Improving early cancer diagnosis – evidence-based interventions for primary care

Part 2 – approach and methodology

Edge Health

RM Partners
NW & SW London Cancer Alliance

NHS

Contents

About this report

This report was funded by RM Partners Cancer Alliance. Individuals from RM Partners supported the design, research and delivery, and provided comments on and peer reviewed the interim and final drafts of this report. This report was researched and written by Edge Health, on behalf of RM Partners.

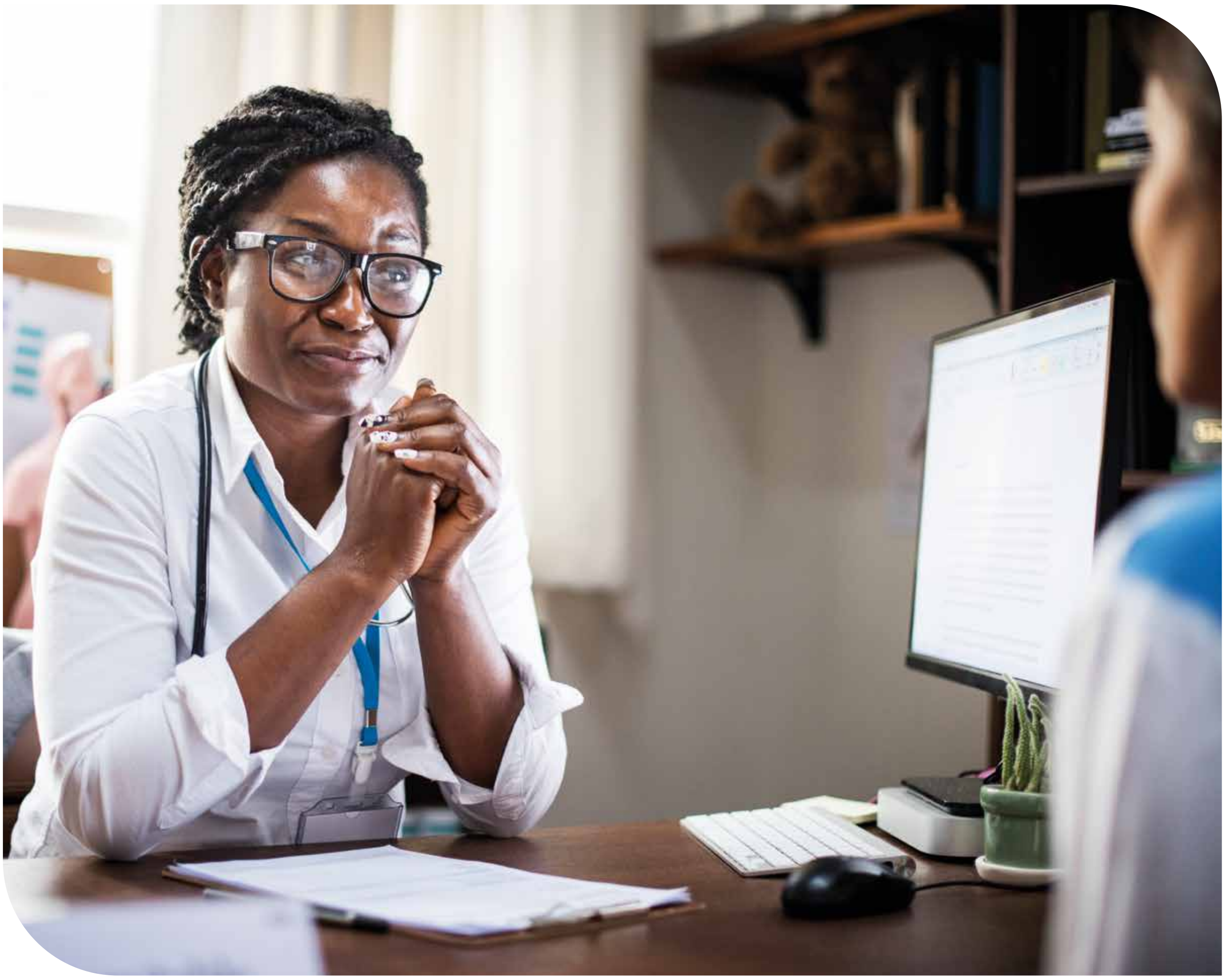
1 Introduction to this report

This is the second part of a report by RM Partners Cancer Alliance and Edge Health into evidence-based interventions to support earlier cancer diagnosis in primary care.

The first part of the report **Part 1 – actionable insights** provides the overall context for the research, as well the findings and recommendations from the research. This report sets out the approach and methodology which was used to undertake the analysis, and in particular, the structure and content of the practice interviews.

As concluded within Part 1 of the report, substantial value was generated in the process of undertaking the research. Of the 46 practices interviewed, only 24 were already aware of and using their cancer data to support quality improvement. Awareness of cancer data was nearly twice as high in the high detection rate practices as the low detection rate practices (64% vs 33%). The interviews included around 185 members of practice staff, with a total of 236 action items taken during the review.

From this experience, it is concluded that this form of structured, data-led conversation is a powerful tool for discussing and implementing best practice. This report includes a description of how this was undertaken, the materials used and the structure of the conversations, in order to inform future roll-out of a similar programme.



2 Questions and approach

To develop the qualitative evidence base around variation in detection rate, RM Partners with the support of Edge Health conducted this qualitative study as part of a quality improvement project to further investigate these factors directly through conversations with practice staff.

The primary objective of this programme was to delve deeper into these factors and develop practical recommendations to shorten the diagnostic interval for cancer care. The primary question was:

1. What clinician or practice factors affect referral practice?

In addition, the project had a secondary question related to areas outside of, or only indirectly linked to, practice behaviour:

2. What can we learn from the clinician perspective on population and system factors related to early diagnosis of cancer?

This latter question is secondary as the clinician perspective provides only one view on population and system factors. Through the interviews, and the interpretation of the findings from those interviews, the project primarily focused on the first question. The second question was approached via interviews enquiring about factors affecting early diagnosis including discussions covering late presentation and delays in diagnosis. No data was available for individual practices on stage of diagnosis and it should not be interpreted that just because a practice was in the “high” detection rate group that they will have above-average early diagnosis, or vice versa.

To answer these questions, the programme aimed to conduct semi-structured interviews with a diverse and large number of practices to investigate factors at the population, clinician, and system level. The methodology involved collaboration with practices to examine the issues around cancer detection in primary care. Practices with both higher and lower detection rates were engaged to identify key successes and barriers.

There were two purposes to sampling practices with high and low detection rates. The first was to try and ensure balance in the practices which were interviewed, and therefore balance in the findings from the discussions.

Alongside this, the project had an underlying **hypothesis that by comparing the behaviour, perspectives, and processes of high and low detection rate practices, consistent themes relating to referral practices in high and low detection rate practices may be uncovered.** The interviews with high and low detection rate practices were conducted in the same manner, but the analysis presented below considers the interview themes jointly and separately for these two groups.

