

# **Safety netting to improve early cancer diagnosis in primary care: development of consensus guidelines.**

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## Summary

Diagnosis of cancer in primary care remains difficult due to the relative infrequency of cancer whereas symptoms are common and often nonspecific. Safety netting is a consultation technique used to ensure the timely re-appraisal of a patient's problem. Whilst the term safety netting is understood by many in clinical practice specific recommendations of what exactly to do have been lacking. This report identifies and prioritises the different components of safety netting in relation to cancer diagnosis in primary care. Our final list includes high and intermediate priority recommendations. These include 1) specific actions to be communicated to patients; 2) actions that GPs should take during or shortly after the consultation 3) procedures that should be implemented at the Practice level. The provision of recommendations for GP consultations and for practices as whole should allow better understanding of the actual components of safety netting enabling improvements to delays in cancer diagnoses.

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## Background

There are approximately 300,000 new cases of cancer each year in the UK, <sup>1</sup> with one in three people developing cancer at some point in their lifetime. Coupled with an ageing population, the numbers of patients diagnosed are set to increase year on year. <sup>2</sup> *Improving Outcomes: A Strategy for Cancer*, published in January 2011 <sup>3</sup>, noted that, “despite improvements in survival and mortality in recent decades, cancer outcomes in England remain poor when compared with the best outcomes in Europe” and set out the Government’s ambition to save an additional 5,000 lives every year by 2014/15. The strategy highlighted the importance of achieving earlier diagnosis of cancer, stating that “diagnosis of cancer at a later stage is generally agreed to be the single most important reason for the lower survival rates in England”. <sup>3</sup>

The National Awareness and Early Diagnosis Initiative (NAEDI) is a partnership between the Department of Health, National Cancer Action Team, and Cancer Research UK <sup>4</sup>. Launched in 2008, NAEDI aims to coordinate and provide support for activities and research that promote the earlier diagnosis of cancer by encouraging early presentation by patients and the public, optimising clinical practice and systems, improving access to diagnostic tests and supporting research, as well as evaluation and monitoring. As part of the NAEDI programme, a secondary analysis of Significant Event Audits (SEAs) of cancer diagnoses in teenagers, young adults, and patients with lung cancer was undertaken. This found that the majority of cases were appropriately recognised and referred, but that there were also opportunities for earlier diagnosis. The report made a series of recommendations, which included several on the use of safety netting. <sup>5</sup>

The National Cancer Intelligence Network (NCIN) recently reported that nearly one in four (23%) newly diagnosed cancer patients were diagnosed after emergency presentation at hospital. Patients who present as an emergency presentation have much lower survival rates than those diagnosed through other routes, strongly suggesting there is room to improve the early diagnosis of cancer in the UK. <sup>6</sup>

NAEDI Workstream 2, ‘optimising clinical practice and systems’, aims to overcome clinical and system barriers to promote referral of suspected cancer cases from primary to secondary care. <sup>4</sup> General practitioners (GPs) face several hurdles in making timely diagnosis of cancer. Firstly, a GP sees on average only eight or nine

new cases of cancer (of all types) a year <sup>3</sup> among thousands of consultations each year. <sup>7</sup> This low incidence means cancer is not always high on the list of differential diagnoses. Secondly, patients with cancer may present with non-specific clinical features, particularly when they are in the early stages of malignancy, and therefore may be indistinguishable clinically from other more common conditions. Often a combination of more than one symptom alongside patient characteristics raises the likelihood of malignancy. <sup>5, 8-12</sup> This increases the complexity of decision making as not all salient features indicating cancer will be present at the initial consultation. Thirdly, even in clinical situations in which a GP suspects cancer, there may be delays at multiple levels (the patient, GP, practice, referral system, secondary care etc) in not only arranging the most appropriate diagnostic investigation but also obtaining results and taking appropriate actions.

Despite these challenges, primary care in the UK has several core strengths which can potentially mitigate these challenges. One of these is the ability to follow up patients over a period of time. This provides opportunities for repeated clinical assessment to gather further clinical information, additional diagnostic testing where appropriate, as well as time for self-limiting conditions to resolve. Within this longitudinal relationship, one of the key diagnostic tools that GPs employ is safety netting.

The term 'safety netting' was introduced to general practice by Roger Neighbour who considered it a core component of the GP consultation <sup>13</sup>. He defined safety netting from the GP perspective as encompassing three questions:

1. If I'm right what do I expect to happen?
2. How will I know if I'm wrong?
3. What would I do then?

Neighbour's seminal work has been cited repeatedly, particularly among GP educators in the UK, as one of the core components of good consultation skills. However, there have been surprisingly few formal attempts in the academic literature to either document its value or further define its key characteristics.

In many respects the diagnostic difficulties that clinicians experience in diagnosing cancer, mirror those faced by GPs (and parents) in the diagnosis of an unwell child,

namely the low incidence of serious illness, varied time course of presentation, and initial non specific clinical features. Each child is seen approximately 3 times per year<sup>14</sup>, yet serious infections (ie those that need immediate treatment and/or referral) occur in less than 1 in 100<sup>15</sup>. Moreover, a UK-wide study of meningococcal disease, found that just over half of the children were identified by a GP at their initial consultation.<sup>16</sup> In order to better understand the components of safety netting, we used a Delphi approach<sup>17</sup> to gather consensus of GPs and Paediatricians about the main elements of safety netting for children with acute illness. The Delphi consensus found safety netting should include: 1) Communicating the existence of uncertainty; 2) Outlining what clinical features to look out for; 3) How exactly to seek further help, and 4) What to expect about time course of the condition, for example when an improvement in symptoms is likely to occur and when it is expected that symptoms have resolved completely.

An audit by a Cancer Network<sup>18</sup> highlighted for the value of safety netting in diagnostic decision making surrounding cancer in general practice. For instance, one of the key messages was that mechanisms should be in place to follow-up, manage and refer non-resolving symptoms. Currently, there is no formal consensus about what the elements of safety netting in primary care for cancer diagnoses are, or the optimal use of these strategies.

## **Aim**

The aim of this study is to identify and prioritise the different components of safety netting in relation to cancer diagnosis in primary care.

## Methods

### *Literature review*

We conducted a scoping search of the literature (11/1/11) in order to identify publications relevant to safety netting for cancer, which we then used to develop the initial Delphi statements. An initial PubMed search which included terms for cancer, diagnosis, delay/referral and primary care/general practice with no restriction on study type, identified a large number of references. Adding the specific term 'safety net\*' to this list yielded no results. Therefore we focused our search using a combination of MeSH terms and cancer terms within the title:

**#1: early detection of cancer[MeSH Terms]**

**#2: (((delay[Title]) OR symptom[Title]) OR symptoms[Title]) OR diagnosis[Title]) OR diagnosing[Title]**

**#3: (((cancer[Title]) OR malignancy[Title]) OR malignant[Title]) OR tumour[Title]) OR tumor[Title]**

**#4: #1 OR #3**

**#5: #4 AND #2**

**#6: (general practice) OR primary care**

**#7: #5 AND #6**

We also searched several different sources (websites, databases) to identify the grey literature relating to safety netting in general and in particular the practices associated with cancer. The following sources were searched:

- Dh.gov.uk
- Trip Database
- NHS Evidence
- Directgov
- National Patient Safety Agency
- NAEDI Workstream 1
- NAEDI Workstream 2
- National Cancer Action Team
- NCIN
- Google

### ***Data extraction***

We reviewed papers, reports and websites to extract information regarding safety netting in general and its role in primary care consultations. Specific issues relating to improving diagnosis and referral for cancer were mainly identified using reports of audits and significant event analyses. The information obtained from these sources was used to develop the statements for the initial version of a Delphi questionnaire.

