National Cancer Diagnosis Audit (NCDA)

# UK-wide Impact Report

*December 2021*

Together we will beat cancer

CANCER RESEARCH UK

## Cancer Research UK

Cancer Research UK is the world's largest independent cancer charity dedicated to saving lives through research. We support research into all aspects of cancer through the work of over 4,000 scientists, doctors and nurses.

The NCDA was delivered in partnership with the following organisations:











**This work used data provided by patients and collected by the NHS as part of their routine care and support.**

We thank all patients whose data were included, as well as the health professionals who took part in this audit.

## Lay Summary

The National Cancer Diagnosis Audit (NCDA) collects data from GP surgeries, and combines this with existing hospital data, to help us better understand what happens to patients on their path to a cancer diagnosis. Information from the audit allows health professionals, other NHS staff and researchers to find out what works well and where improvements could be made.

This report summarises feedback received about the audit in a survey and interviews. It also provides details on key findings, publications and media coverage from the audit.

Nearly all survey respondents (97%) reported that they had gained value from taking part. Benefits included the ability to identify good practice as well as challenges to be addressed, and being able to compare their practice to other services.

Around 1 in 3 survey respondents (64%) said they had already made changes or were planning to make changes as a result of the audit. Most often, these changes focused on improving 'safety netting' processes to ensure patients do not slip through the net. Safety netting can include actions such as scheduling another appointment for follow-up, or adding a reminder to the medical record to check a test result was reviewed and actioned. Other projects focused on cancer screening, use of referral guidelines and smoking.

More than 8 in 10 survey respondents (85%) confirmed they would take part in NCDA again in future. This shows that there is an appetite for ongoing audit of cancer diagnosis with regular feedback to monitor progress and inform improvement work.

## Executive Summary

There is limited routine data available on pathways to cancer diagnosis through primary care. The National Cancer Diagnosis Audit (NCDA) collects data from primary care services, combining this with existing secondary care data, to further our understanding of pathways to cancer diagnosis and to inform quality improvement efforts.

This impact report summarises findings from a survey and interviews to evaluate the NCDA, as well providing an overview of key findings, publications and communications linked to the audit up to August 2021.

Survey findings showed that 97% of respondents felt they had gained value from taking part, specifically noting that the audit enabled identification of existing good practice as well as diagnostic challenges, allowed benchmarking to other services, and that it helped highlight cases for further in-depth review.

As a result of the audit, 64% of survey respondents stated that they had made or were planning to make changes to their practice and processes. A range of quality improvement projects were planned and carried out as a result of taking part in the audit. A key area of focus for improvement work often identified by practices was safety netting, with other projects focused on consistent use of referral guidelines, increasing cancer screening uptake, as well as promoting smoking cessation.

85% of survey respondents confirmed they would take part again in future if another cycle of NCDA was launched. This demonstrates interest among health professionals in continuous audit of cancer diagnosis and regular feedback loops to support ongoing monitoring and inform quality improvement efforts.

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## Foreword

*By John Marsh (Patient Representative) and Richard Roope (General Practitioner)*

Cancer remains the largest cause of premature death (death before the age of 75) in the UK, as in all developed countries[1]. In the UK, cancer is the cause of more premature deaths than those caused by cardiovascular, respiratory, and liver conditions combined[2]. Year on year a higher proportion of cancer cases are being diagnosed through an urgent cancer pathway, which is known to result in earlier diagnosis, better treatment options and better outcomes. Data just recently released by Public Health England/NHS Digital[3] show this has continued through 2020/21, with an all-time high of 53.8% of all new cancers having been diagnosed following a referral on an urgent cancer pathway, despite the challenges of the Covid pandemic. However, despite this good news, we know that outcomes in the UK lag behind those of comparable national health systems[4]. Research suggests the factors contributing to this can be grouped as patient, professional and process factors.

The previous NCDA provided a wealth of data and showed some common themes in those cases where a delay in accessing first treatment occurred. Undertaking the audit allowed practice teams to undertake case reviews and identify where care had gone well, and other times where this care could be improved. This allowed practice teams to heighten awareness across the clinical team and invoke new and better systems of investigation, referral and safety netting.

This iteration of the NCDA has in many ways been even more impressive than the previous one, and has the potential to drive change wider and deeper, ultimately improving both patient outcomes and the experience of them and those close to them. A remarkable 2,007 practices across the four nations took part, with more than 68,000 cases reviewed (over 18% of the average of 375,400 cancer cases per year[5]). In each of these cases any delays were identified, and each practice was then presented with a document with the amassed data and helpful benchmarking. This, in turn, will allow further reflections and will generate further changes and improvement to clinical and administrative processes, and indeed 64% of practices have, or intend to put in place such improvements as a result of this audit. Despite the challenging times, it is a testament to primary care that so many practices engaged and delivered the mass of data, and despite the not insignificant investment of time, a remarkable 85% of respondents would take part in another cycle of the NCDA.

Clinicians all have a desire to "make a difference" and be advocates for their patients and to maximise their health and well-being. Early analysis of the audit data suggests the NCDA has already, and will continue to contribute to this leading to those better outcomes and patient outcomes and their experience we seek.

There is a strong case to have further similar audits to assess the impact of this and the previous NCDAs, and to engender further reflective practice and drive up outcomes and contribute to closing the gap in outcomes seen in comparable health systems.

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[1] https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21660
[2] https://fingertips.phe.org.uk Accessed 12.12.21
[3] https://fingertips.phe.org.uk/ Accessed 12.12.21
[4] https://www.cancerresearchuk.org/health-professional/data-and-statistics/international-cancer-benchmarking-partnership-icbp Accessed 12.12.21
[5] https://www.cancerresearchuk.org/health-professional/cancer-statistics-for-the-uk Accessed 12.12.21

The audit was ably supported and delivered by a steering committee and collaboration between Cancer Research UK, Public Health England (now NHS Digital), NHS England, Iechyd Cyhoeddus Cymru/Public Health Wales, Public Health Scotland, the Northern Ireland Cancer Registry at Queen's University Belfast, Macmillan Cancer Support, the Royal College of General Practitioners, Rhwydwaith Canser Cymru/Wales Cancer Network, Scottish Government and academic institutions. We would like to acknowledge and thank the literally thousands of clinical and administrative colleagues across these organisations who have contributed to this remarkable project.

John Marsh
Patient Representative for
National Cancer Diagnosis Audit

Richard Roope
GP and Cancer Research UK
Primary Care Advisor

# Background

## Why early diagnosis matters

Early diagnosis of cancer is key to improving patient outcomes and experiences. If cancer is diagnosed at an early stage, there may be more treatment options available and the chances of survival are higher. Unfortunately, UK nations still lag behind other, comparable, countries when it comes to cancer survival[6] and the recent Covid pandemic has likely slowed efforts to improve cancer outcomes across the UK.

There is an urgent need to better understand patient pathways to cancer diagnosis to identify existing good practice and areas for targeted improvement work. While there are several routine data collections in secondary care of events occurring after referral and diagnosis, such as 'cancer waiting times', there is no mandated routine national data collection of events occurring in primary care prior to referral. Given the GP Team is often the first point of contact for patients experiencing worrying symptoms, there now is recognition throughout the UK that, in order to diagnose cancers at as early a stage as possible, we need to identify and address issues along the whole pathway, including in primary care. The National Cancer Diagnosis Audit (NCDA) partnership was established to address the lack of national level data on cancer pathways through primary care, to provide insights into such pathways, and to enable quality and service improvement.

While the most recent cycle of NCDA focused on diagnoses made pre-Covid, the audit findings could still support recovery efforts by highlighting areas of need or unwarranted variation that existed before the pandemic and are likely to have been exacerbated by Covid. Cancer Research UK estimates that there were more than 380,000 fewer urgent suspected cancer referrals in the UK between March 2020 and March 2021, and that the number of tests and investigations carried out to diagnose cancer had also dropped during the first year of the pandemic[7]. In addition, provisional data suggest the number of patients diagnosed at stage 1 or 2 was 32% lower in April-October 2020 compared with pre-pandemic levels in England[2]. The NCDA may, therefore, act as a useful baseline for practices, Primary Care Networks and other organisations to monitor Covid-recovery and the impact of efforts to drive forward earlier cancer diagnosis.

## Cancer Early Diagnosis – a priority for governments

The importance of early cancer diagnosis is acknowledged in the NHS Long-Term Plan, first published in 2018, in which NHS England set out its ambitions for the future. In the plan, NHS England calls for 'an extra 55,000 people each year surviving for five years or more following their cancer diagnosis' by 2028. One of the enablers of this is a drive to diagnose three-quarters of all cancers at an early stage, including implementation of a new '28-day Faster Diagnosis Standard'. Another is the roll out of rapid diagnostic centres for those patients who have concerning, but non-site specific presentations. In 2020/21, for the first time, the GP contract in England included a dedicated quality improvement domain for cancer, encouraging audits of referral practice and quality improvement activity[8].

