

March 2013

NAEDI

National Awareness and Early Diagnosis Initiative

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Welcome to the ninth NAEDI newsletter.

2012 was a busy year for NAEDI with lots of work being developed or rolled out across every aspect of early diagnosis, from activities to raise public awareness and support primary care, to research. As a result there's been a longer period than usual between newsletters, but this latest edition brings you details about what has been going on and what is on the horizon for the coming months.

If you have any feedback about the newsletter or any NAEDI-related queries, please get in touch by emailing naedi@cancer.org.uk.

Be Clear on Cancer maintains the pace with campaign launches

Since the last newsletter, the Be Clear on Cancer programme of work has continued to keep up the momentum: a national lung cancer campaign and a repeat of the bowel cancer activity; the launch of regional pilots focussing on breast cancer in women over 70 and the symptom blood in urine (for bladder and kidney cancers); and new local pilots to test campaigns on ovarian cancer and a cancer symptoms campaign, 'Know 4 sure'.

National launch of lung cancer awareness campaign...

The Department of Health ran a national lung cancer awareness campaign from 8 May to the end of June 2012. Be Clear on Cancer advertises raised awareness of a **three-week cough** as a possible symptom of lung cancer, encouraging people with symptoms to go to their doctor. The campaign featured on national TV, radio and in national press. It also appeared on key black and



minority ethnic (BME) TV channels and in BME press. At a local level, the campaign appeared on pharmacy bags and over 150 events took place across England.

The target audience – men and women aged 50 and over from lower socioeconomic groups – had on average 10 opportunities to see the TV advert alone, and initial results have been positive, showing:

- statistically significant increases in unprompted awareness of cough/hoarseness (41% to 50%) and persistent/prolonged cough (12% to 15%) amongst the target audience

- an increase of approximately 30% in two week wait referrals for suspected lung cancer in the campaign months, compared with the same period in the previous year, with the bulk of additional referrals in the over 50s.

...and a repeat of the national bowel cancer campaign

From 28 August until the end of September 2012, a national bowel cancer 'reminder' campaign ran on national TV and radio. The adverts again highlighted the two key symptoms: **blood in poo and looser poo for three weeks or more**. The Department of Health planned a lower weight campaign this time, with less advertising than the previous national campaign. In January-March 2012, 94% of the target audience were likely to have seen the TV advert 16 times; this time, 82% of the target audience were likely to have seen the advert 10 times.



The aim of this 'reminder' activity was to build on the national bowel cancer campaign, which ran from January to March 2012. Initial findings following the first national campaign have been encouraging:

- Statistically significant increases in the public's unprompted awareness of blood in poo (27% to 42%) and looser poo (10% to 23%);

- A 29.3% increase in attendances to general practice (a measure of behaviour change) amongst patients over 50 with the campaign related symptoms. The number of attendances by men reporting campaign-related symptoms during the campaign period increased by 37.3%, compared with 21.9% for women;
- An increase of 40% in two week wait referrals for suspected lower gastro-intestinal cancer in the campaign months, compared with the same period in 2011, with the increase maintained to June 2012. The large majority (85%) of the referrals in February and March were in the over 50 age range.

Although we are still evaluating the national bowel cancer 'reminder' campaign, a post-campaign tracking survey shows evidence of building cancer awareness, with spontaneous mentions of key symptoms falling between the first and second national bowel awareness campaigns, but not to the level of the pre-first national campaign tracker. It also shows evidence of building brand awareness.

Professor Sir Mike Richards, National Cancer Director, explains: "We have always recognised that we won't solve the problem of low cancer survival rates overnight. Achieving earlier diagnosis of cancer is complex and, as well as improving treatments and access to diagnostics, it's important to keep running these campaigns to sustain the public's awareness of the key symptoms and to promote earlier presentation to primary care services. Early results from Be Clear on Cancer are encouraging - we're seeing positive changes in the target audience in terms of raised awareness and a manageable increase in attendances in primary care and urgent GP referrals."

