Primary Care and Cancer Matters

Bournemouth University, Holdenhurst Road, BH8 8EB

Dr Richard Roope
RCGP and Cancer Research UK Cancer Clinical Champion
Senior Clinical Advisor Cancer Research UK
@DrRichardRoope
Primary Care and Cancer Matters

Housekeeping

• Fire Exits
• Toilets
• Mobile phones
• Questions
• Thanks to the team who have set up the day:
  • Bournemouth University Staff
  • Cancer Research UK Team
  • RCGP Faculty Staff
Primary Care and Cancer Matters

The Evening:

• Welcome
• Analysis from Learning Events & Educational Tools
  • Tea and Coffee
• Primary Care and Cancer Matters – where are we now and where are we heading? Including NG12: Recognition and referral of Suspected Cancer 2015 Case Studies
• Key take home, evaluation and close
Primary Care and Cancer Matters
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Cancer Research UK Facilitator Programme
Free, practical support to help **your practice** improve cancer early diagnosis and prevention

**Tailored** to your practice’s needs

[facilitators@cancer.org.uk](mailto:facilitators@cancer.org.uk)
Quality improvement support: face-to-face and tailored to your practice’s needs

- Improved screening uptake
- Better symptomatic patient management
- Effective patient conversations about prevention

Learning sessions for clinical and non-clinical staff

Practical help to improve processes and get more from clinical systems

Access to the latest evidence, resources and best practice

Support for reflective practice: data review, audits and learning event analyses

“I would encourage anyone to invite them in - visits totally re-motivate my surgery” GP, Yorkshire

99% of GPs and their teams recommend Facilitator visits

96% of practices plan to take action as a result of our help
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• Aims of the evening
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• Cancer: why all the interest?
• Where are we?
• The future
• Why is prevention important?
• Vaping – where does it fit in?
• NG12 - why?/what?/who?/how?
• Case reviews
• Safety netting
• February Awareness Month

• National Cancer Prevention Month...
Primary Care and Cancer Matters

Cancer: why all the interest?
# Primary Care and Cancer Matters

## Premature Deaths in England (<75)

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Other</td>
<td>5. Respiratory</td>
<td>5. Liver</td>
<td>5. Other</td>
</tr>
</tbody>
</table>
# Primary Care and Cancer Matters

**Premature Deaths in England (<75)**

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
<th>Column 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Other</td>
<td>5. Respiratory</td>
<td>5. Liver</td>
<td>5. Other</td>
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</tbody>
</table>

**Which do you think is the correct column?**
*(high to low)*
## Primary Care and Cancer Matters

### Premature Deaths in England (<75)

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Cardiovascular</td>
<td>Cancer</td>
<td>Liver</td>
<td>Respiratory</td>
<td>Other</td>
</tr>
<tr>
<td>2</td>
<td>Cancer</td>
<td>Other</td>
<td>Cardiovascular</td>
<td>Liver</td>
<td>Respiratory</td>
</tr>
<tr>
<td>3</td>
<td>Liver</td>
<td>Cardiovascular</td>
<td>Other</td>
<td>Respiratory</td>
<td>Liver</td>
</tr>
<tr>
<td>4</td>
<td>Respiratory</td>
<td>Liver</td>
<td>Other</td>
<td>Cardiovascular</td>
<td>Other</td>
</tr>
</tbody>
</table>

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Royal College of General Practitioners

Cancer Research UK
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- Cancer: 40%
- Cardiovascular: 22%
- Respiratory: 10%
- Liver: 6%
- Other: 22%

https://fingertips.phe.org.uk (last accessed 20.2.20)
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- Cardiovascular: 22%
- Respiratory: 10%
- Liver: 6%
- Other: 22%

https://fingertips.phe.org.uk (last accessed 20.2.20)
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Cancer – why all the interest?

Age standardised death rates in England and Wales 2001-2017 (All Age)

- 2011 – Cancer became the leading cause of death in UK

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregistrationsummarytables/2017 (last accessed 20.2.20)
Primary Care and Cancer Matters
How are we doing?
Primary Care and Cancer Matters
How are we doing?

Conversion Rate

Detection Rate

https://fingertips.phe.org.uk/profile/cancerservices  Accessed 20.2.20
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How have the UK done?
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How have the UK done?

All Cancers Combined, Observed Deaths, and Expected Deaths if Mortality Rates Had Not Fallen from Peak, UK, 1979-2016

https://www.cancerresearchuk.org/health-professional/cancer-statistics/mortality/all-cancers-combined#heading-Two  Accessed 20.2.20
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How have the UK done?

An estimated 832,000 cancer deaths had been avoided in the UK by 2016 because mortality rates dropped from their peak levels in the 1980s.

https://www.cancerresearchuk.org/health-professional/cancer-statistics/mortality/all-cancers-combined#heading-Two

Accessed 20.2.20
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However...
However...
the perfect storm is brewing:

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However...
the perfect storm is brewing:
Aging population

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However...

the perfect storm is brewing:

Aging population

• Lifestyles less healthy:
  • Smoking
  • Diet
  • Alcohol
  • Exercise

• Sun exposure  Increasing survival
However... the perfect storm is brewing:

Aging population
• Lifestyles less healthy:
  • Smoking
  • Diet
  • Alcohol
  • Exercise
  • Sun exposure

Increasing survival

“Non-communicable diseases are a slow-motion disaster; these are the diseases that break the bank”.

