Primary Care Audit of Prostate, Bladder and Renal Cancers diagnosed October 2024 - March 2025 in Dorset











This report aims to provide a comprehensive overview of the challenges and good practice examples within the primary care pathway for Prostate, Bladder and Renal Cancers in Wessex, providing key recommendations and generating a clear action plan for future improvements.

This primary care audit has been designed and developed by:

Wessex Cancer Alliance

With support from:

Dorset ICB

Dorset Primary Care Networks (PCNs)

Dorset Intelligence and Insight Service (DiiS)

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Background

Local and national data indicate that rates of early diagnosis for urological cancers, particularly prostate cancer, are lower in Dorset compared with both the wider Wessex region and national averages[1]. The reasons for this variation are not yet fully understood.

Primary Care plays a vital role in the early diagnosis of cancer through the recognition of symptoms, appropriate investigation, and timely referral. Delays may arise at various points within the diagnostic pathway, reflecting the complexity of the process and the range of factors that can influence it.

Clinical audit is widely used to support a culture of shared learning across primary and secondary care. By reviewing practice against agreed standards, it enables clinicians to reflect on current care, identify areas for improvement, and translate learning into sustained improvements in clinical practice.

Auditing the urological cancer referral pathway provides an opportunity to assess how patients progress through the diagnostic and referral pathway, including the recognition of symptoms, investigation, and referral from primary care. It also helps to identify common themes and factors that may influence the timeliness of diagnosis and treatment across the pathway. Findings from this audit will support Wessex Cancer Alliance in understanding the factors influencing current rates of earlier diagnosis, informing shared learning and practical actions to embed good practice in the timely diagnosis of urological cancers and improve outcomes.

This audit aims to:

- Characterise the population of patients diagnosed with prostate, bladder and kidney cancers, including demographic characteristics and known risk factors.
- Describe the presenting symptoms associated with these cancers and consider how they align with current referral guidance.
- Describe the frequency and timeliness of referrals from primary care.
- Understand the use of investigations and their contribution to the diagnostic pathway.
- Identify patterns in the diagnostic process, including factors that may influence the timeliness of diagnosis across the region.
- Explore how the findings can inform future service planning, education, and system-wide quality improvement.

Methods

As part of the Dorset Local Incentive Scheme, Primary Care Networks were paid 18p per registered patient (based on weighted list size) for five requirements relating to cancer prevention and early diagnosis. This audit was one of the requirements. For the audit element of the scheme, a clinical cancer lead for the PCN or nominated clinician were asked to complete a standardised data collection template (Appendix A) on all eligible patients.

Timeframe and eligibility

Dorset PCNs were asked to audit all patients newly diagnosed with either prostate, bladder or kidney cancer in a 6-month period between October 2024 and March 2025.

Data collection

Standardised clinical system searches (SystmOne) were developed and given to all PCNs to ensure consistency of the application of search criteria.

The audit templates requested information that could be obtained from the patient records on the practice clinical system about patient demographics, known risk factors, symptom presentation prior to referral, route and stage of diagnosis, investigations and clinical contacts prior to referral and reported delays to diagnosis. A data tab on the spreadsheet provided further information on each indicator to provide additional clarity.

This audit specifically focused on the primary care presentation interval within the pathway, gathering insight from the patient record up to the point of diagnosis. It did not include information about the secondary care pathway post diagnosis, although there was a section where any secondary care delays could be recorded, if known.

Data analysis

Once data was submitted by all PCNs this was collated, cleansed and a data dashboard was created by the Dorset Intelligence and Insight Service (DiiS) and descriptive statistics produced using Power BI.

Qualitative and quantitative data was reviewed by the Alliance GP lead for urological cancers, who generated themes from the comments and analysed the data.

Limitations

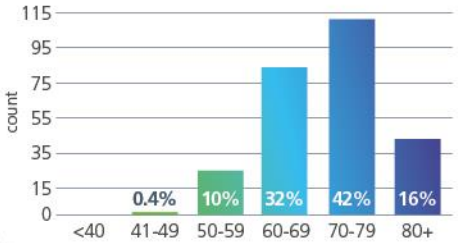
- As an Alliance, it was not possible to access individual practice clinical system to verify that all eligible cases had been included. Consequently, the audit may not include all cases diagnosed in the 6-month audit period.
- Although every effort was made to standardise the audit template and provide clear guidance, some questions may have been interpreted differently between practices. There are some areas where this may have resulted in variation in data recording and completion.
    - In the investigation section of the prostate cancer audit, practices were asked to record the most recent PSA result. This was intended to be at the time of referral. However, on review of the data it appears that in some cases the result recorded was after referral or diagnosis.
- There was variability on reporting of secondary care delays. As this information was collected from primary care records and perspectives, practices may not have had full detail of events occurring within secondary care. Nevertheless, collecting this data does allow us to identify recurring themes, which Wessex Cancer Alliance can explore with secondary care.
- Following data collection, the cases were reviewed to remove any patients that did not meet the criteria (e.g. those with recurrence rather than a primary tumour, or a metastasis from a primary cancer at another site). However, this was only possible where information was written in the further comments/ reflection section of the template. It is therefore possible that ineligible cases that remain within the dataset. Some of the issues with inaccurate case inclusion may be due to clinical coding. Searches created were checked for accuracy, however, this cannot account for any issues with inaccurate coding at individual practice level.
- The audit only covered a 6-month period, this means that there is a small data set, particularly for bladder and kidney cancer so although we can analyse the data, it is often not possible to attribute statistical significance to this.
- The audit was only completed by PCNs in Dorset and not in Hampshire and the Isle of Wight (HIOW). A comparison with HIOW, where earlier diagnosis rates are higher, may have provided useful comparative learning to help explore potential differences in pathways and practice.

Primary Care Prostate Cancer Audit

As part of a Wessex Cancer Alliance Local Improvement Scheme, 17/18 PCNs across Dorset completed a standardised audit template reviewing prostate cancers diagnosed between 1st October 2024-31st March 2025

Demographics

Age/Frailty



42% referred on urgent suspected cancer pathway did not have frailty status recorded

Ethnicity

90% white British reflecting Dorset population

Family history

2% with family history of prostate cancer

14% with family history of another cancer

264 Total Patients

Primary Care Interval

Time from first clinical contact to referral

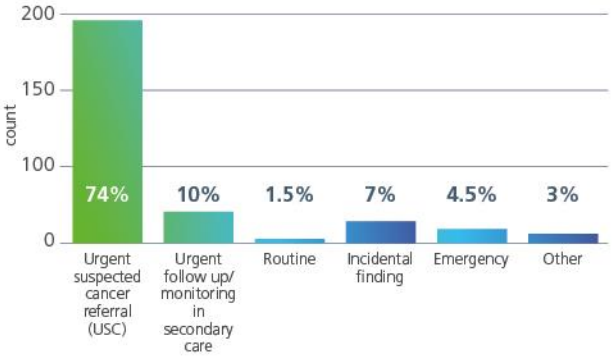


Number of relevant clinical contacts prior to referral

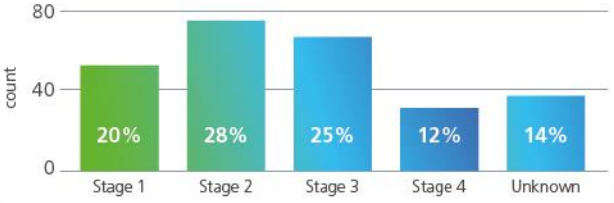


Diagnosis

Route to diagnosis



Stage at Diagnosis



Investigations (excludes those not seen in primary care before diagnosis)

PSA

10% normal PSA

1% not done in primary care

Digital Rectal Exam (DRE)

27% not done in primary care

Symptom Presentation

% with LUTS	% with haematuria	% with recurrent UTI	% with no symptoms	% with erectile dysfunction	% with persistent bone pain	% unexplained weight loss	% with other symptoms
49%	8%	3%	23%	6%	5%	3%	10%

