

PRIMARY CARE 10 TOP TIPS

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Think triggers for early referral in suspected cancer

1 When did you last refresh your knowledge of the referral guidelines for suspected cancer?

2 Remember that clinical suspicion is paramount and can sometimes override what the guidelines indicate.

3 Common things are common and most presentations are fairly predictable. But unusual presentations do happen – what was the last one you had to refer?

4 Do you or your practice undertake a significant event analysis for patients in where there has been a delay in referral or diagnosis? Carrying out a significant event analysis (SEA) can be used for your appraisal and for the Quality and Outcomes Framework (QOF).

5 Do you analyse your urgent or two week wait referral rates? Considering what the outcomes have been for patients referred through this route? If you do, does it affect your referral behaviour? How do you compare with other practices in your area?

6 Have you stopped to think what it is that sometimes makes you reluctant to refer? How can you get round that?

7 Are you aware of all the 'at risk' groups? Everyone knows that smokers are at increased risk of lung cancer but are you aware of the increased risk of malignancy that accompanies some medical conditions?

8 Do you or your practice do anything to encourage those in 'at risk' groups to recognise what could be a serious symptom and (through giving of patient information leaflets) encourage them to come along at an early stage to discuss?

9 If you have niggling concerns about a patient but don't feel you need to refer, do you get advice from your colleagues in the practice? Do you use your local consultants for advice (eg a phone call or email) about whether to refer?

10 If 'open access' or 'direct to test' investigations are available in your area, how often do you make use of them? Do you follow up on patients who have 'normal' or 'negative' tests?