GP Trainers’ Workshop
Using Learning Events (SEA) and Educational Resources

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Learning Events (SEA)

• For *individual and practice learning*

• Highlight areas for development *as Individual and Practice*

• Identify gaps/weaknesses *in systems*

• Stimulate discussion and *reflection as a group*

• 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
  - More advanced disease at diagnosis

- Treatment
  - Access to treatment
  - Other factors
  - Poor survival rates / Premature mortality

- Avoidable deaths

*New or changed since original hypothesis

Service level factors
Individual level factors
The role of primary care in cancer diagnosis via emergency presentation: qualitative synthesis of significant event reports

E D Mitchell\(^{1,}\), G Rubin\(^{2}\), L Merriman\(^{3}\) and U Macleod\(^{4}\)

Research

Elizabeth D Mitchell, Greg Rubin and Una Macleod

Understanding diagnosis of lung cancer in primary care:
qualitative synthesis of significant event audit reports
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 it originated from).  
- 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 the patient 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.
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 OP 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
Training resources for cancer/commissioning leads

Examples of SEAs with thematic analysis

Resources and guidance for training practice staff

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

Safety netting in primary care
Learning Events (SEA)

SIGNIFICANT EVENT AUDIT OF CANCER DIAGNOSIS
Cancer SE Report Template

1. WHAT HAPPENED?
Describe the processes of diagnosis for this patient, including dates of consultations, referrals and diagnosis and the clinicians involved in that process. Consider for instance:
- The initial presentation and investigations, including when and with whom they were conducted.
- The timing of consultations with the patient.
- The communication with the patient.
- Any complications or adverse events.
- Any improvement or potential impact of other events.

2. WHY DIDN’T HAPPEN?
Provide an account of what might have been different or how it could have been improved in the process of diagnosis.

3. WHAT WAS THE OUTCOME?
Describe the outcomes of the diagnosis and treatment, including any complications or adverse events that occurred.

4. WHAT LEARNED?
Discuss the lessons learned from this event, including any improvements that could be made to similar situations.

5. WHAT WOULD YOU DO DIFFERENTLY?
Propose changes that could be made to prevent similar events from occurring in the future.

6. WHAT WAS THE IMPACT?
Describe the impact of the diagnosis and treatment, including any long-term effects.

7. WHAT WAS THE POOR PERFORMANCE?
Identify any poor performance in the process of diagnosis and the steps taken to address it.

8. WHAT WAS THE GOOD PERFORMANCE?
Identify any good performance in the process of diagnosis and the steps taken to maintain it.

9. WHAT WAS THE PATIENT INVOLVED IN THEIR DIAGNOSIS?
Describe the involvement of the patient in their diagnosis, including any discussions or decisions made.

10. WHAT WAS THE CLINICIAN INVOLVED IN THEIR DIAGNOSIS?
Describe the involvement of the clinician in their diagnosis, including any discussions or decisions made.

11. WHAT WAS THE TEAM INVOLVED IN THEIR DIAGNOSIS?
Describe the involvement of the team in their diagnosis, including any discussions or decisions made.

12. WHAT WAS THE ORGANIZATION INVOLVED IN THEIR DIAGNOSIS?
Describe the involvement of the organization in their diagnosis, including any discussions or decisions made.

13. WHAT WAS THE REGULATION INVOLVED IN THEIR DIAGNOSIS?
Describe the involvement of the regulation in their diagnosis, including any discussions or decisions made.

14. WHAT WAS THE LEGISLATION INVOLVED IN THEIR DIAGNOSIS?
Describe the involvement of the legislation in their diagnosis, including any discussions or decisions made.

15. WHAT WAS THE ETHICS INVOLVED IN THEIR DIAGNOSIS?
Describe the involvement of the ethics in their diagnosis, including any discussions or decisions made.

16. WHAT WAS THE LAW INVOLVED IN THEIR DIAGNOSIS?
Describe the involvement of the law in their diagnosis, including any discussions or decisions made.

17. WHAT WAS THE ECONOMICS INVOLVED IN THEIR DIAGNOSIS?
Describe the involvement of the economics in their diagnosis, including any discussions or decisions made.

18. WHAT WAS THE TRANSPORT INVOLVED IN THEIR DIAGNOSIS?
Describe the involvement of the transport in their diagnosis, including any discussions or decisions made.

19. WHAT WAS THE TECHNOLOGY INVOLVED IN THEIR DIAGNOSIS?
Describe the involvement of the technology in their diagnosis, including any discussions or decisions made.

20. WHAT WAS THE COMMUNITY INVOLVED IN THEIR DIAGNOSIS?
Describe the involvement of the community in their diagnosis, including any discussions or decisions made.