Delay Themes

based on qualitative analysis of audit report (in order of frequency they occurred)

Delays

% where there was a delay

20%

1. Repeating PSA testing despite meeting referral threshold

This was a particular issue in patients who met the NG12 referral threshold with risk factors such as family history

2. Communication to primary care regarding PSA monitoring

There were examples of unclear communication from urology to primary care regarding responsibility for monitoring as well as frequency and thresholds for re-referral

3. Digital rectal exam (DRE) findings and assessment

In some cases with a normal PSA result, DRE was not performed or was documented as normal, with subsequent assessment in secondary care identifying abnormal DRE findings

4. Appointment capacity

Clinic capacity for face-to-face assessment or phlebotomy was cited as a reason for delay

5. PSA testing at initial presentation

Delays occurred in requesting PSA testing in some patients presenting with symptoms which may warrant further assessment (eg bone pain, erectile dysfunction, haematuria)

6. Administrative delay

Sending referrals, secondary care investigation

7. Management by other specialties

examples of patients being sent back to primary care instead of direct onward referral, challenges recognising non-site specific symptoms due to prostate cancer

8. Patient factors

Included declining DRE or referral

Next Steps / Recommendations

- **Primary care Education eg PSA, DRE, frailty**
- **Clear secondary care guidance on PSA monitoring**
- **Support for accurate recording of ethnicity and family history in primary care**
- **Awareness raising in high-risk groups informed by national screening committee guidance**

WCA

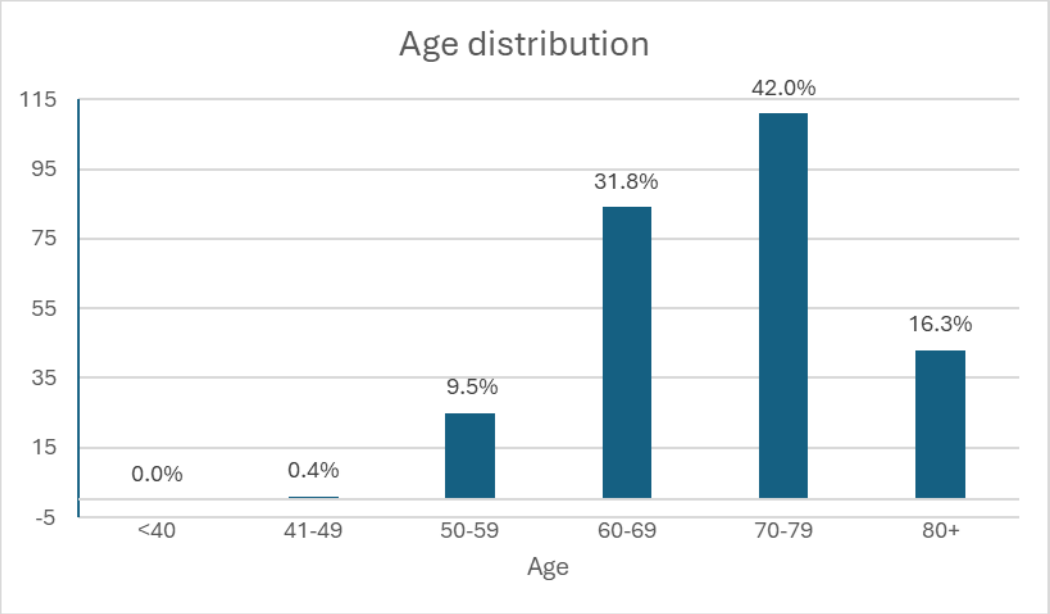
NHS Wessex Cancer Alliance

Prostate Cancer

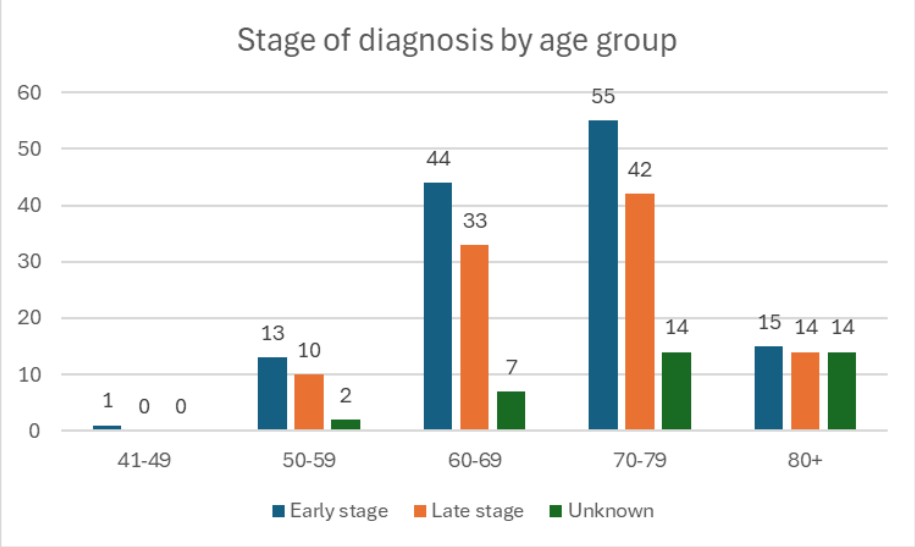
The audit reviewed a total of 264 patients diagnosed with prostate cancer in the 6-month timeframe.

Demographics

Age



There was a wide age range at presentation, with 42.0% of patients being diagnosed in their 70s but a small number being diagnosed in their 40s and 16.3% over the age of 80.

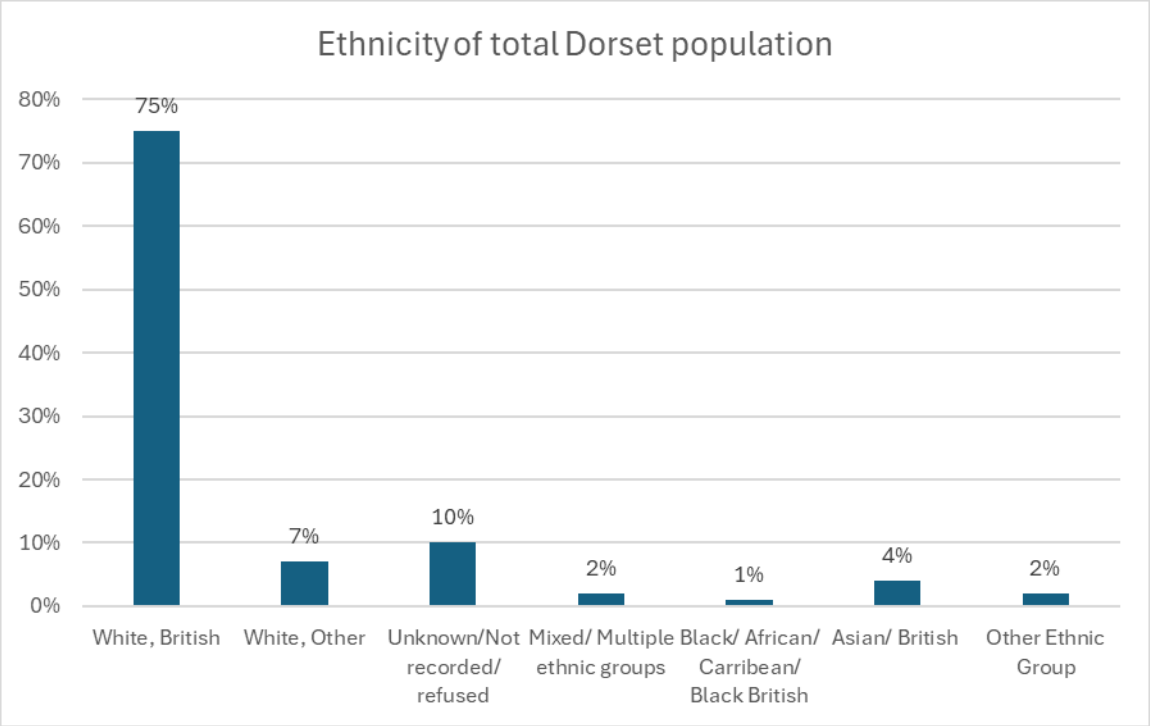


Of note there were 15 patients over the age of 80 diagnosed at an early stage. National[2] and local Wessex guidance[3] on PSA testing suggests that patients over the age of 80 should not have PSA testing carried out unless they have symptoms suggestive of metastatic disease that would benefit from palliative treatment. Many cancers in this age group will be asymptomatic and not shorten life expectancy, and treatments may be considered to cause more potential harm than benefit. There was at least one example of PSA having been tested as part of dementia blood screening. This suggests a potential need for education regarding PSA testing and referral in men over 80 years old.

