RM Partners
NW & SW London Cancer Alliance

NHS

Cancer Quality Improvement Scheme – Retrospective Cancer Audit webinar

10th September 2025

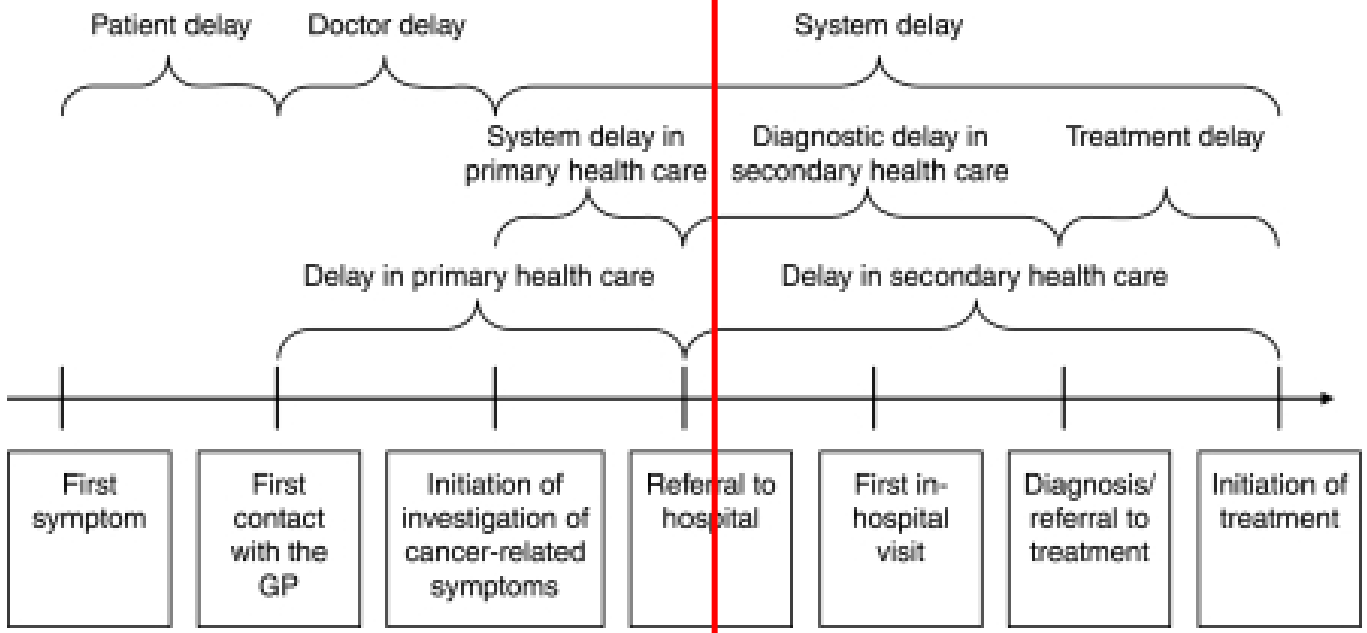
Dr Maria Wallace (Wandsworth GP Cancer Lead, RM Partners)
Dr Nav Alg (Merton, Sutton & Croydon GP Cancer Lead, RM Partners)
Dr Geetali Sharma (Ealing & Hounslow GP Cancer Lead, RM Partners

Hosted by The Royal Marsden NHS Foundation Trust

Agenda

Time	Item	Lead
12:00-12:10	Introductions & Overview of CQIS Deliverable	Nezar Idris
12:10-12:20	Year 1 finding and reflections	Dr Nav Alg
12:20-12:50	Audit sections explained w/ Q&A	Dr Nav Alg Dr Maria Wallace
12:50-12:55	Summary & case study template	Dr Geetali Sharma
12:55-13:00	Close and next steps	Ekta Patel

Improving early diagnosis of cancer

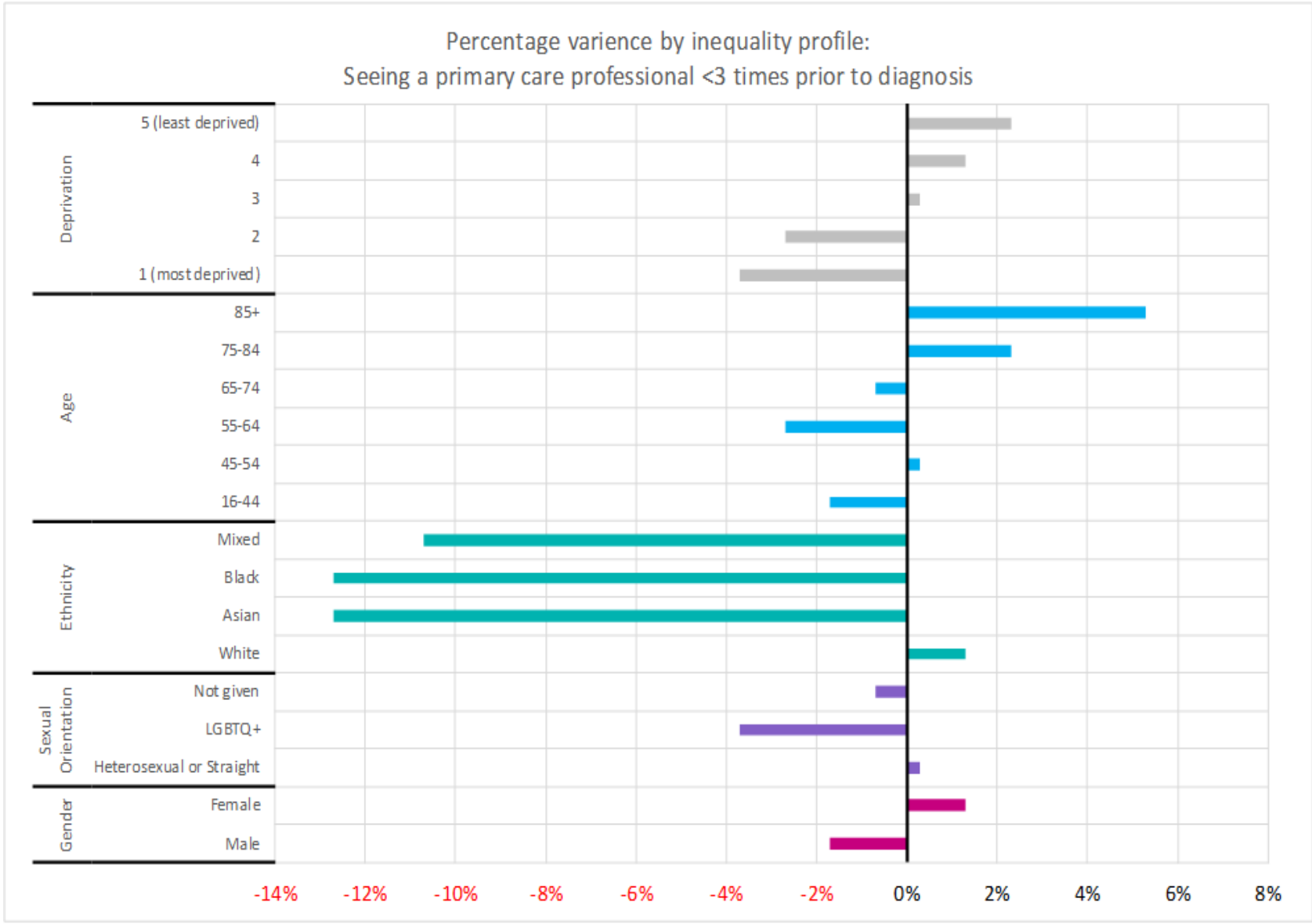


A key part of **early diagnosis** is eliminating any **avoidable delay** in

i) a patient presenting with cancer symptoms
ii) being referred via an appropriate cancer pathway once they present.

