NHS Wessex Cancer Alliance

Safety netting, Red Flags and Jess's Rule Workshop

A systems approach to Early Cancer Diagnosis

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What we will cover

- Talk through a patient presentation
- Discuss & identify how and where there could be opportunities for earlier diagnosis
- Outline the principles of safety netting and tips on how to effectively safety net across systems
- Jess's Rule
- Red Flag Symptoms – a systems approach

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Case for discussion

Helen

- Helen, 64 years old – generally well
- Advises receptionist “I think I have another wee infection, as there was some blood in my wee. I know the doctors are so busy – would it be possible to have some antibiotics – they cleared everything so quickly the last time.”

Helen

- The nurse recommends that Helen does a MSU and prescribes a short course of antibiotics (Nitrofurantoin 100mg MR bd for 3 days) to be started after the sample is done, and to check the result in a few days' time.

Helen

- MSU result (History: ?UTI). Result: No blood, no cells, no growth seen): GP (not her own) signs result as “Normal”.
- Helen checks result via the NHS App: “Normal”.

Helen

- 4 months later, Helen phones surgery, reporting 4 days R loin pain and 2 days of blood in her wee, the latter has now settled.
- Receptionist advises a GP will phone her back
- Helen gives GP her history – UTI 4 months ago, which settled, and the 4-day history as shared with the receptionist.

Helen

- Helen attends face-to-face, bring a sample as requested – examination is unremarkable. GP dips tests urine – blood+++
- GP advises he is going to refer on a fast-track pathway, and she will be seen in the hospital within 2 weeks.

Helen

- 4 weeks later Helen phones reception as she hasn't heard anything – she is put through to the admin team, who give Helen the number for the hospital.
- Helen phones hospital – eventually speaking to someone in the Fast Track team – advised she had missed her appointment. Discovers the clinic had not been able to contact her by phone and so they had sent appointment to her. She never received the letter. She gives them her new mobile number
- Helen is given appointment for KUB CT 3 days later.

Helen

- 3 days after the scan Helen receives a call from the hospital asking her to attend the following day.
- She attends to be told the scan shows she has cancer of the right kidney and will need surgery to remove the kidney, and the lymph nodes are enlarged, and she is likely to need a course of SACT.
- First symptom to treatment 6 months

How could we have done better?

- What ‘red flags’ were missed?
- Where could safety netting have changed the outcome?
- What could we put in place to improve the chances of earlier diagnosis in the future?

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Safety netting

What is safety netting?

If you saw in a patients notes:

‘I have safety netted.’

What would that mean to you?

Definitions of safety netting

Diagnostic management strategy that ensures patients are monitored throughout the diagnostic process until their symptoms or signs are explained[1] and results have been acted upon.

Roger Neighbour: concept of "Safety netting" in 1987[2]:

- *If I'm right, what do I expect to happen?*
- *How will I know if it doesn't?*
- *What would I do then?*

Safety netting principles are referenced within the NICE NG12 guidance for suspected cancer

"Consider a review for people with any symptom that is associated with an increased risk of cancer, but who do not meet the criteria for referral or other investigative action"

What are the principles for safety netting in primary care?

Communicate to patients

Actions for Clinicians

Actions for practices

Communicate to patients

- ✓ The likely **time** course of current symptoms (e.g. cough, bowel symptoms, pain) and when to come back if symptoms resolve
- ✓ Specific warning/red flag symptoms or changes to look out for
- ✓ Who should make a follow up appointment with the GP, if needed
- ✓ The reasons for tests or referrals & how to obtain results
- ✓ Highlight the importance of attending investigations (Patient Information Leaflet)
- ✓ The importance of coming back if symptoms continue, even after a negative test result
- ✓ Check the patient understands the safety netting advice (considering language and/or literacy barriers)

Actions for Clinicians

- ✓ If a negative test result, ensure the patient is followed up until their symptoms are explained, resolved or they are referred for further investigations
- ✓ Consider the accuracy of diagnostic tests (e.g. false negative rates for chest x-rays for lung cancer, different thresholds in FIT for screening vs. FIT for symptomatic patients, etc.)
- ✓ Consider referral after repeated consultations for the same symptom where the diagnosis is uncertain (e.g. three strikes and you are in)
- ✓ Code all symptoms, diagnostic tests, referrals and set up appropriate diary alerts
- ✓ Retain (or explicitly pass on) responsibility over initiated investigations until results are reviewed and acted upon appropriately
- ✓ Detail safety netting advice in the medical notes (as understood by the patient)
- ✓ Obtain up to date contact details for patients undergoing tests or referrals

