widely used by secondary care, which delays communication

    - Patients who DNA USC appointments not adequately followed up
- Downgrading:
    - Downgrading may lead to delayed diagnosis
    - Lack of explanation of decision
    - No robust and consistent system for notifying referrer of decision to downgrade
- MDTs:
    - Feeling that waiting for MDT meeting introduces delay to obtaining diagnosis or commencing treatment
    - Delay and lack of clarity regarding clinical responsibility and transfer of patients between specialties/MDTs

Patient Factors:

- Lack of awareness of concerning symptoms
- Uptake of offers of screening (in particular bowel screening)
- Delayed presentation, and failure to re-present despite safety netting
- Communication/Language Barriers

MACMILLAN FRAMEWORK FOR CANCER IN PRIMARY CARE

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