Since the end of September, three areas of England have been piloting different approaches to sustaining this national campaign until March

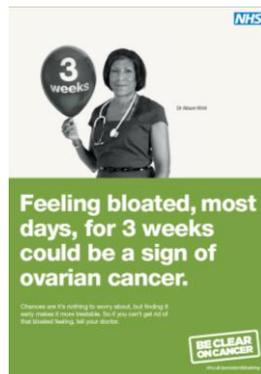
2013. One area has continued with TV advertising, but on a week on, week off basis; whilst two other areas are looking at community activities, which continue to promote the bowel cancer messages. We will be evaluating the different approaches and monitoring how each is keeping the Be Clear on Cancer campaign messages about bowel cancer front of mind. To find out more and check if your area is one of the pilots, visit the NAEDI website:

naedi.org/beclearoncancer/bowel

New year, new campaigns

Be Clear on Cancer entered its third year of activity launching four different campaigns on 14 January. These will all be running through to 17 March 2013.

The 'Know 4 sure' and ovarian cancer campaigns are both new additions to the Be Clear on Cancer brand, raising awareness of key symptoms and encouraging people to go to their doctor.



After several tumour-specific cancer awareness campaigns, the Department of Health is now piloting a new cancer symptoms approach, 'Know 4 sure', in five Cancer Network areas. This campaign focuses on four key symptoms that are indicators for a number of cancers, including less common ones:

1. Unexplained blood that doesn't come from an obvious injury
2. An unexplained lump
3. Unexplained weight loss, which feels significant to you
4. Any type of unexplained pain that doesn't go away

'Know 4 sure' and the key symptoms are used in all the adverts and materials, which also encourage people with any of the symptoms to go to their doctor. In addition, the leaflets include other possible symptoms, as well as the four key ones.

The new ovarian cancer campaign continues the tumour-specific campaigns, highlighting the key symptom **'feeling bloated, most days, for three weeks or more'**. This is being promoted in a further six Cancer Network areas.

The mix of activities to promote the two campaigns vary across each of the pilots, but include local press and radio advertising in some areas and community-based outreach work in others.

Meanwhile, the 'blood in pee' (as a symptom of bladder and kidney cancer) and breast cancer in women over 70 campaigns have now become regional pilots. The 'blood in pee' campaign is being piloted in the Tyne Tees and Borders TV regions, whilst the breast cancer in women over 70 campaign runs in the central TV region. These regional campaigns follow positive initial findings from several local pilots that ran in early 2012:

'Blood in pee'

- Statistically significant increases in prompted and/or spontaneous awareness of blood in urine as a symptom of kidney or bladder cancer in all the pilots that assessed it;
- Urgent referrals for suspected urological cancer* increased by 23% in the intervention areas compared with 16% in the non-intervention areas (January–March 2012 compared with January–March 2011). The number of urgent referrals then decreased in the month following the campaigns.

* The urological cancer category comprises several cancer types in addition to bladder and kidney.

Breast cancer in women over 70

- Urgent referrals for suspected breast cancers and referrals for non-cancer breast symptoms in the target group (women aged 70+) increased by 6.1% in the intervention areas compared to 4.1% in the non-intervention areas (November 2011–March 2012 compared with November 2010–March 2011).



Both campaigns include radio, press, and local events, as well as TV advertising. For the first time, the Department of Health is also trialling the use of direct mail to promote the regional campaigns and their key messages. The letter uses case studies to demonstrate how cancer can be successfully treated when diagnosed earlier and urging anyone with symptoms to see their GP. A Be Clear on Cancer leaflet accompanies the letter. These are being sent to a sample of people in the respective regions, with additional breast cancer letters going out to a sample of women over 70 in Anglia, so the Department of Health can test the approach.

To find out more about the different campaigns and check if your area is in one of the pilots, visit the relevant section of the [NAEDI website](#).

2013/14: Continuing the drive to improve England's cancer survival rates

The Department of Health is currently planning the programme of Be Clear on Cancer campaigns for 2013/14. An initial update letter to the NHS about these plans should be sent out in March and there will be events in April 2013 to inform stakeholders in more detail about the programme and any changes to how the campaigns will be managed as responsibility for the public-facing elements of the programme move to Public Health England.

How NHS Commissioning Board (NHS CB), Public Health England (PHE) and Department of Health (DH) will collaborate to continue to promote earlier diagnosis.

Public Health and the NHS through their respective outcome frameworks will both have a role to play in delivering improvements to cancer survival rates, including in the area of earlier diagnosis. NHS CB and PHE share an under 75 mortality rate from cancer indicator as a means to driving collaboration and integration at a national level as well as having their own separate indicators that will support this work.

