Primary Care Referral Improvement Toolkit:

An information and resource pack to support with early detection of cancer and referral practice

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This information toolkit offers an overview of the PCN Network Directed Enhanced Service 25/26. It is designed for primary and community care colleagues and provides a variety of information, resources, and educational opportunities to help improve awareness and understanding of cancer risk factors, signs, and symptoms.

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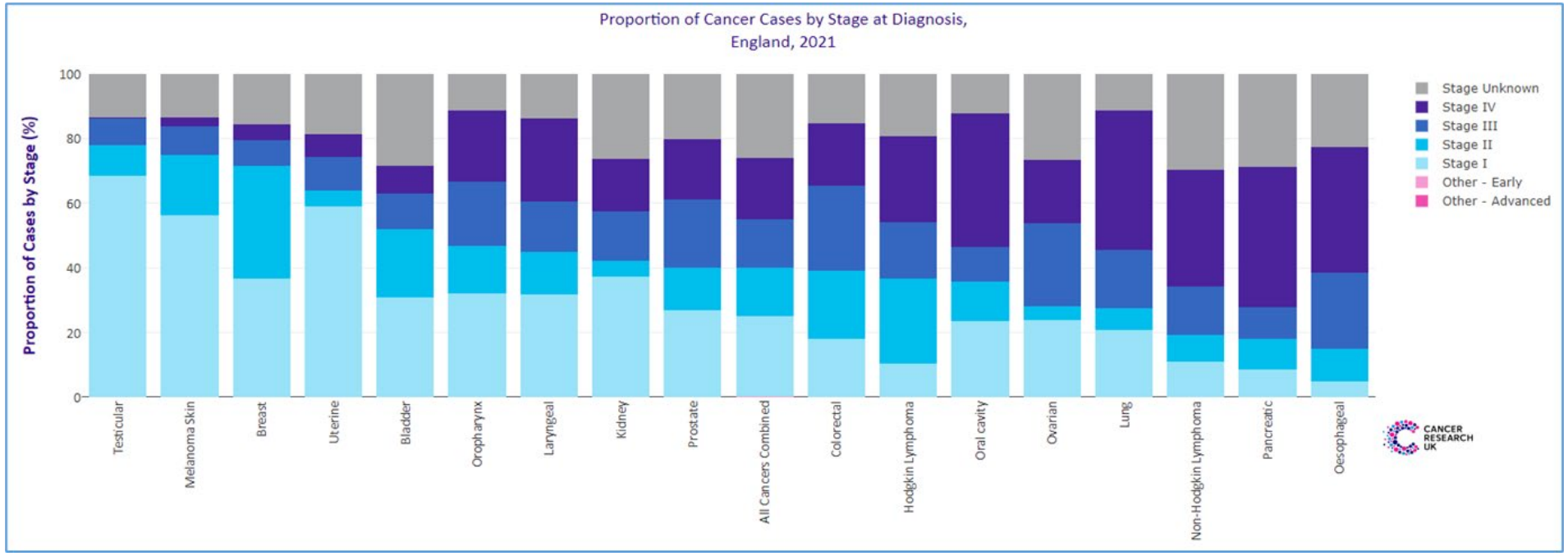
Why is diagnosing cancer early so important?

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If a cancer is diagnosed at an early stage, there is a **much greater chance of being able to treat the disease successfully**, often with less invasive procedures and fewer long-term side effects. But too many people are being diagnosed with cancer at later stages.

It is also important that we **diagnose cancers as fast as possible so that treatment can start quickly and as accurately as possible** - for example, identifying the genetic make-up of an individual's tumour tells us how best to treat it.

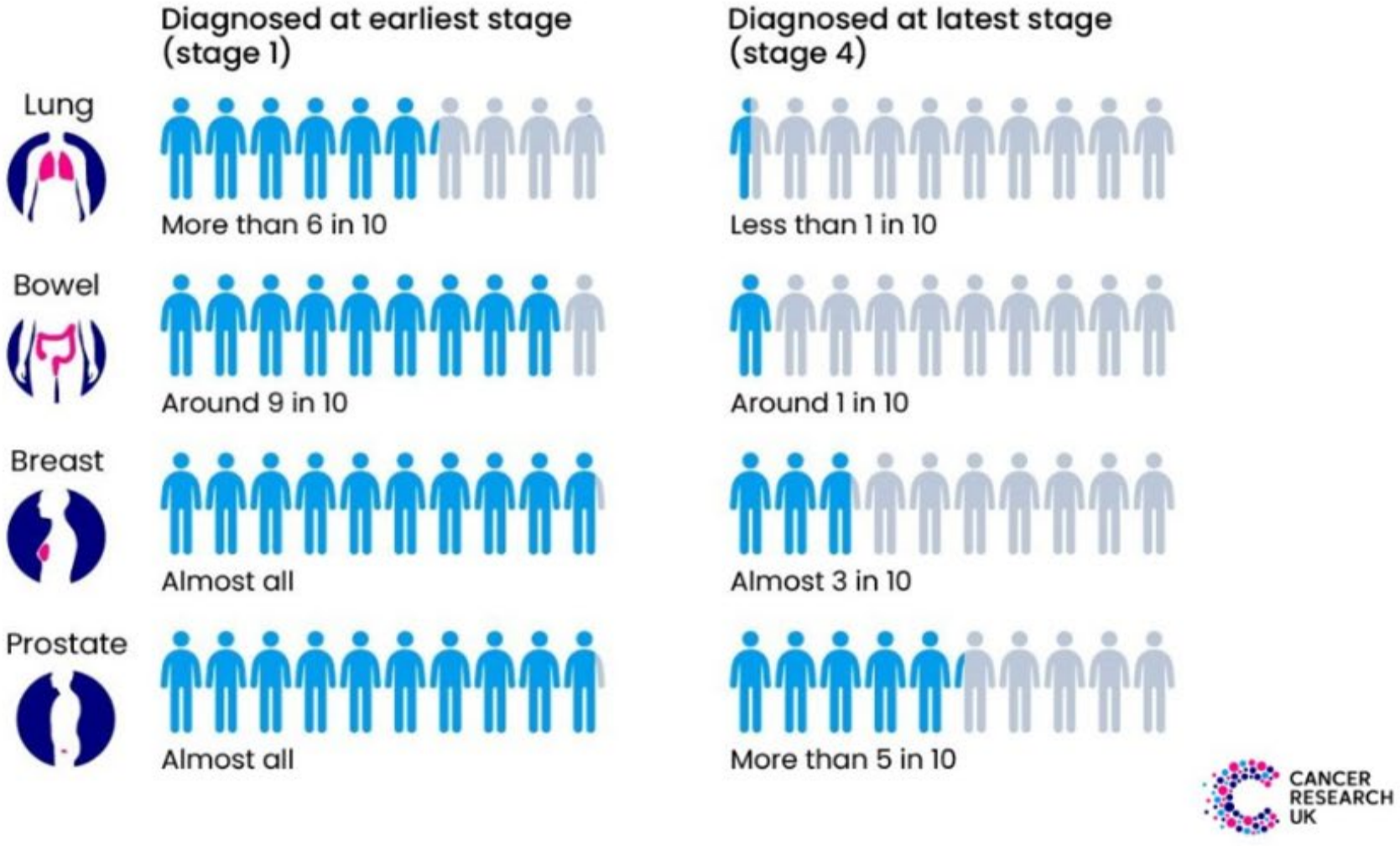
People diagnosed earlier with cancer are not only more likely to survive, but importantly also to have **better experiences of care, lower treatment morbidity, and improved quality of life** compared with those diagnosed late.



Reducing late-stage diagnosis is vital

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Finding and treating cancer earlier increases 5-year survival



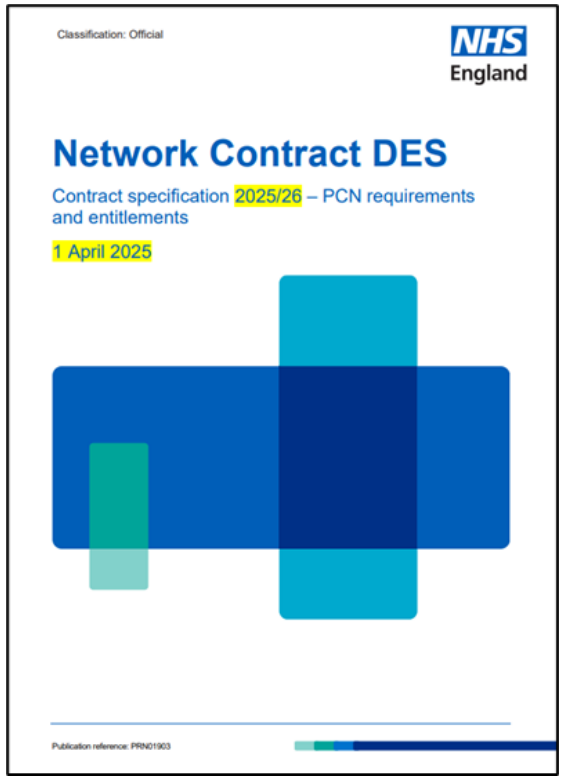
Sources: NHS Digital, Office for National Statistics

CANCER RESEARCH UK

PCN Directed Enhanced Service

The Network Contract Direct Enhanced Service (DES) underpins the role of PCNs in empowering general practice within the wider NHS and improving the range and effectiveness of primary care services.

