National Cancer Diagnosis Audit
2014

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- CRUK Strategic GP & Clinical Lead Thames Valley Cancer Alliance
- Cancer & EOL Clinical Lead Berkshire
- GP, Bracknell
WHAT IS CLINICAL AUDIT

• “Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria...Where indicated, changes are implemented...and further monitoring is used to confirm improvement in healthcare delivery.”

• Its objectives include improving patient’s experience and safety, and raising the standard of care.

Principles for Best Practice in Clinical Audit (2002, NICE/CHI)
• For clinical audit to really work,
  • clinicians and management must be fully engaged in the process, whether directly or indirectly.
  • They should also be encouraged to put forward their ideas for improvements, especially those on the frontline, and
  • assured that they will be listened to and their good suggestions will be taken on board when possible.

• This way, the organisation would truly change the culture.

• “As clinicians are being stretched to capacity, organisations should put in place adequate resources to provide support for clinical audit activities”

George Absi, Royal Marsden Foundation Trust
OVERVIEW

- Objectives
- Data Collection
- Participation
- Key Findings
- Case Studies & learning
- Future Audit

The NCDA is a partnership project led by Cancer Research UK in collaboration with

Public Health England, NHS England, NHS Scotland, Public Health Wales, the RCGP and Macmillan Cancer Support
AUDIT Objectives

• The NCDA seeks to gather data about pathways to cancer diagnosis, incl.:
  • Interval length and number of consultations in primary care
  • Use of investigations prior to referral
  • Referral pathways for patients with cancer

• The last round of the NCDA collected data on patients diagnosed in 2014

• The aim of the 2014 audit data together with follow-up data from future audits was to:
  • Help to understand changes in patterns of cancer diagnosis for all cancer types, following changes in Cancer Referral Guidelines¹
  • Help with assessing the impact of new guidelines

¹NG 12 Cancer Referral Guidelines (NICE) / Scottish referral guidelines for suspected cancer
AUDIT Data Collection

- Participation in the audit was voluntary
- In England and North Wales data were collected from GP practices via an online portal
- In Scotland data were collected on Excel spreadsheets

- All cancer diagnoses in 2014 were in scope of the audit (except diagnoses of non-melanoma skin cancer)
- English practices received £10 per completed patient record if they submitted data on ≥95% of cancer patients on their NCDA practice list
# Data supplied by CANCER REGISTRY – ENGLAND

## Patient information
- NHS Number, Age, Gender

## Dates
- Diagnosis date
- Referral date closest to diagnosis (within 90 days of diagnosis date) (from Cancer Waiting Times database)
- Treatment period start date closest to diagnosis (within 90 days of diagnosis date) (from Cancer Waiting Times database)
- Date of death (if applicable)

## Referrals & Route to Diagnosis
- Type of referral (from Cancer Waiting Times database)
- Route to diagnosis as determined by NCRAS

## Cancer information
- Cancer type (ICD-10)
- Stage at tumour diagnosis

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1 Some data items differed slightly for Scotland and Wales
### Data supplied by GP practice - ENGLAND