Peer review project assists GPs to hone SEA skills

GPs and practices have the chance to get expert feedback on writing a significant event audit (SEA) of cancer diagnosis through a pilot project being run by the Royal College of General Practitioners (RCGP) with the National Cancer Action Team (NCAT) and Macmillan Cancer Support.

All GPs are required to submit two SEAs a year for their appraisal and, in future, for revalidation.

Practices within the pilot areas can submit an SEA of a delayed or missed cancer diagnosis for peer review by the College. Practices will be contacted after six months to see what changes they have made as a result of doing the SEA. Currently practices in 13 Cancer Networks can take part.

Project steering group member and Associate Director of Avon, Somerset and Wiltshire Cancer Services, Dr Alison Wint, said, 'A cancer SEA is such a powerful tool for GPs. It reflects on something that happened to one of their patients, so it resonates in their memory.'

The SEAs are scored poor, fair, good, excellent or outstanding. According to Dr Wint, the most important points reviewers are looking for are: 'Have the GPs provided all the necessary details of the event? Have they reflected significantly? Have they come up with learning that they can apply in future?'

Dr Praveen Gupta, GP lead from Merseyside and Cheshire Cancer Network, stresses the advantage to the practices of taking part. 'It is a real opportunity for learning, to get feedback on your SEA and how the practice handles cancer diagnosis. You are receiving feedback from two trained peer reviewers and from the quality assurance from the RCGP so it is a good learning tool.' What is needed is reflective learning: 'What could we change or do differently?'

Dr Russell Thorpe from Lancashire and South Cumbria Cancer Network says picking the case carefully is important. 'For improving outcomes in cancer, we want to get to the cases that were more difficult, such as dual pathology, falsely reassuring tests, or where there is a breakdown in safety netting in a practice. What is really valuable – and the hardest to do – are the "Oh my God" cases when something didn't go well.'

Yorkshire Cancer Network GP lead Dr Joan Meakins says having a cancer SEA externally assessed improves skills that may help with non-cancer SEAs. Her advice on how to do an SEA is:

'Make sure you write down who sees the patient. Is it the same GP every time or a different GP? It is also important to say who is at the meeting that discusses the SEA – we want to make sure as many people as possible are involved.' And don't choose a case where the delay happened in secondary care – there may be nothing meaningful to put in the SEA.

Dr Jackie Dominey from Pan Birmingham Cancer Network says that the best SEAs show engagement of the whole practice team in a no-blame discussion. She looks for 'a practice with an open culture not a defensive approach'.

'The most useful SEAs are those that have chosen common diagnoses and have picked up on issues that need attention, such as safety netting or perhaps a patient who was on steroids for another diagnosis so masking cancer symptoms.'

Dr Dominey believes the advantage of the pilot is that more effort goes into discussing the case at a partner or practice meeting than would happen for a routine SEA for a GP's own appraisal, so useful learning is more likely to result.

Although SEAs do not have to be peer reviewed for appraisal purposes, she believes an RCGP-assessed SEA will look good in the portfolio.

Dr Thorpe believes practices could also benefit because failed diagnosis of cancer is one of the most common causes of negligence cases against GPs. 'If you can show that you have a process of SEA, that you have learned from previous problems and you are very much aware of potential malignancy when anyone presents to the practice, that should go a long way to ameliorating any criticism.'

More information about the SEA Cancer Pilot is on the [RCGP website](#)

The areas involved in the pilot are Avon, Somerset and Wiltshire; Dorset; Greater

Manchester and Cheshire; North East Yorkshire and Humber Clinical Alliance; Lancashire and South Cumbria; Merseyside and Cheshire; Mount Vernon; North of England; North West London; Pan Birmingham; Sussex; Thames Valley and Yorkshire.

Primary care facilitators' project now running in 14 CCGs

Cancer Research UK and the National Cancer Action Team are testing a new model of providing intensive support to primary care around early diagnosis of cancer in a pilot project running in 14, soon to be 15, Clinical Commissioning Groups (CCGs).

Facilitators are now working in all eleven CCGs in Merseyside and Cheshire and three CCGs in North Central (Islington and Enfield) and North East London (Waltham Forest), building on the cancer networks' previous work with primary care.