At a PCN level, practices can discuss variation, build consensus, implement best practice and hold each other to account. They can potentially benefit from operational economies of scale and a shared primary care workforce.



Essential Resources:

- PCN DES specifications for 2025-26
- PCN DES Video Mini-Series **25/26**
- CRUK GP Contract Hub **25/26**
- CRUK PCN top tips **(2022)**

Note: there are no national requirements for monitoring of the early cancer element of the PCN DES and the only monitoring and direct funding is for IIF element. However, we would encourage PCNs to feedback using the Des checklist at the end of this toolkit so we collate learning and exchange ideas.
Send to england.tvcaadmin@nhs.net

PCN Directed Enhanced Service: Early cancer 25/26 – **No change**

The PCN Directed Enhanced Service ask for two things focused on cancer:

1. **Review referral practice to improve early detection with clear actions and milestones (this toolkit)**
2. Work with partners to improve screening uptake

The Des also focuses on health inequalities:



2.1.6 A PCN should **"actively seek to reduce health inequalities across its Core Network Practices in line with guidance and the CORE20PLUS5 approach."**

2.1.7 A PCN should **work in partnership within local communities to address health inequalities** that are amenable to primary care interventions. The CORE20PLUS5 approach provides a helpful focal point for galvanising action and guiding targeting and outreach regarding conditions which disproportionately affect people from areas of greater deprivation.

2.1.8 Two of the five clinical areas set out in the of CORE20PLUS5 approach for adults focus on improving cardiovascular disease (CVD) prevention and diagnosis, and **early cancer diagnosis**.

Quality Outcomes Framework 25/26

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4.5 Cervical screening (CS)

Indicator	Points	Thresholds
CS005. The proportion of women eligible for screening aged 25-49 years at end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 3 years and 6 months	7	45-80%
CS006. The proportion of women eligible for screening and aged 50-64 years at end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 5 years and 6 months	4	45-80%

QOF CS005 CS006 – Cervical Screening: NO CHANGE

3.14 Cancer (CAN)

Indicator	Points	Thresholds
Records		
CAN001. The contractor establishes and maintains a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003'	5	N/A
Ongoing management		
CAN004. The percentage of patients with cancer, diagnosed within the preceding 24 months, who have a patient Cancer Care Review using a structured template recorded as occurring within 12 months of the date of diagnosis	6	50–90%
CAN005. The percentage of patients with cancer, diagnosed within the preceding 12 months, who have had the opportunity for a discussion and informed of the support available from primary care, within 3 months of diagnosis	2	70-90%

CAN001,CAN004,CAN005: RETIRED

Investment & Impact Fund Indicators (IIF) 25/26, CAN 04:

No change

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D2.1 A PCN is able to achieve up to 22 points in the Cancer domain. The following indicator definition applies for the indicator in this domain.

ID	Description	Numerator (N)	Denominator (D)	Prevalence numerator (E)	Indicator Type; Points; Desired Direction; Thresholds; Data source
Cancer (CAN) area					
CAN04	The proportion of patients who have had a lower gastrointestinal urgent suspected cancer referral in the reporting year where at least one urgent suspected cancer referral was accompanied by a faecal immunochemical test result, with the result recorded in the 21 days leading up to the referral.	Of the denominator, those where at least one urgent suspected cancer referral was accompanied by a faecal immunochemical test result, with the result recorded in the 21 days leading up to the referral.	The number of patients who have had a lower gastrointestinal urgent suspected cancer referral in the reporting year.	Indicator denominator	Standard Quantitative; Upwards; 22; 65% (LT) / 80% (UT); GPES

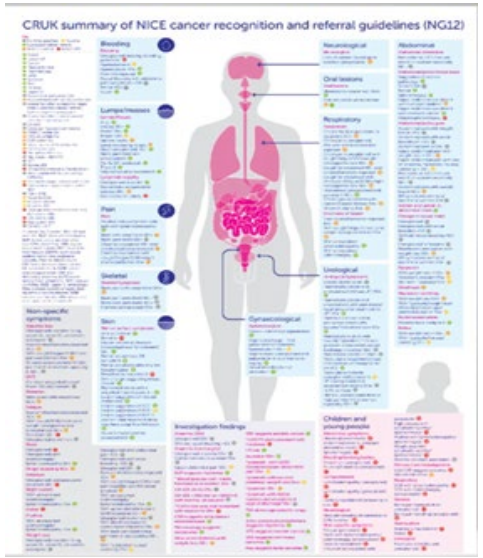
Improving referral practice

Improving referral practice

“Reviewing cancer referral practice in collaboration with partners and making efforts to improve support of early diagnosis rates with clear actions and milestones”

What you can do:

- Ensure local referral practice reflects NICE Guideline NG12
- Audit referrals for people who have received a diagnosis of cancer using templates like the National Cancer Diagnosis Audit (NCDA) Patient Proforma and NCDA Data collection template
- Use Office for Health Improvement and Disparities (OHID) Fingertips to inform improvement actions
- Assess different stages in the pathway for improvement eg the interval between first presentation and when an urgent suspected cancer referral is made or the number of appointments prior to urgent suspected cancer referral



Education and resources:

- NG12 Body Map and NG12 Interactive symptom guide
- CRUK Coding and Safety-netting
- Macmillan Cancer Awareness
- CRUK Cancer awareness and prevention for professionals
- Remote consultations
- Gateway C – improving the quality of your referral

What makes a good referral?

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Identifying early symptoms of cancer



Using the right diagnostics



Referring in a timely way



Referring using agreed form and pathway to optimise triage and the potential for straight to test



Counselling the patient and supporting with written materials



Safety netting throughout

Improving referral practice: 3 step plan - examples

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STEP 1: Understand your referral data to identify cancer areas of focus:

- Look at PCN level reports on Urgent Suspected Cancer (USC) referrals, diagnostics, demographics using **Cancer services - OHID Fingertip (phe.org.uk)**
- Review ERS monthly data to understand trends in referral rates
- Conduct a *referral practice review* across your PCN and core practices to assess suspected-cancer referrals and identify gaps, especially for disadvantaged groups

STEP 2: Consider which aspects of referral to focus on e.g.

- Interval between patient first presenting with symptoms and when Urgent Suspected Cancer referral made and the number of appointments attended prior to referral
- Referrals resulting in a cancer diagnosis to identify variation in management of referrals/change in pathway
- Routes of presentation to diagnosis – Urgent Suspected Cancer referral or A&E
- Ensuring that there is a consistent approach (safety netting) in monitoring patients referred urgently, or
- Checking patients receive information (signposting) on - why they are being referred, importance of attending, appointment and accessing further support

STEP 3: Create a PCN action plan following these steps:

- Agree project scope – what will and won't be done during the project?
- Establish milestones – what will be done and by when?
- Project team – who will do what?
- Reporting and governance – who needs to see your work? Does it need approval and by which group?
- Evaluation - write up you project and make sure you share what you have found with others and to support shared learning and sustainability

Improve referral practice: Promote use of Faecal Immunochemical Testing (FIT) in symptomatic patients

Guidance has been updated to support and streamline diagnosis and referral practice in primary care. A PCN should:

- Use Faecal Immunochemical Testing (FIT) for patients with signs and symptoms of colorectal cancer to identify those requiring a Lower GI Urgent Suspected Cancer referral
- FIT testing should be delivered in accordance with NICE Diagnostics Guidance 56. **Patients living in more deprived areas are more likely to be diagnosed with bowel cancer at a later stage and are less likely to complete a FIT test**
- PCNs should target action to address variation in completion of FIT tests in symptomatic patients by deprivation and develop patient education and safety netting approaches to follow up with those who have not returned their FIT test

Education and resources

- Watch the TVCA FIT videos for both screening and symptomatic patients, available in x languages and BSL. To access, follow the link
- Get CPD points and refresh your knowledge by completing a short online course: Gateway C – colorectal cancer
- Gateway C FIT resources, FIT for clinicians and FIT for administrators
- Check out Cancer Research UK Symptomatic FIT page
- Provide information to patients on how to collect a sample with this CRUK leaflet
- CRUK Be clear on the difference between screening and symptomatic FIT
- Doctors.net.uk bowel cancer symptomatic and screening resources