Referral Interval

NCPES data (National Cancer Patient Experience Survey) shows that there are differences between patient groups in the time taken to receive an urgent suspect cancer referral once they present to primary care with suspected cancer symptoms (**referral interval**).



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CQIS Specification overview

Section B2: Conduct a Practice based retrospective cancer diagnosis audit (using the RMP audit template v12) to understand and collect insights on recent cancer diagnoses.

- To undertake a retrospective audit of cancer diagnoses from **1st April 2024 – 31st March 2025** using the bespoke RMP Audit Template to reflect and learn from past diagnoses and patient journeys.
- **Data will be analysed by RMP (and nominated third party evaluation provider)** and shared with the PCN to facilitate in-Practice and PCN learning and discussions from the audit data.
- Practices should, whilst conducting the audit, **identify cases they think may be useful to develop into a case study** for peer review reflection and learning
- **Each clinician should do no more than 30 audits each**, this is to ensure the benefit of the audit is spread amongst staff and resources used wisely.
- The audit template should be **completed in full** for each cancer diagnosis.
- If a patient fall outside of the search date criteria or has a wrong diagnosis, please complete the audit with as much information and make use of the free text fields. **The number of patients expected in your audit has been shared with PCN member practice CQIS leads and PCN Clinical Directors.**

CQIS Specification overview - reporting and funding

The number of audits to be completed by each Practice for this deliverable will be confirmed, and shared by, RMP.

Practices are additionally **entitled to completion payment** if they complete and submit the audit:

i. **for all their 24/25 diagnoses** (as per the numbers shared by RMP)

ii. **by the 31/12/2025** deadline and

iii. the template is **completed in full** for each patient audit

Examples:

Practice	Number of cancer diagnoses in 24/25	Numbers completed	Payment for patient cases completed	Additional completion payment (20%)	Total Payment
A	15	15	£375	£75	£450
B	50	50	£1250	£250	£1500
C	75	50	£1250	£0*	£1250

*Practice did not receive completion payment as they completed only 50 audits (less than number of 24/25 cancer diagnoses)

Funding will be provided at **£25 per patient** audit completed using the RMP cancer audit template+ **completion payment by the deadline - 20% of total**

Reporting/Deadline: To submit the completed 'Retrospective Cancer Diagnosis Audit Template' to rmpartners.cqis@nhs.net by **31/12/2025**.

What Croydon & Brent colleagues said…

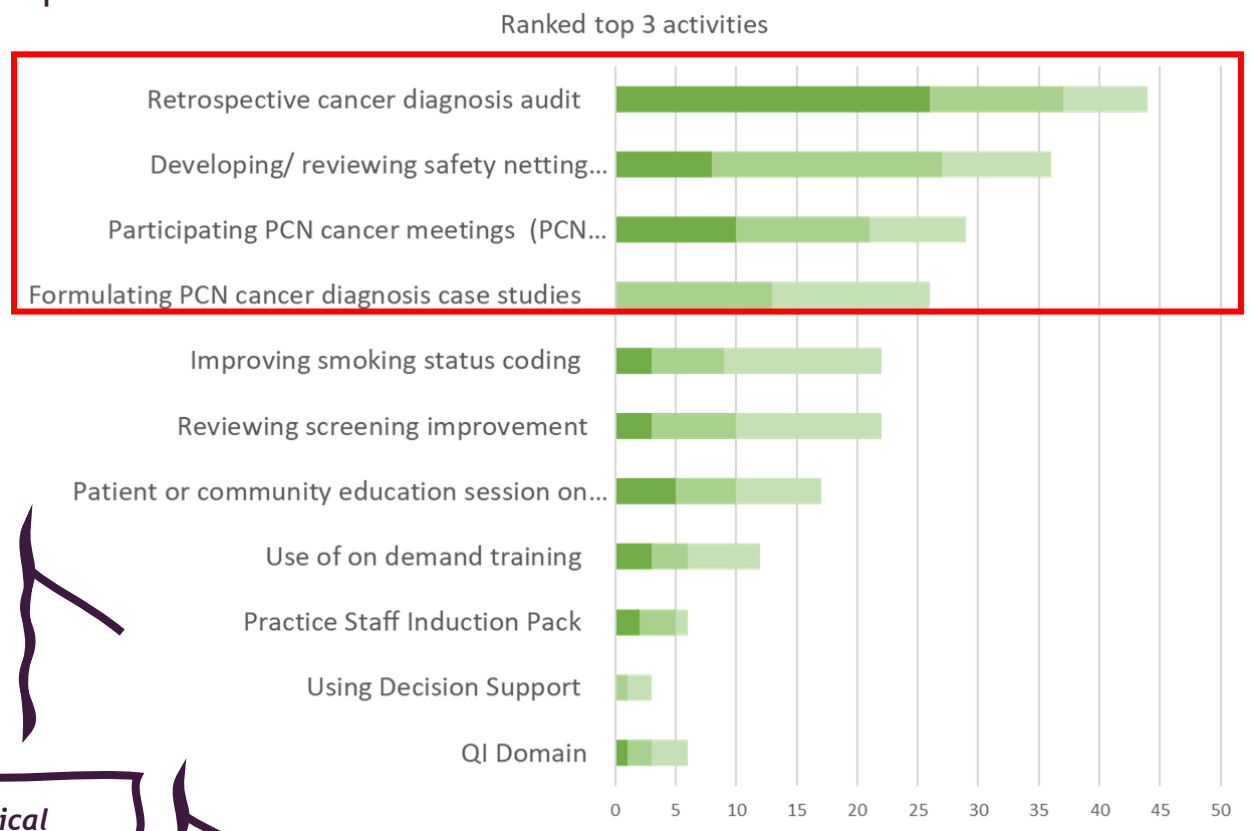
" The other beneficial aspect to the scheme was reviewing our practice safety net policy. ***We were not aware of the fact that safety netting could be done for test requests i.e., CXR's and FIT testing and putting in diary entries will help any missed opportunities.*** *"*

"The audit was a useful learning tool - the practice has reviewed new cancer diagnoses monthly for several years, but the ***RMP audit included additional information to reflect on diagnosis and care which we have incorporated into our monthly meetings.*** *It was also useful to review working practices from other primary care organisations."*

" The retrospective cancer diagnosis audit was really eye-opening as it helped to ***identify certain cancers that had numerous consultations before being referred on such as bladder cancer.*** *This showed a possible knowledge gap at practice level that we could bring up in a future teaching session during our clinical meetings."*

"The case studies were a good learning initiative which ***helped all staff especially clinical to re-evaluate how they deal with certain symptoms.*** *It did pull up the* ***issues with communication between Primary & Secondary care.*** *"*

Top rated deliverables



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Year 1 - findings: Primary care appointments and attendance history

Attendance History prior to diagnosis

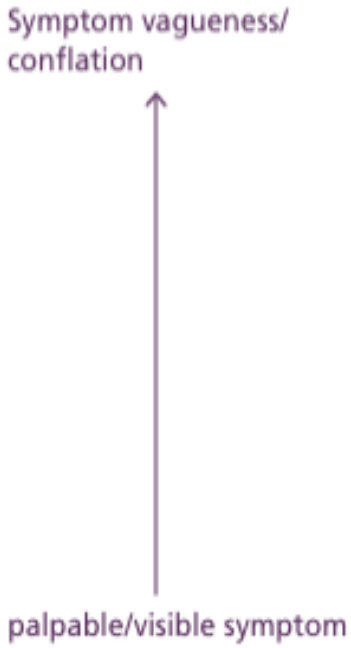
Cancer patients were higher users of primary care in the two years prior to their diagnosis both in overall use, and in the group with 10 or more appointments.