[6] CRUK International Cancer Benchmarking Partnership (ICBP) https://www.cancerresearchuk.org/health-professional/data-and-statistics/international-cancer-benchmarking-partnership-icbp/icbp-findings
[7] CRUK Covid and Cancer Key Statistics August 2021 https://www.cancerresearchuk.org/health-professional/our-research-into-the-impact-of-Covid-on-cancer
[8] https://www.england.nhs.uk/gp/investment/gp-contract/gp-contact-documentation-2020-21/

In Scotland, the recent 'Recovery and Re-design: Cancer Services Action Plan', agreed in response to the pandemic, builds on achievements of Scotland's 'Detect Cancer Early' programme, which has been running since 2012. Among other aims, the Plan sets out ambitions to further invest in diagnostic services, including the set-up of Early Cancer Diagnostic Centres[9] (ECDCs) to provide new referral pathway options for patients who do not meet standard referral criteria.

Similarly, in Wales and Northern Ireland several programmes of work are underway to improve cancer early diagnosis and tackle the drop in cancer referrals seen during the pandemic. The Quality Statement for Cancer in Wales, published in March 2021, highlights the importance of early diagnosis, focusing on nationally optimised pathways through full implementation of the 'Single Cancer Pathway' first introduced in 2019[10]. And a new Cancer Strategy for Northern Ireland is expected to be published in December 2021.

The NCDA has the potential to support ongoing work as part of these government plans, both through insights from existing NCDA datasets, as well as through future cycles of the audit, which would enable ongoing monitoring and quality improvement efforts.

## The National Cancer Diagnosis Audit (NCDA)

The NCDA collects data on cancer patients' pathways through primary care and provides tailored feedback to support quality improvement. It helps to identify existing good practice, to explore events leading to emergency presentations and avoidable delays, and to highlight areas for intervention at various levels, including individual clinician's, practice, local and national levels.

The audit consists of three phases:

- the data collection phase, during which GPs receive a list of eligible patients diagnosed with cancer, review the notes of such cases, and submit data to the local partner (usually a Public Health body or cancer registry); and
- the feedback phase, during which GP practices receive tailored reports, discuss their findings and use these to plan quality improvement activity; and
- the analysis phase, during which analysts and researchers carry out in-depth analyses on the NCDA dataset

The feedback and analysis phases may occur in parallel where sufficient analytic resource is available to produce feedback reports and carry out a full analysis.

### *Current and previous audit cycles*

In 2009/10, the first National Audit of Cancer Diagnosis in Primary Care was undertaken in England, providing the basis for the National Cancer Diagnosis Audit (NCDA) a few years later.

The first cycle of the NCDA took place between September 2016 and February 2017. It collected data on new primary cancers diagnosed between 1st January and 31st December 2014 and took place in England and Scotland, with a small pilot in Wales.

[9] https://www.gov.scot/news/new-services-to-help-find-cancer-sooner/
[10] https://collaborative.nhs.wales/networks/wales-cancer-network/workstreams/single-cancer-pathway/

The second cycle of the NCDA took place between April 2019 and December 2020[11]. This audit cycle collected data on cancers diagnosed between 1st January and 31st December 2018 in all nations except Scotland, where the use of preliminary registration data allowed collection of data from patients diagnosed between 1st October 2018 to 30th September 2019. Audit start and end dates differed by nation and extensions to deadlines were granted due to the Covid pandemic.

In England and Wales, data were collected through a secure online portal managed by Public Health England (PHE), with relevant agreements in place with Public Health Wales (PHW) for the Welsh data collection. In Scotland, data were collected through Public Health Scotland (PHS) using securely transferred Excel spreadsheets. The NCDA pilot in Northern Ireland was managed by the Northern Ireland Cancer Registry (NICR) and employed a similar approach to the Scottish audit.

### *NCDA and Quality Improvement*

The NCDA has a strong quality improvement component and seeks to encourage reflection throughout the audit process. For example, while entering data on the online portal, GPs were made aware if a case warranted more in-depth review through a digital flag and were encouraged to reflect further on non-standard cases and on patients who had experienced avoidable delays. In Scotland, such cases were flagged to GPs later-on, when reports were shared.

Following completion of the data collection, each participating practice was issued with a tailored feedback report, summarising their audit data and providing a national comparator for benchmarking, which was based on the full NCDA dataset from the relevant UK nation. In England, the reports for practices also included additional comparators, e.g. Cancer Alliance level.

The recent formation of Primary Care Networks[12] (PCNs) in England meant that practices were joining in geographical groups of 3-5 practices that would work together in future to deliver the new PCN Direct Enhanced Service (DES) Specification, which includes activities to improve cancer outcomes. To support PCNs in this work, if at least three practices from a PCN had taken part, a PCN-level NCDA report was also issued to all participating practices across the Network. And in Scotland, where practices work together in defined clusters[13], any practices that had taken part together as a cluster were issued a cluster-level NCDA report in addition to individual practice reports. All practices in receipt of a report were encouraged to review and discuss findings presented, and to share any learning with others.

Participating GP practices were also signposted to a quality improvement (QI) toolkit[14] developed by the RCGP and Cancer Research UK, and were offered support from dedicated staff (CRUK Facilitators) and colleagues (CRUK and Macmillan GPs), where available, to reflect on their data and plan QI activity. CRUK Facilitators and GPs were available in many areas across England to promote the audit and encourage completion, with more limited coverage in devolved nations.

[11] Includes various extensions in different nations to the data collection period due to the Covid pandemic [England extension: from 30th April to 31st August 2020; Wales extension: from 1st October to 30th November 2020; Scotland extension: 1st August to 15th November 2020]

[12] https://www.england.nhs.uk/primary-care/primary-care-networks/

[13] https://www.isdscotland.org/Health-Topics/General-Practice/GP-Clusters/

[14] https://www.rcgp.org.uk/-/media/Files/CIRC/Toolkits-2017/Cancer/NCDA-toolkit-110917b

Local/Regional tailored NCDA reports were also offered where sufficient data had been received from the relevant area. In England, Clinical Commissioning Group (CCG) and Cancer Alliance level reports were made available, while Scotland and Wales offered Health Board level reports.

## Audit Participation and Completion – Cycle Two

The NCDA is a voluntary audit promoted through audit partners and other relevant organisations. Some areas/nations offered support payments to participating GP practices, while others did not. Data collection for the second cycle of NCDA in all nations began in 2019 and extensions were granted to data collection periods due to the impact of the Covid pandemic on primary care.

### England

In England, 1,879 GP practices took part (27% of practices) and completed over 64,000 case audits for the NCDA, which is the biggest dataset of its kind collected to date. This compares to a dataset of 17,042 collected in the first cycle of NCDA in England from 439 participating GP practices.

Participation varied by geographical area and was highest in the North East and London regions. No national funding scheme was available, but some areas offered incentive payments for participation in the audit, which is likely to have impacted on uptake and completion levels (Appendix 1 – NCDA Funding Infographic).

### Wales

This was the first full-scale NCDA in Wales. Thirty-two GP practices took part (8% of practices) and 1,235 audit returns were received. This compares to a small pilot sample of 125 completed audits from five GP practices collected during the NCDA Wales pilot in 2017 as part of feasibility work prior to running a full-scale national audit.

A pan-Wales funding scheme managed by the Wales Cancer Network offered support payments at the level of £10 per completed case for any practice that completed to 90% or above. Each of the seven Welsh Health Boards were represented in the sample of participating practices, but in one Health Board only a single practice contributed to NCDA. Participation was highest in Hywel Dda, Cardiff & Vale and Aneurin Bevan Health Boards.

### Scotland

In Scotland, 90 practices took part (9.6% of practices) and completed 2,665 case reviews for NCDA. This compares to a dataset of 2,014 collected in the first cycle of NCDA in Scotland from 72 participating GP practices.

As the Scottish audit used preliminary cancer registration data to identify eligible patients, which was later complemented with the final registration data, 2,318 cases were included in the final national analysis. Participation varied by geographical area and was highest in the Greater Glasgow & Clyde and Lothian regions. In Lothian, support payments were offered to some selected practices, but no national funding scheme was available in Scotland.

### Northern Ireland

In Northern Ireland, the NCDA had not run before. Therefore, a pilot was planned in collaboration with the Northern Ireland Cancer Registry (NICR), in which six GP practices took part, completing 164 case reviews for the NCDA.

## Impact Assessment: Methods

To better understand the value of the NCDA, both to health professionals, organisations, researchers, as well as patients and the public, the impact of the audit was assessed in the months after reports were made available to practices. Findings from the impact assessments up to July 2021 are presented in this report. The initial evaluation work was carried out by a CRUK Graduate Trainee, with the final surveys administered by NCDA programme management.

### GP Survey & Interviews

To explore the value of audit participation for health professionals and the impact on clinical practice and quality improvement, a series of surveys and interviews were conducted following the start of the feedback phase in England (June 2020), which included early feedback offered to practices that had completed the audit by the original deadline. The survey was open from June 2020 to June 2021 to all participants of the NCDA in England and Wales. It was promoted by email and through CRUK GP facilitators. To complement the GP survey findings, six interviews were completed with GPs in England between July and August 2020 by a CRUK Graduate Trainee.