Dr. Margaret Chan, Former Director-General of WHO
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Cancer – why all the interest?

The Future:
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The perfect storm:

Numbers of cancers (ex NMSC)

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2040</th>
<th>% increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>401,507</td>
<td>538,481</td>
<td>33.8%</td>
</tr>
<tr>
<td>Global</td>
<td>17.0 million</td>
<td>27.5 million</td>
<td>61.4%</td>
</tr>
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</table>

http://gco.iarc.fr/tomorrow/graphic-line?type=0&population=900&mode=population&sex=0&cancer=39&age_group=value&apc_male=0&apc_female=0&collapse-by_country (Accessed 20.2.20)
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Cancer: why all the interest?

1 in 2 people born after 1960 will be diagnosed with one or more cancers in their lifetime
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10 year survival has improved to reach 50% surviving their disease
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Cancer: why all the interest?

1 in 2 people born after 1960 will be diagnosed with one or more cancers in their lifetime

10 year survival has improved to reach 50% surviving their disease, but...

Cancer survival in the UK still lags behind comparable health economies
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Why is cancer prevention important?
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Why is cancer prevention important?

“Addressing non-communicable diseases (NCDs) is critical for global public health, but it will also be good for the economy; for the environment; for the global public good in the broadest sense. If we come together to tackle NCDs, we can do more than heal individuals— we can safeguard our very future.”

Former UN Secretary General Ban Ki-moon
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Why is cancer prevention important?

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Former UN Secretary General Ban Ki-moon
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Why is cancer prevention important?

THE PROPORTION OF CANCERS WHICH COULD BE PREVENTED VARIES BETWEEN UK COUNTRIES

<table>
<thead>
<tr>
<th>Percentage of cancer cases each year attributable to risk factors shown</th>
<th>Tobacco smoking</th>
<th>Overweight and obesity</th>
<th>Radiation UV</th>
<th>Occupation</th>
<th>Infections</th>
<th>Alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Scotland</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wales</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northern Ireland</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tbody>
</table>

% Cancer cases preventable

- England: 37.3%
- Scotland: 41.5%
- Wales: 37.8%
- Northern Ireland: 38.0%

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Why is cancer prevention important?

The proportion of cancers which could be prevented varies between UK countries.
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Why is cancer prevention important?

Together we can help beat cancer in Bournemouth East

This data refers to:
CCG: NHS Dorset CCG
Local Authority (LA): Bournemouth, Christchurch and Poole
Cancer Alliance: Wessex

We have chosen data most relevant to your constituency. The following CCGs cover your area: NHS Dorset CCG

1 in 2 people will get cancer in their lifetime. Rising referrals and a growing population will increase pressure on cancer services. To achieve world-class outcomes for patients, Government must tackle preventable risk factors and address shortages in the cancer workforce.

Together we can prevent more cancers

Almost 4 in 10 cancer cases in England could be prevented.

- Smoking is the largest preventable cause of cancer in England.
- Overweight and obesity is England’s second largest preventable cause of cancer.

Smoking

14.6% of adults currently smoke cigarettes in this LA. This is similar to the England average (14.4%).

Action: Ask the Chancellor to provide sustainable funding for public health and introduce a levy on tobacco manufacturers’ profits so the polluter pays.

Childhood obesity

20.2% of 4-5 year-olds are overweight or obese in this LA. This is lower than the England average (22.4%).

Action: Ask the Culture Secretary to support families and implement a 9pm watershed for junk food adverts on TV and online.

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Why is cancer prevention important?

Numbers of preventable cancer

- Lung
- Bowel
- Melanoma skin cancer
- Breast
- Oesophageal
- Bladder
- Kidney
- Stomach
- Pancreatic
- Cervical
- Other preventable cancer types

Number of Cases per Year

Source: [http://www.cancerresearchuk.org/health-professional/cancer-statistics/risk/preventable-cancers#heading](http://www.cancerresearchuk.org/health-professional/cancer-statistics/risk/preventable-cancers#heading) (last accessed 20.2.20)
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Why is cancer prevention important?

[Image of a pie chart showing preventable cancers]

- Lung: 27%
- Bowel: 9%
- Melanoma skin cancer: 17%
- Breast: 10%
- Oesophageal: 4%
- Bladder: 3%
- Kidney: 3%
- Stomach: 3%
- Pancreatic: 2%
- Cervical: 2%
- Other preventable cancer types: 2%

[Source: http://www.cancerresearchuk.org/health-professional/cancer-statistics/risk/preventable-cancers#heading-One (last accessed 20.2.20)]
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Why is cancer prevention important?

http://www.cancerresearchuk.org/health-professional/cancer-statistics/risk/preventable-cancers#heading Two (last accessed 20.2.20)
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Why is cancer prevention important?

Smoking Rates in Adults

Dorset CCG
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Why is cancer prevention important?