Actions for practices

- ✓ Inform patients about how to obtain their results
- ✓ Have a system for communicating abnormal test results to patients
- ✓ Have a system for contacting patients with abnormal test results who fail to attend for follow up
- ✓ Have a system to document that all results have been viewed and acted upon appropriately
- ✓ Have policies in place to ensure that tests/investigations ordered by locums are followed up
- ✓ Have systems that can highlight repeat consultations for unexplained recurrent signs/symptoms
- ✓ Practice staff involved in logging results are aware of reasons for urgent tests and referrals
- ✓ Conduct learning events for patients diagnosed via an emergency presentation
- ✓ Conduct an annual audit of new cancer diagnoses (e.g. internal practice audit)
- ✓ Have a system to follow up that FIT kits are completed and returned by patients

Coding for safety netting

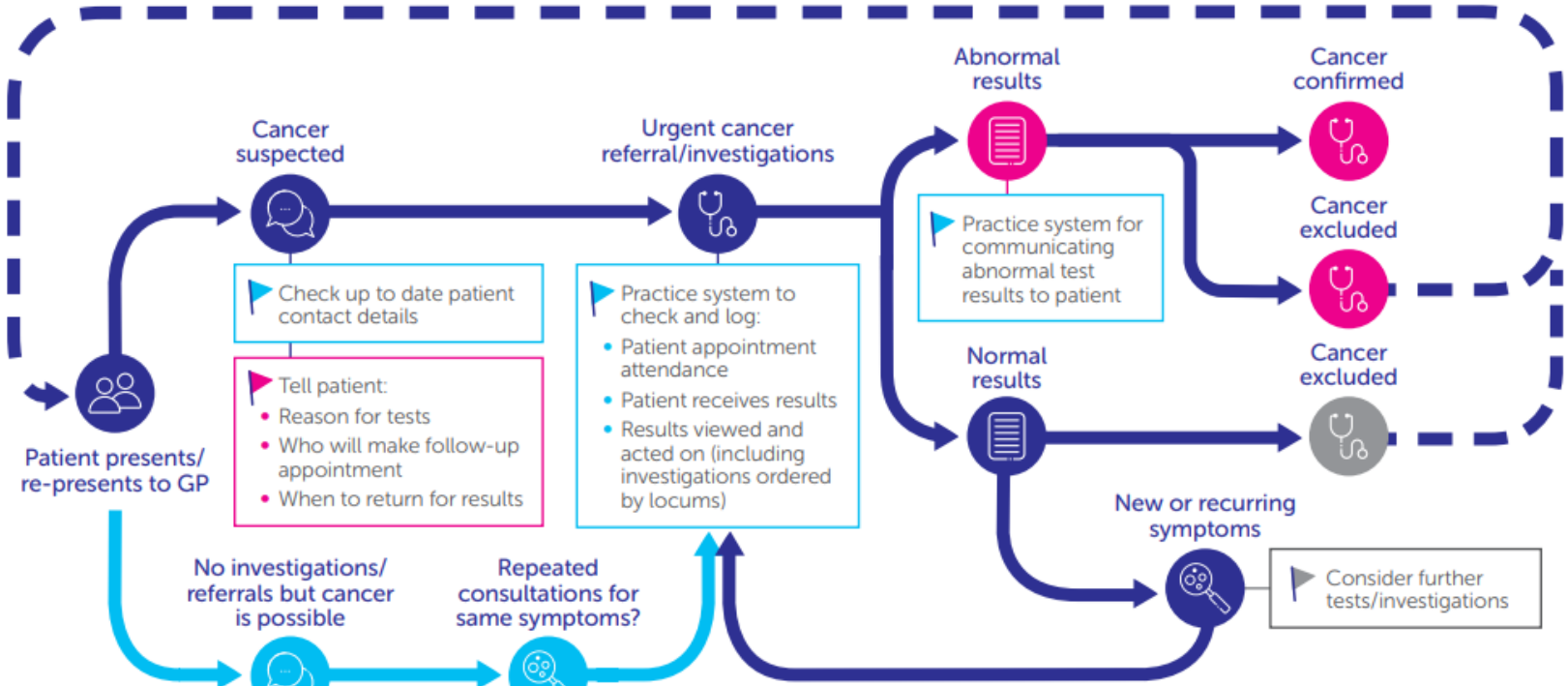
- Ensure you use the SNOMED code for: Delivery of safety netting for patients on urgent referral pathway for suspected cancer.