The project implemented a mixed-methods approach, including analysis of routinely collected practice data supplemented by review of the semi-structured practice interviews. This broad approach and questions were maintained throughout, but the specifics of the topics discussed in the interview evolved and iterated. This was based on reflection on earlier interviews and on the need to broaden and deepen some of the domains being investigated.

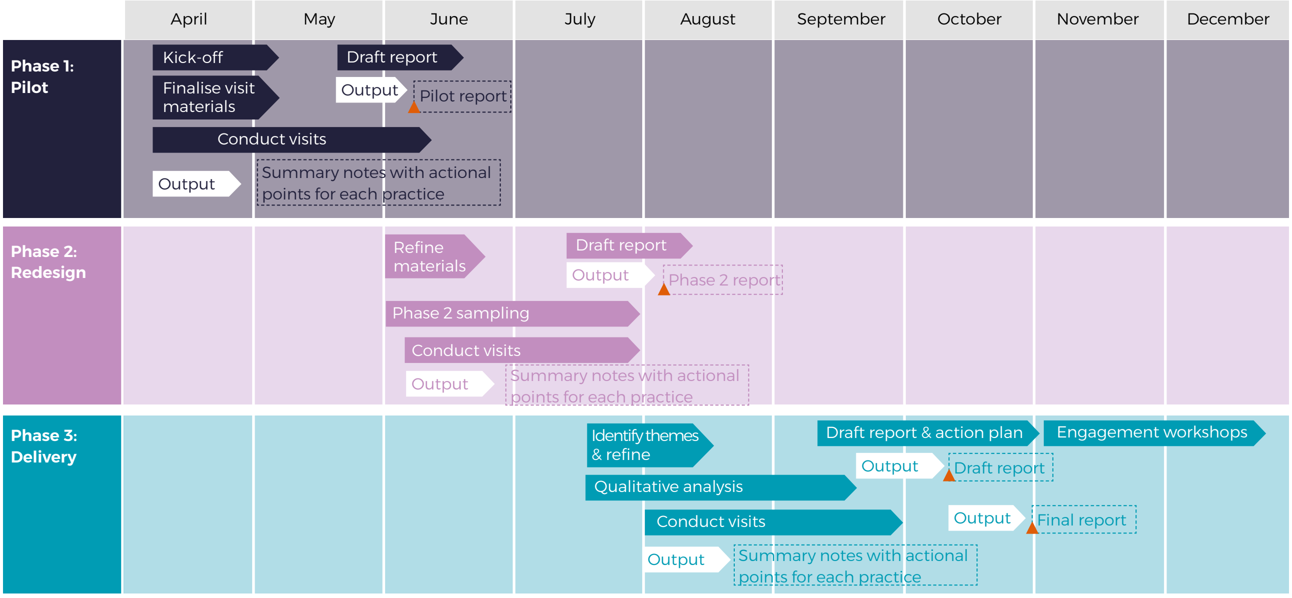
The following section in this report describes the approach and methodology for the programme. The quantitative and qualitative results, the headline findings, and the next steps for carrying the work forward are included within the accompanying **Part 1 – actionable insights report**.

3 Methodology

To achieve its key objectives, the Primary Care Cancer Detection Programme was set up to deliver over three phases: an initial pilot to test the approach and methodology and begin gathering key themes across a subset of practices, followed by two phases of wider roll-out across North West and South West London (NWL & SWL).

The overall project timeline is shown in Figure 1 below. The approach and focus of each phase were refined and targeted, based on the emerging findings from earlier phases.

Figure 1: **Project timeline**



3.1 Phases and sampling

3.1.1 Phase 1 (Pilot)

The rapid initial phase of the project developed, refined, and tested the topic guide and approach. A targeted sample of visits (both high and low detector practices with diverse characteristics) was used to gather feedback on the proposed approach and develop initial themes for further exploration.

Sampling Approach

Practices were sampled based on the 5-year cancer detection rate average for 2016/17-2020/21. The top 10 and bottom 10 ranking practices were contacted to schedule interviews. This approach was taken to maximise the chances of capturing specific themes corresponding to differences in detection rate.

During this and all subsequent phases we used a purposive sampling approach: the selection of practices for interview was informed by existing data on detection rate. This is an approach which is frequently used in qualitative literature in order to ensure that an information-rich sample can be generated.

Key Learnings

- The response rate of sampled practices included in the pilot phase was 50%. This informed the sampling for the next phase, i.e. oversampling practices by 50% to increase the chances of a satisfactory response rate.
- The practices which did respond were equally representative of practices with low and high detection rates. As a result, no targeted over-sampling of low detection rate practices was used during phase 2.
- Whilst practices were given the option to meet face to face, interviews were largely conducted over Teams, which was a much easier format to have these conversations in terms of discussion, note taking, and recording.
- Practices were incentivised to participate in the programme.

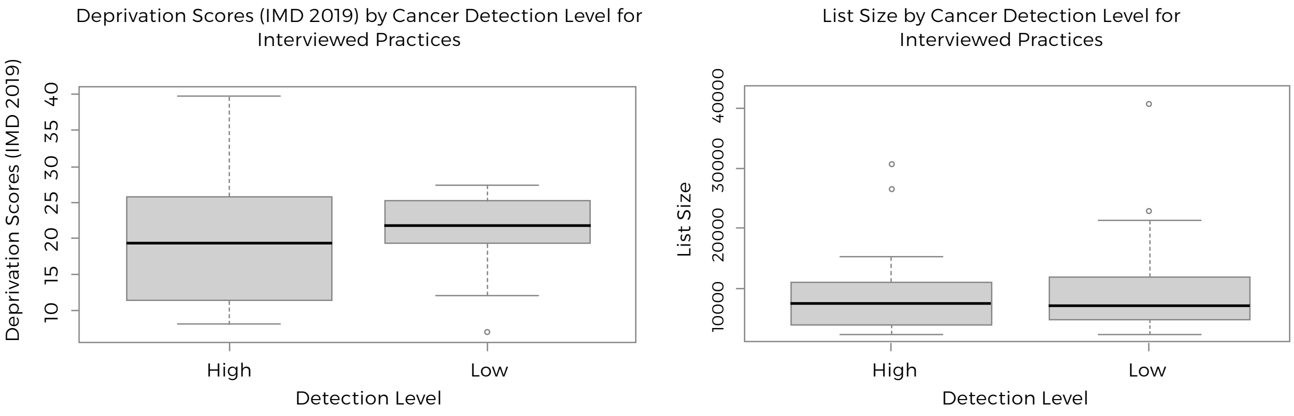
3.1.2 Phase 2 (First phase of wider roll-out)

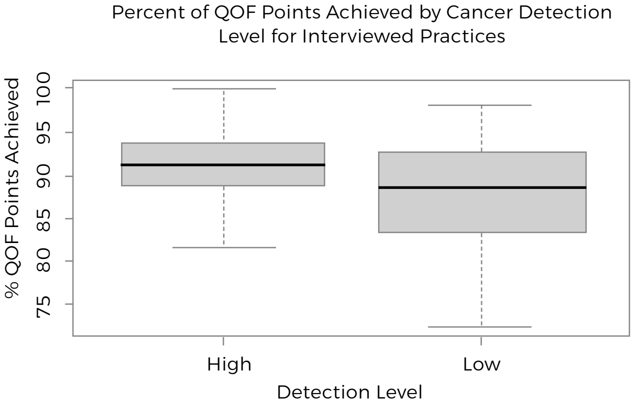
The second phase of the project covered roughly a third of the total volume of interviews during the study. The primary objective of this phase was to identify the major themes and begin to develop actionable insight from the work.