% drop in smoking prevalence compared to 2011 baseline

<table>
<thead>
<tr>
<th>Year</th>
<th>England</th>
<th>Wales</th>
<th>Scotland</th>
<th>Northern Ireland</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>-2.5%</td>
<td>-5.8%</td>
<td>-7.3%</td>
<td>1.6%</td>
<td>-3.0%</td>
</tr>
<tr>
<td>2013</td>
<td>-7.1%</td>
<td>-9.4%</td>
<td>-8.1%</td>
<td>-2.1%</td>
<td>-6.9%</td>
</tr>
<tr>
<td>2014</td>
<td>-10.1%</td>
<td>-13.0%</td>
<td>-13.2%</td>
<td>-4.8%</td>
<td>-10.4%</td>
</tr>
<tr>
<td>2015</td>
<td>-14.6%</td>
<td>-18.8%</td>
<td>-18.4%</td>
<td>0.5%</td>
<td>-14.9%</td>
</tr>
<tr>
<td>2016</td>
<td>-21.7%</td>
<td>-24.2%</td>
<td>-24.4%</td>
<td>-4.2%</td>
<td>-21.8%</td>
</tr>
<tr>
<td>2017</td>
<td>-24.7%</td>
<td>-27.8%</td>
<td>-30.3%</td>
<td>-12.7%</td>
<td>-25.2%</td>
</tr>
<tr>
<td>2018</td>
<td>-27.3%</td>
<td>-28.7%</td>
<td>-30.3%</td>
<td>-18.0%</td>
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</tr>
</tbody>
</table>

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Why is cancer prevention important?

Smoking prevalence in adults (18+)

NHS Dorset CCG
13.6%

Better  Similar  Worse

https://fingertips.phe.org.uk/profile/tobacco-control/data#page/8/gid/1938132885/pat/46/par/E39000048/ati/154/are/E38000044 Accessed 20.2.20
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Why is cancer prevention important?

**Figure 4.1:** Effects of stopping smoking at various ages on the cumulative risk (%) of death from lung cancer by age 75 for men

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Why is cancer prevention important?

£1 investment leads to a return of (including NHS savings and value of health gains)

<table>
<thead>
<tr>
<th>Time</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 years</td>
<td>£ 0.63</td>
</tr>
<tr>
<td>5 years</td>
<td>£ 1.46</td>
</tr>
<tr>
<td>10 years</td>
<td>£ 2.82</td>
</tr>
<tr>
<td>Lifetime</td>
<td>£ 9.35</td>
</tr>
</tbody>
</table>
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WHAT’S THE MOST SUCCESSFUL WAY TO STOP SMOKING?
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What's the most successful way to stop smoking?
Success of popular methods compared with going cold turkey

- Cold Turkey: Quitting with no support
- NRT: Using nicotine replacement therapy without professional support
- E-Cigarettes: Using electronic cigarettes without professional support
- Support and Medication: Combined specialist support and prescription medication

No more successful than cold turkey—probably because people don't use enough

225% More successful
60% More successful

*Available free from your local Stop Smoking Service nhs.uk/smokefree


We will beat cancer sooner. cruk.org/smoking
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RCGP Position Statement on e-cigarettes
Primary Care and Cancer Matters

RCGP Position Statement on e-cigarettes

**E-cigarettes**

E-cigarettes – re-position statement

- Using their clinical judgement on an individual patient basis, PCCs may wish to promote EC use as a means to stopping. Patients choosing to use an e-cigarette in a quit attempt should be advised that seeking behavioural support alongside e-cigarette use increases the chances of quit success further. Most SSS are EC friendly and patients can be advised to bring one to their appointment if they would like to quit using their device.
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RCGP Position Statement on e-cigarettes

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RCGP Position Statement on e-cigarettes

• PCCs recognise ECs offer a wide reaching, low-cost opportunity to reduce smoking (especially in deprived groups in society and those with poor mental health, both having elevated rates of smoking). In the UK, though start-up costs can be higher, it likely to be less expensive to use an EC over time than it is to smoke.
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RCGP Position Statement on e-cigarettes

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Smoking data (2017)

1/3 of all tobacco is smoked by people with mental health condition
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The evidence so far shows that e-cigarettes are far safer than smoking

1. E-cigarettes contain nicotine but **not cancer causing tobacco**
2. Nicotine is addictive, but does **not cause cancer**
3. **Tobacco** is the biggest cause of preventable death in the UK
   Over 100,000 deaths per year
4. Passively breathing vapour from e-cigarettes is **unlikely to be harmful**
5. Growing evidence shows e-cigarettes are helping people to **stop smoking**

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https://theassethub.cancerresearchuk.org/media/?mediaId=1C8B1338-048B-4F26-AFFDBB13A1820C9
Accessed 20.2.20
Cost of smoking vs e-cigarettes
Every 3 months, in Great Britain

£540
The average smoker spends around £540 on cigarettes.

£150
The average e-cigarette user spends around £150 on e-liquid and equipment.

Smoking cigarettes costs around 3.5 times as much as using e-cigarettes.

Figures are calculated by the Cancer Intelligence Team, Cancer Research UK, based on data from the Office of National Statistics and other sources. The above figures are intended to act as estimates based on widely available products, their costs and average use. Calculations made May 2019.

Together we will beat cancer

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Why is cancer prevention important?
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Why is cancer prevention important?

Overweight and Obese 2015

https://www.cancerresearchuk.org/health-professional/cancer-statistics/risk/overweight-and-obesity#headingTwo (accessed 20.2.20)
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Why is early diagnosis important?

