Analysis from Learning Events and Educational Tools

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Learning events (formerly SEA)

• For *individual and practice/PCN learning*
• Highlight areas for development *as individual and Practice*
• Identify gaps/weaknesses *in systems*
• Stimulate discussion and *reflection as a group/Network*
• Consider *particular types of presentation e.g emergency*
Factors influencing cancer survival and premature mortality
Updated NAEDI hypothesis

- Age
- Sex
- Ethnicity
- Socio-economic status*

- Difficulty accessing primary care
  - Low public awareness
  - Barriers to help-seeking
  - Negative beliefs about cancer*

- Delays in primary care interval
  - Late presentation to a GP
  - Low uptake of cancer screening

- Access to diagnostics and primary-secondary care interface factors*
  - Late presentation to hospital services
  - Emergency presentations*

- Delays in secondary care interval

- Treatment
  - More advanced disease at diagnosis
  - Poor survival rates
  - Premature mortality
  - Avoidable deaths

*New or changed since original hypothesis

Service level factors
Individual level factors
- Difficulty accessing primary care
- Delays in primary care interval
- Access to diagnostics and primary-secondary care interface factors*
- Delays in secondary care interval
- Treatment
  - Access to treatment
- Other factors
Learning Events (SEA) - Overview

• What happened and why?
• What was the impact on those involved (patient, carer, family, GP, practice)?
• How could things have been different?
• What can we learn from what happened?
• What needs to change?
Learning Events (SEA) – Key Points

- Title and date of the SEA discussion and subsequent events
- Date the event was discussed and the roles of those present
- A description of the event involving the GP(s) and other colleagues
- Reflections on the event in terms of knowledge, skills and performance
- Safety and Quality Improvement
Learning Events (SEA) - Key Points

- Communication, partnership and teamwork
- Maintaining trust
- What changes have been agreed for me personally and the practice team, roles and agreed timelines for action(s)
- Changes carried out and their impact?
- How could things have been different?
- What can we learn from what happened?
- What needs to change?
Improving diagnosis of cancer

A TOOLKIT FOR GENERAL PRACTICE

E. Mitchell, G. Rubin & U. Macleod

SIGNIFICANT EVENT AUDIT OF CANCER DIAGNOSIS

Cancer SEA Report Template

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

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

1. WHAT HAPPENED?

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

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

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

- The initial presentation and presenting symptoms (including where if outwith primary care).
- The key consultation at which the diagnosis was made.
- Consultations in the year prior to diagnosis and referral (how often the patient had been seen by the practice; for what reasons; the type of consultation held: telephone, in clinic etc; and who - GP1, GP2, Nurse 1 - saw them).
- Whether s/he had been seen by the Out of Hours service, at A&E, or in secondary care clinics.
- If there appears to be delay on the part of the patient in presenting with their symptoms.
- What the impact or potential impact of the event was.

June 2014 - Attended GP surgery concerned about aching right groin lump. GP1 referred to Surgeon for possible hernia. Surgeon diagnosed a few 'a few shotty lymph nodes but no hernia', which he didn’t think warranted a scan.¹

June 2014 - Normal mammogram.

Nov 2014 - Negative bowel cancer screening test.²

Dec 2014 - Consultation with GP1 for Hypertension review and statin discussion for raised cholesterol, QRisk 19%.³

Feb 2015 - Consulted with GP1 for weeping area in umbilicus. Diagnosed as Pyogenic Granuloma and cauterized with silver nitrate.

11th April 2015 – Consultation with GP2 for aching in left lower leg 2d after long haul flight. No clinical signs of DVT and Wells score -1. Muscle strain thought more likely. Counselling for signs of DVT and advised to raise concerns at BP check the following week and if worse would need scan to exclude DVT.⁴
1. WHAT HAPPENED?

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

- The initial presentation and presenting symptoms (including where it occurred with primary care).
- The key consultation at which the diagnosis was made.
- Consultations in the year prior to diagnosis and referral (how often the patient had been seen by the practice; for what reasons; the type of consultation held: telephone, in clinic etc; and who - GP1, GP2, Nurse 1 - saw them).
- Whether s/he had been seen by the Out of Hours service, at A&E, or in secondary care clinics.
- If there appears to be delay on the part of the patient in presenting with their symptoms.
- What the impact or potential impact of the event was.
Early Diagnosis of Cancer Significant Event Analysis Toolkit

Cancer SEAs prompt a GP to reflect on their diagnosis, and identify any potential improvements in practice systems using documentation or proactive safety netting. At CCG or Health Body level, a cancer or quality improvement lead may find emerging themes and use local intelligence to address and manage issues. Cancer Significant Event Analysis (SEA) can support dialogue between the primary and secondary care interface and have benefits for clinicians, practices and patients.