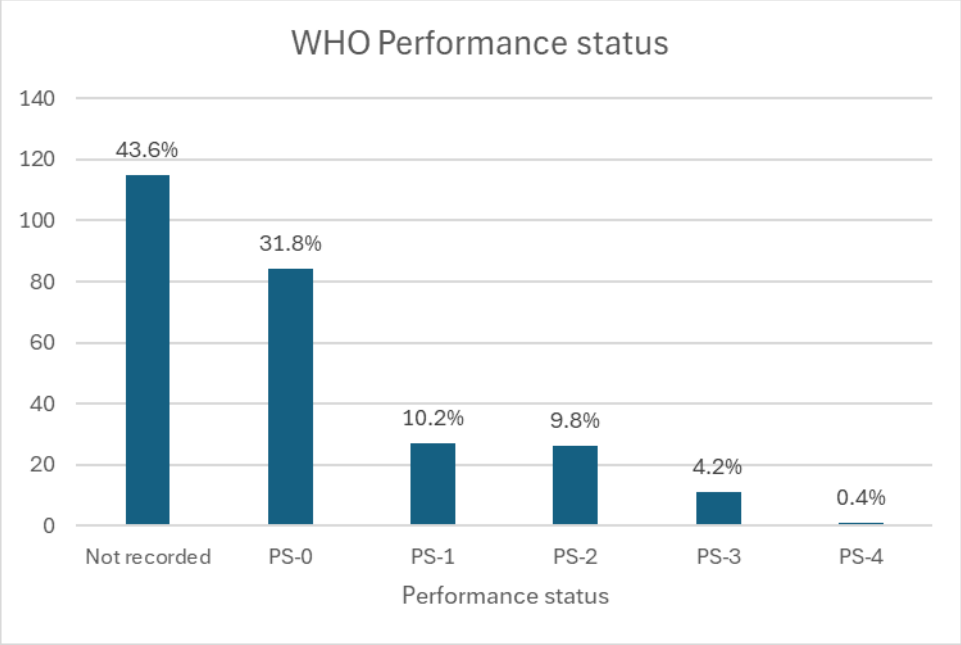
Ethnicity

Ethnicity	***Percentage***
English / Welsh / Scottish / Northern Irish / British	89.8%
Any other Black / African / Caribbean background	0.8%
Any other mixed / multiple ethnic background	1.1%
Any other White	1.1%
Not Known/ not recorded	7.2%

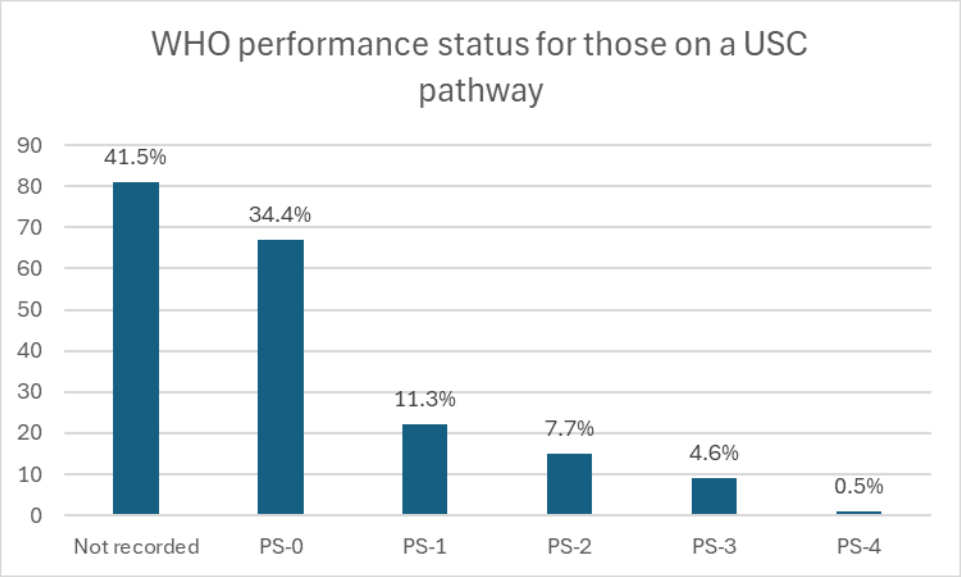
Though there is well documented higher incidence rate nationally for men of black ethnicity than white men, the majority of newly diagnosed patients in Dorset were white British, with very small numbers of black men in the audit cohort. This is reflective of the ethnicity of the wider Dorset population - see graph below from DiiS (accessed 6th March 2026). The lifetime risk of prostate cancer diagnosis is 1 in 4 for black men compared with 1 in 8 for white men[4] and is important to ensure that primary care education continues to highlight this.



Performance status

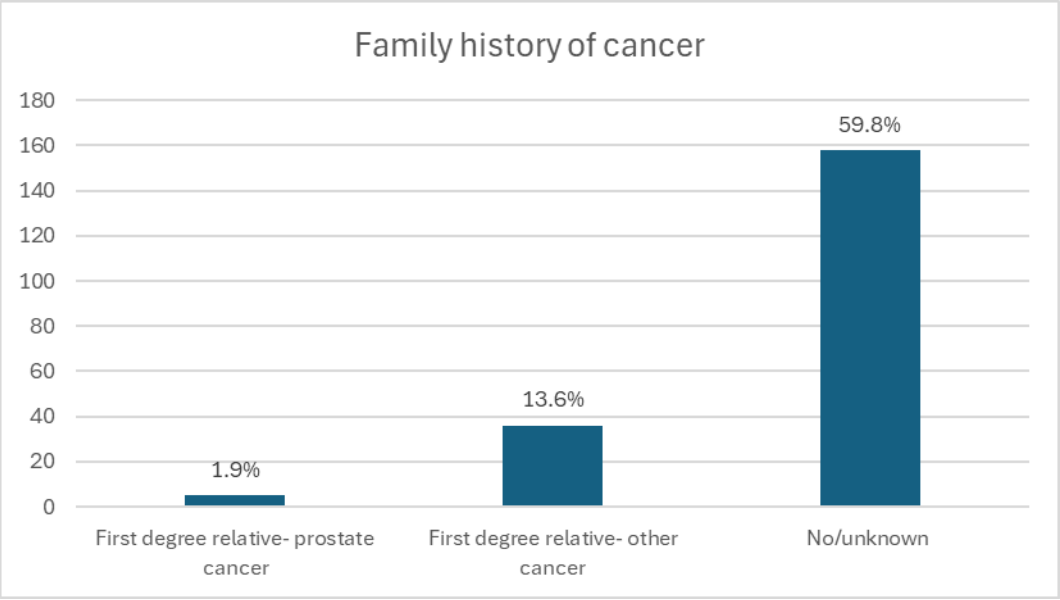


Approximately a third (31.8%) of all patients were recorded as performance status (PS) 0 meaning they were 'fully active'. Smaller numbers were less fit, with 4.6% being recorded as PS 3 or 4. It is difficult to draw conclusions as to whether patients were referred appropriately for symptom palliation as staging varied between this cohort.