Actionable insights

- 26% of total adult GP appointments were utilised by patients aged 50-80 years with 10+ appointments over a 2-year period.

Appointments related to cancer type

Cancer diagnosis	Number of patients in analysis	% of people who had 3+ related appointments within tumour cohort
Bladder	64	39
Haematological	91	18
Lower GI	164	17
Gynaecological	133	17
Lung	119	17
All tumours	1,799	14
Upper GI	103	14
Head and neck	59	14
Prostate	396	10
Breast	367	7
Skin	77	3



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Year 1 - findings: Time between appointment and referral

43% *of patients referred 4 weeks or more after initial primary care appointment.*

Chest X-ray	28 days median	89 days mean
NOUS	22-59 days median*	45-85 days mean*
CT/MRI	10-20 days median*	25-121 days mean*
FIT test	16 days median	80 days mean
Blood tests	8-19 days median*	60-86 days mean*

Actionable insights

- Safety netting practice
- Patient reminders
- Tasks + Alerts
- Commissioning practice

*dependant on which scan

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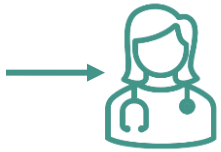
Year 1 - findings: Emergency diagnosis

12% diagnosed via an Emergency route.



48% had seen a GP about symptoms

18% had seen a GP about symptoms 3+ times

29% Of Housebound patients diagnosed via an Emergency route.

Year 1 – findings: Comorbidities

Cancer population 13% more likely to have a comorbidity compared to peers.

COPD and previous cancer rates were far higher in the cancer population than the matched population.

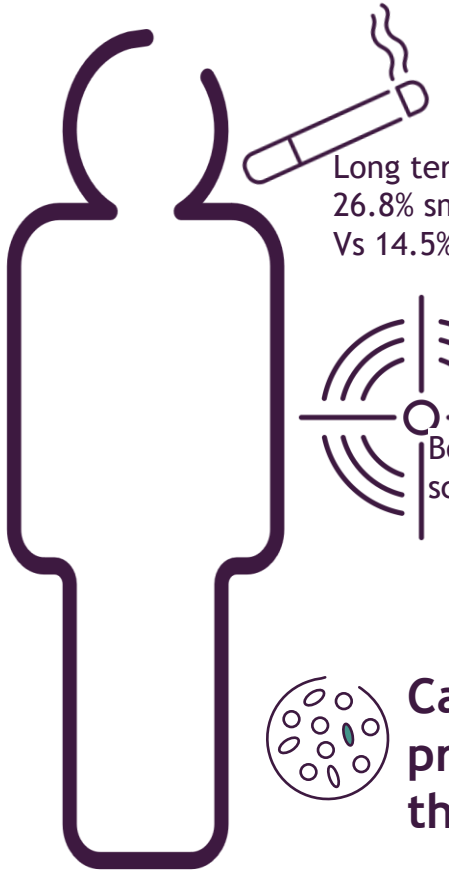
Those with comorbidities had longer primary care intervals than those without- potentially as a result of symptom conflation

Comorbidity	CQIS Audit (age 50 – 80, Croydon)		Total population (age 50 – 80, Croydon)		Difference in cancer population to aged matched population
	Number of patients	% of cohort	Number of patients	% of cohort	
No comorbities*	414	32%	58,798	45%	-13%
Previous cancer	144	11%	8,601	7%	5%
COPD	75	6%	3,610	3%	3%
Hypertension	350	27%	38,696	30%	-2%
Diabetes	195	15%	19,736	15%	0%
Cardiovascular	156	12%	13,927	11%	1%
Severe Mental Illness	12	1%	2,600	2%	-1%
Cognitive impairment	17	1%	1,674	1%	0%

Actionable insights

- Stocktake and Stand back

Year 1 – findings: What parity?



Long term MH condition:
26.8% smokers
Vs 14.5% adult population smokers

Bowel screening: 11-15% less screened than ICS average (SMI) *

Cancer leading cause of premature death for those with SMI

….yet those with anxiety/depression or severe mental illness had:

- Highest average related GP appointments
- Highest % of patients waiting more than 30 days for a referral.

Those diagnosed with breast cancer with anxiety/ depression/ SMI:

- Less likely to be screened
- More likely to have late-stage disease
- Have a lower age of diagnosis

Actionable insights

- Regular physical assessment & encouragement for cancer screening

**https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2023/05/17/over-26-000-adults-with-severe-mental-illness-die-prematurely-from-preventable-illness-each-year

*Pop health dashboards SWL/ NWL

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Year 1 – findings: Symptoms

- Those presenting with multiple symptoms were more likely to be diagnosed with late-stage disease
- Less specific symptoms associated with several cancers.

Pain

- Most common symptom reported in those with multiple attendances
- MSK pain associated with longer referral interval

Actionable insights

- Red flag for: unexplained, persistent and/ or progressive pain, with incongruent recovery
- Consider either a tumour specific pathway or via an RDC for vague symptoms

Main presenting symptom	Number of cancers the symptom is present in	Types of cancer
Abdominal pain	11	All except Metastatic/Secondary, Brain/Nervous System, Skin Cancer
Back pain	9	Bladder*, Blood, Brain/Nervous System*, Breast*, Gynaecological, Lower GI*, Lung, Prostate, Upper GI
Dyspnoea	9	Blood, Breast, Gynaecological*, Head and Neck*, Lower GI, Lung, Prostate*, Skin Cancer*, Upper GI*
Weight loss	9	Bladder, Blood*, Breast*, Head and Neck*, Kidney, Lower GI, Lung, Prostate, Upper GI
Fatigue	8	Blood, Breast, Gynaecological, Head and Neck*, Lower GI, Lung, Prostate, Upper GI
Haematuria	8	Bladder, Blood*, Gynaecological, Kidney, Lower GI*, Lung*, Prostate*
Nausea and/or vomiting	6	Blood*, Brain/Nervous System*, Breast*, Lower GI*, Prostate*, Upper GI*
Rectal bleeding	6	Blood, Breast*, Gynaecological, Lower GI, Lung*, Prostate
Bone pain	5	Blood, Gynaecological, Lung, Prostate*, Upper GI*
Chest infection	5	Bladder, Blood*, Lower GI*, Lung, Prostate
Headache	5	Blood*, Brain/Nervous System, Head and Neck*, Prostate*, Skin Cancer*
LUTS	5	Bladder, Gynaecological, Kidney*, Prostate, Upper GI*
Urinary tract infection	5	Bladder, Breast*, Gynaecological, Kidney, Prostate, Upper GI*
Bloating/ascites	4	Gynaecological, Kidney*, Lower GI, Upper GI*

*symptom only present in one patient

Retrospective Cancer Audit

The audit consists of four sections:

1. **Patient demographics** e.g. postcode (first half and first digit of the second half)
2. **Diagnosis stage** e.g. cancer diagnosis/type/date/staging (if known)
3. **Pre-diagnosis stage** e.g. symptoms, co-morbidities, investigations
4. **Pre-referral stage** e.g. safety netting, number of appointments

- The red tabs contain important information on how to complete the audit
- The yellow tabs are to be completed
- The grey tabs 'totals' is automated and summarises the type, route to diagnosis and stage of cancer diagnoses in your audit (save & refresh all). The cancer staging guidance supports column J (stage of cancer at diagnosis).