In all the CCGs the facilitators' are making contact with every GP practice and providing them with practice information packs containing key cancer data tailored to the individual practice. Facilitators then support practices to develop practice cancer action plans. The facilitators are also working with the CCGs to help develop their role as cancer commissioners and to help them embed early diagnosis in their commissioning and in their development work with practices. They are also collaborating with local authorities to raise the profile of cancer in Health and Well Being Boards.

The project is also working closely with practice managers to identify the support and tools they need to address non-clinical factors that may impact on earlier diagnosis. This work is being led by a practice manager in Merseyside and Cheshire who had been a facilitator herself. According to project co-ordinator Liz Bates, the work is evidence based. 'We know from Greg Rubin's evaluation of the NCAT Cancer Networks

Supporting Primary Care Project that encouraging practices to do audits and SEAs, use risk assessment tools and develop action plans based on their practice profile leads to positive changes in GP referral behaviour with more suspected cancers being referred as two week wait referrals. These are the areas our facilitators will be concentrating on with colleagues in primary care.'

The pilot will be evaluated as part of an on-going evaluation of work supporting early diagnosis in primary care.

The pilot was funded this year by NCAT and CRUK, with support for Islington from public health, and will run with CRUK funding for another year from April. A fourth network, Central South Coast, will join the project in April.

For more information contact Liz Bates
liz.bates@cancer.org.uk

NAEDI leaders plan action at sharing and learning workshops

People attending the National Cancer Action Team's 'NAEDI – Working Together to Save 5000 Lives' Sharing and Learning workshops are planning a variety of actions aimed at improving outcomes from early diagnosis of cancer. The workshops discussed opportunities in:

- commissioning
- pathway interfaces
- primary care support
- Domain 1 – preventing people from dying prematurely
- innovation

A total of 75 participants have attended the four workshop programme.

The first London workshop heard from Merseyside and Cheshire Cancer Network Associate Director Michelle Timoney about how the network's 18 GP cancer leads were aiming

to persuade every Clinical Commissioning Group (CCG) to have a cancer strategy and every practice an early diagnosis action plan. The network is in an advantageous position in working with CCGs and Health and Wellbeing Boards (HWBB) because the team had permanent jobs and was building on many years' experience of promoting early diagnosis.

Kath Nuttall, Neil Swindlehurst and Keith Swindle from Lancashire and South Cumbria Cancer Network contributed to the Manchester workshop with a presentation focusing on the benefits of using their Intelligence Network to 'inform excellence in engagement with primary care'. Of particular interest was how they used their GP and primary care intelligence to design and deliver a GP training programme which achieved the accolade of being the highest rated course in 2011 by North West RCGP. LSCCN's training programmes, together with their other work, demonstrate the rewards to be gained by putting primary care at the centre of everything you do.

The Bristol workshop shared experience from three networks. Central South Coast Cancer Network primary care lead Richard Roope had everyone chomping at the bit to understand how to use detection and conversion rates locally as a quality indicator in general practice. Helen Thomas, a GP lead from Peninsula Cancer Network, described how the network was incentivising significant event audits (SEAs) through Quality and Outcomes Frameworks and Quality and Productivity indicators (QPs). This work taps into GPs' concern 'not to let patients down' with an intervention that can be also used for revalidation purposes. Helen is interested in taking this work forward focusing on patients with learning difficulties and dementia. Finally, Avon, Somerset and Wiltshire Cancer Network Associate Medical Director Alison Wint gave a demonstration of the GPSim, a series of virtual patient consultations developed to support GPs in diagnosing cancer. The network and its university partners are now

working on eight further case scenarios for slightly rarer cancers.

Roy McLachlan and the team from the North of England Cancer Network presented at the final workshop in London. Their four-year NAEDI journey was brought to life as they shared their learning and successes which they put down to the need to be both reactive and proactive, making incremental changes, taking calculated risks to be fleet of foot and localising the agenda through the formation of a Cancer in the Community Group. The resulting synergy and cohesion experienced across the patch was an unexpected yet important benefit which should help sustain this work going forward.

Stimulated by the presentations, participants worked in groups and have so far identified 108 actions to take forward as a result of their sharing and learning experience, including:

- presenting data in easily accessible forms to make the case for early diagnosis to CCGs, HWBBs and practices
- finding synergy between the CCG and HWBB priorities, such as long-term care, and the cancer agenda
- working with Domain 1 for
 - o respiratory care
 - o discussion around co-morbidities which could benefit cancer outcomes e.g. obesity, smoking
- continuing to encourage practices to use their cancer profiles to make action plans, including presenting three years of profiles to demonstrate trends on conversion/detection rates.