Sampling Approach

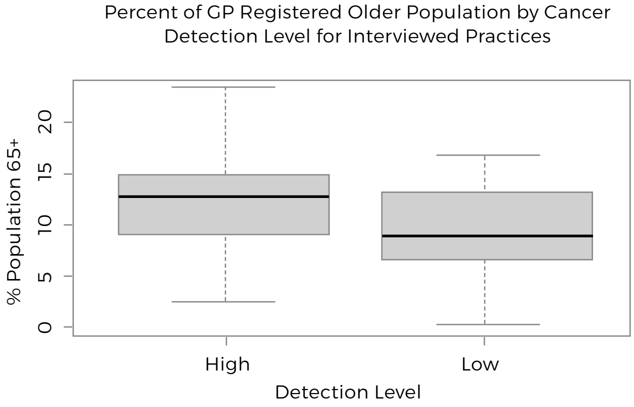
The next phase of sampling was designed to capture practices which were underrepresented in the pilot phase. Given responsiveness among some practices in the pilot phase, the interviewed sample was found to underrepresent certain geographic areas. To address this, phase 2 practices were sampled by extracting the next top 20 and lowest 20 practices by detection rate as well as with the addition of practices from Croydon, Hammersmith & Fulham, Merton, and Richmond. We also regularly confirmed that there was representativeness across various metrics shown in the box plots below: deprivation; list size; % QOF points achieved; % older population; % non-white population; and ratio of list size to FTE GPs.

Figure 2: **Summary of sampling for interviewed practices**

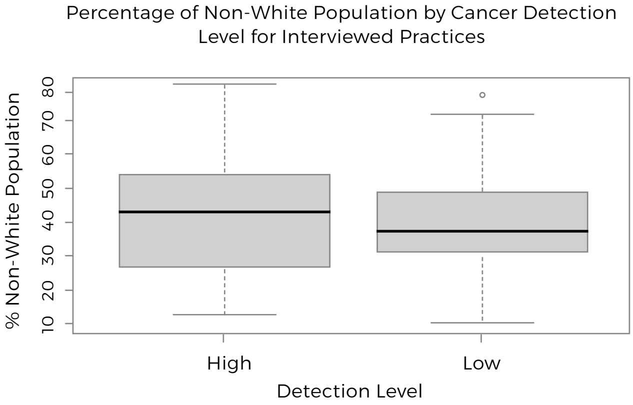




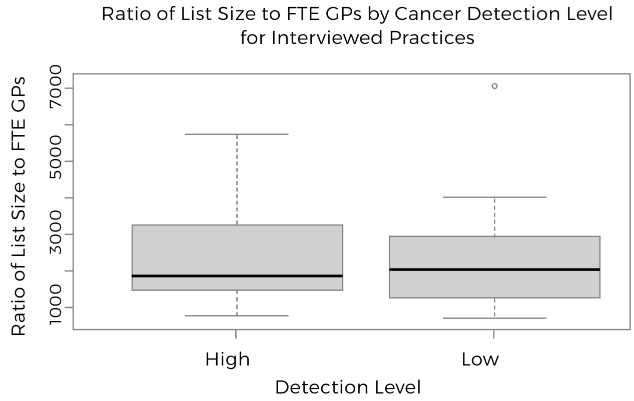
Percent of QOF Points Achieved by Cancer Detection Level for Interviewed Practices



Percent of GP Registered Older Population by Cancer Detection Level for Interviewed Practices



Percentage of Non-White Population by Cancer Detection Level for Interviewed Practices



Ratio of List Size to FTE GPs by Cancer Detection Level for Interviewed Practices

Sources: PHE Fingertips data (1 June 2023). RMP cancer dashboard data (1 June 2023). NHS Digital workforce data (31 August 2023).

Key Learnings

- Findings from this phase were used to inform and shape the final delivery phase, informing the evolution of the interview structure and revised sampling of practices to ensure appropriate coverage and input.
- When the metrics above were compared between high and low detecting interviewed practices, there was slight variation for certain metrics, mainly for deprivation and proportion of elderly patients. However, in general, we obtained a representative sample across these measures.
- To build on learnings and capture additional insight, we made the following changes to the topic guide and interview structure during the redesign phase:
  - Added additional prompts for patient population questions (i.e. specific adjustments practices are making to serve these groups and awareness of differences in risk of cancer between groups)
  - Added a question on patient access to appointments
  - Added a question on how the practice is working with the PCN
  - Added a question on the main drivers of referrals (patient anxiety or clinical concern)
  - Added several questions around access to diagnostics and any perceived barriers
  - Added a question around awareness of RDC pathways
  - Added a question on awareness of cancer training sessions
  - Added a final question on the most useful interventions to support practices going forward

3.1.3 Phase 3 (Second phase of wider roll-out)

The final phase of the project delivered the final interviews and culminated in the development of a series of considerations for addressing variation in detection rate. Building on learning from the redesign phase, key themes and considerations were tested and refined. In order to clearly structure and target considerations, they are structured around three elements of the health system: the population, the clinician/practice, and the wider system. This phase also included sharing and discussion of the outputs with primary stakeholders of the work with the aim of a future presentation of the findings and considerations at a learning event to be hosted in February 2024.

Total practices **sampled:**	Total practices **that responded:**	Total practices **interviewed:**
114	56	46
(52 low, 62 high)	(22 low, 34 high)	(18 low, 28 high)

Sampling Approach

The final sampling phase was designed to capture practices which were underrepresented in the previous two phases. Specifically, larger practices (list size > 10,000) and three boroughs (Hammersmith and Fulham, Hounslow, and Sutton) were found to be underrepresented. To address this, phase 3 practices were sampled by extracting remaining large practices, with count for high detection versus low detection varying by existing borough representation, by detection rate.

3.2 Quantitative methodology

The quantitative analysis reviewed publicly available data on practices included within the study and assessed the extent to which this data showed a difference between the high and low detection rate groups. In addition to the detection rate, the two most important measures reviewed were the age-sex standardised volume of referrals and the conversion rate from referral to diagnosis of cancer. This data was taken from the CancerData website[1].

When reviewing the detection rate for individual GP practices, the 5-year average (2017/18 to 2021/22) was used. Given the small number of cancers diagnosed each year in some practices, a single year of data does not provide sufficient data for a robust detection rate to be estimated.