SURVIVAL BY STAGE AT DIAGNOSIS

DIAGNOSED EARLIER AT STAGE I

DIAGNOSED LATER AT STAGE IV

LUNG

AROUND 8 IN 10

LESS THAN 2 IN 10

BOWEL

MORE THAN 9 IN 10

AROUND 4 IN 10

Data for people diagnosed in England in 2014
Source: COS/PHE, Cancer survival by stage at diagnosis for England (experimental statistics)
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Why is early diagnosis important?

WHEN THE NHS DIAGNOSES PATIENTS EARLIER, TREATMENT COSTS MUCH LESS

- **Colon Cancer**
  - EARLIER DIAGNOSIS (STAGE 1): £3,400
  - LATER DIAGNOSIS (STAGE 4): £12,500
  - Survival: More than 9 in 10 survive 5 or more years
  - Cost reduction: ↓72.8%

- **Rectal Cancer**
  - EARLIER DIAGNOSIS (STAGE 1): £4,400
  - LATER DIAGNOSIS (STAGE 4): £11,800
  - Survival: More than 9 in 10 survive 5 or more years
  - Cost reduction: ↓62.7%

- **Ovarian Cancer**
  - EARLIER DIAGNOSIS (STAGE 1): £5,300
  - LATER DIAGNOSIS (STAGE 4): £15,100
  - Survival: Almost 9 in 10 survive 5 or more years
  - Cost reduction: ↓64.9%

- **Lung Cancer**
  - EARLIER DIAGNOSIS (STAGE 1): £8,000
  - LATER DIAGNOSIS (STAGE 4): £13,100
  - Survival: More than 3 in 10 survive 5 or more years
  - Cost reduction: ↓38.9%

= Estimated cost of treating a patient

*Rectal and Colon Cancer survival is based on bowel statistics

http://www.cancerresearchuk.org/sites/default/files/saving_lives_averting_costs.pdf 20.2.20
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Compared to Europe?
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Compared to Europe?

Lancet paper published 11.9.19

https://www.thelancet.com/action/showPdf?pii=S1470-2045%2819%2930456-5 Accessed 20.2.20
Primary Care and Cancer Matters

Compared to Europe?

https://www.thelancet.com/action/showPdf?pii=S1470-2045%2819%2930456-5 Accessed 20.2.20
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Why do we lag behind other Health Systems?
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Why do we lag behind other Health Systems?

- International Cancer Benchmarking Partnership
  - As gatekeepers – the gate needs to be wider
  - Outcomes closely linked to “readiness to act”
  - Patients fear wasting GP time

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Gate openers...
The expanding role of primary care in cancer control

"For a long time, the role of primary care in cancer was largely seen as peripheral, but as prevention, diagnosis, survivorship, and end-of-life care assume greater importance in cancer policy, the defining characteristics of primary care become more important."
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<td>Tobacco</td>
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<td>Follow-up</td>
<td>Basic palliation</td>
</tr>
<tr>
<td>Food</td>
<td>Health care seeking</td>
<td>Access</td>
<td>Chemotherapy</td>
<td>Late effects</td>
<td>Specialised</td>
</tr>
<tr>
<td>Immunisations</td>
<td>Screening</td>
<td>Technology</td>
<td>Radiotherapy</td>
<td>Rehabilitation</td>
<td>Social</td>
</tr>
<tr>
<td>Exercise</td>
<td>Access</td>
<td>Decision support</td>
<td>Comorbidity</td>
<td>Health promotion</td>
<td>Bereavement</td>
</tr>
<tr>
<td>Environment</td>
<td></td>
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**Primary Care and Cancer Matters**

Royal College of General Practitioners

Cancer Research UK
Primary Care and Cancer Matters

Prevention
- Tobacco
- Food
- Immunisations
- Exercise
- Environment

Early detection
- Awareness
- Health care seeking
- Screening
- Access

Diagnosis
- Investigations
- Access
- Technology
- Decision support

Treatment
- Surgery
- Chemotherapy
- Radiotherapy
- Comorbidity
- Psychology

Survivorship
- Follow-up
- Late effects
- Rehabilitation
- Health promotion

End of life
- Basic palliation
- Specialised
- Social
- Bereavement

Primary Care could (should?) have a part to play throughout the cancer pathway, and is well placed to do so...
Primary Care and Cancer Matters

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Primary Care could (should?) have a part to play throughout the cancer pathway, and is well placed to do so... if adequately resourced...
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The Lancet Oncology: “The expanding role of Primary Care in Cancer Control”

“For a long time, the role of primary care in cancer was largely seen as peripheral, but as prevention, diagnosis, survivorship, and end-of-life care assume greater importance in cancer policy, the defining characteristics of primary care become more important”

The Lancet Oncology, Vol. 16, No. 12
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Primary Care and Cancer Matters

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The Lancet Oncology, Vol. 16, No. 12
Primary Care and Cancer Matters

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Primary Care and Cancer Matters

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The Lancet Oncology, Vol. 16, No. 12
Primary Care and Cancer Matters

Value in investing in early diagnosis:
Primary Care and Cancer Matters

Value in investing in early diagnosis:

• Why? To address our lowly cancer outcomes rank
• How? To lower threshold/readiness to refer with consistency
• When? Now
Primary Care and Cancer Matters

Value in investing in early diagnosis:

• Results?
Primary Care and Cancer Matters

Value in investing in early diagnosis:

• Results?
  • Better medicine – earlier diagnosis (not just of cancer)
  • Fewer consultations
  • Better outcomes
  • Less complaints/litigation
  • Less £££
Primary Care and Cancer Matters

Value in investing in early diagnosis:

• Results?
  • Better medicine – earlier diagnosis (not just of cancer)
  • Fewer consultations
  • Better outcomes
  • Less complaints/litigation
  • Less £££

WIN, WIN, WIN...
Primary Care and Cancer Matters

Cancer Prevention Awareness Month

What proportion of cancers were preventable in UK in 2015?