#### *GP Demographic Summary*

Of 34 survey respondents, 33 were based in England and one was based in Wales. Of respondents in England, six were from the West Midlands (18.2%) and six from areas in the East of England (18.2%). Other areas had one or two respondents each.

The majority of survey respondents (n=21; 61.8%) were GP partners, with six salaried GPs (17.6%) and three Practice Managers (8.8%) among those who replied. Thirteen survey respondents (38.2%) had previously taken part in the NCDA. Six GPs, all of whom were cancer leads and several of whom had previously taken part in NCDA, participated in follow-up interviews to talk about their experiences of the audit. The findings of the survey and interviews are presented in this report. It is a limitation that no GPs from Scotland or Northern Ireland could be included in this assessment.

### Facilitator Interviews

In addition to work with GPs, the Trainee carried out several interviews with CRUK facilitators between June and August 2020. CRUK facilitators support primary care with reviewing and reflecting on NCDA findings and planning quality improvement activity. The interviews were only open to facilitators in England, as this was the only nation at the time to have started the feedback phase.

#### *Facilitator Demographic Summary*

Five complementary interviews were conducted with facilitators from South London, North West London, Kent & Medway, Yorkshire & Humber, and Thames Valley. Several of these facilitators had been involved in Phase 2 of the first NCDA cycle as well and spoke about experiences from both cycles.

### Wider Impact Assessment

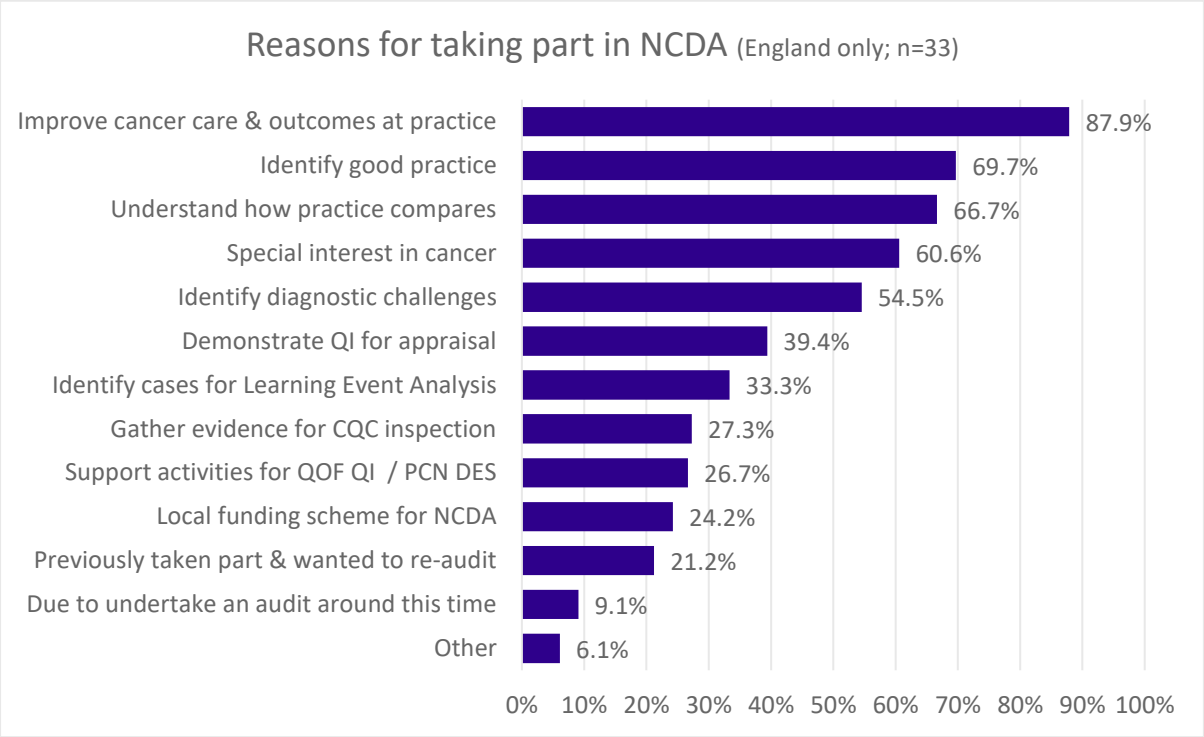
To explore wider impact of the audit publications, such as national summaries and academic papers, as well as accompanying communications, were also tracked.

## Impact on primary care practice

### Reasons for taking part & value gained

#### *Reasons for taking part*

The motivation for taking part in the audit varied. In the survey, thirty-three GPs from England reported their primary reasons for participating were a desire to 'improve cancer care & outcomes' (87.9%), 'identify good practice' (69.7%) and 'understand how the practice compared to other services' (66.7%). Those reasons were also selected by the one respondent from Wales. These findings align with reasons previously provided for undertaking the first cycle of NCDA, where, in a survey in 2017, 84% of respondents had stated that 'improving cancer care & outcomes' was a reason for taking part.




One in four respondents (26.7%) in England additionally stated they took part to support and inform activities for the cancer elements in the Quality Outcomes Framework (QOF) and/or the PCN DES, both of which are contractual arrangements between NHS England / Improvement and primary care. In interview, one of the CRUK Facilitators confirmed that, in their view, the cancer elements in GP contractual arrangements drove interest in the audit.

> "I think what's recently happened is, where practices were further ahead with their PCN development and in touch with what was going on in the new DES – because it's mentioned in there about the importance of doing audits – I've noticed that there's a bit of interest now. There's been a more positive response."
> *Facilitator 1*

One in five (21.2%) survey respondents from England stated that having previously taken part in the NCDA had motivated them to register again. The respondent from Wales had not previously taken part. Of the respondents who had participated before, several added comments in the survey as to why they had re-registered.

> "Previously gained so much learning on a personal and at a practice-based level." *Survey Respondent 22*

> "It [the audit] helps understand our data compared to other practices to help us improve our patient outcomes." *Survey Respondent 4*

> "The Partners felt the last NCDA had been a very positive experience, and was good both for patients and the practice team." *Survey Respondent 17*

> "Useful information gathering to aid QI work." *Survey Respondent 8*

In interviews, GPs elaborated further on their reasons for, and experiences of, participating in NCDA. One of the reasons for taking part highlighted in interviews was the value of undertaking audit activity. Several interviewees shared that they regularly took part in audits in their practice and found them useful tools for learning and reflection.

> "We had taken part in the data analysis of the 2014 [audit] and we found it a very helpful experience, and because of that we decided that it [NCDA] was a good thing to do and was beneficial to doctors and patients alike." *GP 6*

> "I don't think you can really know what your practice is doing unless you have a look. Because you can make assumptions that everything's okay or wait for the problems to happen, but if you look for issues, you can often pick things up sooner and rectify them by making a change." *GP 3*

> "At the practice level, I was interested to understand what messages we could give to the rest of the clinical staff and other staff at the practice about what we could do to better, what we're doing well, particular groups of cancers that we should pay particular attention to." *GP 4*

Complementary data from interviews with CRUK Facilitator staff working in England confirm changes in attitudes to cancer audits appeared to result in more positive responses to invitations to the audit and higher uptake in several areas compared to the previous cycle of NCDA.

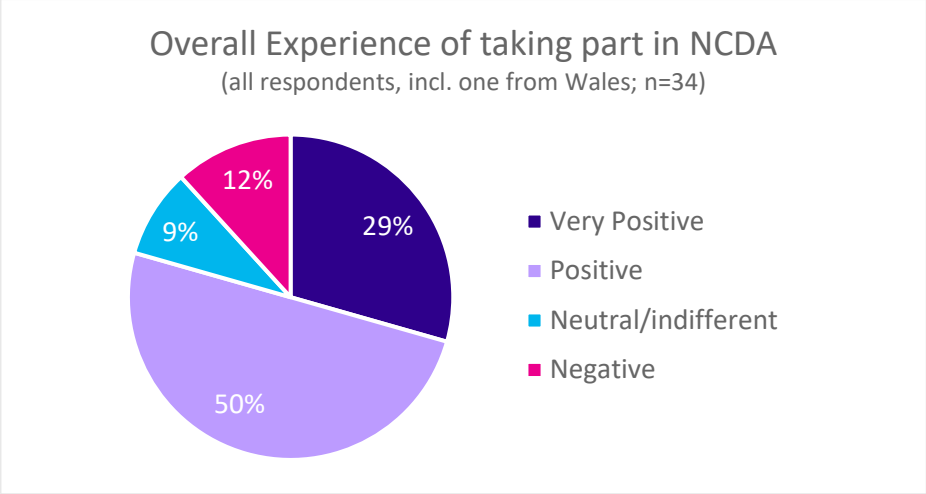
> "…a lot more practices have just generally become more aware of cancer audits and are generally more likely to be open and amenable to reviewing their cancer cases. […] I think probably once they've done this audit, it might just trigger them to be more curious about the cancer cases going forward, as that's partly why it felt a bit easier to recruit people the second time round." *Facilitator 2*

> "I think audit is something that GPs are familiar with and grasp very quickly. So, I think it's very relatable to them what the ask is." *Facilitator 5*

> "I also think perhaps because people had heard about the audit, again, because it's been a short period of time between the two [audit cycles], so it is perhaps at the forefront of GPs minds a little bit more as well." *Facilitator 1*

### *Experience of taking part*

Nearly 8 in 10 survey respondents (79%) said they had an overall positive experience of taking part in the NCDA. No respondents said they had had a 'very negative' experience of NCDA.