### ***Delphi methods***

We used a modified Delphi approach <sup>19</sup>, which is an objective process that gathers consensus opinion from a panel of experts through an iterative questionnaire process interspersed with controlled opinion feedback, to seek consensus regarding how safety netting for cancer could be incorporated into primary care. This method has been used extensively in developing criteria frameworks <sup>20;21</sup>, and has been used by the authors for several publications <sup>17;22</sup>.

The modified Delphi approach used a two-stage process where participants were asked to respond to two rounds of questionnaires. Questionnaires in both rounds were distributed and returned by email. Up to two reminders were sent to non-responders.

### ***Sample***

Delphi methods generally involve panels of 10 to 50 members and experts who are anonymous, in that other panel members do not know their identity at the time of data collection. We aimed to include participants from the following groups: primary care cancer experts; GP cancer leads from the 28 local cancer networks; and GPs who are not cancer leads (to be identified by each of the cancer leads). We anticipated that participants would represent a range of experience as measured by years in current role. We chose to include primary care practitioners and researchers of cancer in primary care, in order to specifically address the perspectives that are faced at the patient/primary care physician interface, and to explore factors associated with cancer diagnosis in primary care. Secondary care and specialist services perspectives were not addressed. In addition, we did not attempt to investigate patient perspectives associated with cancer safety netting in primary care.

Potential participants were identified from two sources: GP Cancer Leads were approached by the National Lead of the National Cancer Action Team (KE) (n = 37); and academic clinical and non-clinical experts in cancer diagnosis in primary care were contacted by a researcher with 15 years experience in the field (CB) (n = 17). In total we approached 54 people to participate in the process. All participants were sent a certificate that documented their participation in this activity, which they were able to use as part of their continuing education or revalidation portfolio.

Ethical approval was not required for this study.

### ***First round questionnaire***

The first round questionnaire was developed using experience from our cancer diagnosis work (references), our work in safety netting applied to infections in children (Almond ref) and a scoping review of the published scientific and 'grey' literature relevant to cancer (see section on literature search). The core team (CB, CH, PH, MT) met initially to brainstorm a series of statements relating to potential actions that could be incorporated into safety netting guidance for cancer. These statements were then circulated a number of times to a wider group of GPs (RC, DM, JMV) for refinement before being sent to the Delphi participants.

The statements regarding safety netting appeared to fall into two broad categories: the first focused on actions that an individual GP could take; and the second related to actions which could potentially be implemented at a Practice level. Therefore the questionnaire was divided into two sections, reflecting this natural division. The actions were presented as a series of statements with the key words underlined for emphasis. The survey included 14 items about GP actions and 14 items pertaining to the practice. Participants were asked to rate their level of agreement with the developed statements on a seven-point Likert scale (where 1 indicates low agreement and 7 indicates high agreement). Open-ended comments were invited for each item. (see Appendix One).

### ***Analysis and prioritisation of responses***

Numbers and proportions of respondents for each question were calculated. The 7-point Likert scale was then split into three categories: 1 to 2 = disagreement; 3 to 5 = no agree/disagreement; 6 to 7 = agreement.

Responses to the first questionnaire were categorised into three priority groups based on the level of consensus for each statement. The three categories were: High Priority where 80% or more of the respondents ranked the statement as 6 or 7 on the scale of agreement; Intermediate Priority where 50 to 79% of respondents ranked the statement as 6 or 7; and No Consensus where fewer than 50% of respondents ranked the statement as 6 or 7 on the scale of agreement.

### ***Second round questionnaire***

All respondents to the first round were sent a second round questionnaire by email. The questionnaire in the second round presented the statements in their priority groups (High, Intermediate, or No Consensus) and participants were asked to indicate whether they agreed or disagreed with the placement of each statement into its respective priority group. Where they disagreed, they were asked to suggest which category the statement should be moved into, and clarifying comments were sought. In addition, a brief summary of the comments made during the first round were provided, particularly where statements required modification (see Appendix Two).

### ***Analysis of responses***

Analysis of the questionnaire involved descriptive analysis of the proportions who agreed with the positioning of the statement within the three levels of priority groups. Where agreement between participants exceeded 90%, the prioritisation of the statement was deemed to have reached consensus. Where fewer than 60% of participants agreed with the suggested priority level, the qualifying comments were examined in order to determine whether this should apply in all situations, or only in particular conditions or circumstances.

### ***Final consensus recommendations***

Based on the two Delphi rounds, we developed a final list of statements related to safety netting. This included all the high and intermediate priority statements.

## Results

### *Literature review*

The PubMed search identified 558 articles, of which 226 titles and/or abstracts were potentially relevant. Of these, 82 were related to delays or diagnostic difficulties, consultation patterns or symptom recognition in primary care related to patients with cancer. The grey literature search yielded a further 16 unique references relevant to safety netting for cancer in primary care as shown in Table 1. The majority of these were reports from NCIN and NAEDI.

**Table 1. Details and results of the ‘grey literature’ search for safety netting literature**

Source searched	Date searched	Terms used	Retrieved	Useful	Unique and useful
Dh.gov.uk	15/12/2010	Safety net* within this result	37	0	0
Trip Database	5/01/2011	“safety netting”	3	1	1 <sup>23</sup>
NHS Evidence	15/12/2010	Cancer & safety net*	3	0	0
Direct.gov	15/12/2010	Cancer & safety net*	0	0	0
National Patient Safety Agency	15/12/2010	Cancer & safety net*	3	1	1 <sup>24</sup>
NAEDI Workstream 1	15/12/2010		4	3	3 <sup>5, 18, 25</sup>
NAEDI Workstream 2	4/1/2011		4	2	0
National Cancer Action Team	4/1/2011		0	0	0
NCIN	15/12/2010		2	1	1 <sup>6</sup>
Google	05/01/2011	“safety netting” and Primary Care	many	many	10 <sup>26–35</sup>
<b>Total</b>					<b>16</b>

### ***Safety netting - general publications***

Safety netting from the GP perspective was originally defined by Neighbour as encompassing three questions<sup>13</sup>, namely: 1) If I'm right what do I expect to happen? 2) How will I know if I'm wrong?, and 3) What would I do then?