Who is the toolkit for?

This cancer SEA toolkit and its resources support GPs, practice staff and commissioners in conducting high quality cancer SEAs with the aim of improving patient outcomes in the early diagnosis of cancer. This toolkit may be used by CCG/Health Body or cancer leads, practice GP leads or any GP in practice delivering training and includes guidance for quality improvement across the primary secondary care interface.

If you are based in Wales or Scotland and interested in your practice taking part in the National Cancer Diagnosis Audit, please find out more and register here. Note that the audit in England has now closed.

Training resources for cancer/commissioning leads
Examples of SEAs with thematic analysis
Resources and guidance for training practice staff
Safety netting in primary care
Additional cancer risk assessment tools
Background and rationale
The Cancer SEA GP guide can be used by any GP wishing to undertake a Cancer SEA. The guide can also be issued as a 'hand-out' for GPs in your training events.

'Early Diagnosis of Cancer - Quality Improvement Using Cancer Significant Event Analysis' training session resources

The following resources consist of a presentation that can be adapted for your training events, and resources to support this:

- Cancer SEA training slides with trainer notes
- Cancer SEA session - lesson plan
- Example cancer SEA session agenda

Resources for training sessions:
- Cancer SEA Template (2016)
- Instrument feedback tool
- Workshop brief
- Example SEA – Patient A handout
- Example SEA – Patient B handout
- Example SEA – Patient C handout
- Example evaluation form
The role of primary care in cancer diagnosis via emergency presentation: qualitative synthesis of significant event reports

E D Mitchell*, G Rubin*, L Merriman§ and U Macleod‡
The Practices

Eastgate Medical Group

Church View Surgery

The Hedon Group Practice

Orchard 2000 Medical Centre

New Hall Surgery
Oakfield Court Cottingham Road

Royal College of General Practitioners

The Ridings Medical Group
Cancer Research UK
Presenting symptoms

Significant Event Analysis of Lung and Colorectal Cancer in Hull (and safety netting!)
A pie chart showing the referrals of patients diagnosed with bowel cancer

- 2ww colorectal
- Urgent colorectal
- Routine colorectal
- Private
- 2ww upper GI
- Emergency admission
- 2ww gynaecology

Significant Event Analysis of Lung and Colorectal Cancer in Hull (and safety netting!)
<table>
<thead>
<tr>
<th>Learning point</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety netting is important when managing patients with red flag symptoms, arranging investigations and sending referrals</td>
<td>39</td>
</tr>
<tr>
<td>Know the NICE guidelines on the recognition and referral of cancer and the red flags</td>
<td>26</td>
</tr>
<tr>
<td>Have a robust system for dealing with the results of investigations</td>
<td>17</td>
</tr>
<tr>
<td>A careful examination should be undertaken and documented in patients presenting with abdominal symptoms</td>
<td>15</td>
</tr>
<tr>
<td>Patients presenting multiple times with similar symptoms should be monitored</td>
<td>6</td>
</tr>
<tr>
<td>Have a low threshold for investigating patients who present infrequently</td>
<td>6</td>
</tr>
<tr>
<td>Patients with significant comorbidities, may present late or have new symptoms labelled as part of their existing disease</td>
<td>6</td>
</tr>
<tr>
<td>Investigate patients with iron deficiency anaemia and know the local referral pathway</td>
<td>4</td>
</tr>
<tr>
<td>Good communication with secondary care can improve diagnosis times</td>
<td>3</td>
</tr>
<tr>
<td>Do not be reassured by normal blood results when a diagnosis of colorectal cancer is suspected</td>
<td>3</td>
</tr>
<tr>
<td>Ensure patient contact details are correct when organising investigations and referrals</td>
<td>2</td>
</tr>
</tbody>
</table>
Presenting complaint

- Cough: 90
- Sore: 80
- Chest pain: 50
- Increasing sputum: 40
- Weight loss: 30
- Loss of appetite: 20
- Wheeze: 15
- Haemoptysis: 10
- Generally unwell: 5
- Tiredness: 5
- Night sweats: 5
- Headache: 5
- Dizziness: 5
- Hoarse voice: 5
- Abnormal bloods: 5

Significant Event Analysis of Lung and Colorectal Cancer in Hull (and safety netting!)
Key Lung Cancer Learning Point

• 37 (31%) patients had a first CXR which was negative for lung cancer.