RM Partners | Read Me | GP Practice Details | Audit Template | Add Reflections | Totals | Cancer Staging Guidance

Information for the Retrospective Cancer Diagnosis Audit 2025/26

This work forms part of the Primary Care Cancer Quality Improvement Scheme 25/26

INFORMATION

1	This Audit Template (yellow box) should be used to complete the audit under GP Practice deliverable Section B2 of the Cancer QI Specification (Conduct a Practice based based retrospective cancer diagnosis audit to understand and collect insights on recent cancer diagnoses).
2	This audit will enable your GP Practice to reflect and learn from past cancer diagnoses and patient journeys, providing data across different cancer types and tumours as well as relevant timelines and primary care activity/appointment utilisation.
3	Please use the developed Cancer QI Retrospective Cancer Diagnosis Audit EMIS/SystemOne search to identify the relevant cohort of patients to audit that were diagnosed between 01/04/2024 and 31/03/2025.
4	Whilst completing the audit, your GP Practice should make a note of any delayed/late stage diagnosis or where a patient has been referred and diagnosed in a timely way/earlier that could be used by your GP Practice/PCN to reflect and learn from as part of GP Practice deliverable 3 (Explore and develop a cancer diagnosis for reflection and learning in the Practice and PCN). An example of such a case study can be found in the Cancer QI Resource Pack.
5	Please complete the audit template (yellow tab) with as much information as possible for each patient and cancer diagnosis in order to make the analysis and exercise as meaningful as possible for your GP Practice. It is acknowledged that occasionally some data may be missing and there may be gaps in the audit or some patients will have incorrectly dated cancers- In such instances the GP Practices should complete the audit template with as much information as possible that they have available to them and make use of Column AB or AV to provide detail of any data gaps (free text).
6	Columns AP, AQ & AR have been formatted to only allow the relevant fields to be completed based on the patients route to diagnosis (column K). Count one for each relevant primary care contact. Zero can only be recorded for patients diagnosed through screening or other routes (such as incidental findings in secondary care or A&E) where no related primary care contact occurred.
7	This information is being collected as part of a learning exercise in primary care to improve the early detection and diagnosis of cancer. RM Partners (and any relevant system partners/third parties if applicable) may analyse the data submitted for sharing high-level insights & trends and for the benefit of reflecting these back to PCNs (at GP Practice/PCN/Borough level) to help improve patient care.
8	Most questions have multiple choice (dropdown) answers but please note there are two free text columns (Column AB & AV) for each patient where additional context or information can be added that GP Practices feel is relevant
9	Please see the service specification documentation for information relating to payments for the audit. Funding is calculated on the number of patient cases being
10	The data generated from the audit will update in the 'Totals' Tab. To get the most up to date totals in 'Totals' tab, please save your data and then click on the icon or go to 'Data' tab (at the top of the Audit template) and click **'Refresh Al** 
11	Please complete your GP Practice details (yellow tab) prior to submission
12	Please complete your final reflections (yellow tab), learnings and actions in the 'Reflections' tab

SUBMISSION

This audit should be completed by 31/12/2025.

RM Partners will contact Practices by early Dec 2025 around next steps and how to submit the audit template.

HELP

For further information please contact your local (borough) GP Cancer Clinical lead or email rmpartners.cqis@nhs.net

Please review our privacy policy on how your data will be stored and managed https://rmpartners.nhs.uk/privacy-policy/

- Use the search provided by RM Partners
- Complete all fields to the best of your knowledge and make use of the free text fields and guidance
- Ensure all primary care contacts are accounted for
- Most columns provide drop down options
- Refer to deadline and payment calculations prior to submitting
- All submissions will be subject to review to ensure completion and maximum payment can be awarded
- Contact the RMP team for clarity on any part of the audit/scheme

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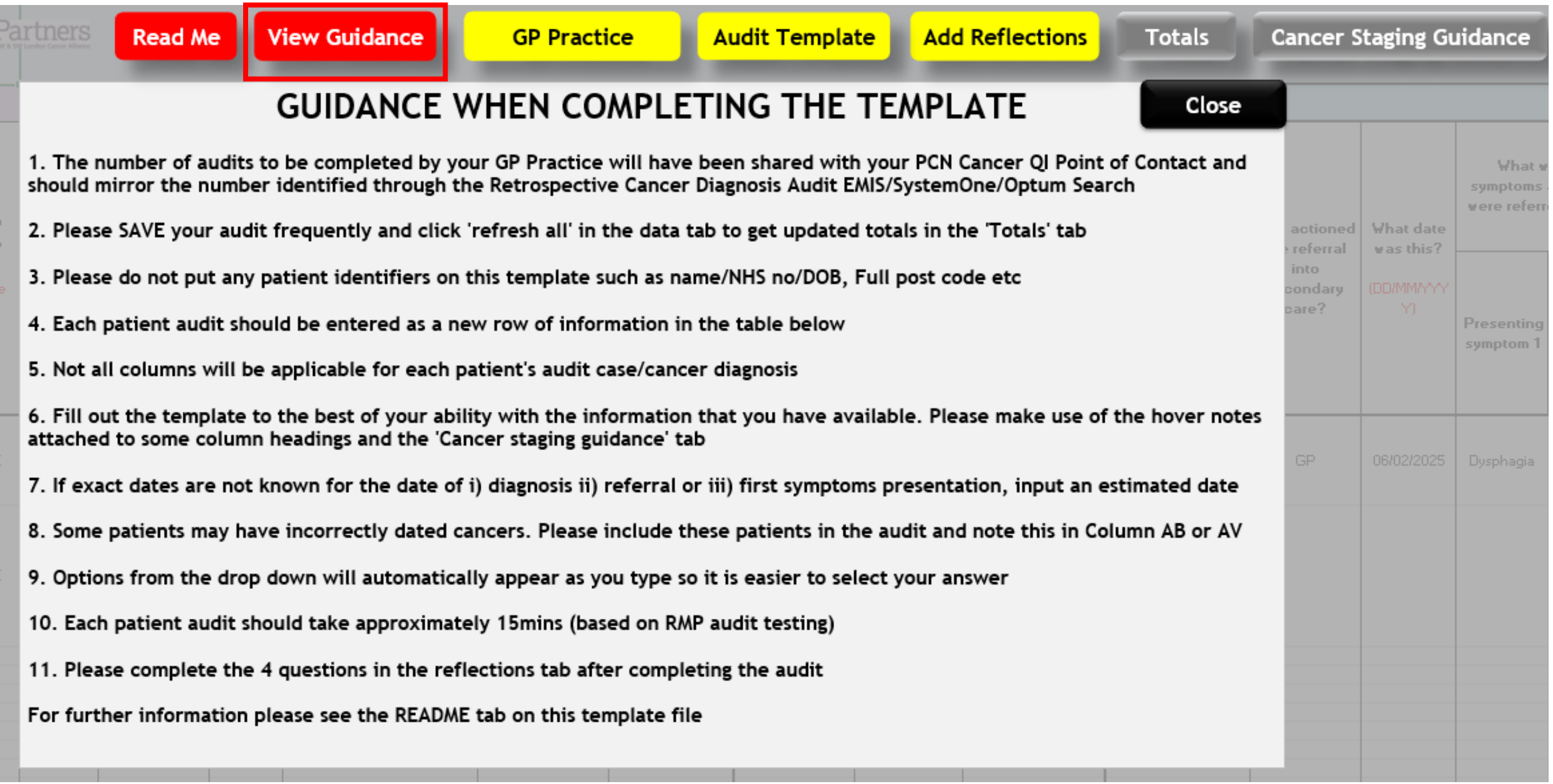