A more recent model for primary care consultations, the Calgary Cambridge model, also recommends that safety netting should be included at the end of the consultation and include the following features:<sup>32</sup>

- Summarizing the likely symptoms which may be experienced
- Providing realistic time frames for symptom resolution
- Explain uncertainty associated with the diagnosis (or non-diagnosis)

- Give information on potential ‘alarm symptoms’ and advice regarding when and where to consult in that event (consider written information)
- Suggest a time–frame for follow-up

We also identified several issues relating to communicating safety netting with patients:

- Providing the patient with information on what to expect and what to do if they do not improve <sup>24</sup>
- Acknowledging that things may not turn out as planned, and ensure that the patient knows what to do should this happen <sup>28</sup>
- Ensuring there is a contingency plan for the worst case scenario <sup>27</sup>

The Delphi consensus on safety netting for children with acute illness <sup>17</sup> identified four elements of safety netting:

- The existence of uncertainty and communication of this with the parent
- What specific clinical features parents should look out for
- How and where to seek further help if needed
- What to expect about the time course of the illness.

It also recommended that safety net advice should be recorded in the medical notes, but found no consensus regarding the whether safety netting advice should be given in verbal or written format.

For out-of-hours telephone consultations, one study recommended that safety netting advice should be limited to two items. <sup>31</sup> However, within these they suggested communicating several points, namely 1) Specific reasons to call back - additional symptoms developing, changing severity of existing symptoms, taking longer than expected to recover, and 2) Provide specific action to take (e.g. call back, or go to hospital).

### ***Safety netting - cancer specific publications***

The majority of literature regarding cancer-specific safety netting was found in audits or significant event analyses (SEA) <sup>5,18,24,25,34</sup>. We identified five themes related to cancer safety netting from this literature:

- 1) Recognition of possible cancer based on symptoms
- 2) Reassessing patients where necessary

- 3) Referral for suspected cancer and guidelines for referral
- 4) Issues related to the GP practice
- 5) Particular types of patient/situations.

**1) Recognition of possible cancer based on symptoms:**

- The difficulties of separating cancer symptoms from the symptoms of benign disease.
- The difficulties that can be caused by attributing new symptoms to pre-existing medical conditions, for example cough in people with COPD.
- Presentation with unusual or vague symptoms which can lead to more lengthy diagnostic pathways for cancer.
- False reassurance from common symptoms such as cough, constipation or sore throat; there is a need to maintain suspicion in cases where symptoms do not resolve or worsen.

**2) Reassessing patients where necessary**

- The false reassurance of a negative physical examination, and if symptoms persist the need to review the case and re-examine a patient, especially if the initial examination was done by someone-else.
- Being prepared to challenge a previously made diagnosis.
- Ensuring that patients follow up when clinical features persist.

**3) Referral for suspected cancer and guidelines for referral**

- Situations where GPs had poor knowledge of the National Institute for Health and Clinical Excellence (NICE) referral guidelines, or chose to ignore them.
- Problems with locum Doctors and GP registrars in following NICE referral guidelines.
- Considering referral even when patients do not fit the NICE referral guidelines, for example patients the GP is worried about.

**4) Particular types of patient/situations**

- Some patients may downplay the significance of their symptoms, such as those who rarely attend the practice, those who are stoical or uncomplaining, or who dislike doctors.
- Certain groups of patients (e.g. alcoholics or drug users) may present late, or not attend their appointments, therefore need to be chased up.

- An awareness that rare cancers still do occur, such as cancer in young patients.
- The difficulties in diagnosing skin cancers.
- Frequent attenders where there is a suspicion from the clinician's viewpoint of disproportionate patient concern about seemingly minor symptoms, somatisation regarding physical symptoms, or malingering.

#### **5) Issues related to the GP practice:**

- The lack of "safety netting" processes in some practices, for example: follow up of patients with unexplained symptoms, follow up of abnormal test results and ensuring that 2 week referrals are received by the local hospital.
- Failing to review patients because they are already under the care of a consultant or waiting for a hospital appointment.
- False reassurance from negative results of investigations, for example relying on a negative X-Ray report may prove to be erroneous. There should be a low threshold for repeating investigations if necessary.

## ***Delphi method***

### ***The content of the First Round Questionnaire***

We identified and included 28 items relating to cancer safety netting in the first Delphi questionnaire. This was then subjected to several iterations involving the research team and GPs, and refined to produce the statements for the first Delphi questionnaire (Appendix One). The items were grouped into two themes:

- 1) Actions to be undertaken by the GPs
- 2) Actions to be undertaken by the practice.

The first questionnaire was sent to a total of 54 participants on 26/01/2011: 37 identified by the NCAT and 17 academics specialising in primary care cancer diagnosis. We received responses from 43 of these (79.6%), with a higher response rate from the NCAT contacts (86.5%) than the academic sample (64.7%). The number and years in role of participants are shown in Table 2.

**Table 2. Description of Delphi participants**

Work place setting	Number	Time in role	Number
Primary Health Care	30	< 1 year	0
Academia	7	1- 5 years	2
Primary Health Care & Academia	5	6-10 years	8
Medical Education	1	11-15 years	7
		16-20 years	10
		> 20 years	16

### ***Results from the First Round Questionnaire***

The output from the first round questionnaire was used to categorise each statement into one of three categories: high, intermediate or no consensus. Although we obtained 43 responses in total, one was received too late to be included in the analysis. Therefore, the results are based on a sample of 42 respondents. Most participants commented on one or more of the statements and the comments were collated and analysed to identify key themes emerging from the data.

#### **1) GP actions**

Seven of the fourteen items relating to GP actions were initially coded as High Priority. A further six were identified as being Intermediate Priority, and there was no consensus for one statement. Prioritisation of the statements related to GP actions is shown in Appendix Three. There was universal consensus that GPs should keep up to date about cancer referral guidelines, although respondents noted that this is time consuming and could be difficult to achieve in practice.

The participants who commented about ensuring patients understand who is responsible for making a further appointment were evenly divided between those who felt the responsibility should lie with the patient, and those who reported that they would book the appointment themselves if they were particularly concerned. Related to this point was whether patients should be advised when and how to re-consult. A typical comment was *“Many patients do not want to ‘bother the doctor’ with what they feel may be trivial complaints – it is important for health professionals to give clear advice about how and when to re-present if symptoms are not resolving”*.

Providing a likely time course for the resolution of symptoms was felt to be good clinical practice for all GP consultations, whether or not a cancer diagnosis was

considered. This could avoid unnecessary re-attendances and encourage appropriate return by patients with unresolved or suspicious symptoms. However, participants commented that this depends entirely on what the presenting symptom is (e.g. cough, change in bowel habits), and would be different for different symptoms.