<table>
<thead>
<tr>
<th><strong>Patient characteristics</strong></th>
<th><strong>Investigations</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity, language – fluency of English, communication difficulties, housebound status, living arrangements, co-morbidities</td>
<td>Type and number of primary care led investigations</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th><strong>Symptoms</strong></th>
<th><strong>Referrals</strong></th>
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<tbody>
<tr>
<td>Symptoms related to cancer at first presentation</td>
<td>Type of referral</td>
</tr>
<tr>
<td>Presenting signs and abnormal investigations</td>
<td>Number of specialty referrals</td>
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<td>Type of emergency referral</td>
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<table>
<thead>
<tr>
<th><strong>Intervals and consultations</strong></th>
<th><strong>Routes to diagnosis</strong></th>
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<tbody>
<tr>
<td>Place and date of first presentation</td>
<td>Verification of NCRAS data</td>
</tr>
<tr>
<td>Number of consultations before referral</td>
<td></td>
</tr>
<tr>
<td>Reason why there were multiple consultations</td>
<td></td>
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<tr>
<td>Date of referral</td>
<td></td>
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<tr>
<td>Safety netting</td>
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<tr>
<td>Date first seen by specialist</td>
<td></td>
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<tr>
<td>Date patient was informed they had cancer</td>
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<table>
<thead>
<tr>
<th><strong>Avoidable delays to diagnosis</strong></th>
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<tbody>
<tr>
<td>Whether there was an avoidable delay</td>
</tr>
<tr>
<td>Location of the avoidable delay, which stage in the pathway and to whom the delay was chiefly attributable to</td>
</tr>
</tbody>
</table>
“LET’S DO THE AUDIT”
“LET’S DO THE AUDIT”
“LET’S DO THE AUDIT”
PREMATURE
EJACULATORS
ANONYMOUS

...looks like I came too soon!

A partnership with:

AUDIT
TRAINING
MEETINGS
Audit Summary - ENGLAND

The NCDA combined primary care data with data from the Cancer Registry for patients diagnosed with cancer in 2014 across England to understand pathways to cancer diagnosis.

439 practices from 139 CCGs took part in the England audit (this is 5.4% of all practices in England).

17,042 patient records were collected (this is 5.7% of all patients diagnosed with cancer in 2014).
NATIONAL CANCER DIAGNOSIS AUDIT
PARTICIPATION BY CLINICAL COMMISSIONING GROUP (CCG)

The National Cancer Diagnosis Audit (NCDA) gathered primary and secondary care data for patients diagnosed with cancer in 2014 to better understand patient pathways to diagnosis and, ultimately, improve clinical care and early diagnosis of cancer. CCGs were encouraged to support practices to take part, and a total of 439 GP practices from across England submitted data to the audit. Participation varied across CCGs.

PROPORTION OF PRACTICES WITHIN A CCG THAT TOOK PART IN THE NCDA.

- 0%
- 1-4%
- 5-9%
- 10-14%
- 15-19%
- 20-24%
- 25-50%
- >50%

CAVEAT:
Participation in the NCDA was not mandatory. Some CCGs offered incentive schemes for participation in the audit. All practices that submitted data to the audit, regardless of the volume or completeness of data, were included in this infographic.

SOURCE: National Cancer Diagnosis Audit 2014
KEY FINDINGS
(ENGLAND)
Key Findings – ENGLAND (my practice)

Data were representative of the national cancer incidence for 2014

- 76% of patients had at least one co-morbidity (71%)
- Most patients (72%) first presented at the GP surgery (or had a home visit) (68%)
- 74% of patients were referred to a specialist after only one or two consultations (75%);
- approximately 52% (48%) were referred through the Two Week Wait route
- Primary care led investigations before referral were used in 45% (59%) of all patients
- For 44% (34%) of patients, there was evidence in the clinical record that safety netting had been used
- For one in five (1:8) patients the GP considered there to have been an avoidable delay in the patient receiving their diagnosis

Swann et al. BJGP 2018: https://doi.org/10.3399/bjgp17X694169
Data from the NCDA were representative of the national cancer incidence for 2014

*From Cancer Research UK cancer incidence statistics for 2014
Stage distribution in the NCDA mapped onto national data on cancer stage distribution from 2010-14*

*From National Cancer Intelligence Network (NCIN)
PLACE OF FIRST PRESENTATION

Most patients (72%) first presented at the GP surgery (or had a home visit) with symptoms deemed to be relevant to the subsequent diagnosis of cancer.