- You can search for this by putting in ‘cancer safety netting’ into your code browser and will find the code 1239431000000107.

- Use safety netting templates which incorporate this SNOMED code and allow you to tick the relevant section on the templates, as well as set a date for any reminders.

Safety netting summary

Communication to patients | Action for GPs | Action for practice | Education



Also consider...

- ☐ Keep up to date with referral guidelines for suspected cancer
- ☐ Conduct an annual audit of new cancer diagnoses
- ☐ Carry out a Learning Event of every delayed diagnosis of cancer

For references see **cruk.org/safetynetting**

Together we will beat cancer

CANCER RESEARCH UK

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Early Diagnosis is key

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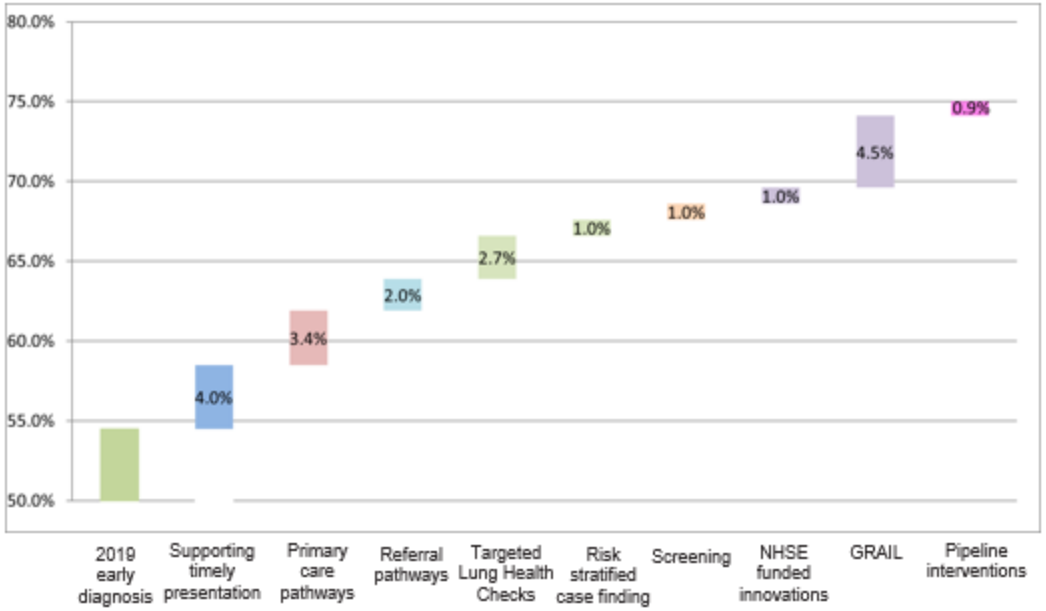
We are implementing the most ambitious and wide-ranging early diagnosis strategy anywhere in the world to deliver on our ambition

Estimated impact of interventions on the early diagnosis rate



NHS Cancer Programme – Early diagnosis strategy

Timely presentation (+4%)
Increase public knowledge of the signs and symptoms of cancer, and encourage action

Primary care (+3.4%)
Support timely and effective referrals from primary care

Referral pathways (+2%)
Streamline cancer pathways to support diagnosis within 28 days

Targeted interventions (+3.7%)
Identify and test more risk stratified approaches to case find cancers in higher risk populations

Screening (+1%)
Modernise and expand cancer screening programmes

Innovation (+5.5%)
Support and embed new technologies and tests to support earlier diagnosis

Pipeline interventions (+0.9%) Each year we will expand these programmes, building a pipeline of future interventions to deliver greater impact

Historically, there has been a 8-9% point gap in early diagnosis between the most and least deprived areas. We are ensuring a focus on disadvantage within each strand of our early diagnosis strategy.