The participants who commented about the statement, 'The GP should ensure that the patient understands the safety netting advice' highlighted it as good consultation practice: "*Checking understanding is again part of the standard recommended good clinical practice*". How this is achieved in the context of a consultation can prove difficult: "*People can hear but not listen, despite your best efforts!*" It was suggested the GP should 'check' the patient understands the safety netting advice. One suggested strategy was to ask the patient to repeat back what has been said. In patients with language or literacy barriers, assessing understanding was also deemed to be crucial, but time, funding and availability of translators and literature were raised as problems to achieve this.

Many participants commented about documenting safety net advice in the medical notes and felt it was important from a medico-legal perspective. They also mentioned this could aid continuity of care "*I think this is vital for future [physicians] to realise what has been discussed and said, and is important medico legally*" and "*I try to outline a 'plan' – i.e. what to do if patient returns so other doctors in the surgery know what's going on. This may include advice given to the patient but not by any means always*".

Provision of specific warning signs for cancer was ranked as an intermediate priority by the respondents. Most frequently, the comments talked about balancing the need for information with minimizing anxiety: "*Yes, if appropriate and depending on the exact circumstances. The benefits need to be measured against the disadvantages especially in raising unnecessary anxiety in the 'worried well'.*" Mentioning cancer was recognised as having the potential for causing alarm. Ruling out serious conditions, without mentioning cancer may be an appropriate course of action: "*I think patients should perhaps be told they [the symptoms] may or may not signify something more serious and it is important to come back so anything serious can be ruled out – not sure cancer specifically should be mentioned as symptoms are so non specific and could create lots of anxiety*".

Explaining reasons for ordering tests was rated as intermediate priority, and many respondents commented that it depends on the test, the patient and what disease is being considered. *“We often run general blood screens...for example, so we may just explain this (it’s a blood test) and not explain every individual test and possible diagnosis (all tests that will be performed by the blood test)”*.

If the GP is considering ruling out cancer, then it was felt that this should be communicated to the patient: *“If the reason we are ordering investigations is to try and exclude a diagnosis of cancer it is important that the patient is aware of this - there may be instances where this is not appropriate – patients with high levels of anxiety – but GPs are in a good position and often know their patient well enough to be able to gauge how much information is necessary and how much might be damaging”*

However, if a cancer diagnosis is very unlikely, with low pre-test probabilities due to a normal clinical exam then explaining that the test can be associated with cancer is dependent on whether the patient has mentioned the disease: *“For example if a woman has bloating but is well and abdomen exam normal – I may say we will do a blood test and scan to exclude any ovarian disease and that is routine if a woman has bloating. I would not say this is to rule out ovarian cancer. If a woman had come and said ‘I have bloating – I am concerned about ovarian cancer’ then I would discuss the pros and cons of the test”*.

The issue of how to handle repeated consultations for the same, unexplained symptom lead to the general rule of *“three strikes and you are referred is a good starting point”*. However, consultation with other colleagues, not necessarily referral, could also be considered.

Repeating tests that have previously been normal was accepted as an action of intermediate priority. However, false negative chest X-rays were mentioned several times and respondents reported that it would depend on the test and condition. If this was to be recommended, each test’s accuracy should be considered and also the interval since the previous negative results.

A surprising finding was the lack of consensus about ‘making appointments in advance when there is diagnostic uncertainty’. Some participants reported this was

usual practice for them, others said they would in an ideal world, to avoid the 'not wanting to bother the doctor' situation, but others said it is a waste of appointments.

## 2) Practice actions

Six of the 14 items relating to Practice actions were coded as High Priority. A further five were identified as being of Intermediate Priority, and there was no consensus about three statements. Prioritisation of the statements related to Practice actions are shown in Appendix Four.

Giving patients choice about how they may receive their results was felt to be too much of an operational challenge, with too many options and therefore the potential to lose track of ensuring that results are communicated to patients.

There was strong consensus that practices should have procedures in place to ensure that patients are aware of how to obtain results of investigations. In one case, a respondent commented that it was currently an area for discussion in their practice as *“radiology results (even those organised by secondary care) are now being sent out to us as our responsibility to pass onto patients – under the tick box heading – ‘GP to inform patient’”*

Respondents agreed that practice systems for documenting that all results have been viewed, and acted upon appropriately was a high priority, but not just for safety netting processes, but as part of good medical practice. It was reported that this is already done in many practices *“Clinical staff in our practice see all results either in the post or via the computer lab link and decide on action. Non-clinical staff are never involved in these decisions and receive written (computerised) practice notes (which have an audit trail) asking them to contact patients and to record the outcome of successful or unsuccessful attempts to contact the patient.”*

Respondents felt that it was important that practices should ensure that current contact details are available for patients undergoing tests/investigations or referrals, but is easily forgotten. From the free text comments it appears that there are currently at least three ways in which this is being incorporated into good medical practice: i) prompts for patients in the surgery *“This is difficult to remember to do at the time of arranging tests but a notice in the waiting room and on the website reminding patients to keep their contact details updated helps”*; ii) computerised

systems *“Very important and easily forgotten or overlooked. Can produce a lot of work and anxiety later trying to track down patients. Choose and Book referrals now include a pop up reminder to check that patient details are correct”* and, iii) routinely checking details when an appointment is made *“We have a policy of when any patient books a routine appointment of reception staff checking their mobile number since these are changed frequently”*.

There was strong consensus for agreeing that tests/investigations ordered by locums should be followed up. However, respondents agreed that patients and their private health care providers are responsible for tests conducted in private health care settings. *“There should be a mechanism for following up all results organised by the practice including locums – this is a system issue. However, tests arranged at private clinics are the responsibility of the clinician who organised them and the patient”*. This statement was therefore modified for the Second Round to only focus on tests/investigations instigated by locums. No other statements were modified.

A practice system for communicating abnormal test results to patients was widely accepted as high priority, but incorporating a failsafe default of the patient being asked to contact the surgery if they have not heard their results.

Consensus was achieved over 5 statements that were ranked as intermediate priority. The item on conducting a significant event analysis for delayed diagnoses of cancer raised several issues. It is a powerful learning tool *“This is a powerful learning tool and can be carried out annually quite easily by most practices”*. There was mixed opinion on whether SEAs should be conducted on all cancer diagnoses in order to exemplify good practice *“Significant events are not just those that are problematic; they should also demonstrate excellent practice too as others can learn from them”*, and also to avoid implying blame associated with ‘delay’ *“Delay is a loaded term, implying blame. It might be better to do a SEA on all cancer diagnoses”*. Conversely, some respondents mentioned time pressures as a limit to conducting significant event analyses *“Would be helpful, but we cannot do for cancer, MI, psychiatric illness etc. Which ones should we do?”*

There was stronger agreement that Significant Event Analyses, compared to Audits, would be useful as a learning tool and to prevent future diagnostic delays *“Lots of*

*other things to audit. Significant event analysis of late diagnosis is probably more useful and time efficient”.*