Screening and symptomatic FIT at a glance

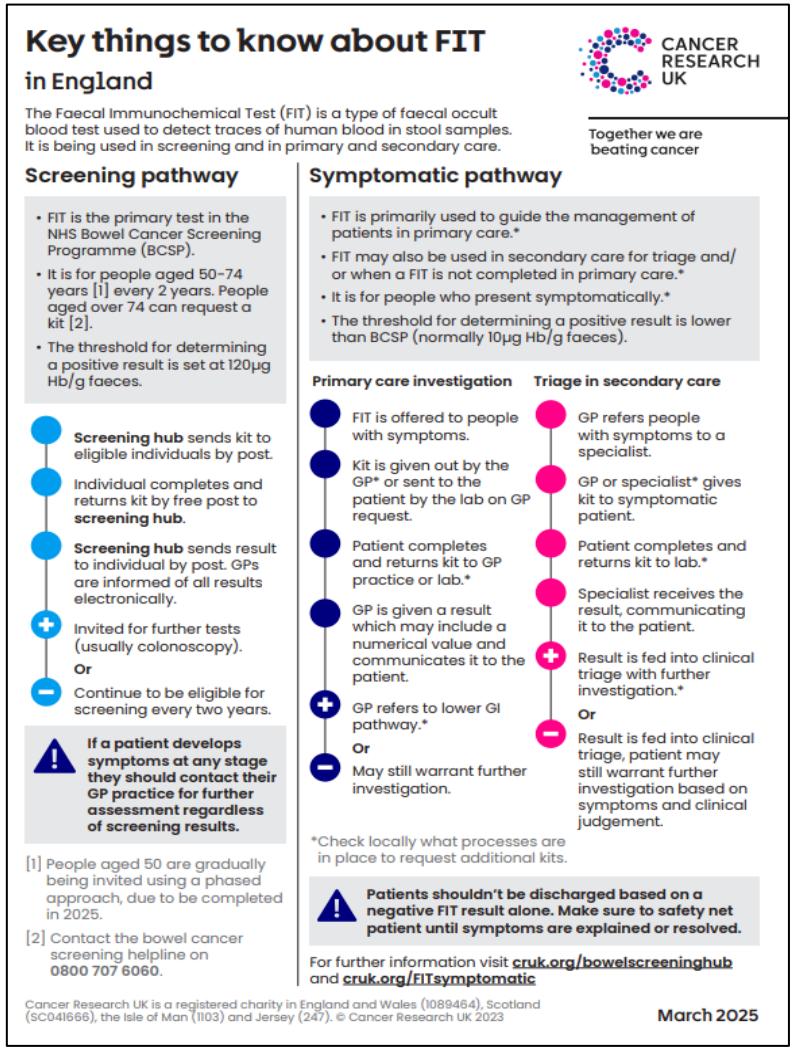
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	Screening	Symptomatic
Who	Assumed asymptomatic patients With age extension, 50-74 years	Symptomatic LGI patients aged 18 years and over
When	Offered every 2 years	Offered when patients present with **eligible signs and symptoms** of lower gastrointestinal cancer
Threshold	Threshold 120µg Hb/g for investigation eg 'positive screen'*	Threshold 10µg Hb/g for investigation eg 'positive result'

*A national programme is in development to lower the screening threshold to 80µg Hb/g (FIT@80). More detail will be shared as it is made available.

Any patient presenting with symptoms of suspected colorectal cancer with a negative screening FIT result, even if very recent, **MUST** be clinically assessed and have a symptomatic FIT if eligible.

DO NOT be falsely reassured by a negative screening FIT result because screening assumes that the patient has no symptoms and a positive screening FIT result is significantly higher



Key things to know about FIT in England

CANCER RESEARCH UK
Together we are beating cancer

The Faecal Immunochemical Test (FIT) is a type of faecal occult blood test used to detect traces of human blood in stool samples. It is being used in screening and in primary and secondary care.

Screening pathway

- FIT is the primary test in the NHS Bowel Cancer Screening Programme (BCSP).
- It is for people aged 50-74 years [1] every 2 years. People aged over 74 can request a kit [2].
- The threshold for determining a positive result is set at 120µg Hb/g faeces.

Screening hub sends kit to eligible individuals by post.

Individual completes and returns kit by free post to **screening hub**.

Screening hub sends result to individual by post. GPs are informed of all results electronically.

Invited for further tests (usually colonoscopy).

Or

Continue to be eligible for screening every two years.

If a patient develops symptoms at any stage they should contact their GP practice for further assessment regardless of screening results.

[1] People aged 50 are gradually being invited using a phased approach, due to be completed in 2025.

[2] Contact the bowel cancer screening helpline on **0800 707 6060**.

Symptomatic pathway

- FIT is primarily used to guide the management of patients in primary care.*
- FIT may also be used in secondary care for triage and/or when a FIT is not completed in primary care.*
- It is for people who present symptomatically.*
- The threshold for determining a positive result is lower than BCSP (normally 10µg Hb/g faeces).

Primary care investigation

FIT is offered to people with symptoms.

Kit is given out by the GP* or sent to the patient by the lab on GP request.

Patient completes and returns kit to GP practice or lab.*

GP is given a result which may include a numerical value and communicates it to the patient.

GP refers to lower GI pathway.*

Or

May still warrant further investigation.

Triage in secondary care

GP refers people with symptoms to a specialist.

GP or specialist* gives kit to symptomatic patient.

Patient completes and returns kit to lab.*

Specialist receives the result, communicating it to the patient.

Result is fed into clinical triage with further investigation.*

Or

Result is fed into clinical triage, patient may still warrant further investigation based on symptoms and clinical judgement.

*Check locally what processes are in place to request additional kits.

Patients shouldn't be discharged based on a negative FIT result alone. Make sure to safety net patient until symptoms are explained or resolved.

For further information visit cruk.org/bowelscreeninghub and cruk.org/FITsymptomatic

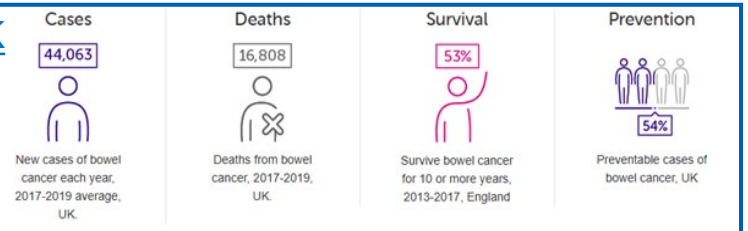
Cancer Research UK is a registered charity in England and Wales (1089464), Scotland (SC041666), the Isle of Man (1103) and Jersey (247). © Cancer Research UK 2023

March 2025

Improve referral practice: Bowel cancer signs, symptoms and risk factors

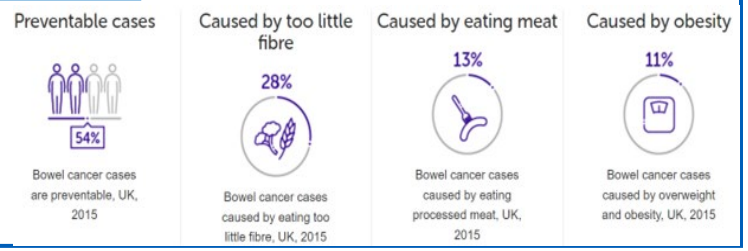
Bowel cancer statistics - for detailed information visit: Bowel cancer statistics | Cancer Research UK

- Bowel cancer is 4th most common cancer in the UK
- Bowel cancer is the 2nd most common cause of cancer death in the UK
- A full time GP is likely to diagnose approximately one person with colorectal cancer every year. (NICE CKS)



Bowel cancer risk factors for detailed information on all risks visit: Bowel cancer risk | Cancer Research UK

- Bowel cancer risk is 70% higher in people with inflammatory bowel disease (IBD) (ulcerative or Crohn's colitis) compared with the general population
- Around 20% of bowel cancers are associated with hereditary factors other than Familial adenomatous polyposis (FAP) and Hereditary non-polyposis colorectal cancer eg Lynch syndrome



Characteristics of bowel cancer – to read full paper, ctrl click here

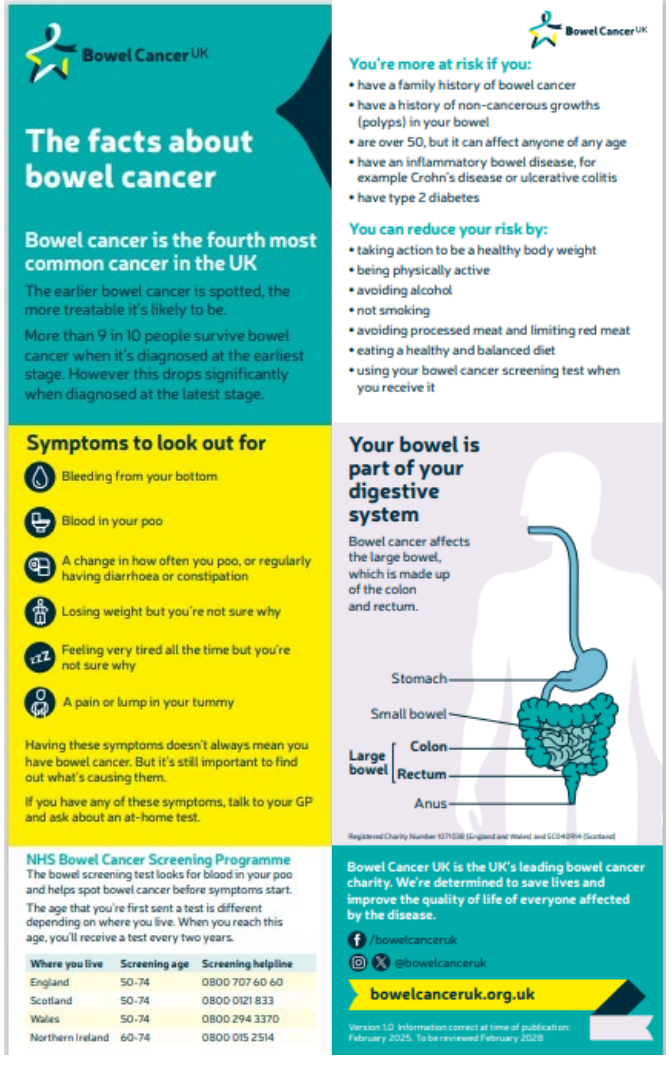
- >50% of all patients with bowel cancer present with rectal bleeding in combination with a persistent and unremitting change in bowel habit to increased frequency of defaecation and looser stools (odds ratio 5.4*)
- >20% have a similar change in bowel habit without rectal bleeding (odds ratio 2.1-2.5*)
- >12% have persistent rectal bleeding without anal symptoms without a change in bowel habit (odds ratio 2.9*)
- <2% have abdominal pain (odds ratio 0.6†) as a single symptom, which is always provoked by eating, causing weight loss
- 25% have a rectal mass (odds ratio 31.5)
- 12% have an abdominal mass (odds ratio 1.8-8.5*)
- 8% have an iron deficiency anaemia with or without bowel symptoms (odds ratio 4.4-8.4*)