In addition to data on cancer referral and detection, other publicly available measures of practice structure (e.g. list size, number of GPs and number of locums) as well as practice population (e.g. age, deprivation, and ethnicity) were also reviewed. For all measures, comparison was made between the two groups and with the national average.

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[1] Data available here: https://www.cancerdata.nhs.uk/

3.3 Outreach and qualitative interview approaches

3.3.1 Pre-visit Materials

A number of pre-visit materials were shared with GP practices approximately two weeks prior to the interview to prepare them for the discussion and ensure that all participants had access to the same context and data. The materials were also shared in the invitation and reminder correspondence with the practice including any updates made. These materials included:

- **Pre-visit Checklist:** This provided a structured guide to help practices prepare for the interview.
- **Data Proforma:** The proforma consisted of an interactive Excel dashboard displaying data relevant to the practice's cancer detection.
- **Cancer Inequalities Dashboard and Guide**: A link to a dashboard summarising key cancer detection metrics and population health factors developed for RMP was shared together with a user guide.
- **Summary Slide Deck**: A slide deck summarised the most salient data from the proforma, the latest PHE Fingertips data, as well as the PCN Dashboard and Cancer Inequalities dashboard, as a visual aid to guide the initial data exploration with the practice.
- **FAQ Document:** This was provided to anticipate and answer common queries, contributing to a more focused and efficient interview process.

These pre-visit materials, with the exclusion of practice-specific data, are included in Appendix B.

3.3.2 Topic Guide Development

Together with the above, a separate topic guide was developed to standardise interviews and ensure key questions relating to clinical, patient and system factors that may influence the cancer detection rate were discussed, built on previous research in this area. The guide was divided into the following sections: introduction, exploratory questions on practice's cancer data; population factors; clinician and practice factors; cancer quality improvement projects; and closing questions. This guide was shared with GP Cancer Leads and other members of the interview panel, but not with the practice. During the course of the project, the project team discussed and continuously iterated the content and structure of the guide, for example, with more focus on health inequalities and system-level interventions in later phases of the project.

3.3.3 Scheduling Interviews

The process of scheduling visits involved several steps, each contributing to the goal of facilitating comprehensive engagement and ensuring flexibility for participating practices.

GP Cancer Leads initiated the process by reaching out to their respective practices, providing an overview of the programme, its objectives, and the benefits of participation. As part of the efforts to encourage participation, it was agreed that the practices' engagement and the action points resulting from the interview would be counted towards their early cancer diagnosis PCN Directed Enhanced Service (DES). Additionally, practices were compensated for their time, with each practice receiving £250.

The availability of the GP Cancer Leads was collated, and potential interview times were planned in most cases around lunch hours (12:00-14:00) to facilitate participation. When a practice expressed interest in participating, they were offered several time options for a meeting, corresponding with their respective Cancer Lead's availability.

Although face-to-face meetings were offered where possible, most practices opted for virtual meetings. Once the meeting format and time were agreed upon, the visits were scheduled, and invitations were sent to the relevant team members. For those practices who did not initially respond to the invitation, a follow-up was sent, involving further contact via both email and sometimes phone calls. Non-responsive practices demonstrated an even split between high and low detection rates, as well as across different boroughs (results are shown in Appendix A).

3.3.4 Conducting Interviews

To facilitate an effective dialogue and informed discussion, pre-visit materials were distributed to the practices ahead of the scheduled interviews as outlined in a previous section. Given the prevailing circumstances and convenience, most practices expressed a preference for virtual interviews over Teams.

Interview attendees typically included the GP Cancer Lead, a member of the Edge Health team, and optionally, a member of the RM Partners team. Each practice was represented by at least one GP, and where possible, at least one member of the practice administrative team. Interviews lasted approximately 1 hour. Interviews were recorded after obtaining consent from the practice for the sole purpose of improving note-keeping.

Each interview was structured as follows:

1. The session began with a review of the practice's understanding of the programme and its respective detection rate.
2. The discussion then moved on to practice-specific data, including detection rate, safety netting, and faecal immunochemical testing (FIT), and other measures.
3. The interviewers proceeded with structured questions from the topic guide, focusing on the referral approach, perceived benefits or barriers, and exploring population, clinician, and system factors that might influence the detection rate.
4. Next, a Significant Event Analysis (SEA) case was reviewed, followed by an examination of the practice's involvement in broader care quality initiatives.
5. The interview wrapped up with closing remarks centred around suggestions for referrals and the overall programme.

During the interview, the Edge Health team member maintained detailed notes to accurately capture the discussion's nuances. The topic guide proved a useful tool to ensure all key factor areas were covered during the interview, and maintained its utility even when it was used as a reference rather than a comprehensive checklist.

3.3.5 Post Interviews

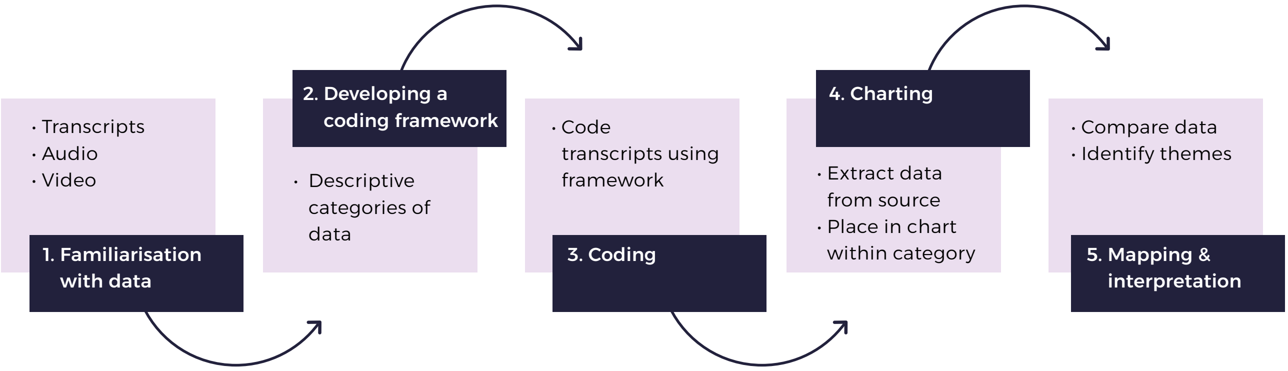
Upon concluding each interview, a 15-minute debriefing session between the interviewers was held to discuss first impressions and key takeaways. The interview notes were subsequently reviewed and compiled. Approximately one week following each interview, these notes were returned to the practice along with a practice-specific action plan as part of quality improvement efforts. This list included actionable points for both the practice and RMP. This approach ensured a thorough review of the interview content and facilitated constructive feedback and action planning. An example, anonymised, action plan is included within Appendix C.