Documentation of repeated consultations for unexplained recurrent symptoms was categorised as of intermediate priority, but was felt to be important particularly in large practices where continuity of care can be a problem, *“A tricky area - often repeat consultations for unexplained symptoms go unnoticed, the systematic procedure of audit maybe the best approach”, “Given the issues that we have with continuity of care good record keeping is essential”* The mechanism of how to do this was cited as being difficult *“I think this is a very important issue which is often done very badly and is not supported by the system we use where it is quite difficult to bring together all recent consultation notes for a particular problem in order to review: particularly critical in a large practice like mine with a number of part time doctors where continuity is often a problem, and different doctors have varying approaches to coding”.*

Practice participation in cancer awareness campaigns was rated as being of intermediate priority. This is reflected in the types of comments received regarding this item which ranged from overwhelmingly positive, *“Essential part of our role” and “Clinicians can clearly add considerable weight and significance to awareness campaigns by supporting a reinforcing the messages”*, through positive, with provisos: *“Provided they are well thought through evidence based campaigns where potentially adverse effects awareness raising have been carefully considered”* to equivocal: *“Practices and their demographics vary enormously and should determine their own priorities depending on patient need” and “If they can: there are many other pulls on their time and patience!”*

Despite the item regarding non-clinical staff needing to be aware of reasons for urgent referral under the 2 week wait reaching an intermediate level of priority; most of the additional comments were negative regarding this aspect. It was reported that this is a clinical issue and is likely to be an inappropriate responsibility for non-clinical staff.

### ***Circulation of Second Round Questionnaire***

Questionnaire 2 (Appendix Two) was circulated on 07/03/2011. Responses were received from 91% (39/43) of participants in the 1st round. Participants were asked whether they agreed with the placement of each statement into one of the three priority categories. If participants did not agree with the suggested priority level they were asked to upgrade or downgrade the statement.

### **Results from the Second Round Questionnaire: GP actions**

Levels of agreement with each statement regarding the actions the GPs may take are shown in Appendix Five.

Consensus agreement was reached for all seven GP-based criteria that were suggested as high priority. However, respondents disagreed with the priority level of two statements that had been categorised as Intermediate from the 1st Round, and recommended they should be classified as High Priority. These two statements are coloured peach in Appendix Five and were: ‘Safety net advice should include specific warning symptoms and signs of cancer that patients should know about’ and ‘GPs should consider referral after repeated consultations for the same symptom where the diagnosis is uncertain.’

The statement ‘GPs should consider referral after repeated consultations for the same symptom where the diagnosis is uncertain’ was presented in the second round as an intermediate priority. However the statement was upgraded to High Priority based on strong participant responses such as: *“I think this needs to be high priority. The work we did on the analysis of SEAs demonstrated this is an issue. Although what I don’t know is how often repeated symptoms result in no significant diagnosis.”* *“the patient should be admitted to hospital if they have consulted acutely for the same thing 3 times”*.

The second statement that respondents suggested raising from intermediate to high priority was ‘Safety net advice should include specific warning symptoms and signs of cancer that patients should know about’. Respondents commented *“This seems to me the whole point of safety netting”*, and that this should be done sensitively to minimise unnecessary anxiety. *“Compromise between informed decision sharing*

*and raising anxiety levels- it is very patient dependant and not always appropriate - depends on index of suspicion also". It was suggested the term 'serious disease' could be used rather than specifying cancer "Perhaps signs and symptoms of serious disease rather than cancer. Especially for abdominal symptoms".*

Respondents did not suggest any changes to the one statement which had not achieved consensus in the first round: "If a diagnosis is uncertain, a further appointment should be made in advance, and cancelled if symptoms resolve".

### **Results from the Second Round Questionnaire: Practice actions**

Six practice based actions were circulated with a suggestion of high priority for inclusion in safety netting advice. Respondents in the second round agreed that this was appropriate for all six statements. Respondents suggested that one intermediate priority statement should be categorised as high priority: "Practices should conduct significant event analysis for delayed diagnoses of cancer (focusing on symptoms, signs, diagnostic procedures, continuity of care, and reasons for delay". Respondents noted that much can be learnt from this reflective practice, and that this should be included in GP annual appraisal. Examples of the strength of opinion included: *"This should have higher priority as a key learning tool to improve quality of care"; "Really important that any failures in practice systems are reflected on by everyone"; "This is a significant area of learning for practices; each case should also be part of a GP's annual appraisal".*

Respondents did not suggest any changes to the three statements which had not achieved consensus on Round 1: "Safety netting advice should be provided in written format", "Patients should be given a choice of how to obtain results", and "Safety netting advice should be available in different languages appropriate to the practice population".

### **Final list of recommendations**

Based on the two Delphi rounds, we developed a final list of all the high and intermediate priority statements. Our initial division of safety netting statements was based on those that could be implemented at the clinician level, and those at the practice level. We found that the GP actions fell into two further categories, those

that GPs could undertake during or shortly after a consultation, and those related to communicating specific information to patients.

Our final list of safety netting recommendations includes high and intermediate priority recommendations:

- 1) Specific information to be communicated to patients (Box 1)
- 2) Actions that GPs should take during or shortly after the consultation (Box 2)
- 3) Procedures that should be implemented at the Practice level (Box 3).

High priority items could be considered as essential/core aspects which should occur as a matter of routine. Intermediate priority items could be considered on a practice by practice basis according to the demographics of the practice population.

## Recommendations

### Box 1 Recommended safety netting information to communicate to the patient

<b>High Priority Cancer Safety Netting Advice (Include in patient communication)</b>
The likely time course (time to resolution of self-limiting condition) of current symptoms (e.g. cough, bowel symptoms, pain)
Specific information about when and how to re-consult if symptoms do not resolve in the expected time course
Specific warning symptoms and signs of serious disease (e.g. cancer)
Who should make a follow up appointment with the GP, if needed (usually requesting the patient make the appointment, sometimes the doctor)
<b>Intermediate Priority (Consider including in patient communication )</b>
If a diagnosis is uncertain, give a clear explanation for the reasons for tests or investigations (e.g. to exclude the possibility of serious disease or cancer)
If a diagnosis is uncertain, that uncertainty should be communicated to the patient

### Box 2 Recommended safety netting actions that GPs should take during or shortly after the consultation

<b>High Priority Cancer Safety Netting Advice (Include in consultations)</b>
Safety net advice should be documented in the medical notes
GPs should consider referral after repeated consultations for the same symptom where the diagnosis is uncertain (e.g. three strikes and you are in).
The GP should ensure that the patient understands the safety netting advice
GPs should take additional measures to ensure that safety netting advice is understood in patients with language and literacy barriers
GPs should keep up to date on current guidelines for urgent referral for suspected cancer
<b>Intermediate Priority (Consider including in consultations)</b>
If symptoms do not resolve, further investigations should be conducted even if previous tests are negative
Safety netting advice should be given verbally