*Odds ratio on multivariate analysis. †Odds ratio of abdominal pain on univariate analysis without defining whether it is always associated with eating and weight loss

Bowel cancer notice board and engagement resources:

Click on the images below to access





Translated material:
Bowel cancer UK offer information in other languages including: Polish, Punjabi, Romanian, and Welsh.
Click here to access

Improve referral practice: be aware of prostate cancer risk factors

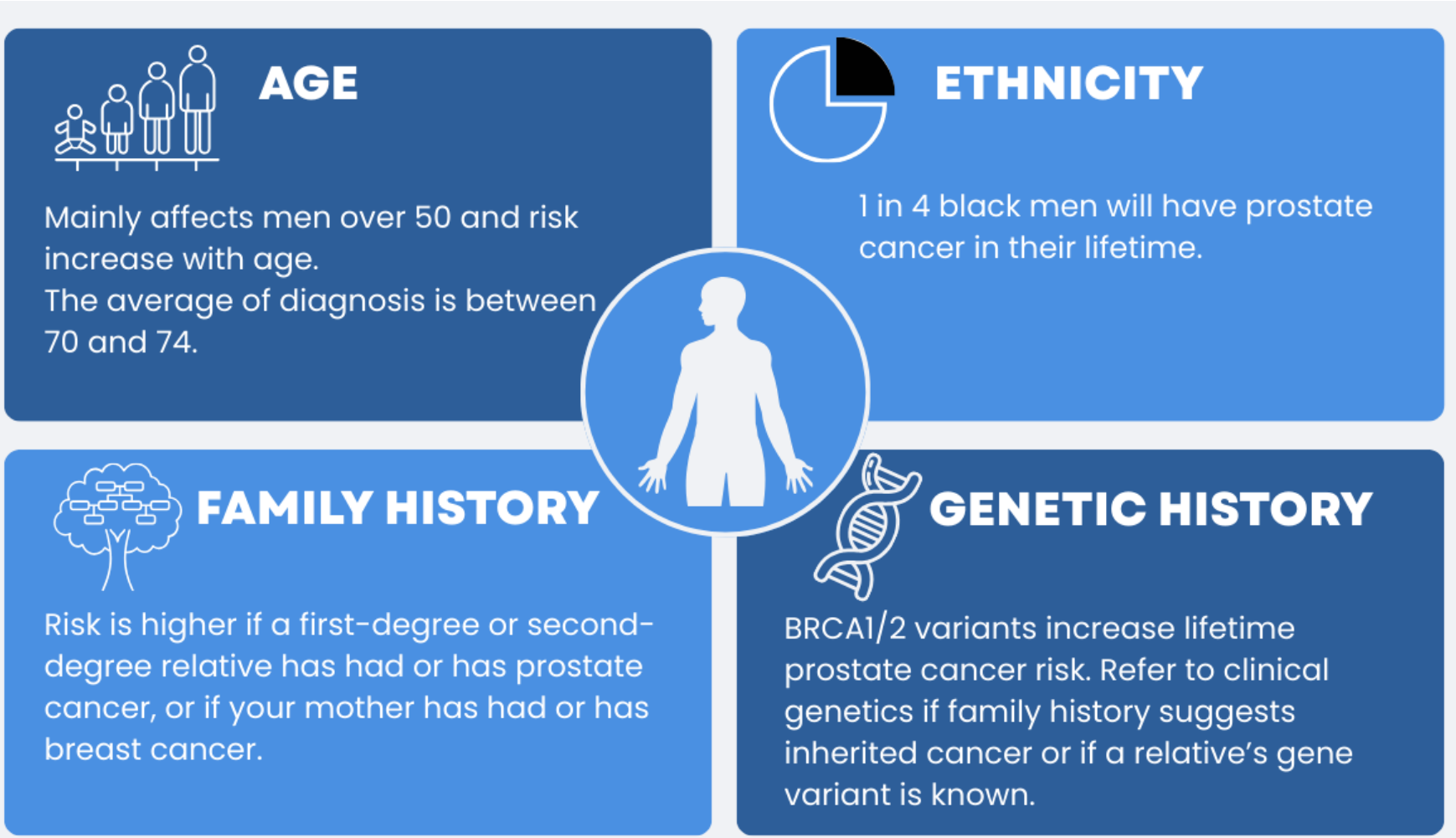
Thames Valley Cancer Alliance

Prostate cancer is the most common cancer affecting males in the UK.

1 in 8 men will be diagnosed with prostate cancer in theirlifetime[1].

The exact cause of prostate cancer isn't known but there are some risk factors that increase the likelihood of getting it.

Read more on increased risk factors at: **Prostate cancer risk | Cancer Research UK**



References:
1. Prostate cancer risk | Cancer Research UK
2. Prostate Cancer Risk Factors | Prostate Cancer UK | Prostate Cancer UK

Be aware of prostate cancer – the PSA test

Thames Valley Cancer Alliance

- Patients can ask their GP for a Prostate-Specific Antigen (PSA) test from the age of 50 years or 45 years if they have a higher risk of prostate cancer

- The decision to request a PSA test should be made on a case-by-case basis with careful counselling regarding the risk of false positives or negatives and describing any potential onward investigations

- When counselling a patient on PSA testing, consider what can falsely raise the result such as:
  - Vigorous exercise, such as cycling, within the last 48 hours
  - Ejaculation in the last 48 hours
  - Prescription or over-the-counter medicines, for example, 5-alpha-reductase inhibitors such as finasteride (Proscar®) or dutasteride (Avodart®)
  - Having had a urological procedure such as a prostate biopsy within the last 6 weeks
  - Having had a urine infection in the 6 weeks prior to PSA test

- Men should be given balanced information on the pros and cons of the PSA blood test and supported to make an informed choice whether to have one. Consider signposting patients to Cancer Research UK information about PSA testing

- **The use of Digital Rectal Exam (DRE**
- Prostate Cancer UK and the British Association of Urological Surgeons (BAUS) are advising that men with suspected cancer do not require a rectal exam before being referred for further tests. A PSA test should be done first and referral made based on results
- For more information click here for Prostate Cancer UK rectal exam news and read at these FAQs

Prostate cancer education

What you can do:

- Ensure your team is aware of the increased risk factors for Prostate Cancer such as age, family history and black ethnicity
- Read the Gateway C information about family history of prostate cancer published following the news of Sir Chris Hoy's diagnosis
- Download this CRUK poster with information to support timely referrals for patients with suspected prostate cancer
- Listen to BBC radio 4 Inside Health discussion on prostate cancer risk and PSA

Get CPD points and refresh your knowledge by completing a short online course:

- E Learning: Gateway C Early Diagnosis of Prostate Cancer in General Practice
- E learning: Prostate Cancer UK, Prostate cancer essentials

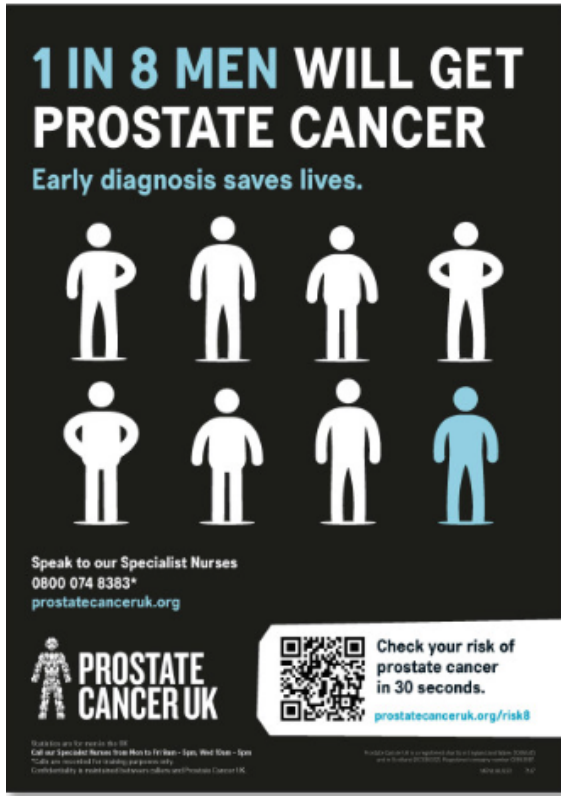
Prostate cancer notice board and engagement resources

Thames Valley Cancer Alliance

Click on the images below to access







Translated material:
Prostate Cancer UK offer information in other languages including: Arabic, Bengali, Chinese, Dari, Fasi, Gujarati, Pashto, Polish, Portuguese, Punjabi, Romanian, Russian, Somali, Tamil, Turkish, Ukrainian, Urdu and Welsh.
Click here to access

NHS **LGBTQ +**

For information to support trans women, visit the Prostate Cancer UK website

Click on this link for Prostate Cancer UK campaign resources including social media posts and email signatures

Improve referral practice: breast pain

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Patients can scan these QR codes to get direct access to a 4 minute video of a GP explaining breast pain and the Breast Cancer Now Breast Pain Patient Information Leaflet. Consider printing to have in your clinic room.