3.4 Thematic analysis and qualitative coding

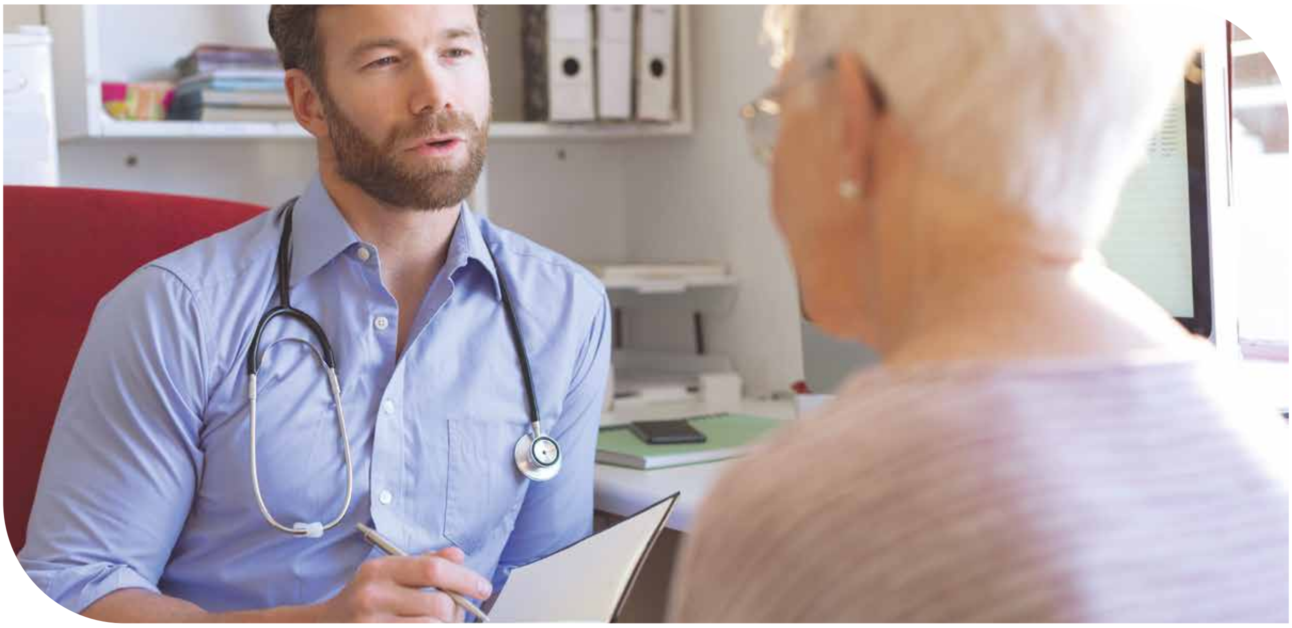
In order to systematically code the interview notes, we developed a methodology that focused mainly on three elements assessed during the interviews: population factors, clinician/practice factors, and system factors. Following this approach, we first conducted a manual review of the assembled notes for the purpose of documenting salient themes in relation to one of the three factors being examined. Each of these themes comprised a series of statements that recurred across multiple interviews, such as “The practice has specifically targeted underrepresented populations to attend screening.” These statements served as a scoring tool to facilitate an orderly and replicable evaluation of each interview.

The modelling used a framework analysis approach. Framework analysis, originally developed in Ritchie & Spencer (1994), is well suited to applied policy research. It involves the thematic analysis of datasets developed through coding of interviews or transcripts. The core steps to framework analysis set out in Figure 5, taken from Johnson et al. (2016).

Figure 3: **Steps within framework analysis**



The initial statements and themes were discussed at regular multi-disciplinary team meetings and the emerging themes workshop (described below) to gather inputs from interviewers and the wider team on whether our findings reflected the general perception.



Emerging Themes Workshops

The workshop was hosted with programme leadership and NWL and SWL Clinical Leads (GP CLs), allowing the opportunity to present, discuss, and consolidate emerging themes from Pilot and Phase 2 interviews. The themes to date were presented in broad categories corresponding to the population, clinician/practice or system level with more detailed themes and codes within these groupings. The discussion provided an opportunity for attendees to give their perspective on whether themes aligned with their interview experience and their perceived value to the research question. This contributed to the iterative process of refining interview questions and focusing on specific themes that illustrated potential variation in detection rate across practices.

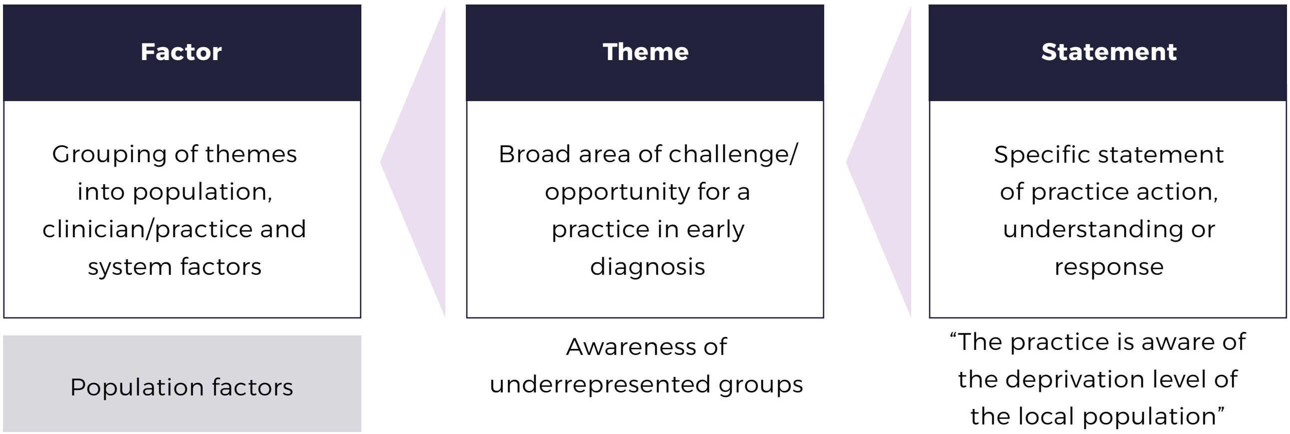
Following this discussion and changes to the topic guide, a second workshop took place where more GP CLs on the project had an opportunity to give their input on the actions taken from the discussion during the first part of the workshop. The second workshop also included discussion on what possible actionable outcomes could be corresponding to the identified themes and how these can best be delivered to support practices with their cancer detection processes going forward. The coding team regrouped following the workshops to consolidate the themes and statements, giving rise to an analytical framework of 11 overarching themes.

During these conversations, it was reflected that the programme is a good opportunity to share and discuss key data with clinicians. It was also recognised that there is greater value in focusing conversations on the areas clinicians and practices have the greatest control over (such as referral practice and interactions with patients from diverse backgrounds) and less on broad discussions regarding variations in access to healthcare and patient behaviour which the practice may perceive as being out of their control.

Once the framework was established, each practice's interview notes underwent a systematic coding and charting process recorded in Microsoft Excel. The practice name, borough and detection rate grouping were also noted to facilitate later analysis.