• A negative CXR significantly increased median time to diagnosis with a fivefold increase in time to referral.

• A detailed review of cases showed that negative CXRs seemed to divert the GPs attention away from the possibility of lung cancer with multiple trials of treatments, routine referrals and referrals to other specialities being made.
<table>
<thead>
<tr>
<th>Learning point</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety netting is important when managing patients with red flag symptoms, arranging investigations and sending referrals</td>
<td>41</td>
</tr>
<tr>
<td>Have a low threshold for requesting chest x-rays, particularly in current or ex-smokers</td>
<td>34</td>
</tr>
<tr>
<td>Know the NICE guidelines on the recognition and referral of cancer and the red flags</td>
<td>22</td>
</tr>
<tr>
<td>Patients presenting multiple times with similar symptoms should be monitored</td>
<td>19</td>
</tr>
<tr>
<td>Have a robust system for dealing with the results of investigations</td>
<td>17</td>
</tr>
<tr>
<td>Be aware that chest x-rays can be negative even in patients with cancer</td>
<td>14</td>
</tr>
<tr>
<td>Patients presenting to A&amp;E or OOH should be monitored and reviewed as needed</td>
<td>11</td>
</tr>
<tr>
<td>Have a low threshold for investigating patients who present infrequently</td>
<td>9</td>
</tr>
<tr>
<td>A careful examination should be undertaken and documented in patients presenting with chest signs</td>
<td>7</td>
</tr>
<tr>
<td>Have a system in place to monitor investigations that have been requested and to chase up patients who do not attend</td>
<td>6</td>
</tr>
<tr>
<td>Good communication with secondary care can improve diagnosis times</td>
<td>6</td>
</tr>
<tr>
<td>Document and record smoking status in patients presenting with chest symptoms</td>
<td>3</td>
</tr>
<tr>
<td>Patients with significant comorbidities, may present late or have new symptoms labelled as part of their existing disease</td>
<td>2</td>
</tr>
<tr>
<td>Ensure patient contact details are correct when organising investigations and referrals</td>
<td>2</td>
</tr>
</tbody>
</table>
Types/Uses of Educational Resources

• For professionals to **understand patient journey**, eg Healthtalkonline
• For professionals to **share with patients** eg If I were Tom
• For professionals to **aid action** eg Cancer Maps
• For professionals to **aid clinical skills** eg Oral and Skin cancer toolkits
• For **Primary Care Teams** including Practice Nurses, Nurse Practitioners, Physician Associates, Pharmacists
• For professional **understanding of systems** eg NG12
GP Educational Needs

- Consultation/Clinical Skills
- Knowledge – Clinical and Administrative
- Larger Care System
- Practice Systems

Patient
Resources

• QCancer
• Cancer Maps
• If I were Tom
• Health talk online
• Cancer Stories
• OCT/Skin Cancer toolkit
• Gateway C

• CRUK CPD
• Cancer screening PHE
• Macmillan Info site
• Cancer Stories
• Fingertips PHE
• CRUK Online Learning
• CRUK Facilitator Visits
GP Educational Needs

- Consultation/Clinical Skills
- Knowledge – Clinical and Administrative
- Larger Care System
- Practice Systems

Patient
There are many different types of cancer. We have interviewed a wide range of people with personal experience of cancer, so that you can share in their stories.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowel screening</td>
<td></td>
</tr>
<tr>
<td>Breast cancer in men</td>
<td></td>
</tr>
<tr>
<td>Breast cancer in women</td>
<td></td>
</tr>
<tr>
<td>Breast screening</td>
<td></td>
</tr>
<tr>
<td>Cancer in young people</td>
<td></td>
</tr>
<tr>
<td>Cervical abnormalities: CIN and CIN</td>
<td></td>
</tr>
<tr>
<td>Cervical cancer</td>
<td></td>
</tr>
<tr>
<td>Cervical screening</td>
<td></td>
</tr>
<tr>
<td>Colorectal cancer</td>
<td></td>
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<tr>
<td>Ductal carcinoma in situ (DCIS)</td>
<td></td>
</tr>
<tr>
<td>Leukemia</td>
<td></td>
</tr>
<tr>
<td>Living with and beyond cancer</td>
<td></td>
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<tr>
<td>Lung cancer</td>
<td></td>
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<tr>
<td>Lymphoma</td>
<td></td>
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<tr>
<td>Ovarian cancer</td>
<td></td>
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<tr>
<td>Pancreatic cancer</td>
<td></td>
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<tr>
<td>Penile cancer</td>
<td></td>
</tr>
<tr>
<td>Prostate cancer</td>
<td></td>
</tr>
<tr>
<td>Testicular cancer</td>
<td></td>
</tr>
<tr>
<td>PSA test for prostate cancer</td>
<td></td>
</tr>
</tbody>
</table>
Overview