21. WHAT WAS THE ENVIRONMENT INVOLVED IN THEIR DIAGNOSIS?
Describe the involvement of the environment in their diagnosis, including any discussions or decisions made.

22. WHAT WAS THE SOCIAL INVOLVED IN THEIR DIAGNOSIS?
Describe the involvement of the social in their diagnosis, including any discussions or decisions made.

23. WHAT WAS THE CULTURAL INVOLVED IN THEIR DIAGNOSIS?
Describe the involvement of the culture in their diagnosis, including any discussions or decisions made.

24. WHAT WAS THE RELIGIOUS INVOLVED IN THEIR DIAGNOSIS?
Describe the involvement of the religion in their diagnosis, including any discussions or decisions made.

25. WHAT WAS THE SPIRITUAL INVOLVED IN THEIR DIAGNOSIS?
Describe the involvement of the spirituality in their diagnosis, including any discussions or decisions made.

26. WHAT WAS THE PSYCHOLOGICAL INVOLVED IN THEIR DIAGNOSIS?
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East Midlands Emergency presentation of lung cancer – SEA Thematic Analysis

- Common themes
- Divided into:
  - Tumour
  - Person
  - System
  - Diagnostics
  - Primary Care
  - Secondary Care
Tumour Themes

- No symptoms
- Anaemia
- Weight loss
- Neurological features:
  - ataxia, arm/facial weakness, seizure
- Breathlessness
- Pain

- Recurrent COPD exacerbations in the 6 months leading to diagnosis
Person Themes

- Nihilism and reluctance to “bother” G.P
  - Seizure 4 months before
  - Haemoptysis, saw pharmacist
- Stoic attitude rarely attend G.P
- Attribution of symptoms to another problem
- Attend AE
- Declining further investigations
  - Abnormal CXR
- Slow to represent after Investigations
- Frail with comorbidity
Community Themes

• Understanding of NICE referral guideline criteria
  • What to do if CXR normal?
  • Symptoms not always respiratory and meet criteria
  • Pathway redesign
The Practices

Eastgate Medical Group

Church View Surgery

The Hedon Group Practice

Orchard 2000 Medical Centre

The Ridings Medical Group

New Hall Surgery
Oakfield Court  Cottingham Road
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>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>
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<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>
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<tr>
<td>Ensure patient contact details are correct when organising investigations and referrals</td>
<td>2</td>
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<tr>
<td>Learning point</td>
<td>Frequency</td>
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<tr>
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<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>
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<td>Ensure patient contact details are correct when organising investigations and referrals</td>
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</tr>
</tbody>
</table>
Types/Uses of Resources

• For professional understanding of systems eg NG12
• 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 Qcancer
• For professionals to aid clinical skills eg Oral and Skin cancer toolkits
Trainees’ 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
Trainees’ Educational Needs

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

Patient
Cancer

Overview
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.

- Bowel Screening
- Breast Cancer in Men
- Breast Cancer in Women
- Breast Screening
- Cancer in Young People
- Cervical Abnormalities: CIN3 and CIN
- Cervical Cancer
- Cervical Screening
- Colorectal Cancer
- Ductal Carcinoma In Situ (DCIS)
- Leukaemia
- Living with and Beyond Cancer
- Lung Cancer
- Lymphoma
- Ovarian Cancer
- Pancreatic Cancer
- Penile Cancer
- Prostate Cancer
- Testicular Cancer
- PSA Test for Prostate Cancer
Pancreatic Cancer

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 8 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.
Introduction to CancerStories

This short series will give you some background to what CancerStories is about and how we help cancer patients and families.

How CancerStories is making a real difference to patients...
How CancerStories is Benefiting Patients: Behind the Scenes
Julie introduces CancerStories (Cancer Stories)
Orientation to CancerStories: Welcome!
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
Trainees’ Educational Needs
GatewayC is an online cancer education platform developed for GPs, practice nurses and other primary care professionals.

The platform aims to improve cancer outcomes by facilitating earlier and faster diagnosis and improving patient experience, through:

- Improved knowledge of symptoms
- Increased confidence in when and when not to refer a patient
- Improved quality of suspected cancer referrals, reducing delays in the system
- Improved communication to enhance the patient experience and support patients at each stage of their cancer journey.

GatewayC has been developed by GPs, specialists and patients.

Courses are endorsed by Cancer Research UK and accredited by the Royal College of General Practitioners.
Every year in the UK over 300,000,000 GP consultations take place
QCancer

• 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.
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.
Review the symptoms and then calculate the QCancer Score.

Symptom Check List
The following check list is not exhaustive.