> "I enjoyed looking at the cases and identifying where delays occurred. It was interesting, eye opening work." *Survey Respondent 3*

> "It's been a very positive experience to be honest and I would really encourage others to participate in it. I think it's a great opportunity for the learning, for clinicians, and then obviously that does then help your patients. So, I think it's a really worthwhile exercise to do." GP 2

> "I think it's helpful on different levels. One, you can look at what your practice is doing, but the other thing is, you can compare what you're doing to other practices because it's a national thing." GP 3

A criticism raised repeatedly in survey responses was the time commitment required to undertake the audit, although several respondents also noted this was partially balanced by the information gained.

> "Quite time consuming but very useful and has promoted discussion in the practice" *Survey Respondent 34*

> "Time consuming but valuable information" *Survey Respondent 18*

Those who had participated in the NCDA before felt that the process had improved compared to the previous cycle. However, several survey respondents and interviewees also shared that it had been difficult to find time to complete the audit and some felt that a lack of funding had been a barrier.

> "It was very easy to sign up compared to the time before […]. The emails coming through saying how many patients you were expecting, that was all fine. I find actually doing the audit very time consuming still. In theory, you can do it quite quickly, but actually, if you do it properly, it does take probably 20 minutes per patient." GP 1

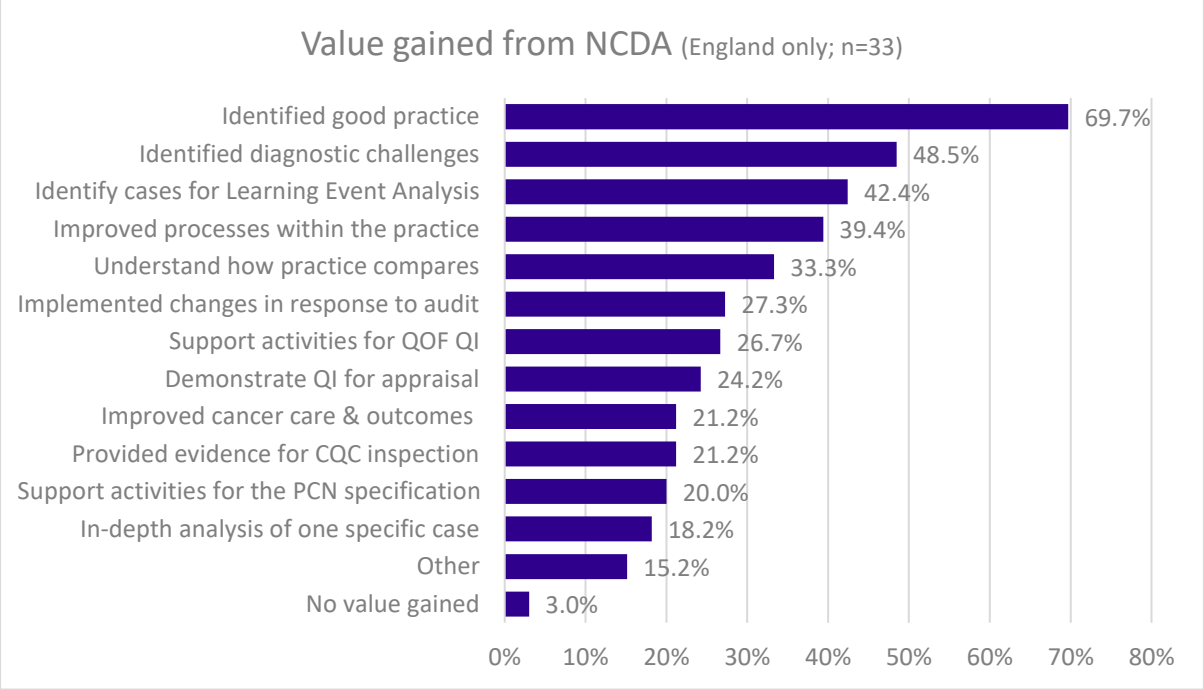
> "I found the whole exercise enlightening and it improved my appreciation of the cancer diagnosis journey. The big negative was lack of funding, and I have had to do all the work in my spare time." *Survey Respondent 16*

However, views on funding were mixed. Some respondents felt that availability of funding is secondary to the benefits of the audit arguing that the benefits outweighed the lack of incentivisation.

> "Financial incentive, it doesn't really make any difference on a personal level. I'm sure the PCN would love to have some [funding] for completing it! But I think the learning that you get out of it far outweighs any sort of financial rewards you can get." *GP 2*

*Value gained from taking part*

When asked about the value gained from taking part in the NCDA, of the 33 GPs from England, many (69.7%) confirmed that they had been able to identify good practice through the audit. Nearly half of respondents from England said they had also identified diagnostic challenges (48.5%) and cases for Learning Event Analysis (LEA; 42.4%), with a third (33.3%) also saying they better understood how their practice compared to other services. Nearly two in five respondents (39.4%) reported that the audit had improved processes within their practice. Only one respondent felt they had gained no value.




> "It was a very small sample but it was helpful to identify areas for improvement." *Survey Respondent 1*

> "[The audit] provided evidence for where there are problems (safety netting)" *Survey Respondent 7*

> "Very helpful to have an objective measurement of our performance as a practice." *Survey Respondent 13*

Similarly, the respondent from Wales felt they had been able to identify good practice and diagnostic challenges, in addition they felt the audit helped them better understand how their practice benchmarks to others.

At the time of the survey, only one in five respondents (21.2%) felt that the audit had improved cancer care and outcomes at the practice. However, it is likely that effects on cancer care and outcomes are only realised after QI activity has been completed. The survey responses were collected between June 2020 and June 2021, and results had only been available to some practices for a few months when responding to the survey. Additionally, primary care was still under pressure due to the Covid pandemic and delivery of the Covid

vaccine programme. It is therefore likely that not all changes had been implemented, nor all QI activities completed, when participants responded to the survey. As such effects on cancer care and outcomes might not yet have been realised. This was also reflected in comments left by some survey respondents.

> "Too soon to ask this question - not all the work as a result of the audit has taken place yet." *Survey Respondent 18*

> "Useful already, and more to unpack" *Survey Respondent 29*

> "Have not had time yet to fully study the report" *Survey Respondent 25*

It is promising that 39.4% of respondents from England said the audit had already resulted in improved processes within the practice, and 27.3% stated that they had implemented changes as a result of the audit. The respondent from Wales, where audit reports were made available later than in England, did not report having made changes or improvements at the time of completing the survey.

More than one in five respondents from England also stated that the audit had helped them demonstrate QI activity for appraisal (24.2%) and had provided evidence for Care Quality Commission (CQC) inspection (21.2%).

*Areas of need and learning*

Survey respondents were also asked to share any issues, themes or learning identified from NCDA to date. One of the most common themes mentioned by respondents was safety netting, i.e. actions taken to ensure patients do not slip through the net and are not lost to follow-up.

> "Safety netting is so very key." *Survey Respondent 15*

> "It is difficult to identify safety netting in the patient notes." *Survey Respondent 18*

> "Need to code/document safety netting" *Survey Respondent 21*

> "So far, lack of safety netting and follow up and lack of continuity of care have been highlighted." *Survey Respondent 22*

> "The importance of prompt referrals in suspected cancer cases and also follow up to ensure that the patient is not lost." *Survey Respondent 13*

Facilitators confirmed in interviews that safety netting was an area of need often identified from undertaking the NCDA, including in the first cycle of the audit.

> "What comes out as a theme is the recommendation that they should be doing more safety netting in practice. I know in one of the areas that incentivised quite heavily, after the last NCDA, they did a piece of follow-up quality improvement work around safety netting. So, they acknowledged that from the NCDA, this was an important area for practices to do improvement on." *Facilitator 1*

Another area where practices identified diagnostic challenges through undertaking the NCDA was in cases where patients present with non-specific symptoms or do not meet standard referral criteria.

> "Issues with patients presenting with vague / multiple symptoms" *Survey Respondent 32*

> "The complexity of the lower GI cancer pathway [and] the role of a vague symptoms pathway." *Survey Respondent 19*

> "Be more confident about making 2ww referrals. Too often you can see the clinician thought about it but wanted more concrete symptoms or evidence, whereas that gut feeling is a strong pointer." *Survey Respondent 29*

> "See people too many times and refer too late. Work needed." *Survey Respondent 8*

One GP described related themes they had identified from undertaking the NCDA, highlighting the importance of continuity of care and exploring patient history and previous presentations to ensure patterns aren't missed.