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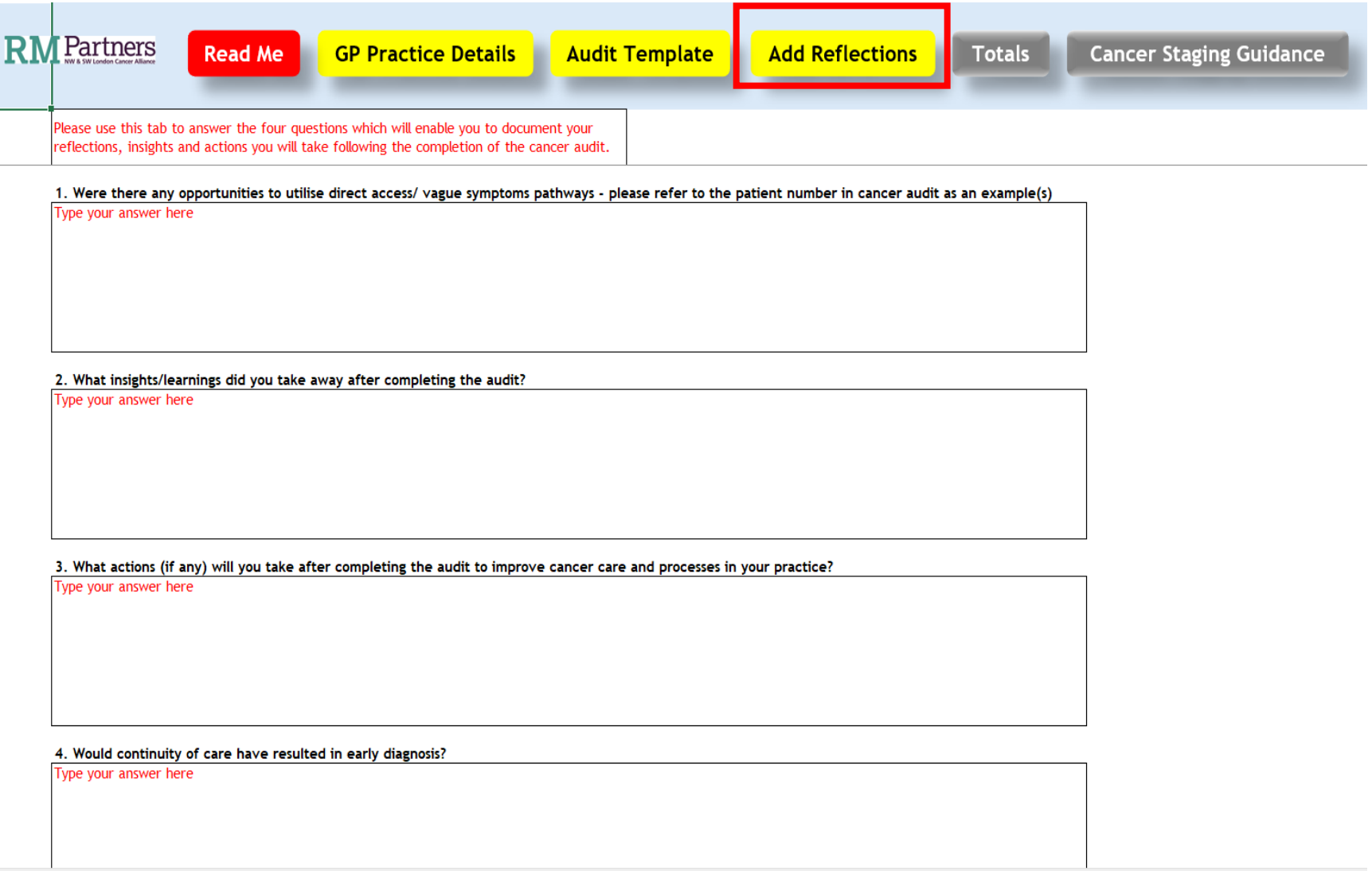
Read Me | GP Practice Details | Audit Template | Add Reflections | Totals | Cancer Staging Guidance

	Cancer Quality Improvement Scheme (CQIS 2025/26)		
GP Practice			
Primary Care Network (PCN)			
For the period of completing this audit, was your practice operating a total triage system? (Delete as appropriate)	Yes	No	Other (please state)
Borough			
Completed by - Name(s) & Role(s) & Email(s)	Name: Role: Email:		

(Maria)



Q1: Were there any opportunities to utilise direct access/vague symptoms pathways – please refer to the patient number in the cancer audit as an example(s)

Q2: What insights/learnings did you take away after completing the audit?

Q3: What actions (if any) will you take after completing the audit to improve cancer care and processes in your practice?

Q4: Would continuity of care have resulted in early diagnosis?

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Read Me | View Guidance | GP Practice | Audit Template | Add Reflections

Patient Info & Demographics							Diagnosis Stage			
Patient / Audit N° (Do not use NHS N°)	**Age** (at Cancer Diagnosis)	**Postcode** (First part of postcode and first digit of the 2nd half of the post code only (Please leave a space) - e.g. SW1 4 or HA10 6)	**Gender**	**Ethnicity**	**Place of residence** (residential/nursing care home/own home)	**Language: In your knowledge, this patient...**	**Cancer Diagnosis** (Type of cancer)	**Date of Cancer Diagnosis** (DD/MM/YYYY)	**Stage of Cancer at diagnosis**	**Wha into care th di** (e.g. routi
EXAMPLE	74	SW20 9	Male	Asian or Asian British - Any other Asian background	Own home	Is not fluent in English (requires a translator/assistance)	Oesophageal	19/02/2025	Stage 4	Urgen Canc Refe
EXAMPLE	78	SW15 1	Female	White - British	Own home	Is fluent in English	Colorectal	27/03/2025	Stage 2	S d

Stage 1
Stage 2
Stage 3
Stage 4
Early stage
Late stage/metastatic
Unstageable
Not Known

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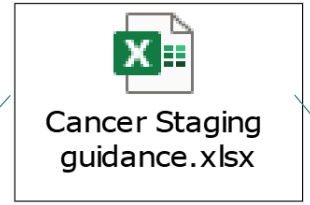
Read Me | GP Practice Details | Audit Template | Add Reflections | Totals | Cancer Staging Guidance

1) Please refer to 'Ref_StagCancerYesNo; tab to determine if cancer is stageable or not.