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RED FLAGS

Red Flags – A Systems Approach

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Why is it important to raise awareness of red flag cancer symptoms to the whole practice team?

- Reception/Admin
- Practice Nurses
- ARRS roles including…

Red Flags – A Systems Approach

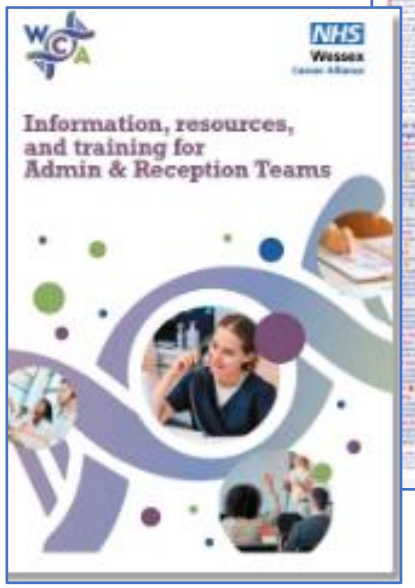
Wessex Cancer Alliance

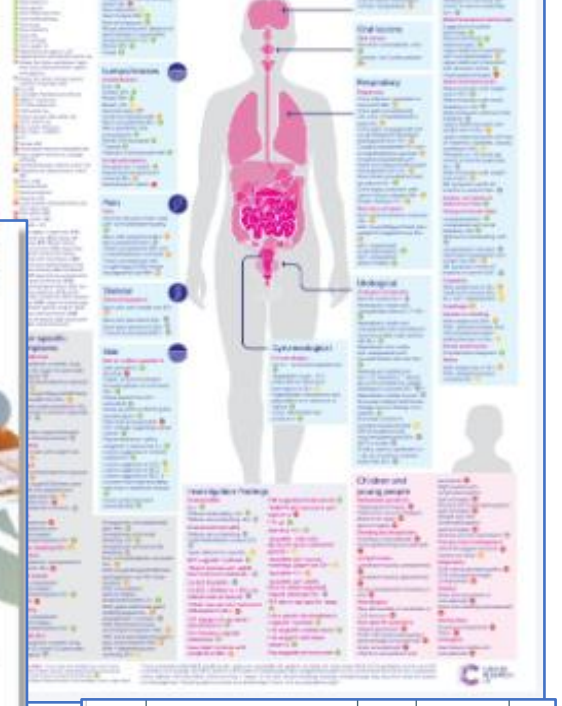
Why is it important to raise awareness of red flag cancer symptoms to the whole practice team?

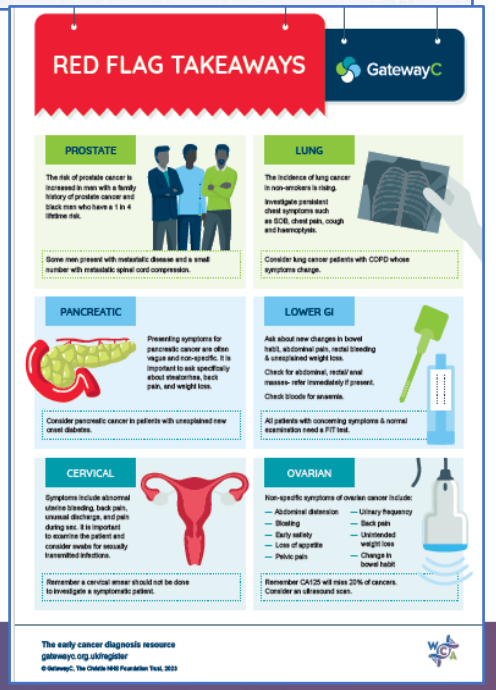
- Reception/Admin
- Practice Nurses
- ARRS roles including…
- Cancer is everyone's business!

Red Flags – A Systems Approach

What support it available:







- [Admin and Reception Guide]
- [ARRS toolkit]
- [GatewayC Study Day Recordings NG12 Referral Education] suitable for all referring and non-referring clinicians
- Red flag infographics (hard copies available)– displayed across the practices
- Cancer signs and symptoms public campaigns – details regularly sent to non-clinical cancer champions
- Lunch and learn webinars – request an invite/forward on topics
- [Clinical Decision Support Tools] & [CDS tools webinar]
- Case Findings

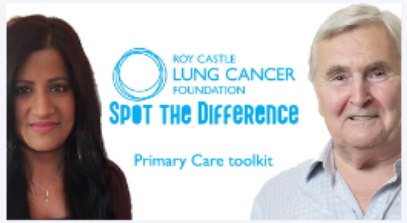
Awareness Campaigns

Symptom awareness resources

There are a huge range of resources available to help you raise awareness of cancer.