1. 7.7%
2. 17.7%
3. 27.7%
4. 37.7%
5. 47.7%
Primary Care and Cancer Matters

Cancer Prevention Awareness Month

What proportion of cancers were preventable in UK in 2015?

1. 7.7%
2. 17.7%
3. 27.7%
4. 37.7%
5. 47.7%
Primary Care and Cancer Matters
Cancer Prevention Awareness Month

4 in 10 CANCER CASES CAN BE PREVENTED...

- Be smoke free: 15.1%
- Keep a healthy weight: 6.3%
- Be safe in the sun: 3.8%
- Avoid certain substances at work such as asbestos: 3.6%
- Protect against certain infections such as HPV and H. Pylori: 3.8%
- Drink less alcohol: 3.3%
- Eat a high fibre diet: 3.3%
- Avoid unnecessary radiation including radon gas and x-rays: 1.9%
- Cut down on processed meat: 1.5%
- Avoid air pollution: 1.0%
- Breastfeed if possible: 0.7%
- Be more active: 0.5%
- Minimise HRT use: 0.4%

LET'S BEAT CANCER SOONER
[cruk.org]

...MAKE A CHANGE TO REDUCE THE RISK OF CANCER

Larger circles indicate more UK cancer cases

Primary Care and Cancer Matters

Cancer Prevention Awareness Month

DSR preventable <75 deaths in England

- Cardiovascular
- Cancer
- Liver
- Respiratory

Accessed 20.2.20
ACHIEVING WORLD-CLASS CANCER OUTCOMES
A STRATEGY FOR ENGLAND
2015-2020

Report of the Independent Cancer Taskforce
GP Trainers' Workshop

• Achieving World Class Cancer Outcomes...

Recommendation 16:

• We recommend the following to take forward the new NICE guidelines:

  • NICE should work with organisations such as Cancer Research UK, the Royal College of GPs and Macmillan Cancer Support to disseminate and communicate the new referral guidelines to GP practices as quickly as possible.
Aim

The aim of the guidelines is to improve cancer diagnosis:

• The timeliness
• The quality
• The consistency
GP Trainers' Workshop

NICE Guidance (NG12)

Implementation

“While guidelines assist the practice of healthcare professionals, they do not replace their knowledge and skills.”
GP Trainers' Workshop

NICE Guidance (NG12)

Implementation

“For all clinical scenarios it is assumed that the health professional will have a discussion with the patient about the risks and benefits of intervention, enabling the patient to exercise a fully informed decision.”
GP Trainers' Workshop

NICE Guidance (NG12)

Implementation

The guideline focuses on those areas of clinical practice:

• That are known to be controversial or uncertain
• Where there is identifiable practice variation
• Where there is lack of high quality evidence
• Where NICE guidelines are likely to have the most impact.
GP Trainers' Workshop

NICE Guidance (NG12)

Implementation

It is assumed that:

• an appropriate history and physical examination are undertaken
• urinalysis is undertaken where appropriate
• simple blood tests (Fbc, biochemistry and inflammatory markers) are done
GP Trainers' Workshop

NICE Guidance (NG12)

What is new?

• This is the first guidance that uses primary care evidence, which is available for the first time
• Adds symptom pathways for the first time
• Uses the same referral thresholds for all cancers
GP Trainers' Workshop

NICE Guidance (NG12)

What is new?

• This is the first guidance that uses primary care evidence, which is available for the first time
• Adds symptom pathways for the first time
• Uses the same minimum referral thresholds for all cancers (PPV 3%)
GP Trainers' Workshop

NICE Guidance (NG12)

What is new?

• Many – being symptom centred and using 3% PPV, the ages vary (range 30-60)
• Some criteria have been dropped (no evidence to support them)
• Timeline specifics have gone – replaced with “recurrent” or “persistent”.