Statements were scored as either 1 - if the statement was applicable to the practice in question - or 0 - if the statement was not applicable. A score of 0 was assigned irrespective of whether the practice failed to mention the statement during the interview or whether they explicitly rejected the statement. The coding process was independently conducted by three distinct members of our team to ensure objectivity.

Figure 4: **Coding Structure**



Factor

Grouping of themes into population, clinician/practice and system factors

Population factors

Theme

Broad area of challenge/ opportunity for a practice in early diagnosis

Awareness of underrepresented groups

Statement

Specific statement of practice action, understanding or response

"The practice is aware of the deprivation level of the local population"

To maintain the uniform direction of the scoring, all statements were framed in the positive tense (i.e. themes are phrased as “the practice actively reaches out…”, “the practice has a stable workforce…” etc as opposed to the negative phrasing of “the practice does not reach out…” or “the practice has an unstable workforce…”). This method ensured the preservation of scoring directionality, allowing us to draw accurate correlations not only within each practice but also across different practices.

The methodology employed a number of strategies to ensure **rigour** and **robustness** in the approach. Findings were triangulated between quantitative and qualitative sources, and over multiple interviewers. Regular check-ins were used throughout the project to ensure that emerging findings and analysis were tested with a multi-disciplinary team as they were developed. The large number of interviewers and interviewees also provides breadth of input and helps to ensure that the findings are not overly influenced by the perspective or experience of any one researcher or participant.

4

Discussion: strengths and limitations of the approach

4.1 Strengths

The findings are based on 46 interviews with GP practices across West London. Interviews from all three phases of the roll-out were used in this analysis. These interviews cover every borough, and a wide range of practice sizes, structures, and populations. The majority of interviews had multiple practice representatives, including clinical, nursing and administrative staff, meaning that hundreds of people working in primary care were able to contribute to the discussion. By the end of the third phase, more than one in five practices within the RM Partners geography had been invited to an interview and more than one in twelve practices had participated.

The scale and breadth of these interviews is a strength of the study. Whilst the specific context of each practice is unique, the large sample of practices means that thematic findings can be pulled across a number of conversations. Throughout the three phases, practices were actively sampled to ensure as much balance and range as possible. This included looking for high and low detection rate practices, as previously discussed, but also in terms of factors such as boroughs, deprivation, practice size and population age. This diversity in practices also meant that some analysis of variation was possible, particularly between high and low detection rate practices.

The interviews were also supported through use of data. Prior to each visit, practices were sent a data proforma containing a broad range of information about their practice and referral behaviour. This data was also used to structure the discussion and prompt questions during the interviews. Practices supported this data collection through completion of a pre-visit checklist covering areas such as safety netting and awareness of RDCs. This use of data meant that the interviewers understood the context of the practices they were interviewing, and practices themselves understood their behaviour and population, relative to their peers. This prompted the conversations to be more detailed, as well as with a richer evidence base, than they would otherwise have been.

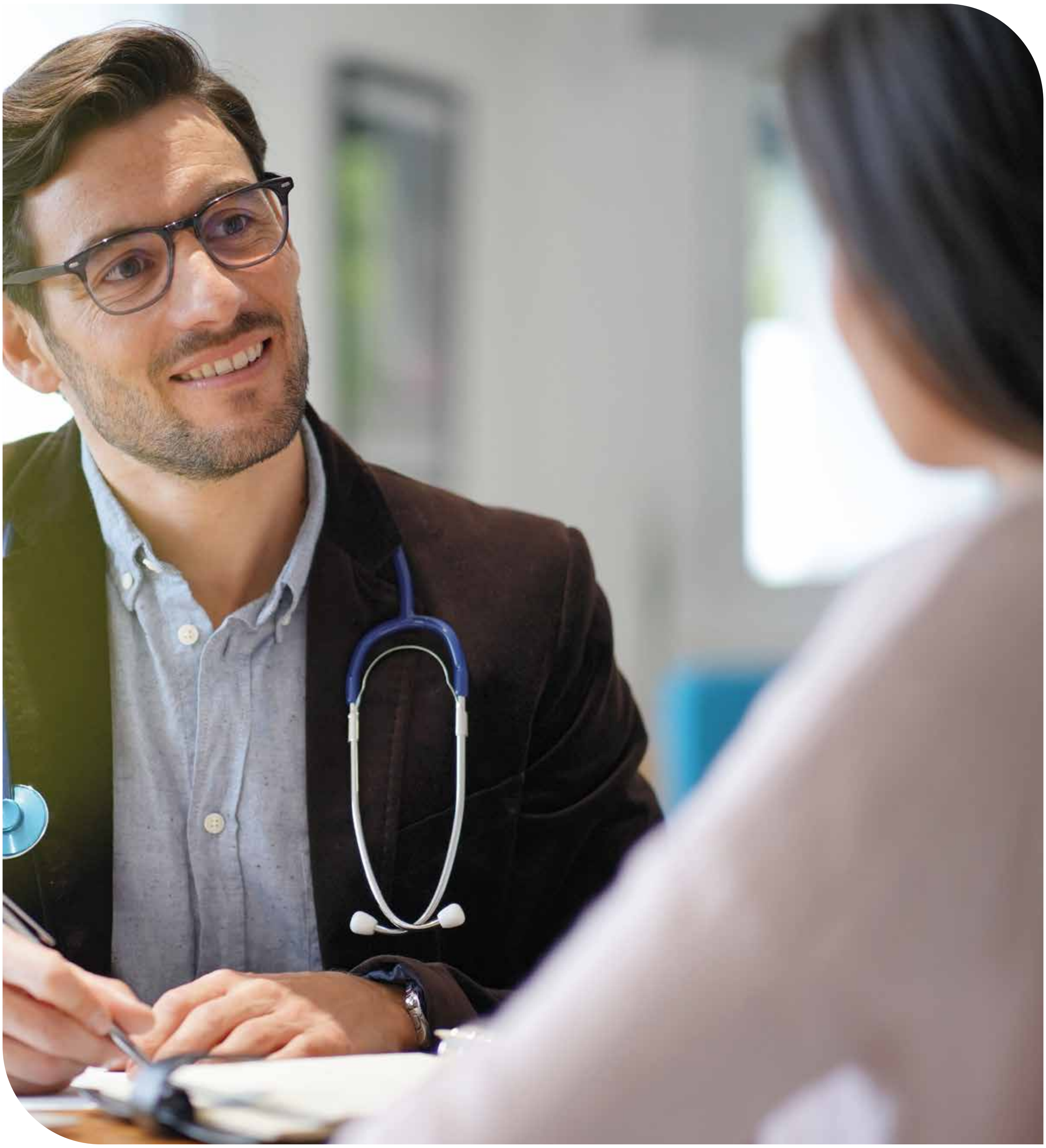
4.2 Limitations

The qualitative interview approach does not rely on a standardised survey questionnaire. Instead, conversations were steered by a topic guide, allowing flexibility. This means that while the guide provided a framework, there was no assurance that all topics were discussed or that questions were asked uniformly across interviews. Nevertheless, the approach allowed for organic, open-ended discussions, potentially leading to more nuanced and diverse insights as a strength of a qualitative approach.