Reports of the sharing and learning workshops, the presentations by the speakers, articles about the presentations, and reports from the networks, listed by network, are on the NCAT website [here](#). The sharing and learning tool, which provides a searchable guide to supporting primary care, is [here](#).

For more information contact Kathy Elliott
Kathy.Elliott@ncat.nhs.uk

Evaluation ‘invaluable’ for those promoting early diagnosis in primary care

The national evaluation of cancer networks’ support for primary care around early diagnosis provides the first hard evidence that work with general practice can boost urgent cancer referrals.

NCAT’s Supporting Primary Care Project ran in 2011/12. GP cancer leads in each network encouraged practices to adopt a range of initiatives including audit and SEA; risk assessment tools for lung and colorectal cancer; and action planning based on the cancer practice profiles.

The evaluation gathered data on take up of interventions and compared referral behaviour in 2010 and 2012 at individual practice level. The researchers found practices that had engaged in any of these initiatives had a greater increase in two week wait referrals, and a smaller proportion of cancer patients being diagnosed as emergency presentations or through routine referrals, than practices that had not engaged.

Over the period studied, two week wait referrals increased overall by 17% and 55% of practices had engaged with one or more interventions. The report estimates for instance that 3,440 additional two week wait referrals would have been made if every practice had done a clinical audit and an SEA and 500 more 2WW colorectal referrals would have been made if all practices had taken up the risk assessment tool.

GP leads and others working in networks are using the evaluation to promote early diagnosis in primary care.

Merseyside and Cheshire GP lead Dr Praveen Gupta says the evaluation will be useful in talking to individual GPs and Clinical Commissioning Groups (CCGs). ‘My experience is that GPs do want things to have been

properly evaluated, especially nationally by someone like Greg Rubin. GPs only listen to practicing GPs, who are facing the same problems, and the evaluation does give a lot of credibility to what I can say.’

Dr Gupta believes CCGs in Merseyside and Cheshire will want to see the results as cancer is high on their agenda. The evaluation will be particularly useful to his local CCG, which is planning to make a Local Enhanced Service offering Quality and Productivity (QP) points for cancer awareness, early detection, two week wait referrals, smoking reduction and obesity.

North of England Cancer Network Modernisation Manager, Suzanne Thompson, says she will take the report to her NAEDI partners to help to decide where to go next with supporting primary care. ‘It’s great timing and excellent to have both qualitative and quantitative data to inform decisions. The report talks about referral rates but the interventions don’t seem to have made a significant difference to conversion and detection rates that measure the quality of referrals. What I would recommend to the steering group for this work, the Cancer in the Community Group, is that we need to continue what we are doing and help practices better assess cases for referral and look at it again in a year.’

Anglia project manager and information analyst, James Perry, said he will put a summary of the evaluation in the network’s awareness and early diagnosis primary care pack that is given to all GPs and is available on the network website.

‘When we started this work we relied on intuitive faith and expert opinion that these were the right things to do to change and improve practice. Now there is an evidence base that we can point to.’

NCAT National Lead - Prevention, Early Diagnosis and Inequalities, Kathy Elliott, is urging colleagues to use the evaluation evidence to support their work.

‘It is invaluable to have evidence that engaging with primary care results in more two week wait referrals for cancer and a smaller proportion of cancer patients being diagnosed through less favorable pathways such as emergency presentation or routine referral.

‘The evidence that 55% of practices had taken up at least one NAEDI initiative, and that there has been a decrease in variation in referral practice for those practices that had engaged, is testimony to the hard work of cancer networks.

‘This evidence needs to be used alongside the evaluation results from the awareness raising campaigns,’ Kathy said.

[Kathy Elliott](#) is keen to hear feedback on the evaluation and how those in cancer networks are using it to promote work on early diagnosis.

NCAT/Cancer Networks Supporting Primary Care Final Report, by Dr Ingrid Ablett-Spence, Dr Jen Howse, Prof Greg Rubin, December 2012 is published in the document box on the Sharing Learning and Evidence [page](#) of the NCAT site and [here](#).

Updated practice profiles now available!