**Box 3 Recommended safety netting actions for Practices.**

<b>High Priority Cancer Safety Netting Advice – (Ensure patient communication procedures are in place)</b>
The practice should have procedures in place to ensure that patients are aware of how to obtain results of investigations
Practices should ensure that current contact details are available for patients undergoing tests/investigations or referrals
The practice should have a system for communicating abnormal test results to patients
Practices should have a system for contacting patients with abnormal test results who fail to attend for follow up
<b>High Priority (Ensure reliable practice systems are in place)</b>
Practice systems should be in place to document that all results have been viewed, and acted upon appropriately
Practices should have policies in place to ensure that tests/investigations ordered by locums are followed up
Practices should conduct significant event analysis for delayed diagnoses of cancer (focusing on symptoms, signs, diagnostic procedures, continuity of care and reasons for delay)
<b>Intermediate Priority (Consider using reliable practice systems)</b>
Practice systems should be able to highlight repeat consultations for unexplained recurrent symptoms/signs
Practices should conduct an annual audit of new cancer diagnoses
Practices should participate in cancer awareness campaigns
Practice staff involved in processing /logging of results should be aware of reasons for urgent referral under the 2 week wait

## Discussion

### Summary of main findings

Diagnosis of cancer in primary care is beset by three interrelated challenges – the relative infrequency of cancer, initial nonspecific presentation of symptoms which occur relatively commonly, and variable time course of evolution of clinical features. As a consequence, we feel that it is inevitable that at least some patients with cancer will not be recognised at initial consultation(s). Safety netting is therefore one of the most important “tools” that GPs and their practices can use for patients whose presentation is not initially recognised as cancer, ensuring they are reevaluated in a timely and appropriate manner. In this study we have attempted to define the key elements of safety netting from the GP perspective, and also rank their relative importance.

Using a Delphi process, GPs and primary care cancer experts identified 16 different safety netting items considered to be high priority in relation to cancer diagnosis. These high priority items could be considered as essential or core aspects of routine practice. Five were related to actions GPs should themselves take during or shortly after consultation, four related to communicating specific information to patients. A further seven items were related to practice level procedures, of which four were specific to patient communication policies, and three related to practice management systems. Respondents also considered a further eight items were of intermediate priority, four related to GP actions, and four related to practice actions.

### Strengths and limitations of the study

The purpose of a Delphi process is to gather consensus among experts in a given field. The utility of the final recommendations are dependent on both the statements provided at the outset, as well as panel of experts approached. We used several methods to systematically gather information about safety netting in relation to primary care cancer diagnosis. These were used to derive the initial list of Delphi statements which were then refined in an iterative process among the research team. The process of the Delphi allowed respondents to modify or change statements, which we used to generate the second version of the questionnaire. We deliberately used a ranking system to categorise those statements which achieved consensus

among respondents, using a high or intermediate priority. We are cautious not to discard any items, as there will be certain situations and certain patients where they are applicable and important.

The panel that we used was drawn largely from primary care leads in cancer, and academics active in this field. While they are expected to be experts in the topic, they may have views that differ from the wider primary care community. Therefore, prior to implementation, it would be important to ensure our results have face validity with a wider group of practising practitioners. In addition, we sought only the input from GPs, rather than the whole primary care team. We did not examine the potentially important views of secondary care specialists, who are on the 'receiving end' of GP cancer referrals. Nor did we solicit opinions and input from patients, for whom this safety netting advice is ultimately intended to benefit. These are all important stakeholders whose input would be valuable in taking forward the recommendations.

## Comparison with existing literature

Since the statements used to create the Delphi were derived from a comprehensive review of the published and grey literature, it is not surprising that many of the items ranked as high priority by respondents have been noted in previous publications. Our statements expanded considerably on the original description of the three elements of safety netting proposed by Neighbour. It includes all the recommendations identified in the Calgary Cambridge model, and those identified in a similar Delphi consensus by Almond *et al* related to the acutely unwell child in primary care. The differences generally appeared in the items ranked as intermediate priority. For example both Almond *et al* and Calgary Cambridge highlighted the importance of communication of uncertainty with patients or parents, while in our study the related items of 'If a diagnosis is uncertain, give a clear explanation for the reasons for tests or investigations' and 'If a diagnosis is uncertain, that uncertainty should be communicated to the patients' were only categorised as intermediate priority. It is possible that, in the case of suspected cancer, communication of uncertainty is balanced with minimising anxiety associated with a possible cancer diagnosis. Further research should explore how this uncertainty about possible cancer symptoms is best communicated. Our study also provides some validation for several of the items which have previously been noted in the literature related to cancer safety netting and significant event analyses, including recognition of possible

cancer based on symptoms, the need to reassess patients, referral and referral guidelines, particular patients and situations, and practice level issues.

## Implications for future research

A number of implications for future research are worth highlighting. Perhaps most importantly, we need a better understanding of patients' perspectives on safety netting, particularly in terms of communicating of uncertainty by GPs to patients, subsequent follow-up and the influence on overall understanding and behaviors. Secondly, further evidence is required to validate the statements judged to be of the highest priority. Moreover, such validation should encompass a wider community of GPs. Thirdly, we need evidence for the optimal strategies to implement the recommendations, as GPs and their practices may well adopt several differing strategies for certain recommendations. Finally, demonstrating an effect on care pathways for cancer and ultimately on improved diagnosis and delays should remain the ultimate goal of this area of diagnostic research.

## Implications for clinical practice

The overall aim of this work for GPs is to reduce the number of patients with cancer whose diagnosis is delayed. Because individual GPs do not see many cases in a year we perceive the recommendations will require prioritisation at the practice level. There are some safety netting items GPs can do within their individual consultations, and there are other items that GP trainers should incorporate in training GP registrars. In addition, we have set out recommendations that practices can implement, but recognize that many practices will already have many of these in place already.

The ways in which these recommendations are adopted, implemented and monitored will be important for understanding safety netting and its subsequent effects on reducing missed or delayed diagnoses. To some extent the recommendations will systematise aspects of good practice. Analysis of this data will be helpful for future audits and demonstration of improvements could form part of GPs appraisal. Commissioners may also perceive the recommendations could form part of an enhanced service, particularly if there is demonstration of improved testing, recall and reduction in delayed diagnoses.

We recommend that statements or actions which were agreed as high priority are included in safety netting procedures. Where processes were agreed as intermediate priority, these should be considered on a practice by practice basis according to the demographics of the practice population. Actions where there was no agreement need not be incorporated into safety netting guidance and procedures.

## Conclusions

Diagnosis of cancer in primary care remains difficult due to the relative infrequency of cancer and the initial nonspecific presentation. Whilst the term safety netting is understood by many in clinical practice specific recommendations of what exactly to do have been lacking for patients who may have cancer. The provision of recommendations for GP consultations and for practices as whole should allow better understanding of the actual components of safety netting. Widespread adoption and implementation should allow optimisation of the recommendations and improvements to delays in cancer diagnoses. The evidence base regarding these recommendations should be reviewed regularly and alterations to Priority Level for the statements altered where necessary.