Royal College of General Practitioners

Cancer Research UK
GP Trainers' Workshop

NICE Guidance (NG12)

What is new? (Specifics - examples)

- 2ww lung - Haemoptysis **only in 40+**
- **Mesothelioma** now covered
- Lower GI – high risk groups (eg ulcerative colitis) not mentioned.
- 2ww breast: **unexplained axillary lump**
- Haematuria and ↑ platelets → gynae ultrasound
- Dermatoscopy suggestive of melanoma → 2ww dermatology
Persistent bone pain, unexplained fracture:

- do Fbc + ESR

- 60+ with hypercalcaemia/↓wbc:
  - electrophoresis and BJP within 48h

- Palpable abdominal mass <16

  (used to be under 1y)
GP Trainers' Workshop

NICE Guidance (NG12)
What is new? (Specifics - examples)

Relevance of ↑ Platelet count
GP Trainers' Workshop

NICE Guidance (NG12)

What is new? (Specifics - examples)

Relevance of ↑ Platelet count

NG12/Lung:
• Consider CXR if to assess for lung cancer in people ≥40 with thrombocytosis (TBC)
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NICE Guidance (NG12)
What is new? (Specifics - examples)

Relevance of ↑ Platelet count
NG12
Lung:
Endometrial:
• Consider a direct access ultrasound to assess for endometrial cancer in women ≥55 with vaginal discharge/visible haematuria with TBC
GP Trainers' Workshop

NICE Guidance (NG12)

What is new? (Specifics - examples)

Relevance of ↑ Platelet count/NG12

Lung
Endometrial
Gastric
Oesophageal:

• Consider non-urgent direct access OGD to assess for oesophageal cancer in people ≥55 with TBC and any of nausea, vomiting, weight loss, reflux, dyspepsia, or upper abdominal pain
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NICE Guidance (NG12)

**What is new? (Specifics - examples)**

Relevance of ↑ Platelet count/NG12

- Lung
- Endometrial
- Gastric
- Oesophageal
Trainers’ Workshop
NICE Guidance (NG12)
What is new? (Specifics)

Relevance of ↑ Platelet count

7.8% of patients (11.6% of males, 6.2% of females) will have a 1 year cancer incidence:

If a second blood test shows platelet count to be the same or higher:
18.1% of males and 10.1% of females will have a 1 year cancer incidence

Br J Gen Pract 2017; 67 (659): e405-e413.
Trainers’ Workshop

NICE Guidance (NG12)

What is new? (Specifics)

• Relevance of ↑ Platelet count

Seen in cancers of:

• Lung
• Colorectal
• OG
• Ovarian

• LEGO+C

Br J Gen Pract 2017; 67 (659): e405-e413.
Trainers’ Workshop

NICE Guidance (NG12)

What is new? (Specifics)

Relevance of ↑ Platelet count

- A 64 year old patient’s FBC comes back with a platelet count of 524 – what do you do next?
Trainers’ Workshop

NICE Guidance (NG12)
What is new? (Specifics)

Relevance of ↑ Platelet count

A 64 year old patient’s FBC comes back with a platelet count of 524 – the second FBC 4 weeks later has a platelet count of 558 - what next?
Trainers’ Workshop

NICE Guidance (NG12)

Early Diagnosis Group Work
Trainers’ Workshop

NICE Guidance (NG12)

Early Diagnosis Group Work

1. Why will the new cancer guidelines inevitably increase referrals for suspected cancer?
Q2a. A 41 year old man presents with cough for the past 6 weeks. He has smoked 20 cigarettes per day for 23 years.

What further assessment would you make?
Q2b. He is well, has a long standing morning cough with clear phlegm. Full examination is normal. What investigations would you request in primary care?

What arrangement / safety net would you put in place for follow up?
Q2c. CXR and FBC are normal but on review 1 week later he has experienced 2 episodes of haemoptysis.

What action would you take?
Q3a. 38 year old women with a history of having felt a lump in her left breast. It is painless, there is no history of trauma, she is not breast feeding.

What further assessment would you undertake and what sings would you look for?
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NICE Guidance (NG12)
Early Diagnosis Group Work

Q3b. There is a 1.5 cm breast lump in the upper outer quadrant of the left breast, there is no lymphadenopathy.

What action would you take?
Q4. A 45 year old lady with a 2cm lump in the right axilla should be referred via the 2WW breast cancer pathway:

True or False
Q5. A 51 year old lady with a unilateral nipple discharge and normal examination should be referred via the 2WW breast pathway.

True or False
Trainers’ Workshop

NICE Guidance (NG12)
Early Diagnosis Group Work

Q6a. A 58 year old man presents with LUTS. What assessment would you make?
Q6b. His IPSS score is 18 indicating moderate symptoms. Examination of his abdomen is normal - no bladder/renal mass. PR reveals a smooth moderately enlarged benign feeling prostate. Dipstick urine shows a trace of nitrite, no blood.

What investigations would you do? He is keen to have a PSA test.
Q6c. His renal function and FBC are normal, PSA 10 (normal ≤2.9) MSSU reveals raised wcc and rbc 100 with E. coli UTI.

What action would you take?
Q6d. PSA is now 2.8 MSSU normal what action would you take?
Trainers’ Workshop

NICE Guidance (NG12)
Early Diagnosis Group Work

Q6e. PSA repeated after 3/12 is 5.4 his symptoms are only slightly improved on treatment and repeat MSSU is normal.

What would you do?
Trainers’ Workshop

NICE Guidance (NG12)
Early Diagnosis Group Work

Q7. A 47 year old man presents with frank / visible haematuria. MSSU is negative He should be referred urgently via a 2ww pathway:

True or False?
Q8a. A 62 year old man presents for a new patient diabetes review having seen the nurse 2 weeks previously. His diabetes was diagnosed 'opportunistically' following a CV Risk appointment. His BMI is 22, there is no FH of DM he asks if this would explain his recent weight loss (4kg in 5 weeks) and upper abdominal discomfort.