- GP Surgery or Home Visit, 72.2%
- A&E, 6.9%
- Screening, 6.4%
- Hospital outpatient, 5.0%
- Hospital inpatient, 1.8%
- Telephone consultation, 1.1%
- Other (incl. walk-in, dentist etc.), 2.1%
- Out Of Hours service, 0.8%
- Not known, 3.7%
Consultations before referral

Where the number of primary care consultations before referral was known:

- **79%** of patients were referred after less than 3 consultations
- **21%** had three or more consultations

Top three reasons for multiple consultations:
- Symptoms suggested different initial diagnosis
- Co-morbidities
- Consultation to discuss test results

Nowadays many more telephone consultations – hence be interesting:
- Delays
- Investigations
- Safety-netting
- Continuity of care
# Intervals

Median primary care interval was 5 days in the NCDA

<table>
<thead>
<tr>
<th></th>
<th>PRIMARY CARE INTERVAL*</th>
<th></th>
<th>DIAGNOSTIC INTERVAL*</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25&lt;sup&gt;th&lt;/sup&gt; centile</td>
<td>Median</td>
<td>75&lt;sup&gt;th&lt;/sup&gt; centile</td>
<td>% over 90 days</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0 days</td>
<td>5 days</td>
<td>27 days</td>
<td>8.3%</td>
</tr>
<tr>
<td><strong>Male</strong></td>
<td>0 days</td>
<td>8 days</td>
<td>30 days</td>
<td>9.2%</td>
</tr>
<tr>
<td><strong>Female</strong></td>
<td>0 days</td>
<td>1 day</td>
<td>21 days</td>
<td>7.3%</td>
</tr>
</tbody>
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*Intervals are available for patients where the relevant valid dates were entered (n=10,493 for primary care interval and n=12,929 for diagnostic interval)
Type of Referral

More than half of patients diagnosed with cancer were referred via the two week wait (TWW) route.
EMERGENCY DIAGNOSES

16.5% of patients were diagnosed through an emergency route (incl. self referral (48.4%) and emergency referral by a GP/Out of Hours service (47.0%))

Percentage of patients diagnosed as emergency...

For 4.6% of patients diagnosed as an emergency prior consultation history was classed as ‘other’

- ...having consulted GP during same episode of illness but not awaiting referral/investigation (29.4%)
- ...while awaiting referral/investigation arranged by GP (19.9%)
- ...without any prior relevant GP consultations (46.1%)
AVOIDABLE DELAYS

For one in five patients the GP considered there to have been an avoidable delay in the patient receiving their diagnosis.

One in three avoidable delays reported by GPs in the audit was linked to diagnostic tests.

GPs considered delays to happen to patients when...

- Waiting for tests & results: 33.7%
  - Waiting for a referral (a specialist appointment): 19.7%
  - Being assessed (by GP or specialist doctor): 16.7%
  - Patient doesn't seek help (e.g. missing appointments): 15.5%
  - Waiting for an appointment: 7.3%
  - Waiting for follow-up (e.g. after test results): 7.1%
- Unknown: 3.6%
IMPACT TO DATE & CASE STUDIES
Impact

• The audit
  • provided opportunities for targeted review and reflective learning
  • identified avenues for quality improvement activity
  • generated detailed insights into pathways to cancer diagnosis
  • provides a baseline for future audits of the impact of new cancer referral guidelines

• Participating practices in England received tailored feedback reports in May 2017 with ongoing support from Cancer Research UK facilitators and Macmillan GPs to encourage reflection and quality improvement

• CCG\(^1\) and regional reports were made available in June 2017

• The RCGP developed a Quality Improvement toolkit

• The first paper on the national England results was published in Jan 2018 in the BJGP

\(^1\)CCG reports were only issued for CCGs with data from 10+ practices
I found the whole process incredibly easy and very informative. The information gathered highlighted good practice and areas that require improvements to help change future practice and improve patient care.

Our audit revealed some interesting case studies and we are already starting to make changes to our practice systems.

In our audit we came across two patients who had an initial normal chest X-ray but we still referred and they were both diagnosed with lung cancer. The audit has reminded us to trust our own judgement when we need to and still refer.