Of those referred using the urgent suspected cancer (USC) pathway from primary care 41.5% did not have frailty status recorded suggesting a need for ongoing education in primary care on the value of recording this and considering this when initiating cancer pathway referral, particularly where patients may be triaged straight-to-test without seeing a secondary care clinician for assessment first.

Risk factors

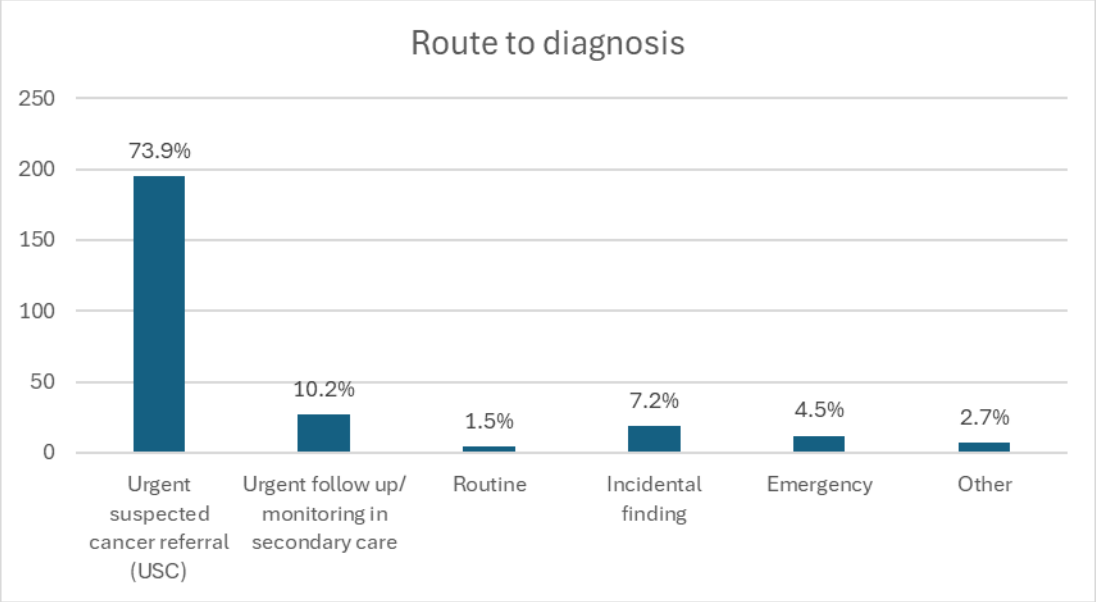


The audit data suggests that only 1.9% of patients had a first degree relative with prostate cancer, and a further 13.6% had a first degree relative with another type of cancer. There are likely to be limitations in the accuracy of this data given that recording of family history in primary care relies on accurate reporting from patients. This is often (but not universally) requested at the time of registration with a practice

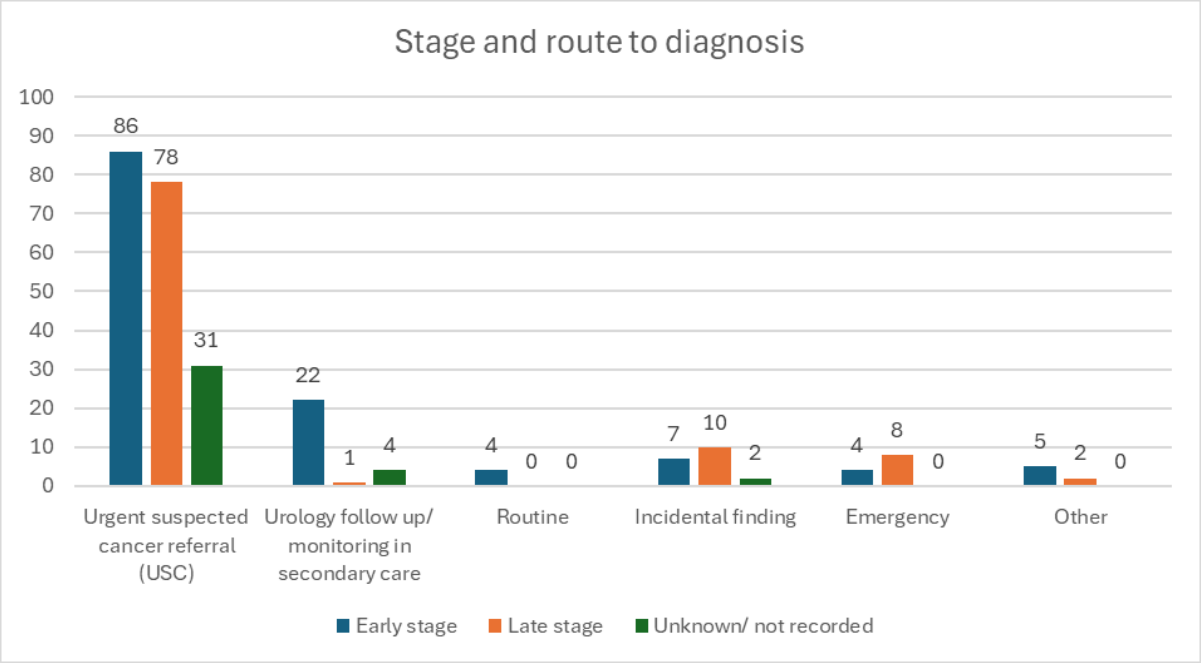
but not always gathered subsequently. Relative risk (RR) of prostate cancer has been reported as 2.48 with men with one first-degree relative with prostate cancer compared with no first-degree family history. This risk increases with more first-degree relatives affected. There is also a known association with genetic mutations such as BRCA 1/2[4]. The low number of patients with a family history in the audit data suggests a need to reinforce importance of recording family history of cancer and considering this within future awareness raising in higher risk patients.

It is also worth noting that the cohort of patients in the audit were those receiving a diagnosis, many of whom had symptoms and therefore there is a need to educate clinicians in recording family history when making a USC referral. This information is clearly important when considering need for further genetic testing in secondary care.

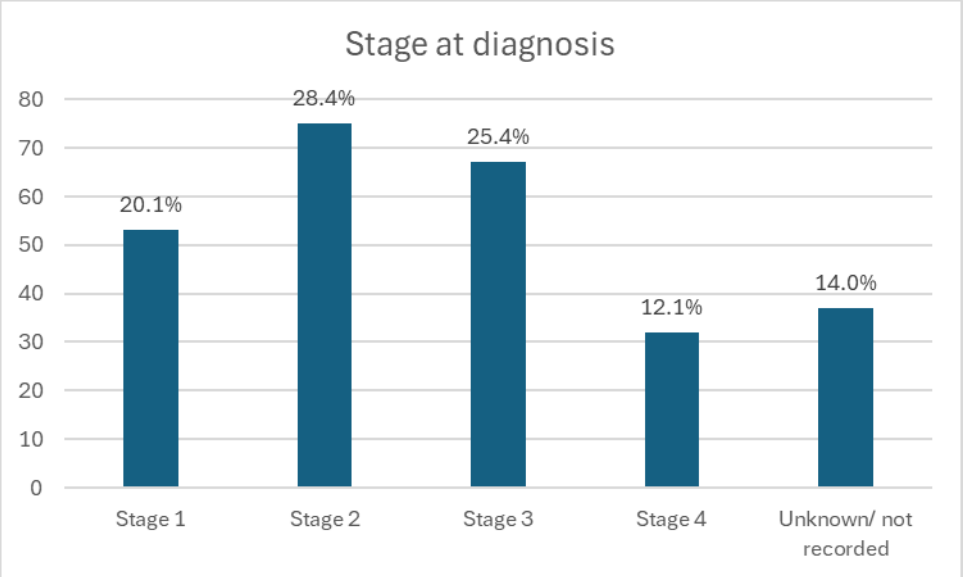
Route to diagnosis



Three quarters of patients (73.9%) were diagnosed following referral via the urgent suspected cancer pathway. Much smaller numbers were diagnosed via other routes, so it is difficult to comment on the correlation with stage of diagnosis. The graph below suggests those diagnosed via emergency or incidental finding were more likely to be later stage at diagnosis.