What examination would you do?
Q8b. He is not clinically anaemic or jaundiced and examination of his abdomen is normal.

What action would you take?
Q8c. CT abdo confirms a suspicious lesion in the pancreas.

What action would you take?
Trainers’ Workshop

NICE Guidance (NG12)
Early Diagnosis Group Work

Q9. A 51 year old man presents with months of intermittent painless rectal bleeding. There is no weight loss or change in bowel habit. Examination of his abdomen is normal and PR NAD.

He should be referred via a 2 WW pathway to a colorectal surgeon.

True or False?
Q10a. A 63 year old electrician presents with a one month history of gradual onset, non mechanical back pain which is now disturbing his sleep.

What assessment would you make?
Q10b. Systemic enquiry reveals slight loss of appetite but no other significant symptoms referable to any system and no weight loss. Examination reveals no general abnormality, he has FROM of his spine although he is tender locally at L 2, PR NAD.

What investigations would you do?
Q10c. His ESR is 70, CRP 66 calcium 2.59.

What investigations would you do and how urgently should they be carried out?
Q10d. BJP are positive and serum protein electrophoresis is abnormal how would you proceed?
Q11. A 58 year old lady presents with weight loss and dyspepsia. Examination of her abdomen is unremarkable and she is not clinically anaemic. What action should you take?
Trainers’ Workshop

NICE Guidance (NG12)
Early Diagnosis Group Work

Q12. Non urgent upper GI endoscopy is appropriate in the following – True or False

a) 56 year old man with treatment resistant dyspepsia?
b) 59 year old man with upper Abdo pain and anaemia (not iron deficient) normal examination?
c) 40 year old male smoker with dysphagia for solids normal examination?
Q12. Non urgent upper GI endoscopy is appropriate in the following – True or False

d) 49 year old man with haematemesis normal examination?
e) 60 year old lady with weight loss upper abdo pain and diarrhoea. Normal examination
Trainers’ Workshop
NICE Guidance (NG12)
Early Diagnosis Group Work:
Abdominal Pain:

64 year old female patient with vague diffuse abdominal pain for 2 weeks. “May have lost a few pounds”
Infrequent attender
No PR bleeding/change in appetite/bowel habit.
Never smoked
No significant PMH/FH/ Meds
Examination NAD
Trainers’ Workshop
NICE Guidance (NG12)
Early Diagnosis Group Work:
Abdominal Pain:

64 year old female patient with vague diffuse abdominal pain for 2 weeks. “May have lost a few pounds”
Infrequent attender
No PR bleeding/change in appetite/bowel habit.
Never smoked
No significant PMH/FH/ Meds
Examination NAD

Differential diagnosis, and what next?
Trainers’ Workshop
NICE Guidance (NG12)
Early Diagnosis Group Work:
Abdominal Pain:
  Abdominal Pain: 64 year old female patient

Later that week....
  FBC - Hb10.6g/dl, WCC 13, platelets 525
  Ca125 normal (< 35IU/ml)

What next?
Trainers’ Workshop

NICE Guidance (NG12) Early Diagnosis Group Work: Appetite Loss:

• Jenny is a 55 year old teacher who stopped smoking one year ago. She has been feeling under the weather for a while but in the past 4 weeks has been eating poorly.

• Her husband has made her come to surgery because he is worried. She is annoyed that he has made her come and seems irritable.

• Jenny has not noticed any urinary symptoms, or worsening of her longstanding cough, she denies symptoms of depression but does feel a bit irritable and she has been sleeping poorly due to pain in her right shoulder/neck region.

• She denies dyspepsia/ weight loss /altered bowel habit. PMH Hypertension: last review 5 months ago and she weighed 52 kg. She now weighs 50kg on your scales.
Trainers’ Workshop

NICE Guidance (NG12) Early Diagnosis Group Work: Appetite Loss:

• Jenny is a 55 year old teacher who stopped smoking one year ago. She has been feeling under the weather for a while but in the past 4 weeks has been eating poorly.

• Her husband has made her come to surgery because he is worried. She is annoyed that he has made her come and seems irritable.

• Jenny has not noticed any urinary symptoms, or worsening of her longstanding cough, she denies symptoms of depression but does feel a bit irritable and she has been sleeping poorly due to pain in her right shoulder/neck region

• She denies dyspepsia/ weight loss /altered bowel habit. PMH Hypertension: last review 5 months ago and she weighed 52 kg. She now weighs 50kg on your scales.

Differential diagnosis; what next?
Mrs W is a 60 year old lady with who attends with dysuria and frequency.

This is the 3rd occasion that she has been seen in 2 months.

Once at the surgery treated for possible UTI with Nitrofurantoin for 3 days (urinalysis: trace blood)

Once at the walk in centre where she was given Trimethoprim for 7 days (no record of urinalysis)

Symptoms come and go.

She denies any history of menopausal bleeding but admits to slight increase in vaginal discharge.

No significant PMHx.