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Appendix One:	First Round Consultation Information and Questionnaire
Appendix Two:	Second Round Questionnaire
Appendix Three:	Prioritisation of GP actions following Round One
Appendix Four:	Prioritisation of Practice actions following Round One
Appendix Five:	Results from the Second Round - Levels of agreement for prioritised statements: GP actions
Appendix Six:	Results from Second Round - Levels of agreement for prioritised statements: Practice actions

# Appendix One: First Round Consultation Information and Questionnaire

## **Safety netting to improve early cancer diagnosis in primary care: development of consensus guidelines.**

We are writing to you from the Oxford University Department of Primary Health Care to ask you to take part in a survey to develop guidelines regarding safety netting in primary care for cancer diagnosis. This work has been funded by the Cancer Policy Team, Department of Health.

Participation in this survey has been approved as an educational activity by the Director of the Centre for Evidence Based Medicine, University of Oxford ([www.cebm.net](http://www.cebm.net)). You will be provided with a certificate at the end of the project acknowledging your involvement which you may use as part of your annual appraisal. We will also acknowledge all participants in the final report of this research, which we will send to you.

### **What will this involve?**

Involvement in the process will be to complete two electronic questionnaires during the next 3 months. This is likely to take about an hour of your time in total (a maximum of half an hour for each questionnaire).

### **Background**

Currently there are approximately 300,000 new cancer cases each year in the UK. However, from a general practice context, GPs only see on average nine new cases of cancer a year, and therefore identifying cancer symptoms may not be considered high on the list of differential diagnoses. Whilst some cancers have obvious 'red flag symptoms' such as a breast lump, the majority present with vague symptoms, making early diagnosis difficult. It is usually a combination of more than one symptom alongside patient characteristics that raises the likelihood of malignancy. This increases the complexity of decision making in primary care as the presenting symptoms and signs may not initially be strong enough to drive referral.

Although the majority of cancer cases are appropriately recognised and referred, a recent report still identified the major importance of safety netting. Currently, there is no formal consensus regarding how to use safety netting for cancer in primary care. Understanding more clearly the elements of safety netting is directly relevant to optimal referral and diagnostic processes, as well as patient empowerment.

### **Research aim**

Therefore our aim is to identify the important components of how and what safety-net advice should be given in relation to cancer diagnosis in primary care.

### **Research methods**

We aim to include approximately 40 participants from the following groups: primary care cancer experts; GP cancer leads from the local cancer networks; and GPs who are not cancer leads.

We are using a modified version of the Delphi process, which is a reliable means of collecting and distilling knowledge from experts, and consists of questioning experts by means of successive questionnaires interspersed with controlled opinion feedback. We would like to invite you to complete the accompanying questionnaire and send it back to us by email attachment. After we have looked at the responses, we will send a second round questionnaire to clarify areas of uncertainty from the first questionnaire and to rank the importance of statements where agreement was reached.



We hope that you will be willing to participate in this research, and we look forward to your response. If you feel there is someone in your organisation who is more suitable, please feel free to pass this on to them, or to let us know.



## Appendix Two

### Appendix Three. Prioritisation of GP actions after the First Round

Statement relating to GP actions	Number and % of participants ranking item as 6-7
<b>High Priority</b>	
80% or more ranked criteria as 6 or 7 on the scale of importance	
GPs should keep up to date on current guidelines for <u>urgent referral</u> for suspected cancer	97.6% (41/42)
If a follow up appointment with the GP is needed, the GP should make it clear <u>whose responsibility</u> it is to make a further appointment (i.e patient or doctor)	95.2% (40/42)
Patients attending general practice should be given information about the <u>likely time course</u> of their current symptoms (e.g. cough, bowel symptoms, pain)	90.2% (37/41)
Patients attending general practice should be given specific information about <u>when and how to re-consult</u> if symptoms do not resolve in the expected time course	90.2% (37/41)
The GP should ensure that the <u>patient understands</u> the safety netting advice	90.0% (36/40)
GPs should take additional measures to ensure that safety netting advice is <u>understood</u> in patients with <u>language and literacy barriers</u>	87.2% (34/39)
Safety net advice should be <u>documented</u> in the medical notes	81.0% (34/42)
<b>Intermediate Priority</b>	
50-79% ranked criteria as 6 or 7 on the scale of importance	
Safety net advice should include <u>specific warning symptoms</u> and signs of cancer that patients should know about	75.6% (31/41)
If a diagnosis is uncertain and tests or investigations are ordered, GPs should <u>clearly explain the reasons for the investigations</u>	73.8% (31/42)
GPs should <u>consider referral after repeated consultations</u> for the same symptom where the diagnosis is uncertain.	71.4% (30/42)
If a diagnosis is uncertain, that <u>uncertainty should be communicated</u> to the patients	70.7% (29/41)
Safety netting advice should be given <u>verbally</u>	58.5% (24/41)
If symptoms do not resolve, <u>further investigations</u> should be conducted even if previous tests are negative	56.1% (23/41)
<b>No consensus</b>	
Less than 50% ranked criteria as 6 or 7 on the scale of importance	
If a diagnosis is uncertain, a further appointment should be <u>made in advance</u> , and cancelled if symptoms resolve	33.3% (14/42)

#### Appendix Four: Prioritisation of Practice actions after the First Round

Statement related to Practice actions	% and number of participants ranking item as 6-7
<b>High Priority</b>	
80% or more ranked criteria as 6 or 7 on the scale of importance	
The practice should have procedures in place to ensure that patients are aware of <u>how to obtain results of investigations</u>	100% (41/41)
Practice systems should be in place to <u>document that all results have been viewed</u> , and acted upon appropriately	97.6% (40/41)
Practices should ensure that <u>current contact details</u> are available for patients undergoing tests/investigations or referrals.	97.6% (40/41)
Practices should have policies in place to ensure that tests/investigations ordered by <u>locums</u> are followed up	95.0% (38/40)
The practice should have a system for <u>communicating abnormal</u> test results to patients	90.2% (37/41)
Practices should have a system for <u>contacting patients</u> with abnormal test results who fail to attend for follow up	90.0% (36/40)
<b>Intermediate Priority</b>	
50-79% ranked criteria as 6 or 7 on the scale of importance	
Practices should conduct <u>significant event analysis</u> for delayed diagnoses of cancer (focusing on symptoms, signs, diagnostic procedures, continuity of care and reasons for delay)	78.1% (32/41)
<u>Repeat consultations for unexplained recurrent symptoms/signs</u> should be clearly coded or documented in the medical record	73.2% (30/41)
Practices should conduct an <u>annual audit of new cancer diagnoses</u>	61.5% (24/39)
Practices should participate in <u>cancer awareness campaigns</u>	61.0% (25/41)
Practice staff involved in processing /logging of results should be aware of <u>reasons for urgent referral</u> under the 2 week wait	56.1% (23/41)
<b>No consensus</b>	
Less than 50% ranked criteria as 6 or 7 on the scale of importance	
Safety netting advice should be <u>available in different languages</u> appropriate to the practice population	48.8% (20/41)
Patients should be given a <u>choice of how</u> to obtain results (e.g. telephone, email, letter, in person)	14.6% (6/41)
Safety netting advice should be provided in <u>written</u> format to <u>all</u> patients	9.8% (4/41)