There are lots of resources available to support practice managers and their teams, including [National General Practice Profiles](#) with cancer data for individual practices. The third version of these, updated for December 2012, are now available and contain some information on emergency presentations. You can also contact the GP lead at your local cancer network, who can give you further information on data and activities for your area.

Evaluation of centrally-funded NAEDI activity – measuring the impact

There is a lack of formal research evidence regarding the most effective ways to raise awareness and encourage prompt presentation amongst the public and address delays in cancer referral in primary care. However, the evaluation of Be Clear on Cancer and supporting primary care activities conducted under NAEDI provides an important opportunity to contribute to knowledge in these areas, as well as to assess the extent to which the government’s ambition of saving an additional 5,000 lives per annum by 2014/15 is being met.

A number of metrics have been identified as significant for NAEDI-related activity, reflecting key points along the patient pathway where one would expect to see impact of efforts to raise awareness, encourage prompt presentation and promote earlier diagnosis. The metrics are selected based on the nature of the activity undertaken and routinely collected data are used wherever possible.

Reports on some areas of work are already available: the 2011 [regional bowel cancer awareness pilot](#); the first report on the [2010/11 local pilot projects](#); reports on the [GP attendance studies](#) undertaken as part of the regional bowel and lung cancer awareness pilots; and reports relating to evaluation of the supporting [primary care activity](#).

The evaluation findings for the national Be Clear on Cancer bowel and lung campaigns (see pages 1-2) and other results, including some promising findings from the regional lung campaign on incidence and staging, have been highlighted in [Improving Outcomes: A Strategy for Cancer Second Annual Report](#) published in December 2012.

As the evaluation of the different streams of activity continues, future reports will be made

available via www.naedi.org.uk. We will also continue to keep you informed in future issues of the NAEDI newsletter.



For more information contact projectsupport@cancer.org.uk

The Aarhus statement: improving design and reporting of studies on early cancer diagnosis

A consensus group, led by the Cancer and Primary Care Research International Network (Ca-PRI), has produced guidance and a checklist to aid researchers working in the field of early diagnosis and to help bring greater precision and transparency to investigation of the pre-diagnostic patient pathway.

'The Aarhus statement: improving design and reporting of studies on early cancer diagnosis' has been published and is available on the [British Journal of Cancer website](http://BritishJournalofCancer.com).

The International Cancer Benchmarking Partnership (ICBP) – Module 4

The ICBP is an exciting and unique initiative that brings together clinicians, researchers and policymakers across six countries to explore why cancer survival rates vary between countries.

The core benchmarking module of the ICBP has reported significant international differences in lung, breast, colorectal and ovarian cancer survival, with England having some of the poorest outcomes.

Module 4 is looking closely at patient pathways, and will provide the first robust international comparison of the time intervals from first symptom(s) until diagnosis and start of treatment for cancer patients. This will test the hypothesis that longer time intervals can contribute to poorer cancer outcomes.

Module 4 will also describe and compare the various routes that patients take to enter the cancer pathway and how they are diagnosed. Possible routes to diagnosis that will be explored include:

- Routine or urgent referral
- Referrals from population based screening programmes
- Emergency presentations to hospitals

The results will identify possible targets for actions to reduce delays.

Module 4 data will be collected using paper surveys. Patients with breast, colorectal, lung or ovarian cancer will be invited to complete the survey within six weeks and six months of their diagnosis. The GP and a specialist care consultant of all consented patients will also be invited to complete a further short survey. This will provide additional information on the patient's cancer journey including:

- The nature of any referrals
- Investigative tests undertaken
- Patient co-morbidities
- Tumour stage at diagnosis

Participating jurisdictions will collect data for at least 200 patients for each of the four tumour types. The patient sample for the study will be

drawn up by cancer registries in participating jurisdictions.

A pilot study in England was launched in autumn 2012, and is now completed. The aim was to assess the feasibility of the protocol and provide a better indication of response rates. Information from the England pilot, as well as that from feasibility studies in partner countries, will be used to finalise the main study materials and protocol.

The main Module 4 study is planned to get underway in early 2013 in all jurisdictions. First outputs of the main study are expected in late 2013/early 2014.

Latest update on the development of cancer decision support tools for GPs

The Department of Health (DH) cancer team is working in partnership with Cancer Research UK (CRUK), Macmillan Cancer Support and the cancer networks to ensure the development of valuable cancer decision support tools for use by GPs.