Here are just a few:

- CRUK Spotting Cancer Early information leaflets
- Macmillan Signs & Symptoms pocket card
- Prostate Cancer UK pocket sized leaflets and display box
- Roy Castle Lung Cancer Foundation Primary Care Toolkit and symptom tracker
- Coppafeel breast awareness resources for health professionals
- Know your lemons breast cancer awareness website and app
- Bowel Cancer UK symptom diary and GP information
- PHE Campaign Resource Centre includes the Help Us Help You Cancer Symptom Awareness campaigns
- Be Clear on Cancer campaigns – Information on previous campaigns, resources and evaluation



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Jess's Rule

Recognising repeat presentations
and reducing missed cancers

Jess's Story

- Jessica Brady, 27, died after delayed diagnosis.
  - advanced adenocarcinoma of unknown primary in 2020
- Multiple GP and NHS 111 contacts.
  - Non-specific symptoms: fatigue, back pain, loss of appetite and bloating.
- Parents' campaign led to Jess's Rule.

The Core Principle

3 strikes and we re-think:

If a patient presents three times with the same or related symptom without resolution or diagnosis — stop and think again:

Could it be cancer?

Why it Matters

- 1 in 4 cancers require ≥3 GP consultations before referral.
- Delays = advanced stage and poorer outcomes.
- System, not individual, failures.

How to Apply Jess's Rule

Reflect: Think back on what the patient has said and consider what has changed or been missed. Offer ongoing continuity of care with follow-up. If previous consultations have been remote, see the patient face-to-face and conduct a physical examination.

Review: Where underlying uncertainty exists, consider seeking a view from a peer and review any red flags that may suggest another diagnosis, regardless of the patient's age or demographic.

Rethink: If appropriate, refer onwards for further tests or for specialist input.

How to Apply Jess's Rule

<u>The National Cancer Plan for England delivering world class cancer care</u>
Section 7

Action 6. We will help GPs identify rare cancers more reliably. GPs may only see patients with a specific rare cancer once or twice in their career. This makes diagnosis more difficult. AI-driven clinical decision support tools and safety nets offer an opportunity to help GPs pick up on patients who might be at greater risk. This will be reinforced by Jess's Rule, which will encourage GPs to reflect, review, and re-think repeat symptoms that could indicate cancer.

What now?

- Think of one patient who kept coming back — did we stop and think?

- How can we build this rule into tomorrow's work?

"Persistence is a red flag — for the patient and the system."

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Helen Revisited

Helen Revisited

- Helen, 64 years old – generally well
- Advises receptionist “I think I have another wee infection, as there was some blood in my wee. I know the doctors are so busy – would it be possible to have some antibiotics – they cleared everything so quickly the last time.”
- Receptionist checks Helen’s address and phone number – updates her record.

Helen Revisited

- The nurse recommends that Helen does a MSU and prescribes a short course of antibiotics (Nitrofurantoin 100mg MR bd for 3 days) to be started after the sample is done, and to check the result in a few days' time. Nurse uses Ardens safety netting template.

Helen Revisited

- MSU result (History: ?UTI – if normal consider USC referral). Result: No blood, no cells, no growth seen): GP (not her own) phones patient and asks her to come in at end of clinic the following morning.

Helen Revisited

- GP advises he is going to refer on a fast-track pathway to exclude the possibility of cancer, and she will be seen in the hospital within 2 weeks. GP uses Ardens safety netting template.

Helen Revisited

- Helen is given appointment for KUB CT 3 days later.
- She attends to be told the scan shows she has cancer of the right kidney and will need surgery to remove the part of the kidney. The lymph nodes are not enlarged and she is unlikely to need any other treatment.
- First symptom to treatment 3 weeks.

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Any Questions?