In this section you can find out about the experience of pancreatic cancer by seeing and hearing people share their personal stories on film. Our researchers travelled all around the UK to talk to 40 people (including 11 people who cared for a relative who died from the cancer) in their own homes. Find out what people said about issues such as symptoms, treatment, potentially curative surgery and impact on family. We hope you find the information helpful and reassuring.

You can start viewing topics by clicking “Next Topic” above, or selecting from the list on the left. You can also view “People’s Profiles” from the tab above.
Tom is dealing with prostate cancer. The waiting. The treatments. The side effects. What would you do in his place? Watch these videos to map out a strategy that will work for you.

IF I WERE TOM
GP Educational Needs

Consultation/Clinical Skills

Knowledge – Clinical and Administrative

Patient

Larger Care System

Practice Systems
The original tool is based on two risk calculators for cancer; the Risk Assessment Tool (RAT) algorithm developed by Professor Willie Hamilton and the QCancer® algorithm developed by Professor Julia Hippisley-Cox.

Currently:

- Integrated QCancer tool is available for EMIS Web users in England, Wales and NI.
- Integrated CDS tool is available for INPS Vision users across the UK.
- Still working with TPP SystmOne.
Q Cancer

Prompts

For each patient with a cancer risk above 2%, a prompt appears with the patient’s QCancer score and the reasoning behind it.

Uses patient record, relevant tests and read-coded symptomatic information from the previous 12 months.

Useful if a patient has presented with vague symptoms and/or has seen a number of GPs.
Symptom Check List

The following check list is not exhaustive

- Appetite loss (1m)
- Abnormal or Unexplained weight loss (1m)
- Abdominal pain (1m)
- Abdominal swelling (1m)
- Difficulty swallowing liquids (1m)
- Difficulty in swallowing solids (1m)
- Indigestion (1m)
- Heartburn (1m)
- Cough (12m)
- Change in bowel habit (12m)
- Constipation (12m)
- Painless rectal bleeding (1m)
- Painful rectal bleeding (1m)
- Blood in vomit (1m)
- Blood in spuor (1m)
- Blood in urine (1m)
## Male Specific Check List

Does the patient currently have:

- Testicular lump (1m)
- Testicular pain (1m)
- Cannot pass urine - retention (12m)
- Urinary frequency (12m)
- Nocturia (12m)
- Erectile dysfunction (12m)

## Family History

Family History of Gastrointestinal cancer

Family History of Prostate cancer

## Clinical History

<table>
<thead>
<tr>
<th>Date</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>05-Aug-2017</td>
<td>20 /day</td>
</tr>
<tr>
<td>01-Feb-2017</td>
<td>0 U/week</td>
</tr>
<tr>
<td>28-Jan-2017</td>
<td>173 cm</td>
</tr>
<tr>
<td>08-Aug-2017</td>
<td>85 kg</td>
</tr>
<tr>
<td>05-Aug-2017</td>
<td>28.4 kg/m²</td>
</tr>
</tbody>
</table>
Referral

- 2 week rule referral
- Routine referral
- No referral - reassurance only

Further Investigation

- Blood test requested
- Plain X-ray requested
- Ultrasound scan requested
- CAT scan requested
- Refer for MRI
- Referral for endoscopy
Welcome to the QCancer®-2016 risk calculator for men:

Calculate risk

About you

Age (25-89): 64

UK postcode: leave blank if unknown
Postcode: 

Clinical information

Smoking status: non-smoker
Alcohol status: non-drinker

Do you have...