> "Themes are: lack of safety netting, lack of patient continuity, and also multiple consultations prior to you being referred. There are other little things that have cropped up, for example raised platelets or an anaemia that is put down to anaemia of old age. […] One where [with] a new diagnosis of diabetes, it turned out that the patient had pancreatic cancer, but that wasn't thought of at the time. Another theme is doing that initial systems inquiry, because otherwise you just kind of bumble along and actually don't really grasp a full understanding of the situation." GP 2

In interviews, several GPs shared how they had discussed the NCDA report and learning from the audit with colleagues, which then led to changes in individual GPs' practice or behaviours, often due to increased awareness of the significance of certain symptoms.

> "I think for the doctors, it's a team activity. Although it was mainly two of the partners who did the data trawl and entry. But cases were discussed. Both cases where things had gone really well, but also cases where things could have gone better. Having that sort of disciplined regular review of cases is very helpful. And there are things to be learned that can be then put into practice, so the patients presenting subsequently with similar symptom clusters are being referred and investigated that little bit earlier." GP 6

> "I think previously, from the audits, we've learned a great deal that has then improved our clinicians' practice, which in turn has benefitted patients. Because things [are] potentially being picked up sooner, managed according to guidelines, and it's made clinicians more aware of factors to look out for, for example, raised platelets, raised B12. Previously maybe GPs weren't aware of the significance of those kinds of results. Whereas having gone through some of the cases and having that highlighted to them, now they've improved their practice." GP 2

One GPs spoke about learning they had gained while taking part in the previous audit cycle and how they had shared this insight with colleagues. The same GP went on to give an example of new learning gained from the second cycle as well and how they would feed this back to the team.

> "In 2014, it was about the number of people who had negative chest x-ray presentation and then subsequent diagnosis of lung cancer. I think that was one of the things that I picked up and took [to] one of the clinical meetings just to

> remind people: 'If you worry, don't take a negative x-ray as being a useful diagnostic tool'.
>
> One of the things I picked out [this time], which I thought was interesting, was that for prostate and breast, there weren't a lot of comorbidities. But 48% of people with a cancer diagnosis had one of four [types of] co-morbidity, which was: 'high blood pressure', 'diabetes', 'COPD' or 'cardiovascular disease'. So, my take back to the team is actually 'these are people that we're seeing anyway, so are there any opportunities when we're seeing them for their annual reviews to think about […] the chance of having cancer as well and [ask about] any symptoms?'" GP 1

In interviews, facilitators also shared reflections on discussing and reviewing NCDA reports with GPs and practice teams, identifying themes and areas of need together to explore in more detail.

> "The GP, some of her learnings from it were just to be always thinking of cancer as an outcome. She had some particular clinical cases, things like people who came in with backache and were sent off for physio, but then it came out that backache was cancer. So, she has cases like that now and she thinks about them and then discusses them with the rest of her team just to highlight those kinds of things." *Facilitator 2*

> "Sometimes it [learning] is quite general. Things like 'Oh yes, we realised we need to be encouraging bowel screening more'. If they see they've got some bowel cancers [that] have been diagnosed late, sometimes that can prompt them to then think about their bowel screening uptake, and if there's something that can be done there." *Facilitator 2*

Facilitators in interviews also reflected how the audit had given them opportunities to raise certain issues with practices and had opened the door for them to share resources or offer further training.

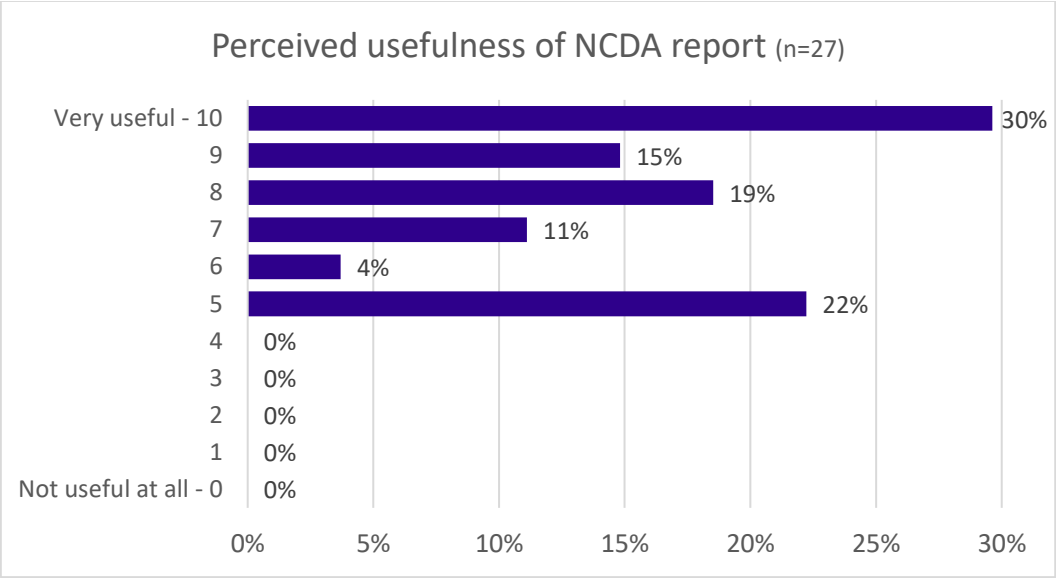
> "The audit report opens the door to the conversation on screening in a way that just going in there 'cold' doesn't. And I think when they're shown the data about the number of cases in the stages, it was a real opportune moment to talk about screening again, particularly bowel screening." *Facilitator 5*

## Quality Improvement

From themes and issues identified in the NCDA, individual GPs and practice teams were able to reflect further on processes and areas of need. While the audit activity itself can help to identify cases for in-depth review and areas for improvement, the bulk of quality improvement activity is planned and carried out after receipt and discussion of the tailored NCDA reports.

### *Usefulness of feedback reports*

Primary care staff who responded to the survey were asked to rate the usefulness of their NCDA report. Twenty-seven respondents (79%) said they had reviewed their report and provided a score between 10 (very useful) and 0 (not useful at all). There were no scores lower than 5 recorded.




Some respondents added further comments about the reports, highlighting features such as the ability to compare and to review information by cancer types.

> "It gave a detailed breakdown of our practice and how it compared to the national picture. This is useful to identify areas for improvement." *Survey Respondent 5*

> "Clearly presented. Broken down into easy chunks. Site specific information helpful." *Survey Respondent 8*

Others felt that, while information was comprehensive, the reports were lengthy and sometimes based on very small numbers at practice level.

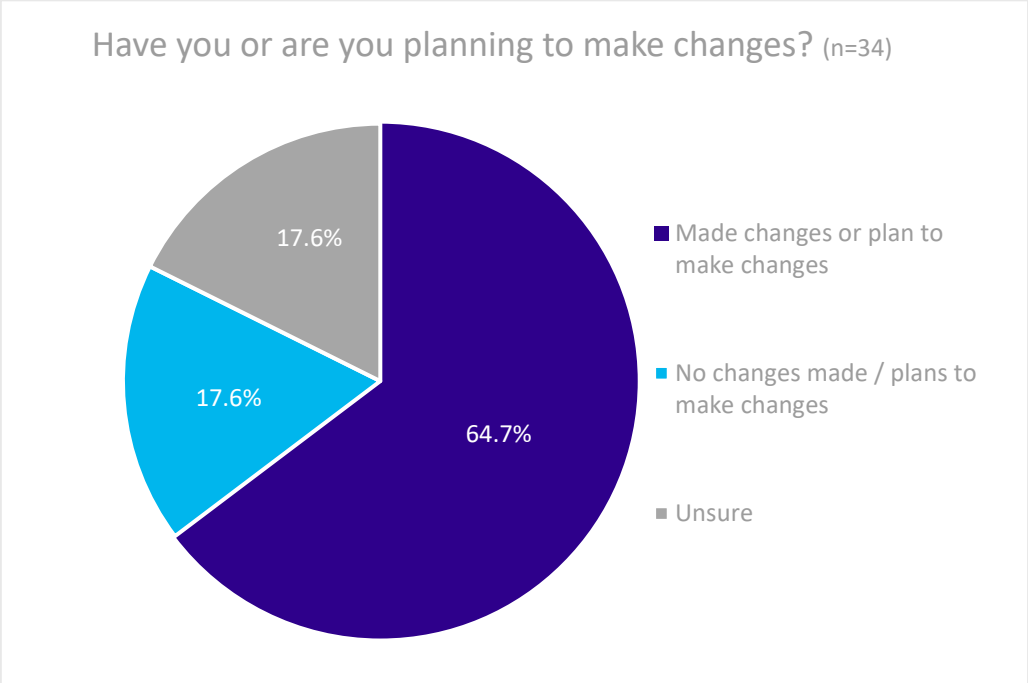
> "Useful information and very comprehensive. I think it is too long and sometimes may lead to 'not seeing the wood for the trees'" *Survey Respondent 26*

> "Helpful statistical breakdown but due to small numbers there are some findings which are probably disproportionate." *Survey Respondent 12*

