QUALITY IMPROVEMENT TO DRIVE THE EARLY DIAGNOSIS OF CANCER: LESSONS FROM THE NATIONAL CANCER DIAGNOSIS AUDIT IN SCOTLAND

Jana Witt1, Marion O’Neill1, Claire Faser1, Alana Struthers1, Laura Wood1, Ruth Swann1,2, Valerie Doherty3, Nicola Barnstable4, Emma McNair4, Peter Murchie4, David Weller4 on behalf of the Scottish NCDA Steering Group

1Cancer Research UK; 2NHS Scotland, Information Services Division; 3National Cancer Registration and Analysis Service, Public Health England; 4Scottish Government, Health and Social Care Directorates; 5University of Aberdeen; 6Edinburgh University

BACKGROUND:
The National Cancer Diagnosis Audit (NCDA) enables GP practices to review and reflect on processes, systems and behaviour, highlighting good practice, allowing benchmarking, and identifying areas for quality improvement (QI) in the context of cancer diagnosis.

METHODS:
General practices in Scotland were invited to submit primary care data on patients diagnosed with cancer in 2014 to Information Services Division, NHS Scotland. Data were collected using Excel spreadsheets between January and May 2017. Following data collection, participating GPs were invited to a brief evaluation survey. After data collection, each practice was issued with a tailored report of their NCDA results, which included a national comparator, a regional comparator, and, where participation levels had been high enough, a Health Board comparator.

Practices were also offered a QI toolkit developed by the RCGP and Cancer Research UK, and support from dedicated staff (Cancer Research UK Facilitators) and peers (Macmillan GPs) – where available – to reflect on their data and plan QI activity in practice meetings.

CONCLUSIONS:
Audit participation in itself stimulates reflection and learning. Tailored feedback in combination with a support offer, as used in the NCDA, ensures audit data are seen as relevant and actionable, driving QI activity that could lead to earlier diagnosis of cancer.

Continuous cycles of the NCDA will support ongoing learning and quality improvement in future.

RESULTS:
73 GP practices from 13 NHS Health Boards submitted data to the audit. Participation varied across Scotland. A total of 2,014 patient records were submitted, which equates to 6.3% of all patients diagnosed with cancer in 2014 in Scotland.

Overview of key findings from the NCDA Scotland [1):
• GPs refer promptly (65.3% of patients referred to a specialist after fewer than three consultations)
• Nearly two thirds of patients (65%) had an investigation ordered by primary care before a referral was made, the majority of these were blood tests
• Half of patients diagnosed as emergencies (51%) had seen their GP in the same episode of illness, but 40% had not
• GPs felt that one in four patients (24.5%) had experienced an avoidable delay on their pathway
• During data collection and submission, reflection and SEAs on individual cases had the potential to result in immediate learning.

Our participation in the cancer audit was a straightforward and worthwhile task. The spreadsheets were easy to complete and precipitated a review of the relevant cancer patient ‘journey’. We identified one SEA and our reflections were utilised for appraisal purposes.

28 GPs responded to the evaluation survey. The majority (64%) indicated that they would recommend the NCDA to others.

Figure 1. Evaluation survey results ‘Would you recommend the NCDA to others in future?’ (n=28)

PRACTICE CASE STUDY:
Following the audit, one practice in Grampian took the following actions:
• Encourage GPs to do SCI Gateway referrals themselves rather than by dictation to minimise delay
• Remind GPs that if they suspect a melanoma, refer directly to secondary care rather than to GP with specialist interest
• Review protocols around bowel screening promotion
• Provide more focus and structure to existing monthly new cancer meetings, highlighting the importance of identifying issues in diagnosis
• Discuss patterns of delay in investigation and treatment highlighted by the audit at a local level with secondary care

Completing the audit really helped shine a light on the whole patient journey and where things could be improved for the better.

GP, Grampian

CLUSTER CASE STUDY:
Following the audit, one cluster in Greater Glasgow & Clyde took the following actions:
• Review of safety netting protocols at cluster level
• Increase communication and work with secondary care colleagues regarding Ear, Nose & Throat (ENT) pathway and rapid access lung cancer clinic
• Repeat audit for 2016 patients to understand any changes in pathways to diagnosis since 2014

The practice reports produced were excellent and a valuable tool for discussion at both practice and cluster level. We aim to repeat the audit again for all of our cluster practices.

GP, Greater Glasgow & Clyde

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REFERENCES:
1 Information Services Division Scotland. National Cancer Diagnosis Audit Report; published March 2018

FOOTNOTE:
1 Participation in the NCDA was not mandatory and the audit was not incentivised in Scotland

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