- a family history of gastrointestinal cancer?  
- a family history of prostate cancer?  
- type 2 diabetes?  
- chronic pancreatitis?  
- chronic obstructive airways disease (COPD)?

Do you currently have...

- loss of appetite?
GP Educational Needs

- Consultation/Clinical Skills
- Knowledge – Clinical and Administrative
- Larger Care System
- Practice Systems
- Patient
NICE suspected cancer referral guidelines

Updated National Institute of Health and Care Excellence (NICE) referral guidelines for suspected cancer were published on 23rd June 2015, replacing the 2005 version.
This resource summarises NICE’s 2015 referral guidelines for suspected cancer (NG12). The information in this summary is correct to the best of our knowledge but does not replace clinical judgement. The full guidelines can be found here: https://www.nice.org.uk/guidance/NG12

If you have any feedback or want more information please contact earlydiagnosis@cancer.org.uk or visit our webpage http://bit.ly/1Q1V6U0

Please note, pathways may differ due to local variation in commissioned services.

Abdominal symptoms

Bleeding symptoms

Gynaecological / urological symptoms

Lumps and lymphadenopathy

Neurological / skeletal / pain symptoms

Respiratory symptoms

Skin / surface symptoms

Investigation findings

Non-specific symptoms

Children and young people

Safety netting summary

<table>
<thead>
<tr>
<th>KEY</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AX</td>
<td>Abdominal X-ray</td>
</tr>
<tr>
<td>AX + 2</td>
<td>2 week wait</td>
</tr>
<tr>
<td>AX 40 and over</td>
<td>40 and over care</td>
</tr>
<tr>
<td>SCCB</td>
<td>Basal cell carcinoma</td>
</tr>
<tr>
<td>STRT</td>
<td>Bene-Jones protein urine test</td>
</tr>
<tr>
<td>CRFE</td>
<td>Chest X-ray</td>
</tr>
<tr>
<td>DME</td>
<td>Digital metal examination</td>
</tr>
<tr>
<td>DVT</td>
<td>Deep vein thrombosis</td>
</tr>
<tr>
<td>ESR</td>
<td>Erythrocyte sedimentation rate</td>
</tr>
<tr>
<td>FBC</td>
<td>Full blood count</td>
</tr>
<tr>
<td>FNAC</td>
<td>Fine needle aspiration biopsy</td>
</tr>
<tr>
<td>GFR</td>
<td>Glomerular filtration rate</td>
</tr>
<tr>
<td>IDA</td>
<td>Iron deficiency anaemia</td>
</tr>
<tr>
<td>LUTS</td>
<td>Lower urinary tract symptoms</td>
</tr>
<tr>
<td>NVP</td>
<td>Nausea/vomiting</td>
</tr>
<tr>
<td>OCT</td>
<td>Upper G.I. endoscopy</td>
</tr>
<tr>
<td>PSA</td>
<td>Prostate specific antigen</td>
</tr>
<tr>
<td>SCC</td>
<td>Squamous cell carcinoma</td>
</tr>
<tr>
<td>SOB</td>
<td>Shortness of breath</td>
</tr>
<tr>
<td>USS</td>
<td>Ultrasound scan</td>
</tr>
<tr>
<td>WBC</td>
<td>White blood cell</td>
</tr>
</tbody>
</table>

June 2016
Cancer Maps

Map 1

- for lung cancer
- suspicious CXR
- (lung cancer only) haemoptysis ≥40 y/o
- ≥2 of ≥40 y/o (non-smoker)
- supraclavicular
- suspicious chest signs
- cervical
- recurrent
- persistent chest infections
- anal
- ulceration
- lung cancer only
- anal
- ≥1 of ≥40 y/o
- ≥40 y/o (ex-smoker/asbestos exp.)
- SOB
- cough
- fatigue
- weight loss
- appetite loss
Improve your knowledge of the prevention and detection of oral cancer, including what to look out for and when and how to respond. This toolkit covers oral and oropharyngeal cancers including lip cancer.

**Referral decision guide**

This practical tool illustrates the red flags which should prompt referral to secondary care via a suspected cancer pathway.

› View referral decision guide

**Test your knowledge**

Boost your knowledge of oral cancer and contribute to your CPD with this quiz-based module.

› Take the quiz

**Lesion recognition resource**

Browse images and descriptions of different types of lesion.

› View resource

**VIDEO: Oral, head and neck examination**

Watch a 3 minute video demonstrating how to perform an examination.