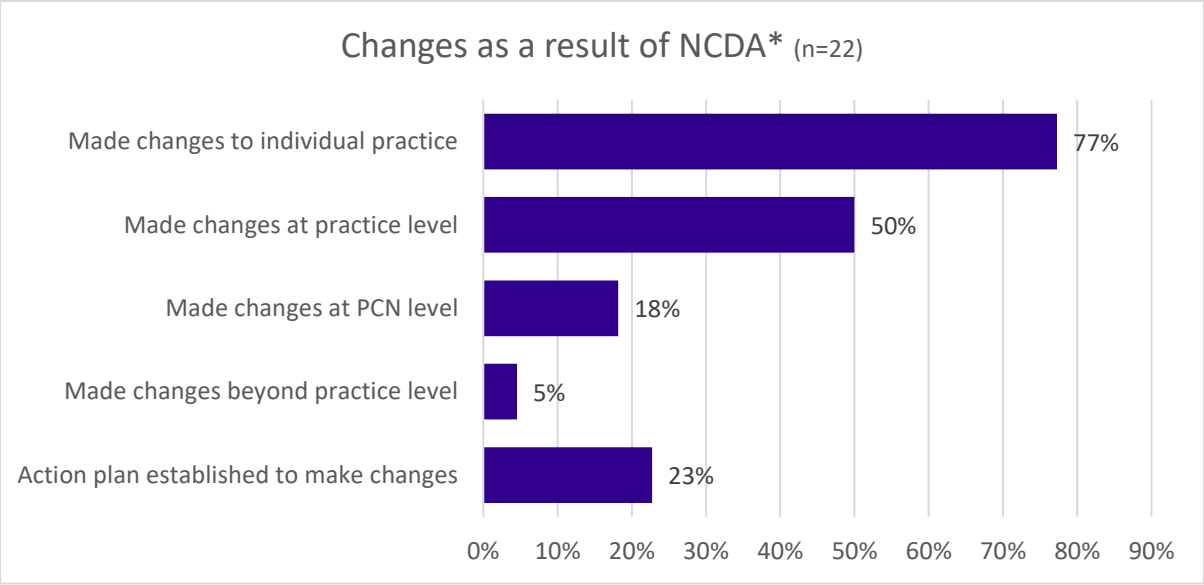
In addition to practice reports, five survey respondents also had received a PCN-level report. In terms of usefulness, PCN reports received two scores of 10, one of 8 and two of 5, similar to the distribution of responses for practice-level reports.

*Changes made and planned*

In the evaluation survey, several respondents reported that they had made changes already as a result of learning from the audit and/or were planning to make changes in future.




Twenty-two respondents (64.7%) said they had either already made changes and/or had plans to make changes based on learning from the NCDA. Of these, 20 had already implemented at least some changes, which included the GP respondent in Wales.




*percentage does not add up to 100% as each respondent was able to select one or more responses

Support from CRUK Facilitators was available for practices to review results. In interviews, some facilitators reflected on visiting practices to discuss NCDA reports and finding that the practice had already gained learning and made changes.

> "The visit itself was really, really positive. In part because the practice was very good at seeing what they did well, which I think is something that is very important to do. But they basically said that they had already made changes, so they're already doing things differently. For instance, they implemented a booking system that was based on clinical need." *Facilitator 3*

One of the cancer leads interviewed explained that their practice had not made changes as a result of the most recent cycle of NCDA, but still felt that they had gained a better understanding and appreciation of patients' pathways to diagnosis.

> "I can't think of anything that we've changed as a result of me doing the NCDA this time around. But what I have gained is that renewed appreciation of the journey to diagnosis. Because that's what really struck me last time. There's so much to appreciate about what's happening around that time. And it's that appreciation of the process until the diagnosis, as opposed to a concrete thing that we have changed as a result." *GP 5*

*Quality Improvement activities*

Based on the themes and areas of need identified from NCDA work, many practices decided to undertake quality improvement work focused on safety netting. Survey as well as interview respondents provided multiple examples of safety netting projects they had either completed as a result of the audit, or were planning to undertake.

> "We have identified a lack of safety netting being documented, so have had a session on this for the whole practice and everyone is now more aware. We are now really working on continuity of care for patients to prevent patients seeing multiple GPs. We are planning on using the Ardens template for documenting safety netting. We have learnt so much from doing the audit." *Survey Respondent 22*

> "Another practice identified that […] they're not safety netting as many patients as the average, so they want to start to look at a safety netting process and ensure that that's more consistent across the practice and that it's documented properly." *Facilitator 4*

> "I'm gonna push a bit harder on looking at bringing in safety netting, particularly for a particular kind of clinical scenario. Probably just abdominal symptoms. There's quite a bit of nervousness about the workload from doing that, but I think the evidence hopefully will support doing it. Everybody who comes in with unexplained abdominal symptoms, safety net [them to be] phoned or texted in a month's time to say: 'Are you better?'" *GP 4*

In interviews, several GPs and facilitators also recalled safety netting activities that had been implemented following the previous cycle of NCDA and described the new protocols that had been put in place to establish better safety netting systems.

> "It turns out that one, possibly two, of our two week wait referrals didn't turn up to their appointments and they were lost to follow up. So, we've now got a safety netting system to make sure that anyone who is being referred has been seen. And if they haven't been, she [admin] leaves them on the list. And if it's more than four weeks, she tells the clinician. So, we've got quite a robust safety netting system now." GP 5

> "I recall when two week wait referrals were sent off, there wasn't necessarily a check in place to make sure that the patient had received their letter and their appointment had gone through. We changed things, so that the secretaries were checking to make sure that patients had received their appointments and that they had attended them as well." GP 2

> "I went for a one to one with the GP and there were some specific learnings she had gotten: Sometimes when patients were going across to tests, she deduced from looking at her audit that sometimes people weren't being told necessarily they were expected to phone up for their results. As a result, she did some major thing across their surgery changing the processes. And when I next went to her practice, in her clinic room on the cupboard door, there was a big sign there, saying 'Don't forget to remind patients to call in for their results' and she'd done something about really raising awareness across all the GPs in the practice." *Facilitator 2*

One facilitator also recalled how she was able to identify an example of good safety netting practice implemented at one practice during an NCDA visit, which she was then able to share with others.

> "We talked about safety netting and I learned on the NCDA visit about the amount of stewardship that practice does for patients. They have dedicated members of staff whose job it is to basically help patients along to do what they haven't done. It's quite a good model actually because they get the trust and get to know the patients and so that kind of admin or non-clinical support for the practice process side of safety netting came out in the visit." *Facilitator 4*

Facilitators also described other examples of activities either planned or implemented as a result of learning from the NCDA, including projects on smoking cessation, referral practice and screening.

> "One practice identified that they had higher than average rates of lung cancer. So, they had a look at smokers and are giving very brief advice for smoking cessation. Another practice has identified that their diagnostic interval was longer than average, so they want to process map their whole referral process to identify where delays can occur." *Facilitator 4*

> "I think we overlook that, even when a practice has a Macmillian GP or a CCG Lead, being able to have that neutrality of CRUK [helps]. You know, they're human. They don't always want to stand up in front of their peers and say: 'Guys, we gotta do better here!'. So, having myself come in and be able to open the door and just have that neutrality… A really clear outcome of that was, that they looked at their bowel screening and then I put in quite a few measures to increase their bowel screening uptake." *Facilitator 5*

### Case Studies

In interviews, some GPs and Facilitators shared detailed reflections on learning from the NCDA and how this had impacted clinical practice and led to quality improvement. Three examples are included as case studies in this section.

## Case Study
### Avoidable Delay & Continuity of Care (GP2)

One of the GPs interviewed recalled a case of substantial avoidable delay identified while undertaking the NCDA, and how learning from this case had informed plans to improve safety netting processes and enhanced efforts to provide continuity of care.

"This lady, in total she had ten consultations with five different GPs. She had ongoing urinary infections and urinary symptoms. When the samples were sent off to the lab, she did need antibiotics and she was treated, but also each time she had a urine dip, there was a trace of blood in it, but everyone just thought that was part of the infection. And, to cut a long story short, she eventually ended up having an ultrasound scan which showed that she had a large pelvic cyst that was suspicious of ovarian cancer. And then she was seen by the gynae team, who confirmed that she did have ovarian cancer. But there was this delay of eight months. So, there's lots of learning. It's multiple consultations, multiple GPs, no one really taking ownership."

"Going forward, what do you think you personally would like to see the practice doing to try and alleviate those issues?"

"We are working on safety netting and we are also waiting for the Arden's cancer safety netting template to come out, so that we can use that in the practice [...]. The other thing is: we do have a usual GP for all our patients, so we're really trying hard to work on continuity of care for patients to see their GP. Obviously, there are emergencies, they can see anyone, but we're really trying to work on our continuity of care.

The hope is, that by going through these SEAs [Significant Event Audits], it reminds clinicians to actually just have a quick look at the patient's previous history. It doesn't take long, but actually it can make all the difference. And it's not just GPs, but involving the whole practice. So, we've got pharmacists, we've got paramedics and they do most of our home visits for us. It's a real multidisciplinary team here, so we're not just focusing on GPs, but focusing on the whole team approach."