Dennis

- Dennis, 58 years old with COPD and type 2 diabetes
- Persistent cough (different to normal) and more SOB for past 3/52 but not unwell
- His wife prompts him to call the practice
- Dennis is asked by the practice receptionist about his symptoms and ‘is it urgent for today?’
- Given appointment in 2 weeks’ time

Dennis

- Seen by GP
- Persistent cough for 5/52, more SOBOE
- No weight loss, no haemoptysis, no FHx of lung ca
- Ex-smoker (20/day for 30 years, stopped 10 years ago)
- Examination temp 36.6, HR 80, BP 135/80, sats 96%, chest clear
- As ex-smoker and cough for > 3/52 CXR ordered and sent for blood tests
- Told to come back if ‘symptoms get worse’

Dennis

- Dennis has a CXR and blood tests 2/7 later
- Results:
  - CXR reported as lung fields clear
  - FBC Hb 130, WCC 7.8, Platelets 450
  - U&E and LFTs in normal range
  - CRP 4
- CXR and bloods seen by GP covering for registered GP
  - CXR marked ‘normal’
  - Bloods marked ‘no action needed’
- Dennis calls reception 1/52 later and asked for the results – told ‘all come back ok’
- Dennis is reassured by the results and hasn’t got any worse so doesn’t book another appointment

Dennis

- Dennis makes another appointment 2/12 later
- His wife is concerned as he is more fatigued and has lost weight
- He still has a cough and is still SOBOE
- Seen by GP, normal examination
- GP repeats the CXR and blood tests
- CXR results are suggestive of lung cancer and the patient sent via the fast track pathway for a chest CT
- Stage 3 lung cancer is confirmed on CT scan

How could we have done better?

- What ‘red flags’ were missed?
- Where could safety netting have changed the outcome?
- What could we put in place to improve the chances of earlier diagnosis in the future?

Dennis Revisited

- Dennis, 58 years old with COPD and type 2 diabetes
- Persistent cough (different to normal) and more SOB for past 3/52 but not unwell
- At his last COPD review he was told to report any changes to his usual symptoms
- Receptionist asks him about his symptoms
  - Asks how long he has had the cough
  - Is aware that a cough for more than 3 weeks could be a sign of cancer
  - Books him an appointment for the following day

Dennis Revisited

- Seen by GP
- Persistent cough for 3/52, more SOBOE
- No weight loss, no haemoptysis, no FHx of lung ca
- Ex-smoker (20/day for 30 years, stopped 10 years ago)
- Examination temp 36.6, HR 80, BP 135/80, sats 96%, chest clear
- As ex-smoker and cough for 3/52 CXR ordered and sent for blood tests
- GP adds '? Lung Ca' on blood request and CXR form.
- GP explains to Dennis that they would expect his symptoms to resolve in the next 2 weeks and if they don't, to come back for a review, even if the test results are normal
- GP sends Dennis a text message with the safety netting advice and a reminder to attend his appointments for CXR and blood test

Dennis Revisited

- Dennis has a CXR and blood tests 2/7 later
- Results:
  - CXR reported as lung fields clear
  - FBC Hb 130, WCC 7.8, Platelets 450
  - U&E and LFTs in normal range
  - CRP 4
- CXR and bloods seen by GP covering for registered GP
  - CXR marked ‘normal’
  - Bloods marked ‘newly raised platelets, needs GP review’
  - GP tasks reception to arrange a follow up appointment

Dennis Revisited

- Follow up appointment 3/7 later
- GP re-checks the history and examination
- Symptoms persist but no worse
- GP notes the raised platelets and normal CXR
  - 20-25% of patients later found to have lung cancer have a normal CXR
  - 11.6% of males and 6.2% of females with new, unexplained raised platelets have a 1 year cancer incidence
  - Most common cancers associated with a raised platelet count are lung and colorectal (LEGO-C)
- Even though the CXR is normal as clinical concern remains high GP refers the patient for a fast track CT scan
  - Via fast track referral form/direct access CT chest/discussion with respiratory consultant

Dennis Revisited

- GP explains the fast-track referral process, the reason for requesting further investigations and the importance of attending the appointment
- GP sends Dennis a text with a link to a PIL (including who to contact if he doesn't receive an appointment and expected time frames)
- GP asks Dennis to come back if he is not found to have lung cancer but his symptoms persist
- GP enters safety netting SNOMED code into the notes
- GP practice has systems in place to monitor fast track referrals and checks that Dennis has attended his appointment

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Any Questions?