› Watch the video

**Oral cancer risk factors**

Some of the risk factors associated with oral cancer include:

- age
- tobacco use (smoking and chewing)
- betel quid (areca nut) use
- alcohol consumption
- human papillomavirus infection
- poor fruit and vegetable consumption
Oral, head and neck examination technique for GPs
Skin cancer recognition toolkit
Improving your knowledge of skin lesions, typical features and referral guidelines

Top 2-week wait referrals
Here is a list of some of the most common referrals under the 2-week wait rule that are subsequently confirmed not to be melanoma. It may be helpful to consider these options when presented with a suspect lesion:

- Benign melanocytic naevoid
- Seborrhoeic keratosis
- Dermatofibroma
- Angioma
- Basal cell carcinoma
- Squamous cell carcinoma, Bowen's disease and solar keratosis
- Solar lentigo
- Lichenoid keratosis
- Viral warts
- Pyogenic granuloma

Medical knowledge and the legislative framework are constantly changing. As new information becomes available changes in treatment, procedures, equipment and the use of drugs is necessary. The authors and editors have, as far as it is possible, taken care to ensure that the information given in this module is accurate and up to date at the time it was created. However, users are strongly advised to confirm that the information complements with current legislation and standards of practice.

Top tips
A systematic approach to lesion recognition in primary care.

Advice for GPs from Dr GC Moncrieff, GPwSI in Dermatology
common referrals under the two-week wait rule that are subsequently confirmed not to be melanoma.

View top tips

Lesion recognition resource
Browse images and descriptions of different types of lesion and view referral guidelines.

View lesion recognition resource
Lesion recognition resource
Differential diagnosis

Seborrhoeic keratosis

Seborrhoeic keratoses (otherwise known as seborrhoeic warts or basal cell papillomas) are benign proliferations of epidermis. They are present in nearly all people over the age of 50 years and many younger adults too. They have no malignant potential. The only issue is in distinguishing them from skin cancers and although most are easily diagnosed, some melanomas actually induce "wartiness" of the overlying epidermis and may mimic seborrhoeic keratoses.

These lesions may look "stuck on" and "greasy". Most often they are coffee coloured but can be very variable in colour from pale grey or yellow to brown or black. There is usually a rough or fissured surface. Milia like cysts may be visible to the naked eye and especially with the dermatoscope. However, such cysts may also be seen in melanomas. It is quite common for parts of the seborrhoeic keratoses to fall off and they are relatively easily picked off. They may be itchy or irritating.

Browse images and descriptions of different types of lesion and view referral guidelines.
Online learning

Self-directed and bite-size learning.

Essentials of Smoking Cessation

Smoking cessation advice, types of pharmacotherapy and how to provide smoking cessation support for different patient groups.

RCGP position statement on e-cigarettes: video and podcast

Watch or listen to the new RCGP video on the role of e-cigarettes as a smoking cessation aid.

Webinar - Why and how to support your patients to stop smoking

Dr Alex Fordham on the size of the problem, clinical and economic benefits, the current landscape, tobacco
To allow quick and easy access to the resources, the library is divided into the following sections, each of which covers a different area of cancer care: Overview; Preventing cancer; Diagnosis of cancer; Specific cancer types; Cancer treatment and; Beyond cancer.

Resources marked as **FREE** are accessible free of charge to all RCGP Members. Resources marked as **FREE** are accessible free of charge to all users. Users may be required to pay to access other resources.

[Link to course](https://elearning.rcgp.org.uk/course/index.php?categoryid=60)
Early Diagnosis of Cancer

This course highlights the importance of recognising cancer in its early stages and the essential role of the GP in identifying common delays. It includes reflective cases, risk toolkits and practical suggestions on how to improve your practice and helps you to discover ways to diagnose cancer earlier.

This course was developed in partnership with Cancer Research UK.

This course is FREE to all healthcare professionals in the UK.

Time to complete this course:
30 minutes

Date of publication:
November 2012

Reviewed and updated:
October 2018

e-certificate for Early Diagnosis of Cancer

When you have completed the activities a link to your eCertificate will appear above.