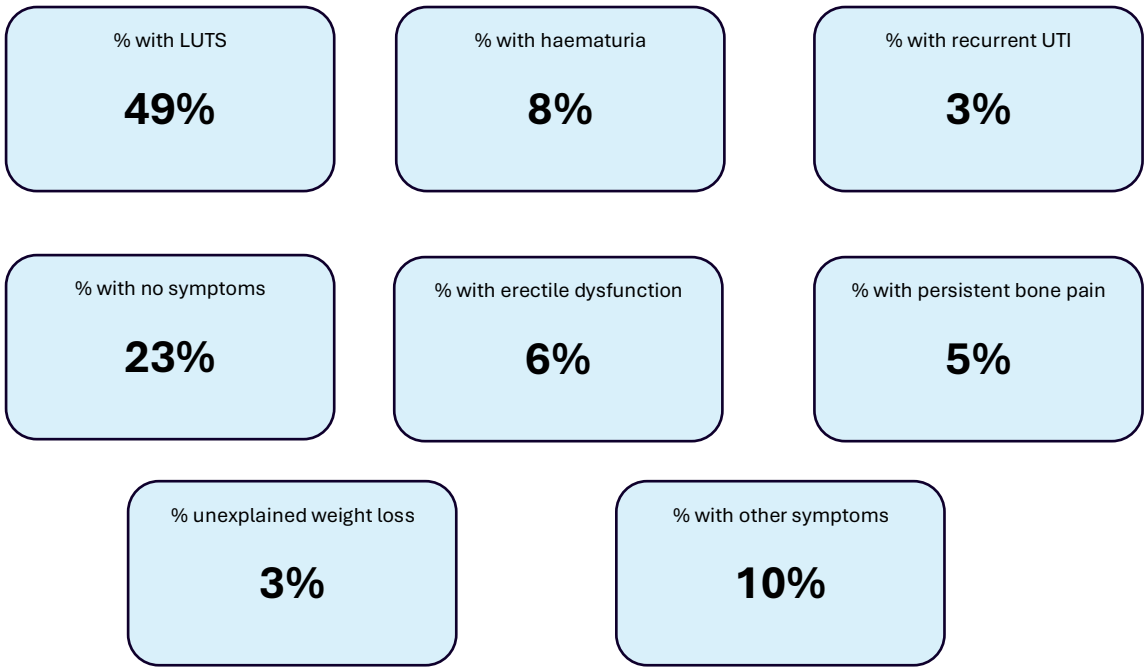


Stage at diagnosis



Overall, 48.5% of patients were diagnosed at early stage (1-2) and 37.5% were diagnosed at late stage (3-4). A further 14% did not have stage of diagnosis recorded.

Symptoms/ Signs

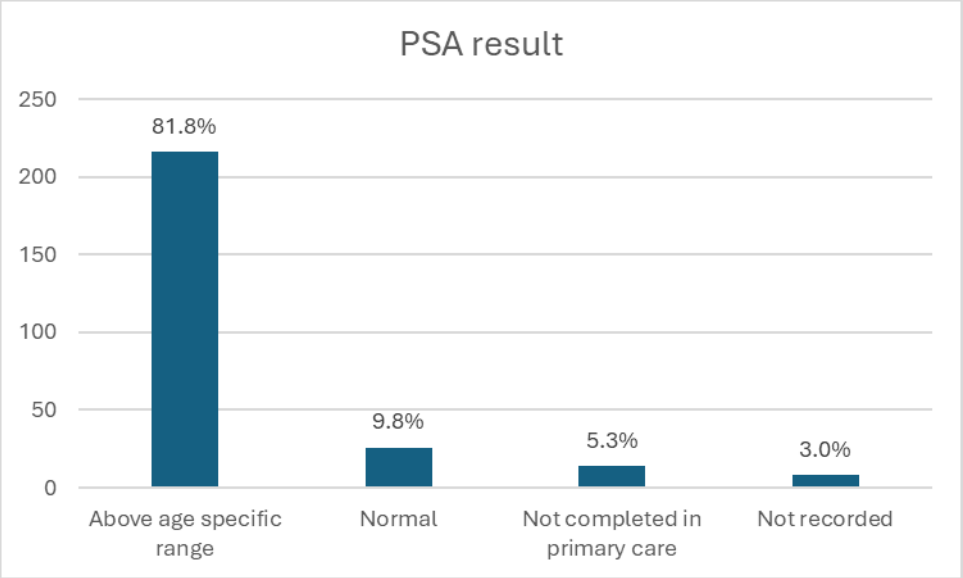


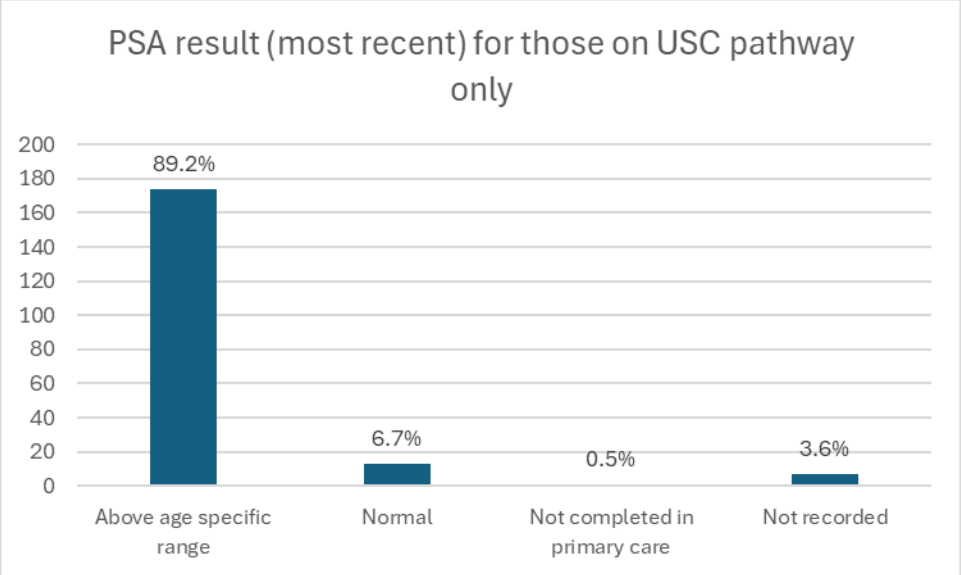
61 patients were recorded as having no symptoms. Of these 52.5% were diagnosed at an early stage and 36% were diagnosed at a late stage. However, although 61 were recorded as asymptomatic, some of these were still recorded as having other symptoms (e.g. LUTs etc), so there may be a data quality issue in symptom reporting.

129 patients were recorded as having LUTs. Of these 50.4% were diagnosed at an early stage and 40.3% were diagnosed at a late stage. Again, there is the same data issue with 4 of these also being reported as asymptomatic. However, this appears to suggest that there was not a strong correlation between symptoms and stage of diagnosis.