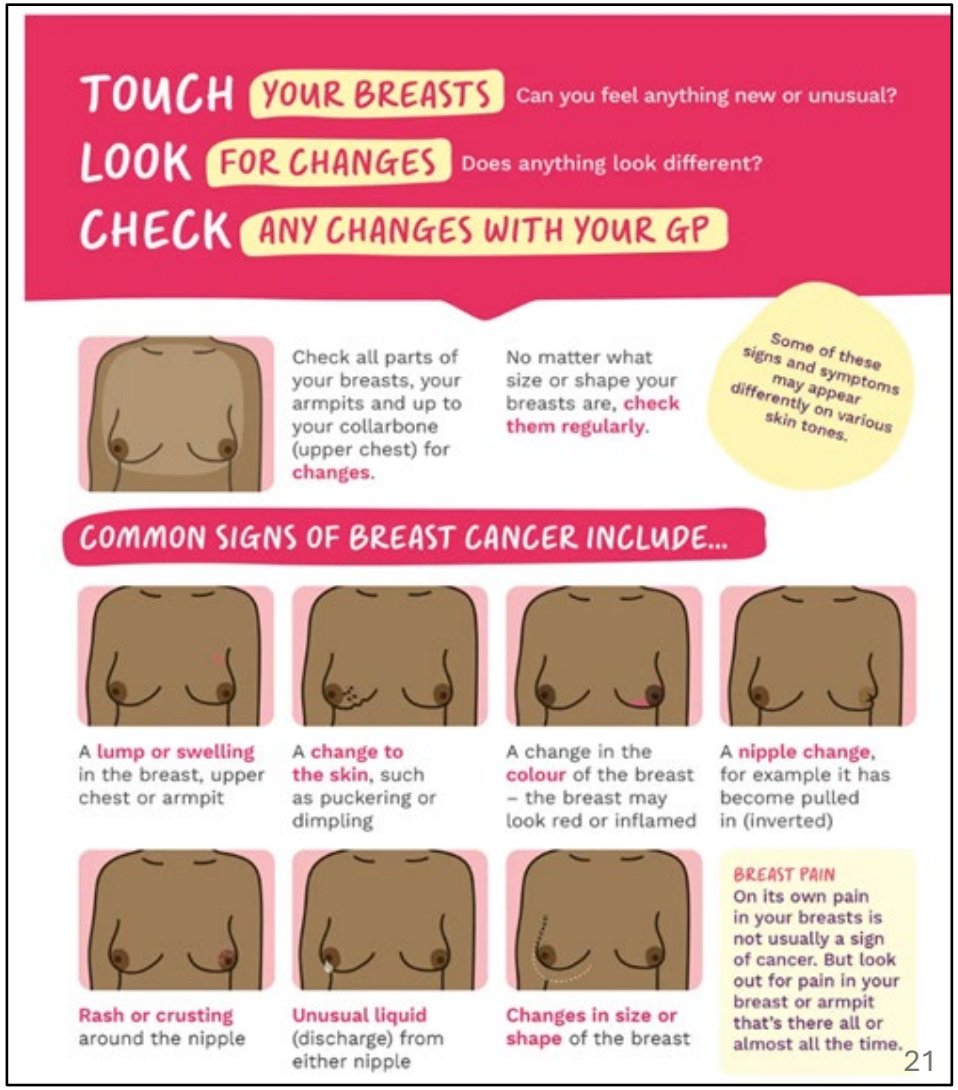
SCAN ME

Understanding Breast Pain Video

SCAN ME

Breast Pain Written Resource

(Breast Cancer Now PDF)



Improve referral practice: breast cancer in Black and Asian women

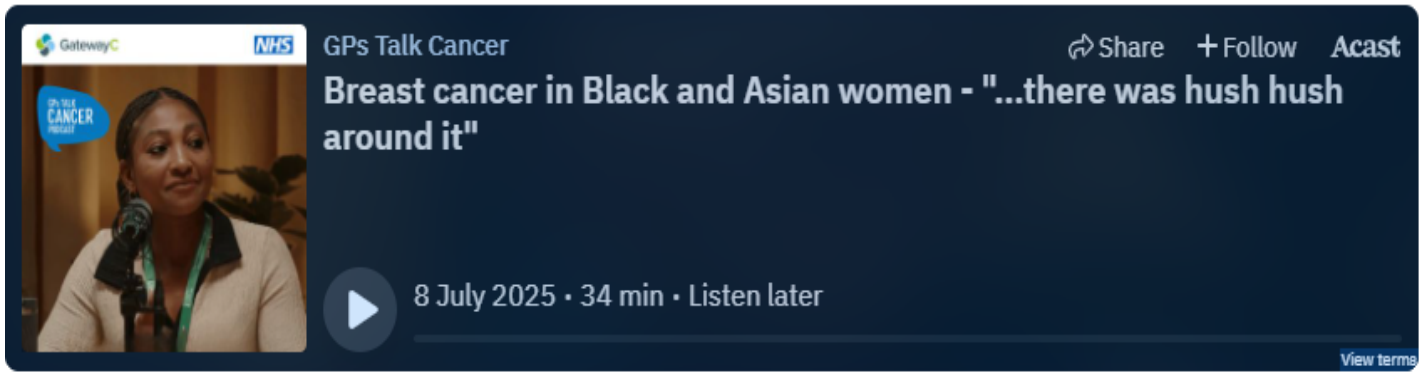


Supported by NHS England and Gilead, the RCGP learning hub have launched a 30minute educational course worth 0.5 CPD points. The course aims to inform GPs about the experiences of Black women with breast cancer. It explores the specific risk factors, challenges related to timely diagnosis, and the lived experience of Black women during the diagnosis process. The course also addresses the social and cultural barriers to healthcare, using case studies to support GPs develop culturally sensitive and effective approaches to care.
Follow the link to access and note RCGP login details are required

RCGP Breast cancer in Black women

Gateway C podcast - Breast cancer early diagnosis in Black and Asian women
The episode explores cultural, social and language barriers impacting healthcare access, the importance of awareness and representation and why empowering patients to seek help early is vital.

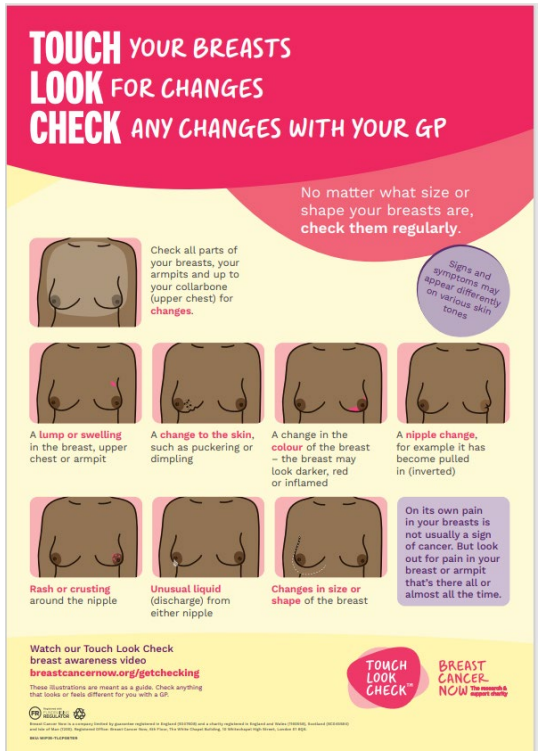
Follow the link to access Breast cancer early diagnosis in Black and Asian women