**Appendix Five: Results from Second Round - Levels of agreement for prioritised statements: GP actions (n = 39)**

<b>Priority A (High Priority)</b> 80% or more ranked criteria as 6 or 7 on the scale of importance		
<b>Statement relating to GP actions</b>	<b>Agree Priority A</b>	<b>Number reporting change</b>
GPs should keep up to date on current guidelines for <u>urgent referral</u> for suspected cancer	100%	
If a follow up appointment with the GP is needed, the GP should make it clear <u>whose responsibility</u> it is to make a further appointment (i.e patient or doctor)	100%	
The GP should ensure that the <u>patient understands</u> the safety netting advice	97.4%	1 (2.6%) Downgrade 1 (2.6%)
Patients attending general practice should be given specific information about <u>when and how to re-consult</u> if symptoms do not resolve in the expected time course	94.9%	2 (5.1%) Downgrade 2 (5.1%)
Patients attending general practice should be given information about the <u>likely time course</u> of their current symptoms (e.g. cough, bowel symptoms, pain)	92.3%	2 (5.1%) Missing 1 Downgrade 2 (5.1%)
GPs should take <u>additional measures</u> to ensure that safety netting advice is <u>understood</u> in patients with <u>language and literacy barriers</u>	92.3%	3 (7.7%) Downgrade 3 (7.7%)
Safety net advice should be <u>documented</u> in the medical notes	87.2%	5 (12.8%) Downgrade 5(12.8%)
<b>Priority B (Intermediate Priority)</b> 50-79% ranked criteria as 6 or 7 on the scale of importance		
<b>Statement relating to GP actions</b>	<b>Agree Priority B</b>	<b>Number reporting change</b>
Safety netting advice should be given <u>verbally</u>	87.2%	4 (10.3%) Missing 1 Upgrade 2 (5.1%) Downgrade 2 (5.1%)
If a diagnosis is uncertain and tests or investigations are ordered, GPs should <u>clearly explain the reasons for the investigations</u>	76.9%	9 (23.1%) Upgrade 8 (20.5%) Not stated 1 (2.6%)
If symptoms do not resolve, <u>further investigations</u> should be conducted even if previous tests are negative	76.9%	8 (20.5%) Missing 1 Upgrade 4 (10.3%) Downgrade 4 (10.3%)
If a diagnosis is uncertain, that <u>uncertainty should be communicated</u> to the patients	69.2%	12 (30.8%) Upgrade 10 (25.6%) Downgrade 1 (2.6%) Missing 1 (2.6%)
GPs should <u>consider referral after repeated consultations</u> for the same symptom where the diagnosis is uncertain.	59.0%	15 (38.5%) Missing 1 Upgrade 15 (38.5%)
Safety net advice should include <u>specific warning symptoms and signs of cancer</u> that patients should know about	53.9%	17 (43.6%) Missing 1 Upgrade 16 (41%) Not stated 1 (2.6%)

**Priority C (No consensus)**

Less than 50% ranked criteria as 6 or 7 on the scale of importance

Statement relating to GP actions	Agree Priority C	Number reporting change
If a diagnosis is uncertain, a further appointment should be <u>made in advance</u> , and cancelled if symptoms resolve	76.9%	<b>8 (20.5%)</b> <b>Missing 1</b> Upgrade 1 (2.6%) Downgrade 6 (15.4%) Missing 1 (2.6%)

**Appendix Six: Results from Second Round - Levels of agreement for prioritised statements: Practice actions (n = 39)**

<b>Priority A (High Priority)</b>		
80% or more ranked criteria as 6 or 7 on the scale of importance		
<b>Statement related to Practice actions</b>	<b>Agree Priority A</b>	<b>Number reporting change</b>
The practice should have procedures in place to ensure that patients are aware of <u>how to obtain results of investigations</u>	94.9%	1 (2.6%) Missing 1 Downgrade 1 (2.6%)
Practice systems should be in place to <u>document that all results have been viewed</u> , and acted upon appropriately	94.9%	Missing 2
Practices should ensure that <u>current contact details</u> are available for patients undergoing tests/investigations or referrals.	94.9%	1 (2.6%) Missing 1 Downgrade 1 (2.6%)
Practices should have policies in place to ensure that tests/investigations ordered by <u>locums</u> are followed up	87.2%	1 (2.6%) Missing 4 Downgrade 1 (2.6%)
The practice should have a system for <u>communicating abnormal</u> test results to patients	87.2%	1 (2.6%) Missing 4
Practices should have a system for <u>contacting patients</u> with abnormal test results who fail to attend for follow up	84.6%	4 (10.3%) Missing 2 Downgrade 4 (10.3%)
<b>Priority B (Intermediate Priority)</b>		
50-79% ranked criteria as 6 or 7 on the scale of importance		
<b>Statement related to Practice actions</b>	<b>Agree Priority B</b>	<b>Number reporting change</b>
<u>Repeat consultations for unexplained recurrent symptoms/signs</u> should be clearly coded or documented in the medical record	76.9%	7 (18.0%) Missing 2 Upgrade 5 (12.8%) Downgrade 2 (5.1%)
Practices should conduct an <u>annual audit of new cancer diagnoses</u>	79.5%	6 (15.4%) Missing 2 Upgrade 3 (7.7%) Downgrade 3 (7.7%)
Practices should participate in <u>cancer awareness campaigns</u>	71.8%	8 (20.5%) Missing 3 Upgrade 3 (7.7%) Downgrade 5 (12.8%)
Practice staff involved in processing /logging of results should be aware of <u>reasons for urgent referral</u> under the 2 week wait	64.1%	10 (25.6%) Missing 4 Upgrade 4 (10.3%) Downgrade 6 (15.4%)
Practices should conduct <u>significant event analysis</u> for delayed diagnoses of cancer (focusing on symptoms, signs, diagnostic procedures, continuity of care and reasons for delay)	53.9%	15 (38.5%) Missing 3 Upgrade 14 (35.9%) Downgrade 1 (2.6%)

<b>Priority C (No consensus)</b> Less than 50% ranked criteria as 6 or 7 on the scale of importance		
<b>Statement related to Practice actions</b>	<b>Agree Priority C</b>	<b>Number reporting change</b>
Safety netting advice should be provided in <u>written</u> format to <u>all</u> patients	97.4%	Missing 1 (2.6%)
Patients should be given a <u>choice of how</u> to obtain results (e.g. telephone, email, letter, in person)	84.6%	4 (10.3%) Missing 2 Upgrade 4 (10.3%)
Safety netting advice should be <u>available in different languages</u> appropriate to the practice population	76.9%	8 (20.5%) Missing 1 Upgrade 8 (20.5%)