## Case Study
### Keeping Cancer Top of Mind (GP6)

One of the GPs interviewed provided an example of how undertaking the NCDA and regular cancer case reviews keep cancer 'at the fore of clinicians' minds', helping to ensure that cancer is considered as a differential diagnosis even in unlikely cases.

"The [NCDA] report was discussed amongst the partners and enabled that 'benchmarking', which was really helpful. And these discussions keep cancer very much at the fore of clinicians' minds.

One really good example was one of our registrars. He had a really very sad case of a late teenager patient who had some bowel symptoms. And the registrar came through, having had these discussions in the months prior to this case, saying "I've got this patient with this particular symptom bundle. It would appear from the recommendations, that I should be referring this patient on a two week wait pathway, but they're only in their late teens. Should I be doing this?" And I said "Yes. Absolutely!" And sadly, that person did indeed have a colorectal cancer.

"I think that was almost a reflection of the learning that's already been gained, in that the guidelines are there for a purpose, that they have the positive predictive value threshold for referral and this patient in their late teens had crossed that percentage."

"And what role would you say having done the NCDA played in this?"

"I would say prior to the discussions we had following on from the [NCDA] reports, it may well have been the case that the doctor concerned might have felt that the patient was too young to be considered for a two week wait referral. But, because we had reviewed the audits and NG12 in more detail, the doctor in training was aware that there was no age limit for that particular collection of symptoms. He just checked with a senior colleague that he was doing the right thing, and indeed he was, and the diagnosis was made."

## Case Study
### Safety Netting (GP6)

One of the GP interviewees described an example, where safety netting processes put in place as a result of learning from the NCDA had resulted in a patient chasing up their appointment and helped identify an issue with a new process in the practice.

"I think following on from 2014 [audit], we had put in a fairly robust safety netting process. For all two week wait referrals, there's a log kept. And where we're doing investigations to rule out a possible cancer diagnosis, a log is kept by one of our administrators as well, so that patients can then be followed up to make sure that the result is being returned. That covers the full pathway: that the referral was made, that the patient attended and that the report has been received and then acted upon."

"And what do you think has been the impact of that? Do you have any examples of where this new approach to safety netting made a difference?"

"There was an interesting one and it shows the challenge with a change of systems. Between the 2014 NCDA and this NCDA audit, we had had a change of our dictation system. There was one patient where the dictation had been done remotely and the clinician had forgotten to put it down as a task [in the system]. The secretaries didn't pick up that this dictation was on file and waiting to be processed, and this only came to light when the patient then phoned in because they had been advised that they would hear about their appointment within a week or so for their two-week Hospital Review. That hadn't happened. And the safety net, the verbal safety netting and the written material that had been given to the patient, then triggered [them to call in].

And then we unravelled it. And it showed that, because of this IT change in the way that we do the referrals, there was a chink in the armour that the clinician concerned wasn't aware of. That showed the value of safety netting and of the different strands of safety netting, and it was the first safety net in terms of the timeline that came into force, which was the patient not getting the appointment time that they were expecting, and they then phoned through to say "I haven't heard from the hospital yet. Should I have done?" And we were then able to see what happened."

## Case Study
### Safety Netting (Facilitator 5)

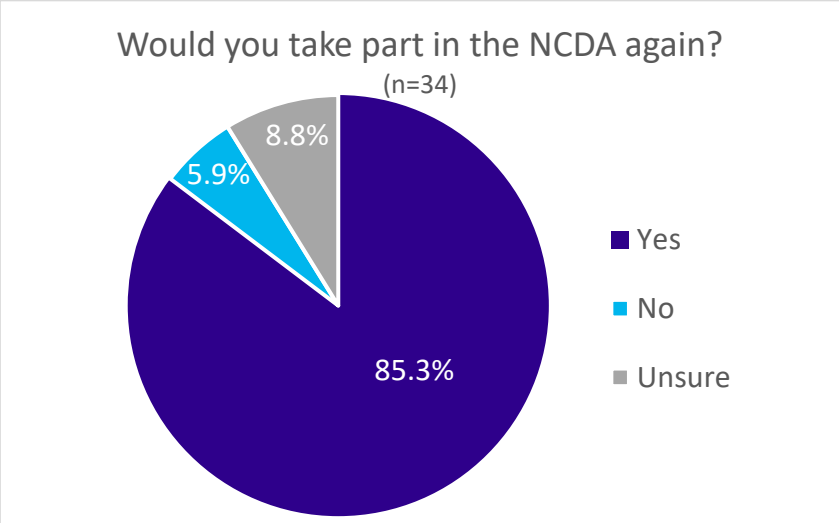
A CRUK Facilitator recalled working with a practice following the first cycle of the NCDA. As a result of the audit, the practice had decided to work on their safety netting processes and the facilitator was aware of this. When a new safety netting template became available, the facilitator described how they were able to make the connection and share the new resource with the practice to support their ongoing commitment to quality safety netting.

"About 15 months ago, I learned of a new safety netting tool, that has been produced by one of the Alliances. So, I was able to go into the practice to say "I think this might be of interest for you". They were interested. But they were a bit reluctant about flying solo on that, so I was then able to use my contacts to get them onto a workshop, which one of the GPs and one of the admin team went to, and they then switched on the safety netting tool.

So, I guess it was a two-way thing, the NCDA [and] my knowing more about their practice's thinking... I thought: "this is what they're looking for". Where it's come into its own in Covid is, they have then been able to say to the CCG lead "we're using this tool and it works really well and it's there in the software system. You just need to switch it on and start using it for tracking patients who had a downgraded referral or whatever." That's kind of come out of the audit still, many years later. I think it got safety netting higher up on their agenda."

## Taking part in future

When asked if they would take part in the NCDA again, 85.3% of survey respondents confirmed that they would. This included the respondent from Wales.




> "I would strongly recommend taking part in the audit as there is an abundance of learning for all, which ultimately benefits our patients." *Survey Respondent 24*

Several interviewees also reflected on the value of future audits, such as the NCDA, and confirmed they would participate again.

> "I think it's a really good thing and really important to keep it going, particularly in the Covid era. I think there's lots of really important stuff that comes out of it. There's so much discussion and it's such a subject across the country, and yet we don't really have a systematic way of collecting data and I think we need to." *GP 4*

> "I would say that the NCDA was a very useful project to be involved in and I would recommend it to any practice in any PCN. We all get up each morning to make a difference and I think doing the NCDA does make a difference to the clinical practice of both the individuals involved, but actually the wider practice and clinical team. I think if there is another iteration of the NCDA the PCN will be right there, keen to volunteer and sign up at the earliest opportunity." *GP 6*

One Cancer Lead interviewed reflected on the need to ensure that practices without cancer leads are involved in the audit in future.

> "I think what we should [be] aiming to do with the NCDA is to reach those practices where there isn't a cancer lead. Maybe their systems could do with looking at from a cancer lead point of view and that's what the NCDA can do for you. It puts you in that frame of mind that we as leads are kind of in all the time. That's why I think it's really useful for people who don't have that interest." *GP 5*

## Wider impact

In addition to practice- and PCN/cluster-level reports, the NCDA produced reports for CCG and Cancer Alliance levels in England, cluster and Health Board levels in Scotland, and Health Board level in Wales. A pan-London report covering more than 14,000 cases was also produced for the Greater London area. These regional reports can help to explore and better understand cancer pathways and to identify areas of need, and may now also act as useful pre-Covid baseline.

As a result of the previous cycle of NCDA, one CCG found that large proportions of patients were being diagnosed through emergency routes, without any prior presentation to the GP. The CCG, as a result, invited the Cancer Research UK Roadshow to several locations in the area to increase public awareness of cancer symptoms and encourage anyone concerned to contact their GP.

Both cycles of the NCDA have also generated large datasets on cancer pathways through primary care, which are available in pseudonymised form to researchers and analysts via PHE and the Office for Data Release[15]. Data from the Scottish audit is additionally made available via the NHS Research Scotland Data Safe Haven[16].

## Publications, Press and Media

### *Academic publications*

From research activity undertaken on the datasets generated in the first cycle of the NCDA, several research papers have been published to date, these are listed in Table 1.

Table 1 – Academic publications from NCDA to August 2021

| Journal and year | Title (linked to paper) | Lead author |
|---|---|---|
| BJGP 2018 | Diagnosing cancer in primary care: results from the National Cancer Diagnosis Audit | Ruth Swann |
| Lancet 2020 | Presenting symptoms of cancer and stage at diagnosis: evidence from a cross-sectional, population-based study | Monica Koo |
| Cancer Epi 2020 | The frequency, nature and impact of GP-assessed avoidable delays in a population-based cohort of cancer patients | Ruth Swann |
| BMJ Open 2020 | Cross-sectional study using primary care and cancer registration data to investigate patients with cancer presenting with non-specific symptoms | Clare Pearson |
| Eur J Cancer Care 2020 | Cancer diagnosis in Scottish primary care: Results from the National Cancer Diagnosis Audit | Peter Murchie |
| Cancer Epi 2020 | Impact of geography on Scottish cancer diagnoses in primary care: Results from a national cancer diagnosis audit | Peter Murchie |

[15] https://www.gov.uk/government/publications/accessing-public-health-england-data (Note: as of 1st September, the ODR approval service is temporarily suspended due to focus on the handover of data applications to the new system (NHS Digital, NHSEI, DHSC and UKHSA))

[16] https://www.nhsresearchscotland.org.uk/research-in-scotland/data/safe-havens

Analysis work is ongoing on the NCDA 2014 dataset as well as the datasets from the latest cycle of NCDA. Further publications are expected in the coming months.