Learning Sessions

Work your way through the course by clicking on the links below:
GP Educational Needs

Consultation/Clinical Skills

Knowledge – Clinical and Administrative

Patient

Larger Care System

Practice Systems
Safety netting is an important tool that can be used to support management of diagnostic uncertainty, helping ensure patients are re-evaluated in a timely and appropriate manner.
Safety netting

Cancer detection in patients with vague symptoms’ BJGP 2016:355;i5515

• Most cancer cases present with vague, undifferentiated symptoms
• Key factors in missed diagnoses include
  (i) lack of continuity, (ii) poor record keeping & (iii) false reassurance
Safety netting

Cancer detection in patients with vague symptoms’ BJGP 2016:355;i5515

• Take responsibility for reviewing & acting on results
• Explain the presence of diagnostic uncertainty
• Anticipated time-frame for symptom resolution
• How, when & where to consult if no resolution
• The process of being informed of test results
• Potential alarm symptoms to trigger re-consultation
• Document carefully advice given in the notes
## Safety netting

### COMMUNICATE TO PATIENTS

- Likely time course of current symptoms
- When to come back if symptoms do not resolve in expected time course
- Specific warning/red flag symptoms or changes to look out for
- Who should make a follow up appointment with the GP, if needed
- The reasons for tests or referrals
- If a diagnosis is uncertain

### ACTIONS FOR GPS

- Detail any safety netting advice in the medical notes
- Consider referral after repeated consultations for the same symptom where the diagnosis is uncertain (e.g. three strikes and you are in)
- Ensure the patient understands the safety netting advice (take into account language/literacy barriers)
- Code all symptoms and urgent referrals
- If symptoms do not resolve, carry out further investigations even if previous tests are negative

### ACTIONS FOR PRACTICES

- Ensure that you have current contact details for patients undergoing tests or referrals
- Ensure patients know how to obtain their results
- Have a system for communicating abnormal test results to patients
- Have a system for contacting patients with abnormal test results who fail to attend for follow up
- Put in place systems to document that all results have been viewed, and acted upon appropriately
- Have policies in place to ensure that tests/investigations ordered by locums are followed up
- Have systems that can highlight repeat consultations for unexplained recurrent symptoms/signs
- Make sure practice staff involved in logging results are aware of reasons for urgent tests and referrals under the two week wait
- Conduct significant event analyses for patients diagnosed as a result of an emergency admission
- Conduct an annual audit of new cancer diagnoses

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Safety netting

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RCGP Royal College of General Practitioners
Safety netting
Safety netting

Electronic cancer safety netting toolkit for emis web
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Practice Systems
For health professionals

Primary Care and Cancer Matters

Free to access, high quality evidence-based bite-sized resources specifically for GPs and health professionals

cruk.org/hponlinelearning

Videos and podcasts

• Primary care and cancer matters – videos (3-8 min)
• Early diagnosis of cancer QI – screencast (5 min)
• RCGP position statement on e-cigarettes – podcast (10 min)
• RCGP position statement on e-cigarettes – video (10 min)
• Smoking cessation webinar – video (20 min)

E-learning

• Behaviour change and cancer prevention – e-learning (30 min)
• Essentials of smoking cessation – e-learning (30 min)
• Early diagnosis of cancer – e-learning (30 min)
• Talking About Cancer – online course (3 hrs)
• Demystifying targeted cancer treatments – online course (15 hours)
• Oral toolkit – online resource
• Skin toolkit – online resource
Screening for cancer

Cancer screening involves testing apparently healthy people for signs of the disease. It can save lives by finding cancers at an early stage, or even preventing them. Screening is not the same as the tests a person may have when doctors are diagnosing or treating cancer.

Are you eligible for screening?
- Female
- Male

Age: [Input field]

Where do you live?
- England
- Wales
- N. Ireland
- Scotland

The UK has 3 screening programmes:
- Bowel cancer screening
- Breast cancer screening
- Cervical cancer screening

Benefits and risks of screening

We know that cancer screening saves thousands of lives each year. It can detect cancers at an early stage and, in some cases, even prevent cancers from developing in the first place.

But screening is not perfect. The tests can miss cancers, and have other risks too.

Your choice

Whether or not to go for screening is your choice. You should read the information you are sent with your screening invitation to help you make an informed decision, and ask your doctor if you need help.

Find out more about screening
Bowel screening resources

How we can help
We put together resources and information that can help you increase uptake of bowel screening in your area while providing informed consent.

Email us to find out more

Here you can find resources and examples of good practice that can support you to plan and deliver improvement activity at a local level.

A growing evidence base has highlighted a number of interventions that increase uptake of bowel screening, which is currently low, while providing informed consent.