In addition, interviews were run primarily by locality GP Cancer Leads. In total, more than ten different leads conducted interviews. Whilst all interviewers were provided with topic guides and discussed the interview approach on multiple occasions, this inconsistency in interviewer should be borne in mind when comparing different discussions. The range of interviewers does, however, mean that the findings from the interviews are not overly influenced by the perspective or approach of any individual interviewer.

Secondly, the interview findings were reliant on what practices reported in their interviews. For example, a practice may describe its robust safety netting process, but the implementation of this process could vary. This is particularly relevant where variation in behaviour could be subconscious or unknown to the practice itself.

Finally, it is important to bear in mind the timeliness and granularity of the data which is available at practice level. For smaller practices in particular, the volume of patients within their list who are diagnosed with cancer each year can be very small. To avoid small numbers, the detection rate was considered as a five-year average. This does mean that the measure is affected by practice behaviour and processes from five, or more, years ago and therefore may no longer be reflective of current practice.



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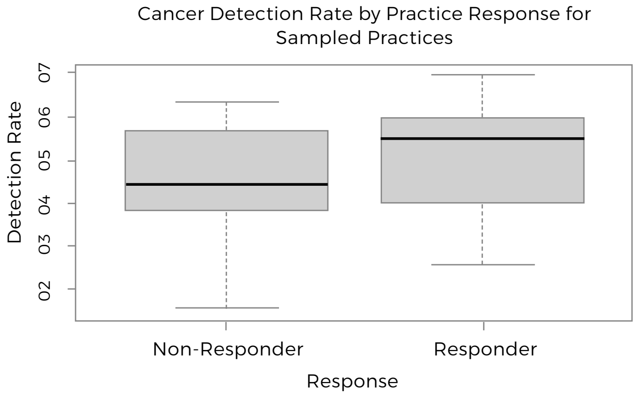
6 Appendices

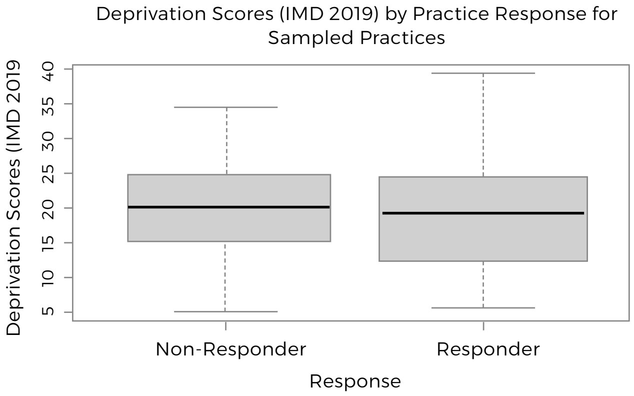
6.1 Appendix A: Profile of responding practices

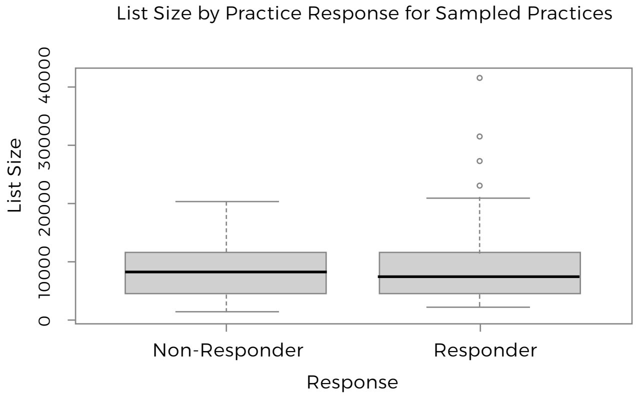
Table A.1.: **Descriptives of sampled practices (responders vs. non-responders)**

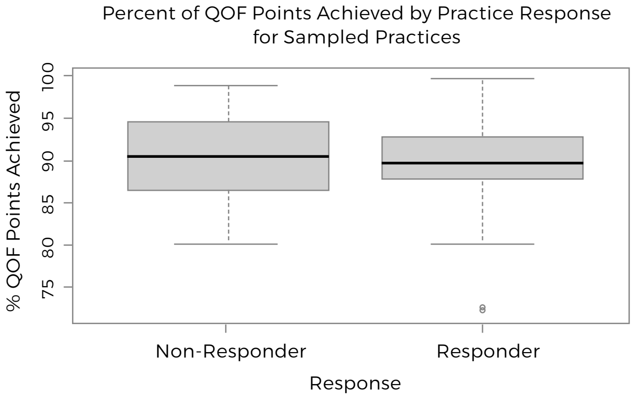
Variable	Responders	Non-Responders	All Sampled Practices
Average detection rate (2017/18 to 2021/22 average)	53.6 %	48.5 %	51.3 %
Average conversion rate (2017/18 to 2021/22 average)	5.1 %	4.6 %	4.9 %
Average age/sex standardised 2WW referral ratio (2017/18 to 2021/22 average)	0.97	0.89	0.93
Average deprivation level (IMD 2019)	19.79	20.46	20.05
Average list size (2022)	9,058	9,112	9,086
Average % QOF points achieved (2021/22)	89.91 %	90.45 %	90.18 %
Average % aged 65+ (2022)	11.56 %	10.83 %	11.19 %
Average % non-white (2022)	45.56 %	48.24 %	46.85 %
Average count of FTE GPs (2022)	5.10	3.88	4.47
Average ratio of list size to GP count (2022)	2,694	2,831	2,765
Average count of locums (2022)	0.23	0.71	0.48

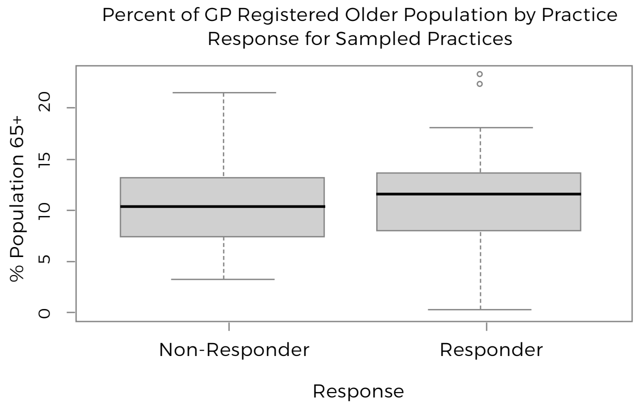
Sources: PHE Fingertips data (1 June 2023). RMP cancer dashboard data (1 June 2023). NHS Digital workforce data (31 August 2023).