QCancer uses a current symptoms algorithm.
Pre-existing information from the medical history.

Does the patient currently have.... (brackets denote calculation):
- 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 sputum (1m)
- Blood in urine (1m)
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? [ ]

Welcome to the QCanCer®-2016 Web Calculator

This website is primarily intended for doctors and researchers to use in the context of their underlying research. Patients are welcome to use the calculator to inform themselves about their risk. Any symptoms or concerns can be addressed within a consultation with their doctor. The authors and publishers of QCanCer®-2016 make no clinical recommendations and reserve the right to modify the calculator at any time.

QCanCer works out the risk of a patient having prostate cancer at a future date, based on their current symptoms. It does not give a diagnosis of prostate cancer.

The QCanCer®-2016 algorithms have been developed using a large dataset of patients as well as collected data from many thousands of GPs as part of the UK Prostate Cancer Prevention Trial and other medical research.

QCanCer®-2016 has been developed for the UK population and may not be fully applicable to other populations.

The science underpinning the QCanCer® equations is explained in the publications linked below.
Trainees’ 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.
NICE: SUSPECTED CANCER RECOGNITION AND REFERRAL – SYMPTOM DESK EASEL

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

**KEY**
- A: Raised
- 2ww: 2 week wait
- 40+: 40 and over etc.
- BCC: Basal cell carcinoma
- BUP: Bone-joins protein urine test
- CFB: Cardio-oesophageal reflux
- DRE: Digital rectal examination
- DVT: Deep vein thrombosis
- ESU: Erythrocyte sedimentation rate
- ISS: Inflammatory bowel syndrome
- LUTS: Lower urinary tract symptoms
- NIV: Naso/o/vomiting
- OGD: Upper GI endoscopy
- PSA: Prostate specific antigen
- SCC: Squamous cell carcinoma
- SCG: Shortness of breath
- USS: Ultrasound scan
- WBC: White blood cell

June 2016

Royal College of General Practitioners

CANCER RESEARCH UK
Cancer Maps
Cancer Maps

Oral Cancer Recognition Toolkit

HOME  REFERRAL DECISION GUIDE  LESION RECOGNITION RESOURCE  EXAMINATION VIDEO

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

Patient case studies
To learn more about diagnosing and referring oral cancer, read case studies from Richard Shaw, Professor of Head and Neck Surgery, University of Liverpool and Liverpool University Hospital NHS Trust.

› View patient case studies

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
• low fruit and vegetable consumption

› Resources

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, head and neck examination technique for GPs
Skin cancer recognition toolkit

Improving your knowledge of skin lesions, typical features and referral guidelines

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

Image discussion
Upload images of diagnosed lesion images to share and discuss with colleagues.
› View resource

Top 2-week referrals
Some of the most common referrals under the 2-week wait rule that are confirmed not to be melanoma.
› View resource

Differentiating carcinomas and melanomas
Increase your confidence in diagnosing basal cell carcinomas, squamous cell carcinomas and melanomas using the CRUK skin lesion gallery.
› View resource

Patient case studies
Mary’s story by Dr Abha Gulati, Academic Clinical Lecturer in Dermatology
Kate’s story by Dr Abha Gulati, Academic Clinical Lecturer in Dermatology
› View patient case studies

Accredited education
Boost your knowledge in differentiating between malignant and benign skin lesions and in appropriate referral pathways with this accredited 20-minute eCME quiz.
› Take the eCME quiz
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 naevi
- 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 complies 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.

Accredited education
Boost your knowledge in differentiating between malignant and benign skin lesions and in appropriate referral pathways with this accredited 20-minute eCME quiz.

What do you think?
Your comments will help us to improve our site.
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 Bubik on the scale of the problem, clinical and economic benefits, the current landscape, tobacco
Welcome to the Cancer Education Hub

There are five key areas where GPs are involved in cancer care. These form a ‘patient journey’, although not all steps will be relevant for individual patients:

Resources:
- Improving diagnosis of cancer - a toolkit for General Practice
- National Cancer Diagnosis Audit Tool

Search courses:  

- Screening
- Early Diagnosis of Cancer
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.
Welcome to the Cancer Education Hub

There are five key areas where GPs are involved in cancer care. These form a ‘patient journey’, although not all steps will be relevant for individual patients.