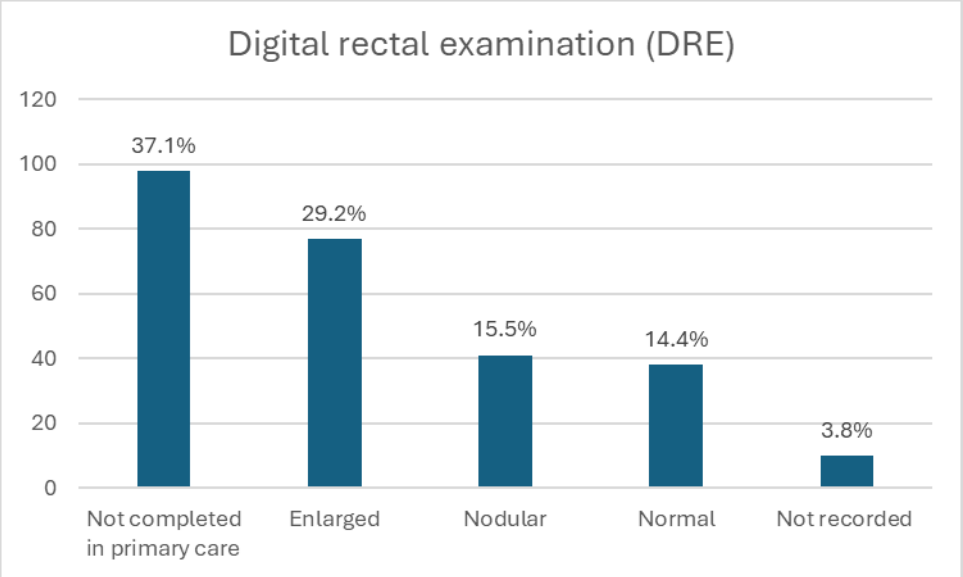
Almost half of patients presented with lower urinary tract symptoms, however a further quarter were asymptomatic at the time of referral. This highlights the need to respond to requests from patients for PSA testing even in the absence of symptoms and demonstrates the need for clear guidance from the national screening committee on testing in these asymptomatic men.

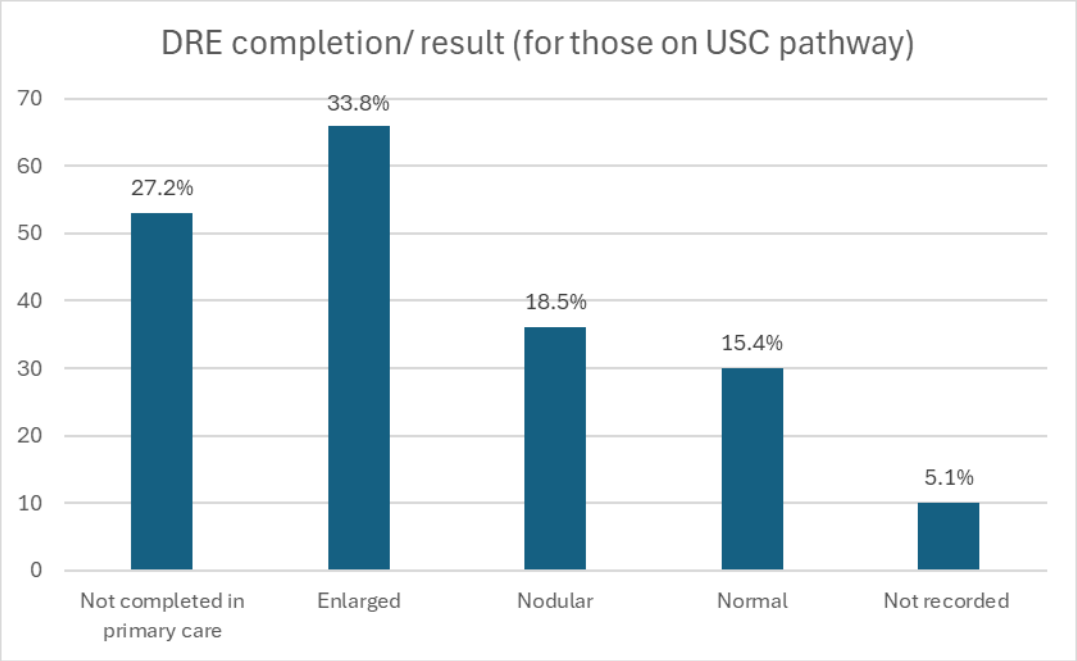
Investigations and examination





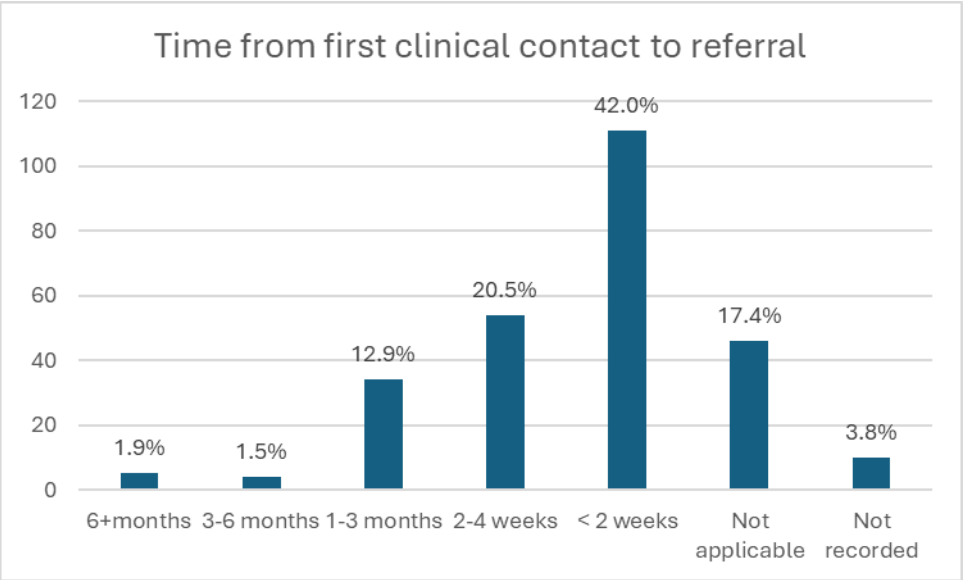
The majority of patients presented with PSA over the age specific reference range. However, 9.8% of all patients had a normal PSA, as did 6.7% of those referred via urgent suspected cancer (USC) pathway. There was a wide range in presenting PSA levels and potential variation in whether these were pre or post diagnosis because data was requested for 'most recent' PSA rather than explicitly requesting the most recent PSA prior to referral. Some of the normal results are <0.01 suggesting these are post treatment results. It is therefore not possible to draw any further conclusions from this information.



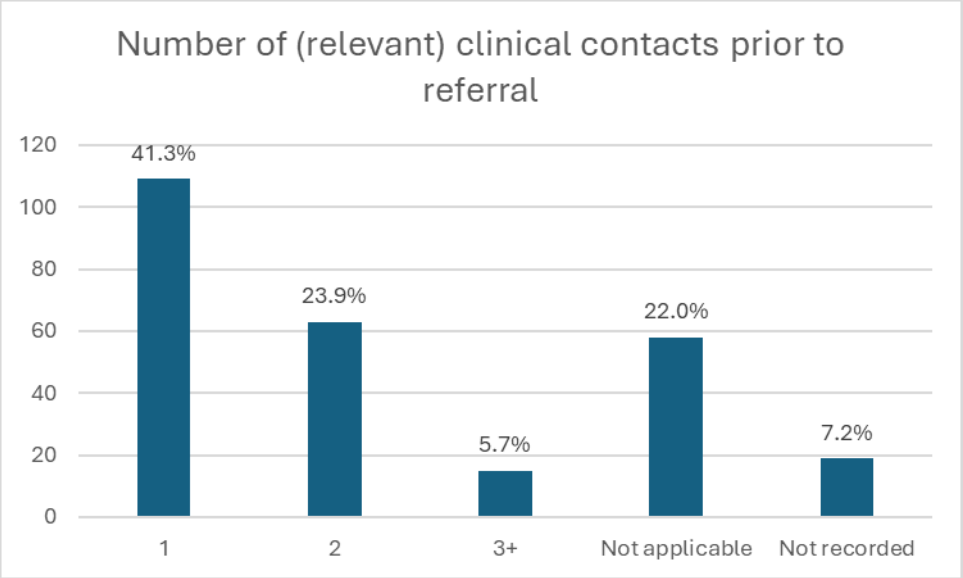


For those patients referred from primary care on a USC pathway over a quarter (27.2%) did not have a DRE completed in primary care. This may well be because they had been found to have raised PSA and therefore referral was appropriately initiated without the need for DRE in primary care in line with guidelines. Within the restraints of the audit data size, it is not possible to draw conclusions on whether patients with normal PSA all had DRE and that those with elevated PSA did not have unnecessary DRE. This was considered as a factor in some of the cases where patients experienced delay and therefore suggests a potential educational need.