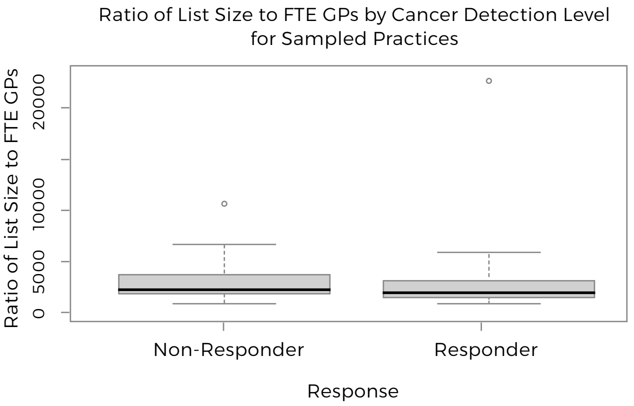

Cancer Detection Rate by Practice Response for Sampled Practices

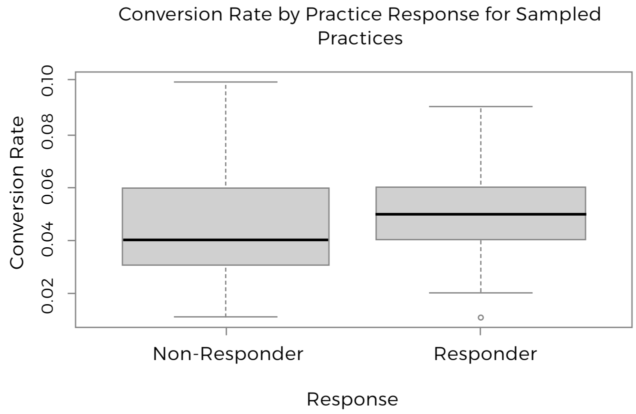

Deprivation Scores (IMD 2019) by Practice Response for Sampled Practices

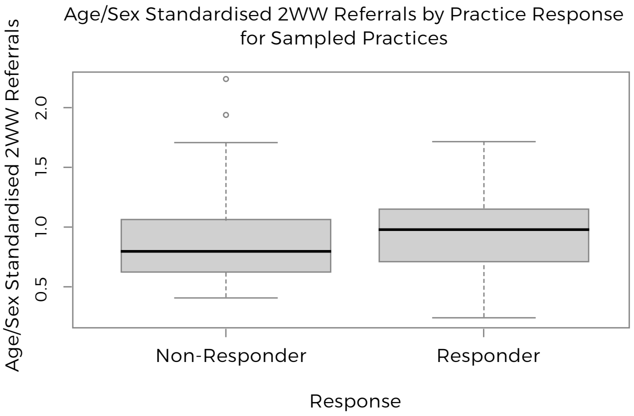

List Size by Practice Response for Sampled Practices


Percent of QOF Points Achieved by Practice Response for Sampled Practices


Percent of GP Registered Older Population by Practice Response for Sampled Practices


Ratio of List Size to FTE GPs by Cancer Detection Level for Sampled Practices


Conversion Rate by Practice Response for Sampled Practices


Age/Sex Standardised 2WW Referrals by Practice Response for Sampled Practices

Sources: PHE Fingertips data (1 June 2023). RMP cancer dashboard data (1 June 2023). NHS Digital workforce data (31 August 2023).

6.2 Appendix B: Pre-visit materials

6.2.1 Pre-visit checklist

Primary Care Detection Checklist	Yes	No
As a practice team, regularly review 2WW referral practice?	☐	☐
Are you aware of the new 2WW referral forms?	☐	☐
Have an awareness of particular patient groups / disadvantaged groups that do not routinely present in primary care / your own practice?	☐	☐
Have a system for safety netting?	☐	☐
Ensure that all patients are given up-to-date patient information, in their language, on referral under a 2WW?	☐	☐
Review patients with late stage diagnoses and discuss with practice team as part of SEA analysis?	☐	☐
Are GP colleagues aware of the Rapid Diagnostic Centres and how to refer to them?	☐	☐
Does your practice have a Cancer Lead?	☐	☐

6.2.2 Inequalities data tool guide

Guide to the Cancer Inequalities Data Tool

6.2.3 FAQ Document

Practice FAQ Document

6.3 Appendix C: Example practice summary and action log

An example practice summary and action plan. This has been anonymised so that the practice in question cannot be identified. In order to preserve anonymity, some elements of the action plan have been deleted.

Glossary of terms and acronyms

2WW	Previous two-week-wait (urgent suspected cancer/USC) referral
CL	Cancer Lead
CR	Conversion rate - The proportion of urgent suspected cancer referrals which result in a diagnosis of cancer. Measured throughout the report using a 5-year average (2017/18-2021/22).
Core20PLUS5	A programme generated by NHS England to target areas of health inequality, focusing on populations living in the top 20% most deprived areas, as well as other population groups identified at a local level.
CRUK	Cancer Research UK
DR	Detection rate - the proportion of cancers diagnosed via an urgent suspected cancer referral from primary care. Measured throughout the report using a 5-year average (2017/18-2021/22).
DES	Directed Enhanced Service
DNA	Did Not Attend
EHR	Electronic Health Record
FIT	Faecal Immunochemical Testing
FTE	Full Time Equivalent
GI	Gastrointestinal
GP	General practice
HPV	Human Papillomavirus
IMD	Index of Multiple Deprivation
MRI	Magnetic Resonance Imaging
NCPES	National Cancer Patient Experience Survey
NICE	National Institute for Health and Care Excellence
NWL	North West London
PCN	Primary Care Network
PHE	Public Health England
QOF	Quality and Outcomes Framework – Measures of disease prevalence and primary care quality achievement
RDC	Rapid Diagnostic Centres – a diagnostic pathway for patients with non-specific symptoms that could indicate cancer
RMP	RM Partners
SEA	Significant Event Analysis
SWL	South West London
USC	Urgent Suspected Cancer referral – previously referred to as a Two Week Wait (2WW) referral

Improving early diagnosis of cancer – primary care practice which makes a difference

The greatest improvement we can make is to reduce the variation between the highest and lowest boroughs for early cancer diagnosis. This would shift 941 patients/ year into early diagnosis.
There are 6 improvement domains:

1

Practice performance + Operations

- ✓ Participation in external cancer audits
- ✓ Knowing practice cancer data
- ✓ Regular team look back & case review
- ✓ Use of Urgent Cancer Referral pathways (NG12)

2

Adoption of quality systems

- ✓ Use of decision support tools
- ✓ Use of a safety netting system that encourages a safety culture

….underpinned by a culture of quality improvement

3

Addressing systemic inequity

- ✓ Understanding causes of systemic inequity and how it impacts cancer
- ✓ Unconscious bias training
- ✓ Implementation of approaches to reduce inequity

4

Workforce stability

- ✓ Stability of workforce across the practice
- ✓ Low locum usage
- ✓ Ensuring clear orientation of locums

5

System Awareness & Participation

- ✓ Awareness and use of direct access
- ✓ Use of Vague Symptom Cancer Pathways
- ✓ Relationships between PCN members,
- ✓ Practice & secondary care

6

Training & Clinical Improvement

- ✓ Participation in cancer training to enhance clinical awareness
- ✓ Cancer referral training to maintain awareness of new guidelines

Edge Health

RM Partners
NW & SW London Cancer Alliance

NHS