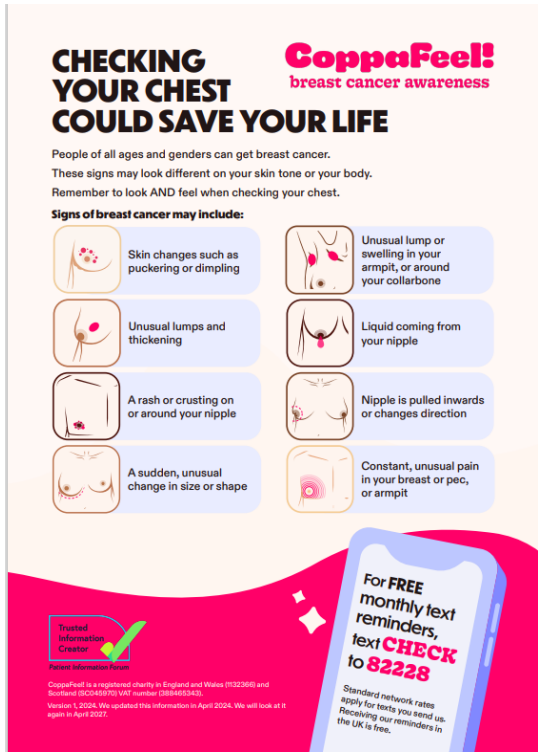


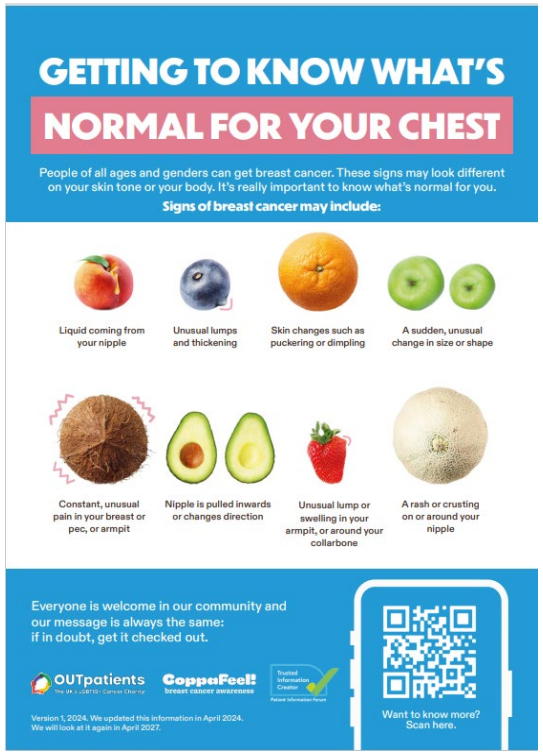
Breast cancer notice board and engagement resources

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Click on the images below to access







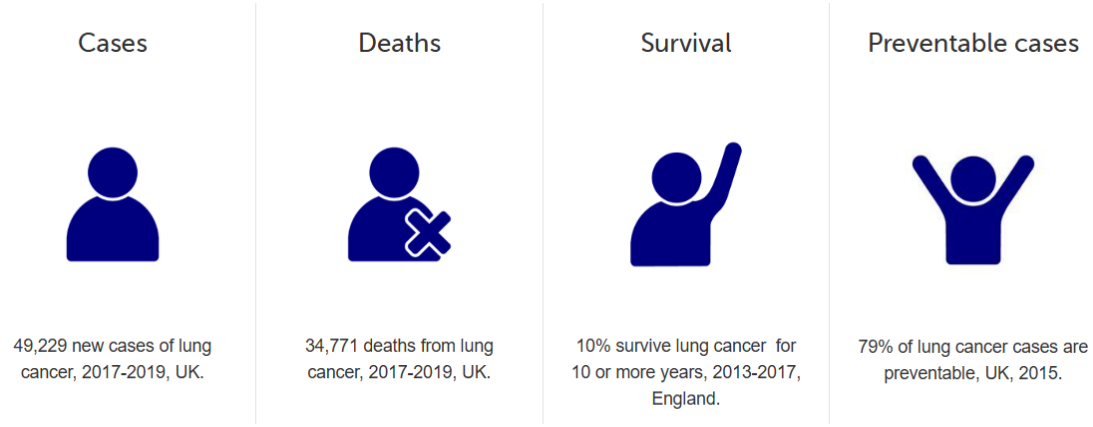
Translated material:
Breast Cancer Now offer information in other languages including: Arabic, Bengali, French, Gujarati, Hindi, Polish, Portuguese, Punjabi, Romanian, Simplified Chinese, Ukrainian Urdu and Welsh. Click here to access

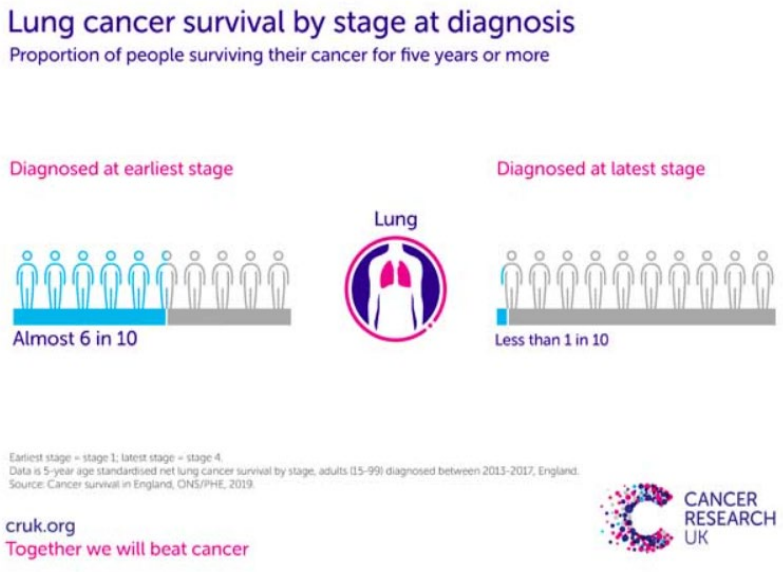
Learning disability:
Coppafeel provide resources and information to support people with a learning disability. Visit the Coppafeel website to access

LGBTQ +

For information to support trans and non-binary people, visit the Coppafeel website

Improving referral practice: lung cancer





Headline statistics:

- Lung cancer is the 3rd most common cancer in the UK and the leading cause of cancer mortality
- Lung cancer primarily affects older adults – almost 45% of new cases occur in those aged 75+
- Smoking is the dominant cause (over 70% of cases)
- Incidence and outcomes are strongly linked to deprivation and other factors. An estimated 14,300 lung cancer cases per year in England are attributable to socioeconomic deprivation (roughly 6,600 in women and 7,800 in men)
- A full time GP is likely to diagnose approximately one person with lung cancer each year

What you can do:

- If you want to learn more about lung cancer, listen to this Podcast for primary care from GatewayC: https://www.gatewayc.org.uk/podcast/lung-cancer
- Use this NHS video explaining the signs/symptoms of lung cancer as part or your local awareness campaigns, or this video developed by CRUK
- Learn more about lung cancer risk factors by visiting the CRUK website

Improving referral practice: lung cancer

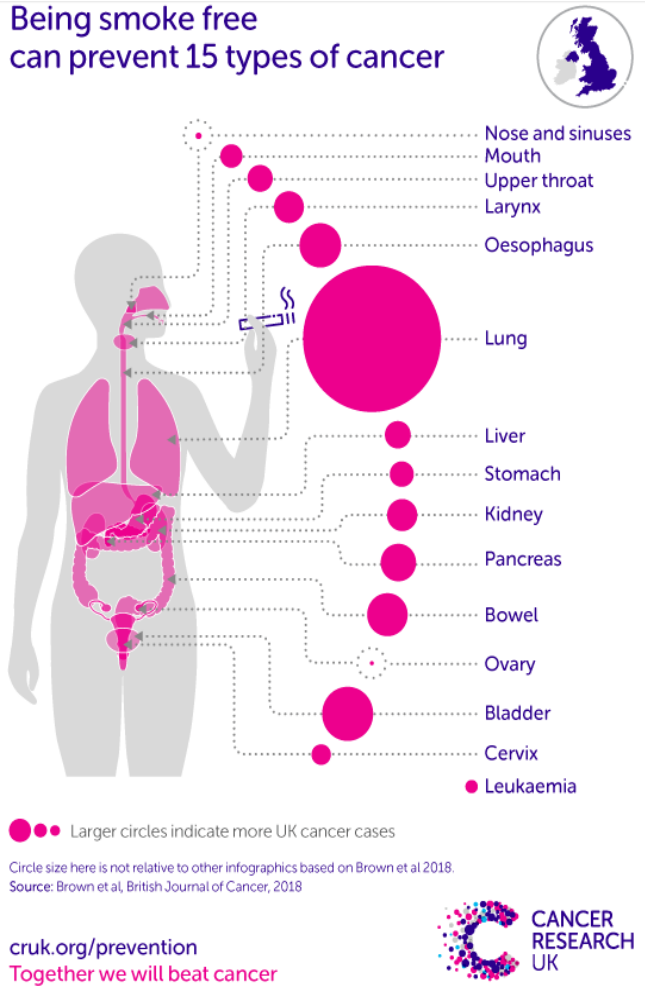
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Signs and symptoms of lung cancer: For more detail see NG12
The main symptoms of lung cancer include:

- a cough that does not go away after 3 weeks
- a long-standing cough that gets worse
- chest infections that keep coming back
- coughing up blood
- an ache or pain when breathing or coughing
- persistent breathlessness
- persistent tiredness or lack of energy
- loss of appetite or unexplained weight loss

NOTE: In symptomatic patients, the majority of chest X-rays will be abnormal, but a normal chest X-ray does not exclude diagnosis of lung cancer. This was shown in the 2006 BJGP study of normal and abnormal chest x-rays in lung cancer patients, 23% of lung cancer patients had a negative X-ray within a year prior to diagnosis.