2) If stageable, then refer to below link/additional guidance to determine the appropriate staging from the drop down options provided.

https://digital.nhs.uk/ndrs/data/cancer-data-training-materials/staging-sheets#chapter-index

3) Please provide the exact staging as provided i.e. stage 1-4. If staging information is not available, please select the most appropriate option.



Guidance:	Please refer to 'Ref_StagCancerYesNo; tab to determine if cancer is stageable or not. If stageable, then refer to link to determine the appropriate staging from the drop down options provided.
Cancer staging guidance sheets	https://digital.nhs.uk/ndrs/data/cancer-data-training-materials/staging-sheets#chapter-index
Available staging systems:	https://www.canstaging.org/

Tumour Group	Sub Tumour Group	Code	Description	Stageable
Pancreatic	Upper GI (HPB)	C25	Malignant neoplasm of pancreas	Yes
Pancreatic	Upper GI (HPB)	C250	Head of pancreas	Yes
Pancreatic	Upper GI (HPB)	C251	Body of pancreas	Yes
Pancreatic	Upper GI (HPB)	C252	Tail of pancreas	Yes
Pancreatic	Upper GI (HPB)	C253	Pancreatic duct	Yes
Pancreatic	Upper GI (HPB)	C254	Endocrine pancreas	Yes
Pancreatic	Upper GI (HPB)	C257	Other parts of pancreas	Yes
Pancreatic	Upper GI (HPB)	C258	Overlapping lesion of pancreas	Yes
Pancreatic	Upper GI (HPB)	C259	Pancreas unspecified	Yes
Lung	Lung	C33	Malignant neoplasm of trachea	No
Lung	Lung	C34	Malignant neoplasm of bronchus and lung	Yes
Lung	Lung	C340	Main bronchus	Yes
Lung	Lung	C341	Upper lobe bronchus or lung	Yes
Lung	Lung	C342	Middle lobe bronchus or lung	Yes
Lung	Lung	C343	Lower lobe bronchus or lung	Yes
Lung	Lung	C348	Overlapping lesion of bronchus and lung	Yes
Lung	Lung	C349	Bronchus or lung unspecified	Yes
Breast	Breast	C50	Malignant neoplasm of breast	Yes
Breast	Breast	C500	Nipple and areola	Yes
Breast	Breast	C501	Central portion of breast	Yes
Breast	Breast	C502	Upper-inner quadrant of breast	Yes
Breast	Breast	C503	Lower-inner quadrant of breast	Yes

Ref_StageCancerYesNo | 2. TNMStaging | 2.1 Haematology | 2.2 Gynaecology | 2.3

Tumour Type	m caple)	Stage Group	T stage	N stage	M stage	TNM Group
Appendix (ICD10 C18.1)		Stage IVC	Any T	Any N	M1c	Any TAny NM1c
Colon and rectum (ICD10 C18-C20)		Stage 0	Tis	N0	M0	TisN0M0
Colon and rectum (ICD10 C18-C20)		Stage I	T1, T2	N0	M0	T1, T2N0M0
Colon and rectum (ICD10 C18-C20)		Stage II	T3, T4	N0	M0	T3, T4N0M0
Colon and rectum (ICD10 C18-C20)		Stage IIA	T3	N0	M0	T3N0M0
Colon and rectum (ICD10 C18-C20)		Stage IIB	T4a	N0	M0	T4aN0M0
Colon and rectum (ICD10 C18-C20)		Stage IIC	T4b	N0	M0	T4bN0M0
Colon and rectum (ICD10 C18-C20)		Stage III	Any T	N1, N2	M0	Any TN1, N2M0
Colon and rectum (ICD10 C18-C20)		Stage IIIA	T1, T2	N1	M0	T1, T2N1M0
Colon and rectum (ICD10 C18-C20)		Stage IIIA	T1	N2a	M0	T1N2aM0
Colon and rectum (ICD10 C18-C20)		Stage IIIB	T1, T2	N2b	M0	T1, T2N2bM0
Colon and rectum (ICD10 C18-C20)		Stage IIIB	T2, T3	N2a	M0	T2, T3N2aM0
Colon and rectum (ICD10 C18-C20)		Stage IIIB	T3, T4a	N1	M0	T3, T4aN1M0
Colon and rectum (ICD10 C18-C20)		Stage IIIC	T3, T4a	N2b	M0	T3, T4aN2bM0
Colon and rectum (ICD10 C18-C20)		Stage IIIC	T4a	N2a	M0	T4aN2aM0
Colon and rectum (ICD10 C18-C20)		Stage IIIC	T4b	N1, N2	M0	T4bN1, N2M0
Colon and rectum (ICD10 C18-C20)		Stage IV	Any T	Any N	M1	Any TAny NM1
Colon and rectum (ICD10 C18-C20)		Stage IVA	Any T	Any N	M1a	Any TAny NM1a
Colon and rectum (ICD10 C18-C20)		Stage IVB	Any T	Any N	M1b	Any TAny NM1b
Colon and rectum (ICD10 C18-C20)		Stage IVC	Any T	Any N	M1c	Any TAny NM1c
Anal canal and perianal skin data (ICD10 C21, C44.5)		Stage 0	Tis	N0	M0	TisN0M0
Anal canal and perianal skin data (ICD10 C21, C44.5)		Stage I	T1	N0	M0	T1N0M0
Anal canal and perianal skin data (ICD10 C21, C44.5)		Stage IIA	T2	N0	M0	T2N0M0
Anal canal and perianal skin data (ICD10 C21, C44.5)		Stage IIB	T3	N0	M0	T3N0M0
Anal canal and perianal skin data (ICD10 C21, C44.5)		Stage IIIA	T1, T2	N1	M0	T1, T2N1M0
Anal canal and perianal skin data (ICD10 C21, C44.5)		Stage IIIB	T4	N0	M0	T4N0M0