*Press and Media*

The release of the Scottish NCDA Summary on 3rd of August 2021 resulted in press coverage in several outlets across Scotland. Five print articles were published on 4th August, including in The Scotsman, The Scottish Daily Express and The Times, as well as two online stories in The Scotsman and Glasgow Live and a radio interview (GoRadio, a local Glasgow station).

Further coverage of NCDA may be seen when new findings and academic papers are published in future.

## Recommendations

Based on the findings from this impact assessment and wider learning from the NCDA, it is clear that ongoing, regular review of cancer diagnosis in primary care is essential to support reflective practice and drive ongoing quality improvement. GPs, and wider practice teams, felt they had gained value from taking part in the NCDA and reported having made changes to their practice as a result. Eighty-five percent confirmed they would take part again in future.

Carrying out such a data collection at national or UK-wide, rather than practice level, means a more consistent approach to data collection, enables practices to benchmark themselves, supports regional feedback to organisations such as Integrated Care Systems and Health Boards, and generates larger datasets for research. It is therefore recommended that future audits of cancer diagnosis in primary care are carried out in all UK nations, ideally through a partnership approach including key stakeholder organisations to achieve maximum reach, engagement and impact. Adequate support for primary care to engage meaningfully with, and implement learning from, such audits is also vital.

## List of acronyms

| Acronym | | Details |
|---|---|---|
| CCG | - | Clinical Commissioning Group |
| DES | - | Direct Enhances Service Specification (for PCNs) |
| ECDC | - | Early Cancer Diagnostic Centres [Scotland only] |
| FAIRS | - | Facilitator Activity Insights Reporting System |
| LEA | - | Learning Event Analysis (previously SEA) |
| NCDA | - | National Cancer Diagnosis Audit |
| NG12 | - | NICE Guideline 12 (Cancer Recognition and Referral) |
| NHS E/I | - | NHS England/Improvement |
| NICR | - | Northern Ireland Cancer Registry |
| PCN | - | Primary Care Network |
| PHE | - | Public Health England |
| PHS | - | Public Health Scotland |
| PHW | - | Public Health Wales |
| QI | - | Quality Improvement |
| QOF | - | Quality Outcomes Framework |
| RDC | - | Rapid Diagnostic Centre [England and Wales only] |
| SEA | - | Significant Event Analysis |
| SRG | - | Scottish Cancer Referral Guidelines |
| TCST | - | Transforming Cancer Services London |

**Appendix 1a**

# National Cancer Diagnosis Audit

## Participation and Funding by Clinical Commissioning Group (CCG)[1]

The National Cancer Diagnosis Audit (NCDA) gathered primary and secondary care data for patients diagnosed with cancer in 2018 to better understand patient pathways to diagnosis and, ultimately, improve clinical care and early diagnosis of cancer.

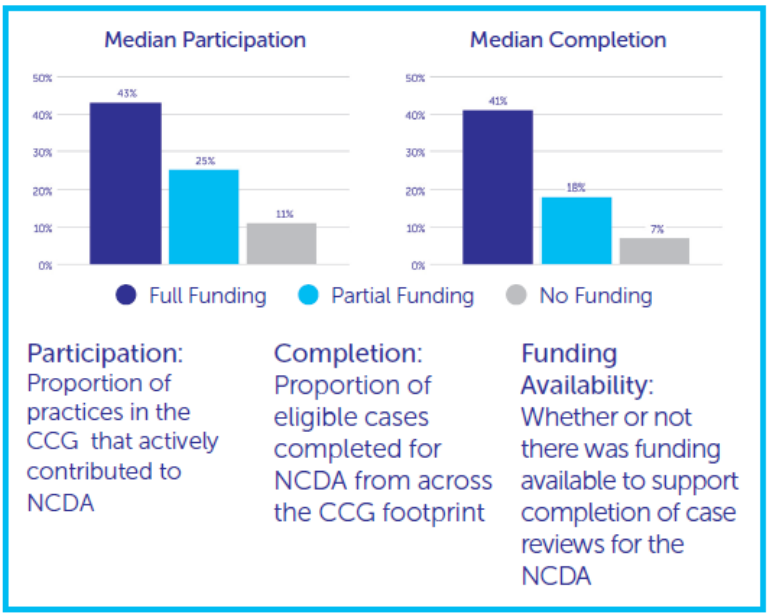
1,879 GP practices from across England submitted data to the NCDA.

Participation was not mandatory but could support work for the GP contract and Primary Care Network specification FY20-21.

Some areas offered funding schemes to support participation in the audit.[2]

Notes:

1. CCG footprints and number of practices in CCG as of 2019/20 (https://fingertips.phe.org.uk/profile/cancerservices)
2. Funding offers varied, incl. one-off payments for registration, incentives for completion to certain thresholds, and/or inclusion in local Quality Accounts or other broader schemes; in some areas funding pots were restricted and not accessible to all practices locally




**Participation:** Proportion of practices in the CCG that actively contributed to NCDA

**Completion:** Proportion of eligible cases completed for NCDA from across the CCG footprint

**Funding Availability:** Whether or not there was funding available to support completion of case reviews for the NCDA

**Caveat:** In addition to availability of funding, participation and completion levels may be affected by numerous other factors, such as size of the CCG, local priorities, local communication about the audit, impact of the Covid-19 pandemic etc.

**Source:** National Cancer Diagnosis Audit 2018, Public Health England and Cancer Research UK September 2020

**Acknowledgement:** The NCDA in England is delivered in partnership with Cancer Research UK, Public Health England, NHS England, the Royal College of General Practitioners and Macmillan Cancer Support

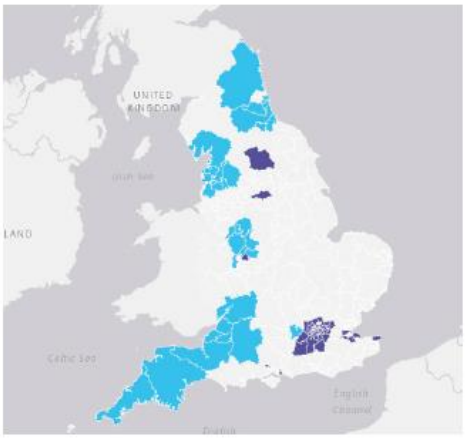
cruk.org/ncda
Together we will beat cancer

CANCER RESEARCH UK

## Appendix 1b

### Funding map

No funding
Partial funding
Full funding



**No funding:**

- 120 CCG areas had no funding linked to NCDA
- Practice participation: **median 11% (range 3% to 80%)**
- Overall completion across CCG: **median 7% (range 0% to 80%)**

**Partial funding:**

- 28 CCG areas had partial funding for NCDA, e.g. one-off payment for registration; or funding as part of a wider incentive scheme for cancer not exclusive
- Practice participation: **median 25% (range 5% to 96%)**
- Overall completion across CCG: **median 18% (range 1% to 96%)**

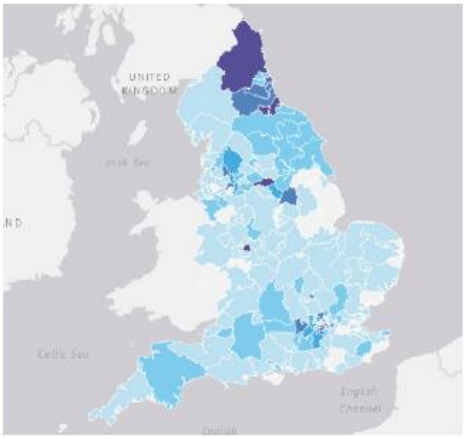
**Full funding:**

- 43 CCG areas had a full funding offer for NCDA, covering registration and completion of audits to meaningful thresholds (>80%)
- Practice participation: **median 43% (range 2% to 97%)**
- Overall completion across CCG: **median 41% (range 1% to 92%)**

### Participation map

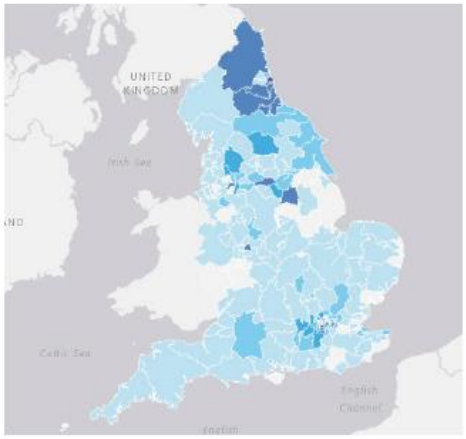
% of practices in CCG that actively contributed to NCDA

0%
1-24%
25-49%
50-69%
70-94%
95+%



### Completion map

% of eligible cases completed for NCDA from across the CCG footprint



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