Resources
- Improving diagnosis of cancer - a toolkit for General Practice
- National Cancer Diagnosis Audit Tool

Search courses: [ ] Go

• Screening
  - Bowel Cancer Screening - The Essentials
  - Breast Cancer Screening - The Essentials
  - Cervical Screening Update
  - HPV - The Essentials

• Early Diagnosis of Cancer
  - Bloating & Other Abdominal Symptoms: Could it be Ovarian Cancer?
  - Cancer in Children and Young People
  - Blood Cancer
  - Brain Tumours in Children
  - Early Diagnosis of Cancer
  - Pancreatic Cancer: Early Diagnosis in General Practice
  - Primary Bone Cancer
  - Prostate Cancer: Early Diagnosis in General Practice
Continual Professional Development (CPD)

Keep up to date in this fast changing clinical area with accredited educational resources designed to test your knowledge and support the early diagnosis of cancer.

These resources have been developed or compiled by Cancer Research UK in partnership with relevant clinical experts and organisations including Doctors.net.uk, RCGP, BMJ and the Department of Health. Most of the resources are open access, some are located on the other organisations’ websites, and some might require a login.

Primary Care Cancer Toolkit

A collection of key evidence-based resources about cancer prevention, diagnosis and care relevant for the primary care setting from CRUK and RCGP. Open access to all health professionals.
Trainees’ Educational Needs

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

Patient
Safety Netting

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.

What is safety netting?

Evidence for safety netting in diagnosing cancer

Safety netting recommendations and resources
Safety Netting

EMIS WEB GUIDE

Delivered in collaboration with the NW London Primary Care Cancer Board, this pilot has been developed for all members of the practice team including clinicians and administrators to improve confidence to implement safety netting systems in your practice using EmisWeb in ways that are already familiar.

Intro Video
Trainees’ Educational Needs

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

Patient
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: 

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.

Am I eligible?
Bowel screening resources

How we can help
We pull together resources and information that can help you increase uptake of bowel screening in your area while promoting 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 promoting 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 bowel.diagnosis@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)

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 surveillance
National General Practice Profiles

Domain: Cancer - TWW referrals

Area: C82017 - Measham Medic

Indicator: Two-week wait referrals for suspected cancer (Number per 100,000 pop)

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Source: NHS England Cancer Waiting Times Database
Find cancer statistics in your local area
Search by a local area or constituency in England

About this data
The data used is from a range of publicly available sources or directly from the health system or the government. Data sets have different availabilities and breakdowns and are not always comparable.

› See more guidance about local data

National cancer statistics
Get the latest cancer statistics including key stats, in-depth explanations and raw data on cancer incidence, mortality, survival, risk, and diagnosis and treatment.

› Go to the national statistics
NATIONAL CANCER DIAGNOSIS AUDIT
HELPING YOU REVIEW PRACTICE PROCESSES AND IMPROVE CANCER OUTCOMES

WHAT IS THE AUDIT ABOUT?

The National Cancer Diagnosis Audit (NCDA) looks at patient pathways from first presentation to cancer diagnosis to:

- provide urgent needed data on the contribution of primary care to cancer diagnoses, which are not available nationally from any other source
- better understand the use of primary care-led investigations and referral pathways
- inform delivery of best care for cancer patients

Repeated rounds of the audit allow monitoring of the impact of changes at practice level, and ongoing reflection and quality improvement.

WHY SHOULD YOU TAKE PART?

- Improve cancer care and outcomes for your patients
- Understand how your practice compares to other services
- Highlight and evidence good practice
- Identify diagnostic challenges
- Demonstrate quality improvement for GP appraisal, re-validation and CQC inspection

WHAT WE'VE LEARNT SO FAR

- Burden of co-morbidities is high with 75% of cancer patients suffering from at least one co-morbidity and nearly half (46%) suffering from multiple co-morbidities
- GPs refer promptly (79% of patients referred to a specialist after fewer than three consultations)
- Half of patients diagnosed as emergencies (49%) had seen their GP in the same episode of illness, but nearly half (46%) had not
- GPs felt that one in five patients (20%) had experienced an avoidable delay on their pathway
- Many practices undertook quality improvement activities, often focusing on referral behaviours, safety netting or screening uptake

HOW IT WORKS...

- You register for the audit online in early 2019
- We will give you a secure account and password to log into the online portal hosted by Public Health England (PHE)
- From April 2019, you will receive a monthly email notification if new cancer patients are added to your practice list by the Cancer Registry
- You submit information about the pathway for each patient, including key dates, presenting symptoms, number of consultations, types of investigations, referrals, and some patient characteristics

WE OFFER...

- analysis of the data by PHE
- a tailored report for your practice and a quality improvement toolkit
- access to support from Cancer Research UK Facilitators and Macmillan GPs to review and discuss your results and plan quality improvement activity

Information governance and data release requirements will be met.

I found the whole process incredibly easy and very informative... it is definitely worth doing and I am planning to do it again next year.

GP from Doncaster

For further information about the audit visit cru.org.uk/ncda
Trainee’s 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