Please refer if there is a normal CXR but high suspicion of lung cancer



Risk factors:

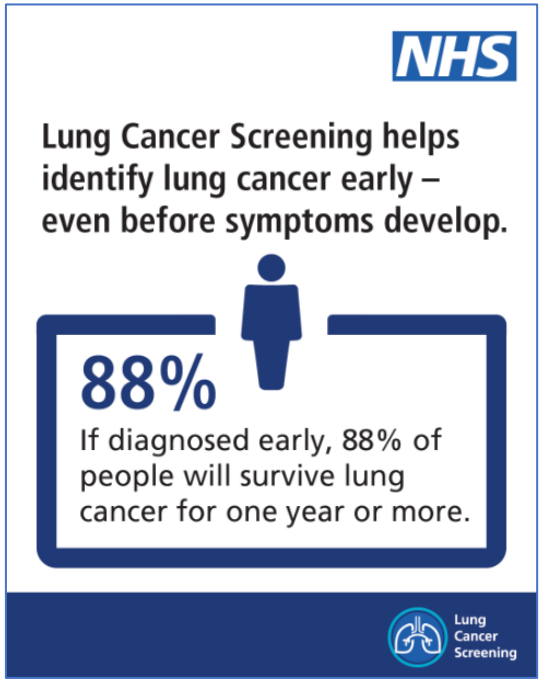
- 79% of lung cancer cases in the UK are preventable
- 72% of lung cancer cases in the UK are caused by smoking
- 5% of lung cancer cases in the UK are caused by ionising radiation
- 13% of lung cancer cases in the UK are caused by workplace exposures
- 8% of lung cancer cases in the UK are caused by air pollution

Lung cancer screening programme:

From February 2025, the Targeted Lung Health Check Programme became known as Lung Cancer Screening.

The aim of the Lung Cancer Screening Programme is to find lung cancer earlier, often before symptoms develop. This can widen the treatment options available and improve patient outcomes.

Approximately **three quarters of people** who have been diagnosed with lung cancer through the programme have been caught at an **early stage** (stages I or II) when lung cancer is easier to treat with curative intent.
A lung health check is offered to people between the ages of **55 and 74** who smoke or have smoked in the past.



NHS England's ambition is to have lung health checks rolled out to all eligible patients by 2030.
Read more here: NHS lung cancer screening

Across the Thames Valley Cancer Alliance, the Lung Cancer Screening Programme is being delivered by the following providers, who aim to have 100% roll out by 2030/31:

- Oxford University Hospital NHS Foundation Trust
- Royal Berkshire Hospital NHS Foundation Trust
- Buckinghamshire Healthcare NHS Trust
- Great Western Hospital NHS Foundation Trust

Registered patients who are aged 55-74 and have a history of smoking on their medical record will be offered Lung Cancer screening when the programme reaches their area.

For more information contact: england.tvcaadmin@nhs.net

Improving referral practice: Pancreatic cancer

Thames Valley Cancer Alliance

Pancreatic cancer is the 10th most common cancer in the UK. It is difficult to detect, is often diagnosed at an advanced stage, and survival rates are extremely poor. One in four people diagnosed with pancreatic cancer in England survive their disease for one year or more, with emergency presentation the most common route to diagnosis. (Cancer Research UK, 2013-2017)

New onset diabetes:

Diabetes, especially Type 2, is common among the general population. However, unexplained new-onset diabetes should be investigated as a possible indicator of pancreatic cancer. It is also important to ask patients about other symptoms of pancreatic cancer such as steatorrhea, back pain and weight loss.

NICE NG12 guidelines recommend an urgent direct access CT scan (to be performed within 2 weeks), or an urgent ultrasound scan if CT is not available, to assess for pancreatic cancer in **people aged 60 and over with weight loss** any of the following: **diarrhoea, back pain, abdominal pain, nausea, vomiting, constipation, new-onset diabetes**.

Refer people using an urgent suspected cancer pathway referral (for an appointment within 2 weeks) for pancreatic cancer if they are aged 40 and over and have jaundice.

See Pancreatic Cancer UK information on diabetes and pancreatic cancer including information for your patients.

pancreatic cancer action

Pancreatic cancer is a difficult disease diagnose. Pancreatic Cancer Action developed resources for GPs including: e-learning, resource packs, NICE diagnostic and referral guidelines, EMIS risk tool and a GP seminar.
Resources for GPs | Pancreatic Cancer Awareness | PCA

For pharmacists, click here to access similar resources

Improving referral practice: Pancreatic cancer and inherited risk

Thames Valley Cancer Alliance

Inherited risk of pancreatic cancer
About 10% of pancreatic cancers are hereditary meaning that for every 10 people with the disease, one likely had increased risk due to genetic mutations.

Mutated DNA can pass from generation to generation (germline mutations). These mutations may lead to hereditary pancreatic cancer. This is the only way the disease can be inherited.

Most individuals with inherited and other risk factors for developing pancreatic cancer are **not aware of their risk** or involved in any surveillance.

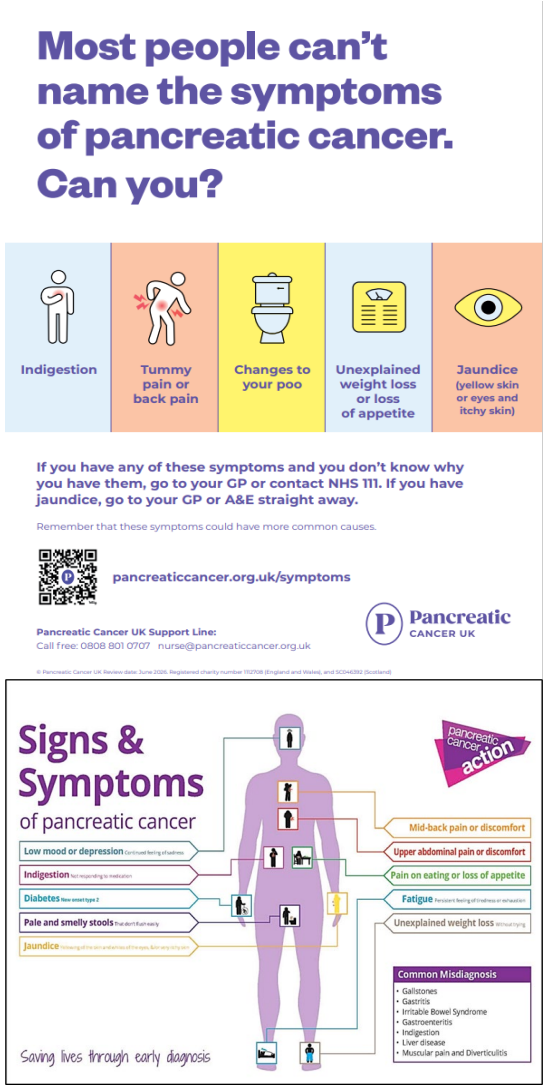
Read more about Family History of Pancreatic Cancer from Pancreatic Cancer UK.

Family History of Pancreatic cancer: SNOMED concept ID 429000004
This code is now available on EMIS and SystmOne

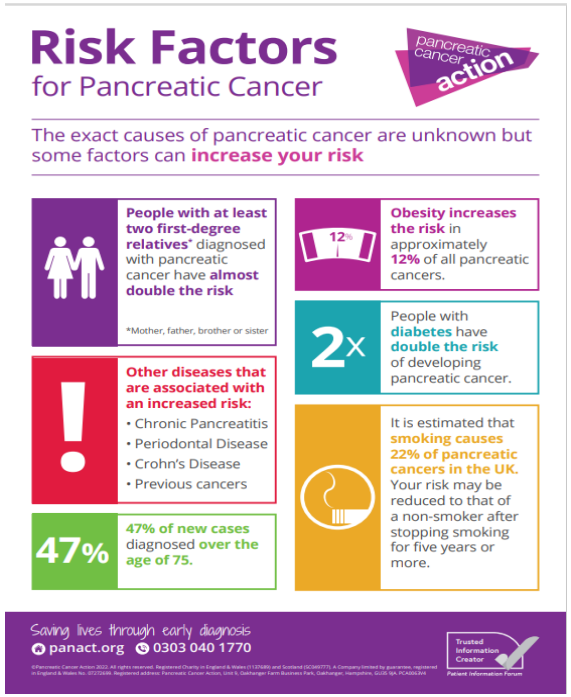


Pancreatic cancer: noticeboard and engagement resources

Click on the images below to access







For campaign materials, visit the Pancreatic Cancer Action website

Translated material:
Pancreatic Cancer Action offer information in other languages including: Arabic, Bengali, Gujarati, Polish, Punjabi and Urdu.
Click here to access

Accessible information:
Pancreatic Cancer Action provide resources and information in accessible formats. Visit the Pancreatic Cancer Action website

Visit Pancreatic Cancer UK for information to support people with learning disabilities

Promote use of Non-Specific-Symptoms pathways (NSS)

Guidance has been updated to support and streamline diagnosis and referral practice in primary care. A PCN should:
Promote use of Non-Specific Symptom (NSS) pathways for patients with symptoms that could indicate cancer but who do not fit clearly into a single Urgent Suspected Cancer referral pathway. PCNs should support practices to undertake clinically appropriate filter function tests for NSS patients.