Primary care interval



16.3% of patients waited more than a month from their first clinical contact to referral. However, we could not demonstrate whether this had a significant influence on stage of diagnosis.



The majority (41.3%) of patients were referred following just one primary care contact. Of the 23.9% requiring two appointments it could be assumed that several of these had separate appointments for DRE exam following initial symptom review/PSA discussion. Although there is not widespread evidence this is contributing to diagnostic delay it would be worth considering whether patient contacts could be reduced with more standardised processes.

Delays and other qualitative analysis

There were 53 delays reported in total (20.1% of patients). Of these 28 were in primary care, 16 in secondary care, and 9 were patient related factors.

Primary care delays (ranked in order of frequency)

1) *Repeating PSA testing despite meeting referral threshold* - The most common reason for delay was due to clinicians awaiting a second PSA test before referring despite the patient having other risk factors such as family history.
2) *Digital rectal exam (DRE) findings and assessment* - Delays were associated with DRE either not being performed or being documented as normal. In some cases, repeat PSA testing was undertaken or a normal PSA result provided reassurance, resulting in a delay to urgent or routine referral. On subsequent assessment by the urologist, the DRE findings were abnormal.
3) *Appointment capacity* - Clinic capacity to see patients for a face-to-face assessment for a phlebotomy appointment was cited as a reason for delay.
4) *PSA testing at initial presentation* - Delays occurred in requesting PSA testing in some patients presenting with symptoms which may warrant further assessment (e.g. bone pain, recurrent UTI, erectile dysfunction, haematuria, decline in renal function). In some cases, alternative causes were considered initially before prostate cancer became part of the differential diagnosis.
5) *Administrative delay* - There were cases of delay in sending urgent suspected cancer referral.
   Other – Additional delays included DRE being carried out despite the PSA meeting the referral threshold and delays to repeat testing when results were borderline.

These delays suggest a need for education within primary care on use of digital rectal exam as an investigation for suspected prostate cancer as well as reviewing indications for PSA testing. The fact that clinical capacity to see patients for examination and blood testing was a cause for delay reflects the current pressures within general practice.

Secondary Care Delays

There were a total of 16 delays attributed to secondary care.

1) *Communication to primary care regarding PSA monitoring* - Unclear communication from urology to primary care regarding who held responsibility for PSA monitoring or the PSA threshold for re-referral.
2) *Management by other specialties* - In one case, a patient who attended the Emergency Department was referred back to primary care for the GP to make an

urgent suspected cancer referral. This highlights an opportunity to support shared understanding of referral pathways across services. There were also examples of patients presenting to other specialties with symptoms that were subsequently found to be complications of metastatic prostate cancer, illustrating the challenges of recognising prostate cancer when presentations are non-specific or attributable to other conditions.

3) *Time from referral to diagnosis* - One PCN evaluated the time taken from referral to diagnosis and noted there were a number of cases where this exceeded the 28-day faster diagnosis standard. This was attributed to delay in investigations taking place. It is hard to draw further conclusions from this data as it was not part of the initial scope of the audit and only 1 PCN evaluated this. Faster diagnosis standard data for urological cancer overall (excluding testicular) in Dorset from October 2024- March 2025 showed variation between 66.3%-86.5%. Although these patients were identified as exceeding the 28-day standard for diagnosis, we are unable to ascertain if this impacted the 62-day standard for treatment. Wessex Cancer Alliance continue to support the Dorset Urology Pathway as an ongoing piece of work.

Patient Factors

There were a total of 9 delays due to patient factors, which include:

- Delay in the patient arranging a PSA test.
- Patients declining onward referral.
- Delay handing in urine sample for analysis.

Next steps

1) Develop education on use of PSA testing and DRE in primary care with the aim of reducing delays to diagnosis. This will include education on frailty/age, ethnicity and family history. We will address this by:
    a. Review the Wessex Cancer Alliance PSA statement for clarity
    b. Arrange education for primary care clinicians with a focus on reaching the wider workforce, as well as PCN Cancer Clinical Champions.
    c. Consider tools to support accurate documentation of family history and ethnicity in primary care.
2) Ensure clear guidance for primary care from secondary care colleagues about PSA monitoring, to include frequency of monitoring and thresholds for re-referral. This will be addressed by:
    a. Presentation of audit findings to the Dorset Urology Site Specific Group and Dorset Urology Colleagues as well as Wessex Urology Clinical Advisory Group

b. Collaboration with Dorset ICB/C the Signs PSA monitoring pathway for primary care development.

3) Although the audit didn't identify many patient related delays to diagnosis, we know that timely presentation of those with symptoms can improve earlier diagnosis. With this in mind, we plan to include prostate cancer education in community engagement work going forward, particularly with those in high-risk groups who might be less likely to engage. As part of the Dorset Local Incentive Scheme 25/26 practices were asked to improve risk awareness in high-risk groups. However, this piece of work has been paused in the context of pending National Screening Committee decisions regarding prostate cancer screening. We will continue this work once a decision has been reached nationally.

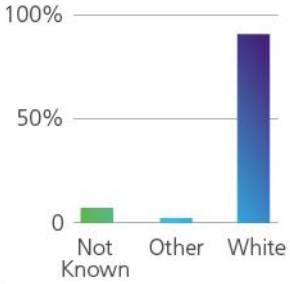
Primary Care Bladder Cancer Audit

As part of a Wessex Cancer Alliance Local Improvement Scheme,
17/18 PCNs across Dorset completed a standardised audit template reviewing
bladder cancers diagnosed between 1st October 2024-31st March 2025

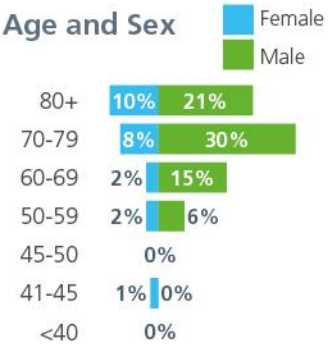
86
Total Patients

Demographics

Ethnicity

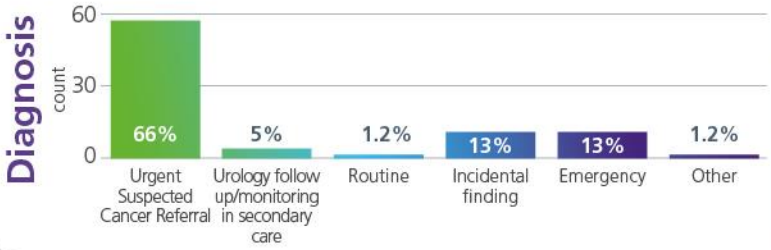


Age and Sex

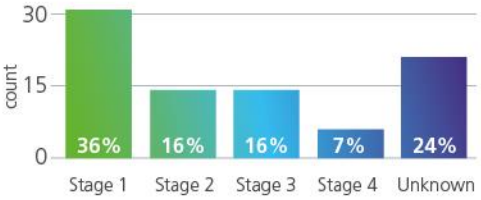


40%
referred on urgent suspected cancer pathway did not have frailty status recorded