Ref_StageCancerYesNo | 2. TNMStaging | 2.1 Haematology | 2.2 Gynaecology | 2.3

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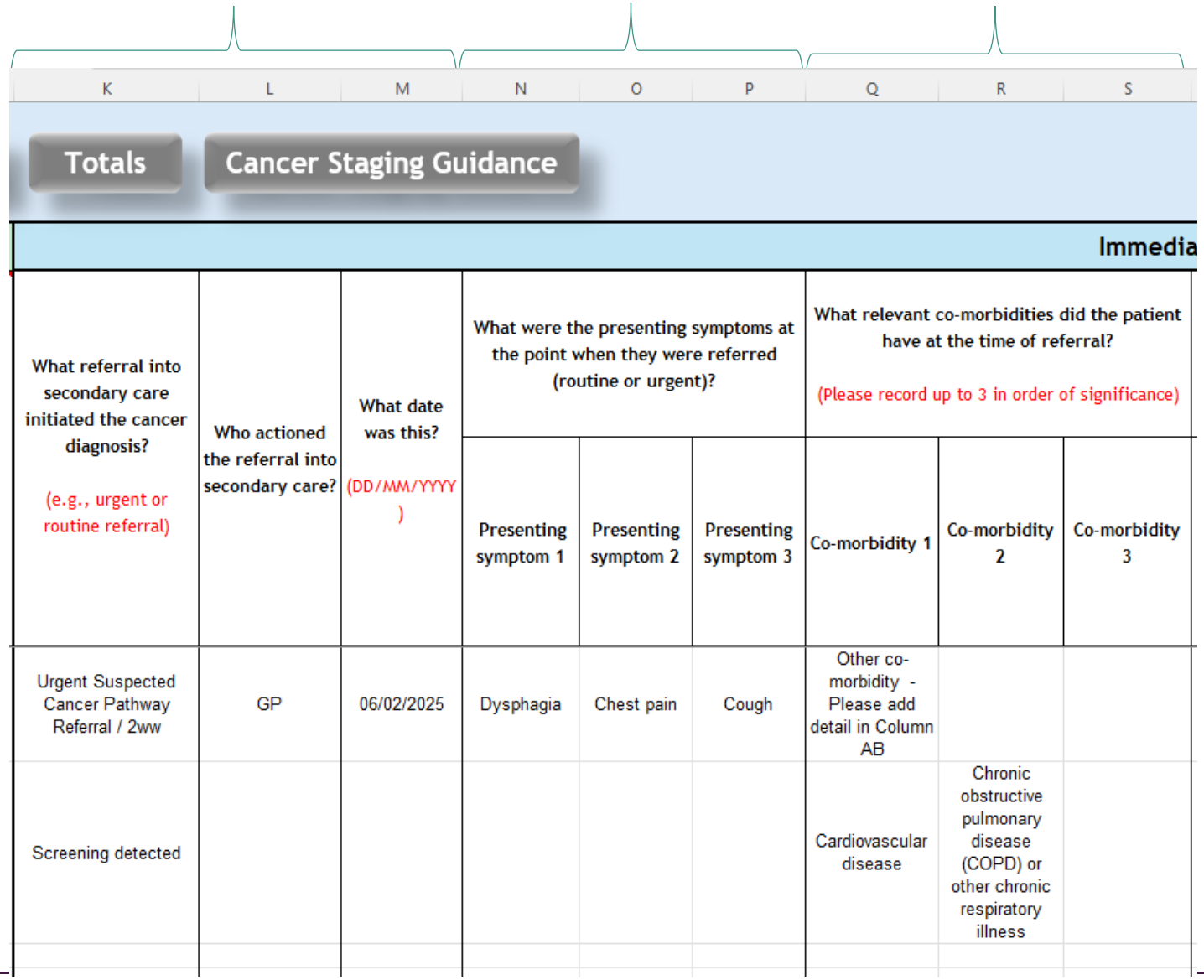
Route to diagnosis

Presenting symptoms

Co-morbidities



K	L	M	N	O	P	Q	R	S

Totals | Cancer Staging Guidance

Immedia

What referral into secondary care initiated the cancer diagnosis? (e.g., urgent or routine referral)	Who actioned the referral into secondary care?	What date was this? (DD/MM/YYYY)	What were the presenting symptoms at the point when they were referred (routine or urgent)?			What relevant co-morbidities did the patient have at the time of referral? (Please record up to 3 in order of significance)		
			Presenting symptom 1	Presenting symptom 2	Presenting symptom 3	Co-morbidity 1	Co-morbidity 2	Co-morbidity 3
Urgent Suspected Cancer Pathway Referral / 2ww	GP	06/02/2025	Dysphagia	Chest pain	Cough	Other co-morbidity - Please add detail in Column AB		
Screening detected						Cardiovascular disease	Chronic obstructive pulmonary disease (COPD) or other chronic respiratory illness	

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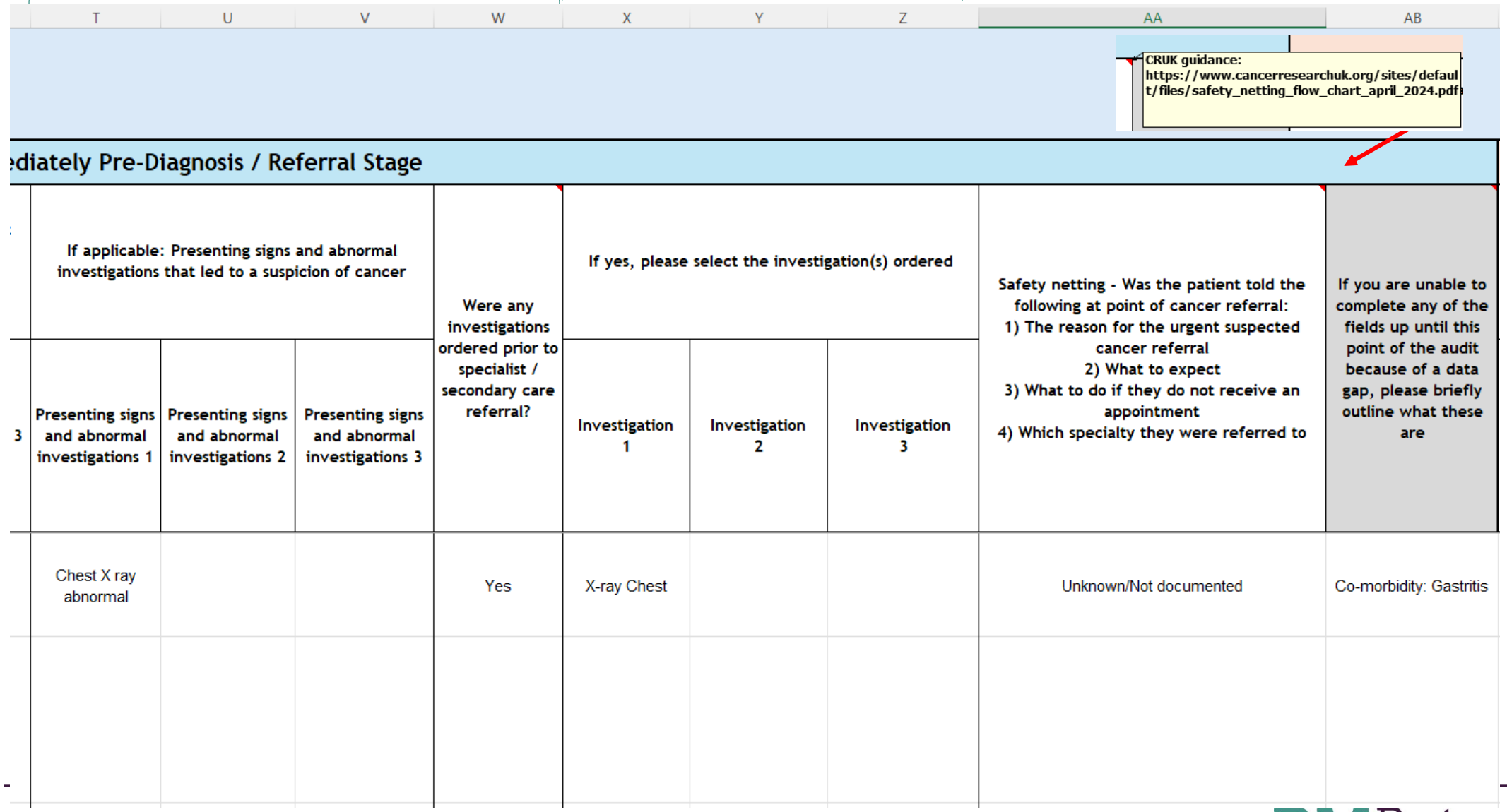
NHS

Abnormal signs/investigations leading to suspicion of cancer

Investigations ordered

Safety netting at point of referral

Free text



Hover notes (red triangle in the top right corner)