Across Thames Valley Cancer Alliance, NSS pathways have been implemented in the following locations:

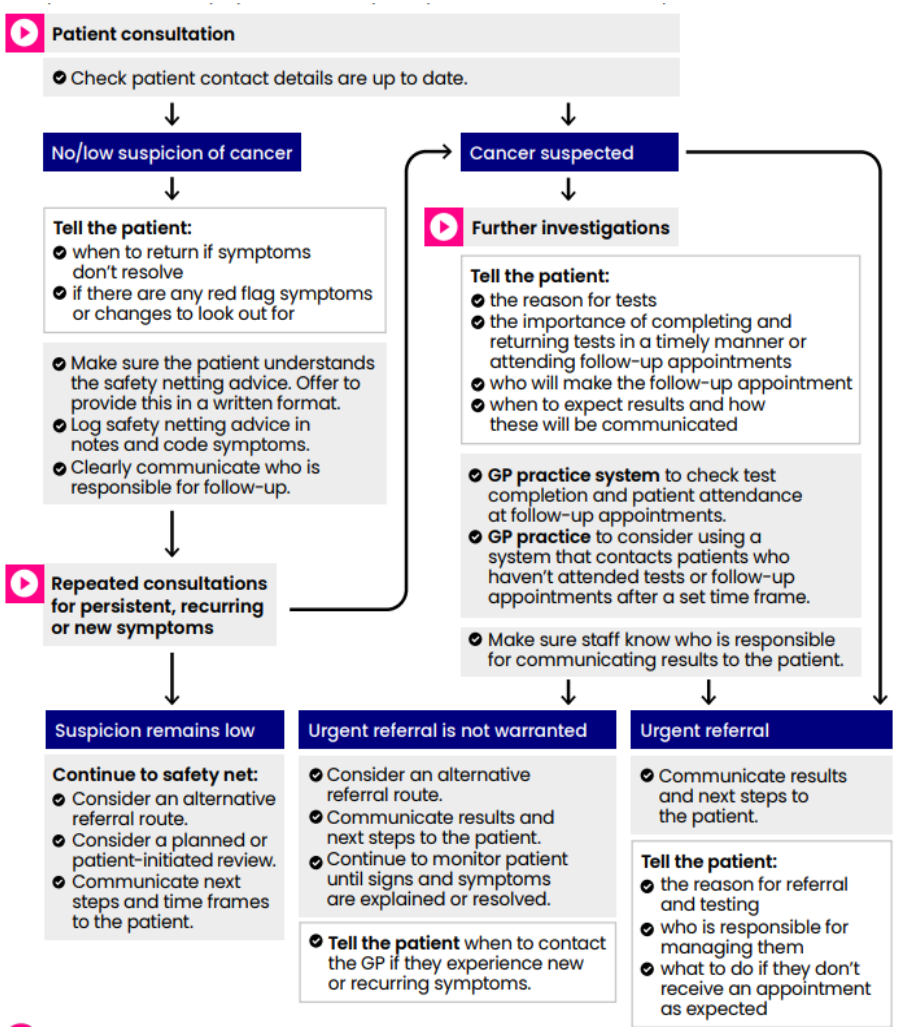
- Oxford University Hospital NHS Foundation Trust
- Royal Berkshire Hospital NHS Foundation Trust
- Buckinghamshire Healthcare NHS Trust
- Great Western Hospital NHS Foundation Trust

Education and resources:

- Access CRUK non-specific symptoms web pages
- Listen to Dr Neil Smith talk about the main considerations when managing people who present with vague symptoms
- Gateway C non-specific symptoms course
- Read about the management of non-specific signs and symptoms of suspected cancer on Doctors Net (free but login required)

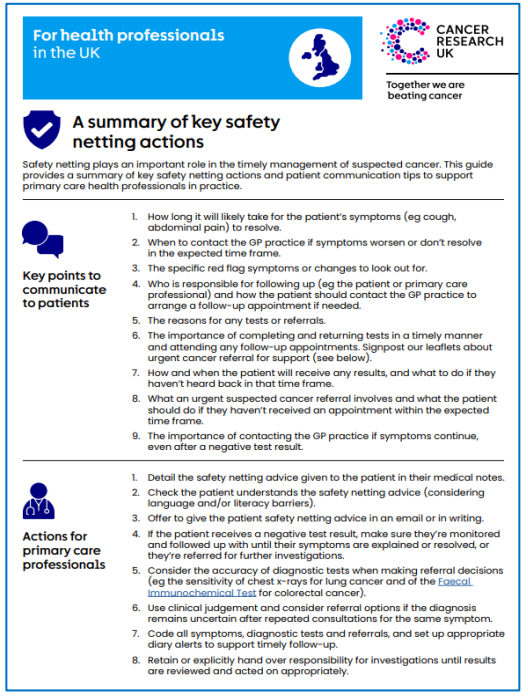
Safety netting

Safety netting is a diagnostic management strategy that ensures patients with potential cancer symptoms are monitored until they are explained or resolved, or the patient is referred.



For a summary of CRUK top safety netting actions, click on the image →

Learn more about safety netting and the Cancer Research UK resources by visiting their safety netting hub.


For health professionals in the UK

CANCER RESEARCH UK
Together we are beating cancer

A summary of key safety netting actions

Safety netting plays an important role in the timely management of suspected cancer. This guide provides a summary of key safety netting actions and patient communication tips to support primary care health professionals in practice.

Key points to communicate to patients

1. How long it will likely take for the patient's symptoms (eg cough, abdominal pain) to resolve.
2. When to contact the GP practice if symptoms worsen or don't resolve in the expected time frame.
3. The specific red flag symptoms or changes to look out for.
4. Who is responsible for following up (eg the patient or primary care professional) and how the patient should contact the GP practice to arrange a follow-up appointment if needed.
5. The reasons for any tests or referrals.
6. The importance of completing and returning tests in a timely manner and attending any follow-up appointments. Signpost our leaflets about urgent cancer referral for support (see below).
7. How and when the patient will receive any results, and what to do if they haven't heard back in that time frame.
8. What an urgent suspected cancer referral involves and what the patient should do if they haven't received an appointment within the expected time frame.
9. The importance of contacting the GP practice if symptoms continue, even after a negative test result.

Actions for primary care professionals

1. Detail the safety netting advice given to the patient in their medical notes.
2. Check the patient understands the safety netting advice (considering language and/or literacy barriers).
3. Offer to give the patient safety netting advice in an email or in writing.
4. If the patient receives a negative test result, make sure they're monitored and followed up with until their symptoms are explained or resolved, or they're referred for further investigations.
5. Consider the accuracy of diagnostic tests when making referral decisions (eg the sensitivity of chest x-rays for lung cancer and of the Faecal Immunochemical Test for colorectal cancer).
6. Use clinical judgement and consider referral options if the diagnosis remains uncertain after repeated consultations for the same symptom.
7. Code all symptoms, diagnostic tests and referrals, and set up appropriate diary alerts to support timely follow-up.
8. Retain or explicitly hand over responsibility for investigations until results are reviewed and acted on appropriately.

Ardens safety netting resources:

- Click here for **Cancer Recognition**
- Click here for **Referral Safety Netting Letter**
- Click here for **Referral Safety Netting - Email Referral Tracking**
- Click here for **Referral Safety Netting - Referral Tracking**

DES checklist: Referral practice

Thames Valley Cancer Alliance

PCN DES requirements	Yes (include date)	No	If Yes, please provide further detail of how you have met the PCN components
Reviewed the quality of referrals for suspected cancer, against the recommendations of NG12?			
Made use of clinical decision support tools?			
Accessed data available to identify cancer tumour groups to focus on?			
Met safety netting requirements?			
Conducted a review of diagnosis via emergency presentation of diagnosis at stage 3/4			
Ensure that all patients are given up to date patient information, in their language?			

DES checklist: FIT

Thames Valley Cancer Alliance

PCN DES requirements	Yes (include date)	No	If Yes, please provide further detail of how you have met the PCN components
Do your Practices have enough FIT kits? Do they have a supply chain?			
Are resources available to support patients understand the importance of completing a FIT (if symptomatic)?			
Are all staff aware of the requirements (both DES and IIF) of the completion of FIT prior to referral to Lower GI pathway?			
Do practices have systems in place to code and track all FIT tests and is there a system in place to ensure results are acted on?			
Is best practice on embedding FIT being shared across the PCN?			