When doing the audit we realised our follow-up process for abnormal blood test results could be tightened up. We’re now looking at this in our practice to see how best to approach this.
A partnership with:

QUALITY IMPROVEMENT

Several GP practices made changes and undertook quality improvement activities based on audit findings

Most QI activity focused on:
• Referral behaviours
• Safety netting protocols
• Bowel screening uptake

Areas for QI identified from NCDA
From a follow-up survey of Cancer Research UK facilitators in Dec 2017 (n=32)
CASE STUDY: Referrals & Safety Netting

Issue identified:
• Practice observed some avoidable delays with getting chest x-ray results and with urgent (two week wait) referrals not being seen promptly (within two weeks)

QI activity:
• Safety net two week wait referrals

Action(s) taken: (but now eRS overcomes some of the process now)
• Introduce new safety net procedure for two week wait referrals to ensure patients do receive an appointment within two weeks
• Practice secretaries now keep an electronic log to track two week wait referrals and when they are seen
• Explain and give leaflet to patients that “being referred for Suspected Cancer” and to be available etc
CASE STUDY: Bowel Screening

Issue identified:
- Practice had an elderly population and higher than average incidence of colorectal cancer (CRC)
- Half of the CRC cases had been diagnosed as emergencies

QI activity:
- Improve bowel screening uptake and awareness of CRC

Action(s) taken:
- Show bowel screening advert on the TV screen in waiting rooms
- Follow up individuals who are eligible but do not take up the offer of screening
- Ensure GPs have a higher index of suspicion for CRC, especially in the presence of other co-morbidities

We understand that the best way to improve colorectal cancer outcomes is to promote bowel cancer screening in order to catch the cancer early.
• Adopt “3 strikes” ethos: Patient presents with the same symptom/s and consider referring to exclude serious pathology

• Use clinical decision tools: eg QCancer, Macmillan Cancer Decision Support Tool, RAT. All rely on Read-code data entry

• Adopt review process for serious but non-specific symptoms: ensure that patients are reviewed and given instructions to return for assessment
Safety-netting

- Adopt “if no better” process: explain clearly to patient
- Have clear abnormal results management process
- Ensure high quality data entry to ensure clear management plan, clear instructions, and recording of consultations
- Referral assurance of:
  - Correct patient details
  - Tell patient “for cancer exclusion”, give leaflet
  - Ensure patient available for appointment
  - Inform patient of process if “no appointment yet” information within 1 week
  - Contact patient on direct referral on notification
  - Feed-back after assessment
SYMPTOMS AND COMPLEX CONDITIONS

• Follow NICE guidance: NG12
• Exclude Red flags: presentation and examination
• Specifically, be aware of:
  • New onset Diabetics in those over 60
  • In LUTS: consider DRE, PSA
  • Unintentional weight loss and abdominal pains in those over 40
  • Thrombocytosis in high risk patient
  • Teachable moments; Risk factor discussion
FUTURE PLANS
Future Plans: NCDA 2019

• The next audit is in 2019, collecting data on patients diagnosed in 2018 or later

• The NCDA team will provide near real time ie monthly, data collection for English and Welsh GPs through the online portal using email alerts (the next audit in Scotland will again use Excel spreadsheets managed by ISD)

• Further details about the next audit will be made available at www.cruk.org/ncda and via all partner organisations

NCDA: Message to all GP practices
NCDA: Message to all GP practices

Don’t FEAR the AUDIT

FEAR IS a natural reaction to moving closer to the truth.

Pema Chodron

TheTappingSolution.com

A partnership with:
NCDA: Message to all GPs & Practices

1. Engaging with the NCDA will:
   • Highlighting good practice
   • Highlighting diagnostic challenges
   • Opportunity for case study discussion - reflection and learning for the whole team

2. Major points! For demonstrating quality improvement for GP appraisal, revalidation and CQC inspection. And of GREAT benefit to patients.

3. Real time data will be available – monthly (avg 1/month/GP)

4. Involve others: eg Medical students, registrars, nurses – feel valued

5. Share findings with whole team
Thank You – any Q?