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NHS

Main presenting symptoms

Safety netting prior to referral

AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO

Pre-referral stage												
Please outline the details of the last 3 GP Practice appointments before the cancer referral was made (excl. smears, travel vaccs, bloods/phlebotomy & admin appts) Please list in reverse chronological order (i.e. the most recent first)						Safety netting - during the patient's primary care consultations and investigations prior referral to secondary care, was it documented that the patient was told:						In the preceeding 2 years from the date of cancer diagnosis, how many GP Practice appointments did the patient have (excluding smear,travel vaccs, bloods/phlebotomy & admin appts)?
Appt 1 - Appt Date (DD/MM/YYYY)	Appt 1 - Main presenting symptom	Appt 2 - Appt Date (DD/MM/YYYY)	Appt 2 - Main presenting symptom	Appt 3 - Appt Date (DD/MM/YYYY)	Appt 3 - Main presenting symptom	1) When to return if symptoms don't resolve (including specified time frames)	2) If there are any red flag symptoms or changes to look out for	3) Reason for tests	4) Importance of completing and returning tests in a timely manner or attending follow-up appointments	5) Who will make the follow-up appointment (if required prior to referral) (patient or clinician)	6) When to expect results and how this will be communicated	
13/01/2025	Other pain - please outline site specific pain in column AB or AU	16/12/2024	Chest infection	13/12/2024	Back pain	Yes	Unknown/Not documented	Unknown/Not documented	Unknown/Not documented	Unknown/Not documented	Unknown/Not documented	7
												9

Type and number of appointments relating to cancer

Main symptom reflection

Free text – learning points

K	AO	AP	AQ	AR	AS	AT	AU	AV
Totals								
	e-referral stage							
What referral into secondary care initiated the cancer diagnosis? (e.g., urgent or routine referral)	In the preceeding 2 years from the date of cancer diagnosis, how many GP Practice appointments did the patient have (excluding smear,travel vaccs, bloods/phlebotomy & admin appts)?	Only complete this column if patient was diagnosed via screening or A&E. How many appointments (face to face, telephone or online-consultations) in the preceding 2 years from the date of cancer diagnosis, were related to symptoms that were/could have been attributable to the cancer?	On reflection, how many appointments (face to face or telephone only) in the preceding 2 years from the date of cancer diagnosis, were due to symptoms that were/could have been related to the cancer? Leave blank for patients diagnosed via screening or A&E.	In the preceding 2 years from the date of cancer diagnosis, how many online-consultations only were in relation to their cancer related symptoms? Leave blank for patients diagnosed via screening or A&E.	If applicable, what was the main reason that multiple (i.e. 3 or more) consultations occured in general practice with the symptoms that were (or could have been) related to cancer?	On reflection, what date did the patient start presenting with symptoms that were (or could have been) related to the cancer? This could have been before the 2 years from date of diagnosis (DD/MM/YYY)	What was the main symptom the patient initially presented with, that could have been related to their cancer?	What key learning point have you taken from this patient's cancer journey?
Urgent Suspected Cancer Pathway Referral / 2ww	7					15/01/2025	Dysphagia	Attended with skin lesion before appointment before referral, PMH of gastritis that could be relevant
Screening detected	9							

Count one for each relevant primary care contact. Zero can only be recorded for patients diagnosed through screening or other routes (such as incidental findings in secondary care or A&E) where no related primary care contact occurred.

E.g., this will include the appointment in which the patient was referred to secondary care services such as via the Urgent Suspected Cancer pathway.

Columns AP and AQ & AR will grey out depending on route to diagnosis (column K)

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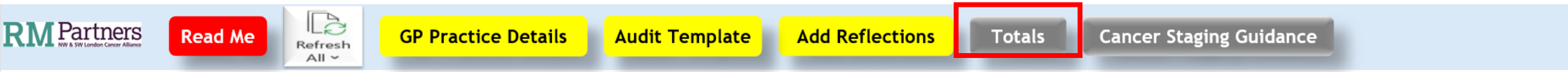
NHS

SAVE & click refresh to update figures



Type of Cancer

Row Labels	Total
(blank)	
Oesophageal	1
Colorectal	1
Grand Total	**2**

What referral into secondary care initiated the cancer diagnosis?

Row Labels	Total
Urgent Suspected Cancer Pathway Referral / 2ww	1
(blank)	
Screening detected	1
Grand Total	**2**

Stage of Cancer at diagnosis

Row Labels	Total
(blank)	
Stage 4	1
Stage 2	1
Grand Total	**2**

Stage of Cancer at diagnosis By Type of Cancer

Total	Column Lab			
Row Labels	**(blank)**	**Stage 4**	**Stage 2**	**Grand Total**
(blank)				
Oesophageal		1		1
Colorectal			1	1
Grand Total		**1**	**1**	**2**

Summary

Guidance

- An EMIS or S1 search has been provided to identify the relevant cohort of patients to audit that were diagnosed between 01/04/2024 and 31/03/2025.
- Not all columns will be applicable for each patient's audit case/cancer diagnosis i.e. if patient was diagnosed via screening.
- If exact dates are not known for the date of i) diagnosis ii) referral or iii) first symptoms presentation, input an estimated date
- Some patients may have incorrectly dated cancers or diagnosis. There will be free text columns to tell us if this is the case.
- Additional guidance or rationale will be provided in the corner of some columns.
- Whilst completing the audit, please make a note of any delayed/late-stage diagnosis or any cases where patient has been diagnosed in a timely way, that could be used by your GP Practice/PCN to reflect and learn from as part of the GP Practice deliverable (Section B3 Case study).
- Both the audit analysis and collation of case studies will be shared back to GP practices and PCNs. You can view a summary of some of the columns in the 'Total's tab.

Please complete the audit for all patients in the search and check against the numbers provided by RM Partners.

Section B3: case study

Summary history and presentation

- Patient profile/demographics
- List relevant clinical & recent appointment history
- Indication of timeline & dates
- Presenting complaints/symptoms and interactions with NHS/health services

Referral & Diagnosis

- Details relating to the urgent suspected cancer/other referral that led to diagnosis
- Include any investigations / diagnostics
- Type of cancer

Learning points

- Did safety netting systems work appropriately?
- Did continuity, or lack of this, play any role?
- Did the patient's profile / background warrant extra attention to certain cancer or risk?
- Could any tests/diagnostics have been requested on reflection to support making a referral?

Resulting change/opportunities for improvement

- Did any practice systems change because of learning from this case?
- How has or will this learning be shared with practice staff?

An example case-study and template will be provided in the resource pack to complete and submit to RM Partners

Thank you & next steps

Deliverable	Deadline	Resources available
Retrospective Cancer Audit *Practice deliverable Section B2*	31st December 2025	Webinar recording, slides, template to submit. Please use version 12.Final Retrospective Cancer Audit Template in the resource packs (this will be shared with recording as well)
PCN action plans *PCN deliverable Section A1*	12th September 2025	One PCN submission form to be submitted only. https://wkf.ms/3Uieug9
Sharing Tobacco Cessation Information *Practice deliverable Section B9*	September – staggered each month	PCNs will be notified if not already, to send out the specified message to patients via SMS (accurx/comms annex) in September and subsequent months throughout the scheme and be provided with the search, FAQs and guidance. All PCNs to review which month they will be asked to prepare for this in the resource pack.
PCN CQIS meeting 1 PCN deliverable Section A2	October or November	Please book in 1 hour as soon as possible and invite your local RMP management and clinical colleagues. A representative from each practice should attend. RMP will send a meeting pack in advance.

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