To let us know if you are aware of or are involved in projects that could provide further evidence of good practice in order to support local teams, please email us on analyses@cancer.org.uk.

English GP Good Practice Guide
Scottish GP Good Practice Guide
Welsh GP Good Practice Guide
GP endorsement letters
Bowel screening leaflets
Introduction of the Faecal Immunochemical Test (FIT)

Any questions?
Contact the Early Diagnosis team for any other questions on FIT introduction.

Email us

Bowel cancer screening reduces bowel cancer mortality. Since bowel cancer screening began in the UK, it has made use of a certain type of faecal occult blood test - a guaiac-based test (gFOBT). Now, the guaiac test is being replaced by a Faecal Immunochemical Test (FIT) test.

Here you can find information on the new test, its implementation and how this will affect healthcare professionals, people invited for screening and patients.

What is FIT?  
FIT in screening  
Why is FIT replacing gFOBT in the bowel screening programme?  
Reporting of FIT screening results to health
Cancer Services

Introduction

This tool contains data on cancer services at GP and CCG level collated by the National Cancer Registration and Analysis Service (NCRAS). It replaces the GP Cancer Profiles that were previously contained within the Cancer Commissioning Toolkit.

Data will be available by PCN on Tuesday 14th January.

The profiles are for commissioners and health professionals to use when assessing the impact of cancer on their local population and making decisions about services. They include data on cancer incidence and screening, diagnostic services, Two Week Wait referrals, emergency presentations and admissions.

Profiles are generated for all practices in QOF 2018/19 with a list size of at least 1000 patients and for other practices if they had according to NHS digital in April 2019 a list size of at least 1000 patients and there is valid GP patient survey data for the practice.

Recent updates

December 2019

All indicators have been updated with the 2018/19 financial year of data, with the exception of the crude cancer incidence rate which has been updated with the 2017/18 financial year of data.

https://fingertips.phe.org.uk/profile/cancerservices/data#page/0/gid/1938132830/pat/152/par/E380000001/ati/7/are/B83620
Find cancer statistics in your local area

Search by a local area or constituency in England

Search...
Online registration for the next NCDA will open from February 2019
Data collection in England due to start from April 2019

How it works:

• GPs register online and will be given a secure account and password for the online NCDA portal which is linked to their practice.

• From April 2019 patients newly diagnosed with cancer registered at their practice will automatically appear on the portal once they are logged on the Cancer Registry; GPs will get a monthly email to alert them to new cases.

• For each patient GPs then submit data on key dates, symptoms, number of consultations, types of investigations, referral(s) and patient characteristics.

• Patients with certain characteristics will automatically be flagged by the system for further review / as a learning event (e.g. emergency diagnosis, those who died within 30 days of diagnosis etc.)

• Analyse the data and create tailored practice reports which will be shared via the online portal.

• Support from CRUK facilitators & Macmillan GPs, and resources from CRUK and the RCGP, are available to support discussion of audit findings and planning of quality improvement activity.
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- Practice Systems
Resources

- QCancer
- Cancer Maps
- If I were Tom
- Health talk online
- Cancer Stories
- OCT/Skin Cancer toolkit
- Gateway C

- CRUK CPD
- Cancer screening PHE
- Macmillan Info site
- Cancer Stories
- Fingertips PHE
- CRUK Online Learning
- CRUK Facilitator Visits
Bonus Resource

• Behind the headlines
Can a single injection prevent cervical cancer?

Tuesday 11 February 2020

"Cervical cancer could be prevented with a single injection," reports The Independent. This is based on a study that looked at the impact of different numbers of doses of human papillomavirus (HPV) vaccination in more than 130,000 women in the US.

At present, young people in the UK are offered 2 doses of the HPV vaccine to help protect against cancers caused by HPV, including cervical cancer. The first dose is given in school Year 8 (at ages 12-13 years), and the second dose 6 to 12 months later.

This large US study found that women who had 1, 2, or 3 or more doses of the HPV vaccine between the ages of 15 and 19 years old had similar reductions in their risk of developing pre-cancerous changes in the cervix over the next 5 years, compared with women who were not vaccinated.

However, this study had several limitations. It did not randomly allocate women to different doses of the vaccine. It relied on existing data, which means factors other than the number of vaccination doses received could have influenced the results.

Because of these limitations we cannot conclude from this study that a single dose would be as effective as 2 doses for reducing cervical