A phased programme of piloting will see tools made available for over 530 GP practices in England. Macmillan, using the insight and clinical leadership of their GP community, will lead this project and are working within, and report to, the wider NAEDI programme. This helps ensure alignment with other initiatives to promote earlier diagnosis of cancer, including DH's cancer awareness campaigns.

CRUK, who are responsible for coordinating the evaluation of some of the NAEDI initiatives this year, are working to define the evaluation metrics and data collection methods for this project. The evaluation will concentrate on better understanding how these tools are used by clinicians, how they can best be integrated into everyday clinical practice, and what impact they might have on a health economy in terms of activity, such as referrals and diagnostic tests.



The plan is to support GPs in adopting electronic versions of two current cancer decision support tools developed by GP academics – Professors Willie Hamilton and Julia Hippisley-Cox. Tools are IT-based, integrated with GP IT software, and calculate risks for five tumour sites. This builds on the experience and evaluation of previous work on decision support tools including the National Cancer Action Team's (NCAT) desk-based risk assessment tools for lung and colorectal cancer, Macmillan's IT-based pilot of a similar tool, and the existing version of Qcancer.

Macmillan has planned a first phase from March 2013 (running for six months) that will aim to test the use of both of these tools in clinical practice and address any issues. This project will, even during the first phase of this project, provide tools which will be a useful aid to clinical practice, provided free at the point of use for participating GPs.

Macmillan is liaising with IT system providers and software developers to create the IT platforms for the cancer decision support tools, making sure they will be available across all GP IT platforms in the future.

Where primary meets secondary in cancer care

Cancer Research UK is running an innovative online project with doctors across primary and secondary care to help improve early diagnosis. The new initiative responds to feedback Cancer Research UK has received from doctors and aims to improve communication between GPs and cancer specialists.

The project encourages GPs to submit challenging cancer case studies that they have encountered through their work. These difficult-to-manage cases are then shared in a dedicated live forum hosted on doctors.net.uk. The forum, available only to members of the site, allows GPs and secondary care specialists to discuss and debate the cases, offer best practice suggestions and explore possible outcomes.

The aim is to facilitate improved dialogue between primary and secondary care doctors and encourage problem solving through sharing advice and perspectives. "Increasing fragmentation and bureaucracy within the NHS has led to deterioration in communication between GPs and the specialists we refer our patients to," said one GP, "which has an impact on our learning and the accuracy of our referrals."

Cancer Research UK's research mirrors these views, indicating that limited feedback from secondary care means GPs often feel unable to assess their own referral accuracy. So important was this issue for GPs that it was frequently cited as one of their key aspirations for the NHS along with more resources and better research.

Discussing challenging cases with peers and specialists can highlight some of the difficulties surrounding early diagnosis and help to improve awareness of symptoms presented. Cancer Research UK hopes this dialogue will provide an opportunity for social learning and result in practical guidance and advice. Dialogue from the forum discussions is also summarised to provide best practice ideas and highlight key learnings.



The screenshot shows the Cancer Research UK website interface. At the top left is the Cancer Research UK logo. The main navigation bar includes 'HOME', 'TOOLS & EDUCATION', and 'CHALLENGING YOUR CLINICAL ACUMEN'. A prominent banner reads 'SOONER OR LATER WE WILL BEAT CANCER. LET'S MAKE IT SOONER.' Below this, there are two main content areas: 'TOOLS & EDUCATION' featuring a stethoscope icon and 'CHALLENGING YOUR CLINICAL ACUMEN' with a list of actions: 'Submit a case', 'Join a discussion', and 'Read or comment'. To the right, there is a 'Sign-up to Cancerinsight' form with fields for 'NAME' (Pharma Guest2) and 'EMAIL' (none@none.com), and a 'Sign up' button. Below the form is a 'Can you help?' section with a 'Learn more' link and an 'Access your Learning Record' button with a right-pointing arrow. A disclaimer is visible at the bottom of the page.

Dr James Quekett, GP, Cheltenham, said: "The clinical cases programme allows doctors from both primary and secondary care to establish and discuss learning points from real-life cancer cases. Traditionally this exchange might have occurred in the face-to-face setting but, due to increasingly busy schedules, this may no longer be possible and the online space provides the potential solution."

Members of doctors.net.uk can access the project at

doctors.net.uk/cancerresearchuk