Examination is normal, ex dipstick: Protein Tr, wbc+, rbc+
Mrs W is a 60 year old lady who attends with dysuria and frequency.
This is the 3rd occasion that she has been seen in 2 months.
Once at the surgery treated for possible UTI with Nitrofurantoin for 3 days (urinalysis: trace blood)
Once at the walk in centre where she was given Trimethoprim for 7 days (no record of urinalysis)
Symptoms come and go.
She denies any history of menopausal bleeding but admits to slight increase in vaginal discharge.
No significant PMHx.
Examination is normal, ex dipstick: Protein Tr, wbc+, rbc+

What next?
Trainers’ Workshop
NICE Guidance (NG12) Early Diagnosis Group Work: Haematuria

What happens next:

You ask Mrs W to have a FBC/U&Es and send an MSU and arrange for her to see you at the end of the week. When you see her she denies any further dysuria or frequency. Results:

- MSU no growth.
- Hb 11.2 Wbc 7.4 Platelets 490
- Renal function Normal
Trainers’ Workshop
NICE Guidance (NG12) Early Diagnosis Group Work: Haematuria

What happens next:

You ask Mrs W to have a FBC/U&Es and send an MSU and arrange for her to see you at the end of the week. When you see her she denies any further dysuria or frequency. Results:

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What next?
Trainers’ Workshop

Resources:
RCGP Cancer Toolkit
Trainers’ Workshop

Resources:
RCGP Cancer Toolkit

Trainers’ Workshop

Resources:
RCGP Early Diagnosis Module
RCGP Cancer Toolkit
Trainers’ Workshop

Resources:
RCGP Early Diagnosis Module

RCGP Cancer Toolkit
Trainers’ Workshop

Resources:

• Need more information about cancer (locally)?
• CRUK facilitator/facilitators
• Local cancer lead GPs
Trainers' Workshop

Our common goal?
Trainers' Workshop

Our common goal?
Trainers’ Workshop

Our common goal? NHS Long Term Plan
Trainers’ Workshop

Our common goal? NHS Long Term Plan

Milestones for cancer

- From 2019 we will start to roll out new Rapid Diagnostic Centres across the country.
- In 2020 a new faster diagnosis standard for cancer will begin to be introduced so that patients receive a definitive diagnosis or ruling out of cancer within 28 days.
- By 2020 HPV primary screening for cervical cancer will be in place across England.
- By 2021, where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support.
- By 2022 the lung health check model will be extended.
- By 2023, stratified, follow-up pathways for people who are worried their cancer may have recurred. These will be in place for all clinically appropriate cancers.
- By 2028, the NHS will diagnose 75% of cancers at stage 1 or 2.
Primary Care and Cancer Matters

Key to cancer
Primary Care and Cancer Matters

Key to cancer

Education
Education
Education
Primary Care and Cancer Matters

Key to cancer

Education - public
Education - patients
Education - profession
Primary Care and Cancer Matters

Key to cancer

Education - public
Education - patients
Education - profession
Education - policy makers
Primary Care and Cancer Matters

Key to cancer

Education - public
Education - patients
Education - profession
Education - policy makers
Education - politicians
Insanity:
Primary Care and Cancer Matters

Insanity:

• doing the same thing over and over again and expecting different results
Primary Care and Cancer Matters

Insanity:

- doing the same thing over and over again and expecting different results

Albert Einstein 1879-1955
Primary Care and Cancer Matters

Our common goal?
Primary Care and Cancer Matters

Our common goal?
Primary Care and Cancer Matters

Our common goal?
Primary Care and Cancer Matters

Our common goal?

We are doing amazingly,
Primary Care and Cancer Matters

Our common goal?

We are doing amazingly, but if resourced we can do even better, and match the best health care systems...
Primary Care and Cancer Matters

Online learning

• E-cigarettes – RCGP podcast¹ and video²:
  ➢ Suitable for the busy GP – 10 minutes long
  ➢ Addresses key concerns around safety, passive vaping and entry into smoking

• Webinar³ – Smoking cessation: Why and how to support your patients to stop smoking (when time and funding are against us!)
  ➢ Suitable for the busy GP – 20 minutes long
  ➢ Addresses current smoking cessation strategies available to GPs

• E-learning modules– VBA and Smoking cessation
  ➢ Behaviour change and cancer prevention
  ➢ Essentials of smoking cessation
  ➢ 30 minutes each, offering practical support

• RCGP Position Statement on e-cigarettes

• https://www.cancerresearchuk.org/health-professional/learning-and-support/online-learning

Primary Care and Cancer Matters

Role of Primary Care
- Prevention
- Early Diagnosis

Increased survival
Survivorship support
End of life care
Primary Care and Cancer Matters

Role of Primary Care
- Prevention
- Early Diagnosis

Increased survival
Survivorship support
End of life care

Address inequalities
Primary Care and Cancer Matters

• Cancer: why all the interest?
• The future
• Why is prevention important?
• Why is early diagnosis important?
• Future – where next?
• Survivorship
• End of life care
• February Awareness Month
  • National Cancer Prevention Month…
Primary Care and Cancer Matters

One person can make a difference, and everyone should try.
Primary Care and Cancer Matters

One person can make a difference, and everyone should try.

John F Kennedy 1917-1963
Primary Care and Cancer Matters
CRUK GP Contract hub
Supporting GPs in England delivering the 2020/21 contract

- Recommendations on what to do and how to get started
- Free practical and evidence-based resources

cruk.org/GPcontract
Primary Care and Cancer Matters

Thank you
Primary Care and Cancer Matters

Any questions?