Route to Diagnosis

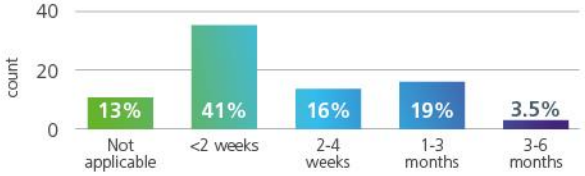


Stage at Diagnosis

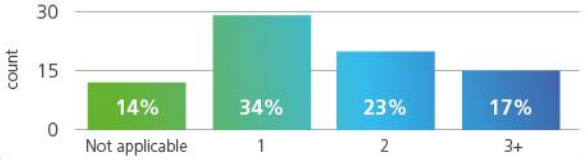


Primary Care Interval

Time from first clinical contact to referral



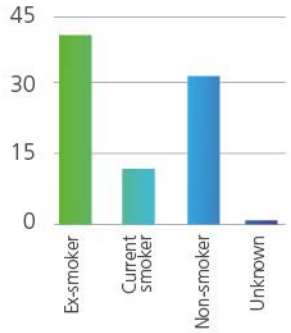
Number of relevant clinical contacts prior to referral



Risk Factors

- smoker/exsmoker **62%**
- occupational exposure **1%**
- catheterisation **6%**
- prior pelvic radiotherapy **6%**

Smoking



Investigations

(excludes those not seen in primary care before diagnosis)

Full blood count (FBC)

- **14%** no FBC
- **25%** anaemia
- **9%** no urine dipstick

Symptom Presentation

% with visible haematuria	% with unexplained UTI	% unexplained weight loss	% with dysuria	% unexplained appetite loss	% non-visible haematuria	% with other symptoms
72%	21%	6%	27%	2%	36%	20%

Delay themes

based on qualitative analysis of audit report (in order of frequency they occurred)

Delays

% where there was a delay

27%



1. Haematuria management

Visible haematuria not referred at first presentation and non-visible haematuria not referred in context of negative urine culture



2. Recurrent UTI

Delays were identified in some cases where referral was not made at an earlier stage



3. Anaemia

Urological causes of anaemia were not always considered or investigated as part of the initial assessment



4. Symptom overlap

Overlay of prostate, gastrointestinal or gynaecological symptoms contributed to diagnostic delay



5. Administrative delay

Capacity for appointment availability in primary and secondary care



6. Patient factors

Variation in awareness of significance of haematuria as a symptom of cancer, delays handing in urine sample

***This audit focused on reviewing the primary care interval only and did not explore the pathway beyond point of referral**

Next Steps / Recommendations

- **Primary care education (haematuria, recurrent UTI, anaemia, symptom overlay, frailty, female patients)**
- **Strengthen haematuria safety netting processes in primary care**
- **Establish consensus for management of non-visible haematuria in patients who do not meet NG12 criteria but still have risk factors**

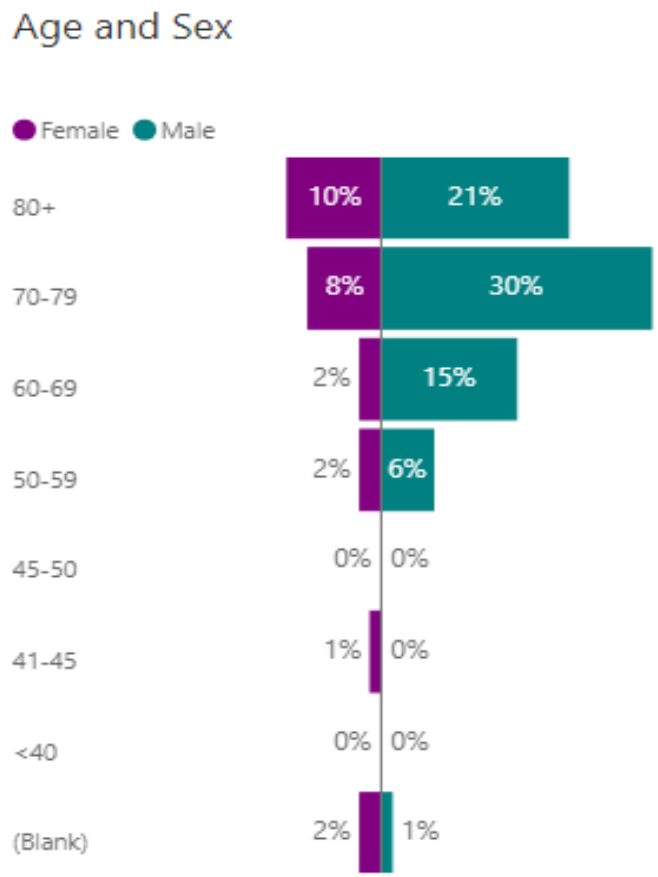
WCA

NHS Wessex Cancer Alliance

Bladder Cancer

The audit reviewed a total of 86 patients diagnosed with bladder cancer in the 6-month timeframe.

Demographics



23 patients (26.7%) were female and 63 were male (73.3%). This reflects national cancer research UK data[5] which suggests each year there are approximately 3,000 new cases in females (27.5%) and 7,900 in males (72.5%).

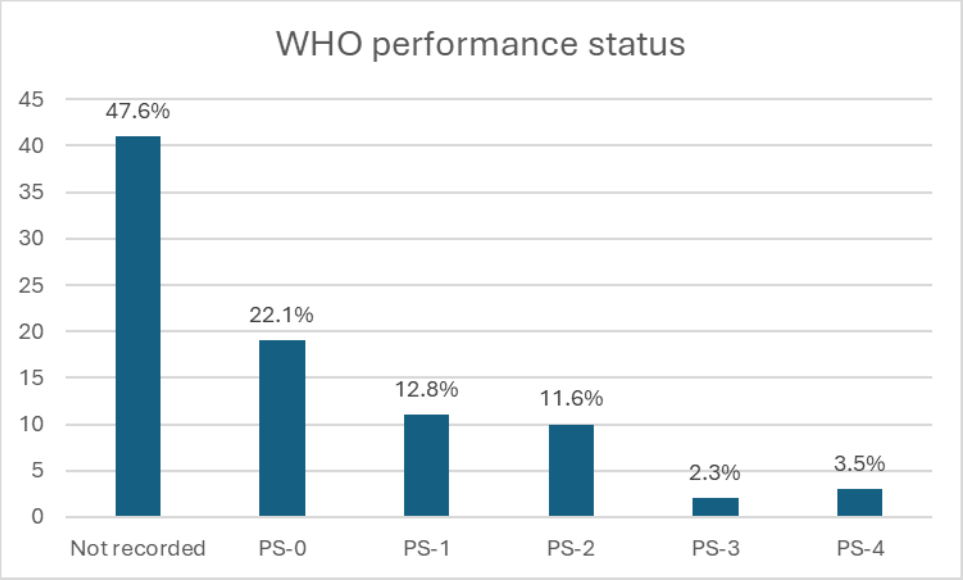
It is known that in contrast to most cancer types, outcomes for bladder cancer are notably worse for females than males. It is thought that this is in part attributed to diagnostic delay with women more likely to need more consultations prior to referral and experience a longer time lag from first presentation to referral. There is also a suggestion that haematuria may be given different relative importance depending on gender. Women with recurrent UTI were also less likely to be referred even where they met NICE criteria[6]. In our audit, we did not demonstrate that there was a gender divide in late versus early diagnosis. Of 23 women, 11 (47.8%) were diagnosed at early stage, 3 (13.0%) late stage and 9 (39.2%) not recorded. Of 63 men, 34 (54.0%) were diagnosed early, 17 (27.0%) late, and 12 (19.0%) not recorded. Given these are small numbers of patients it is difficult to draw firm conclusions, and we did not analyse survival within

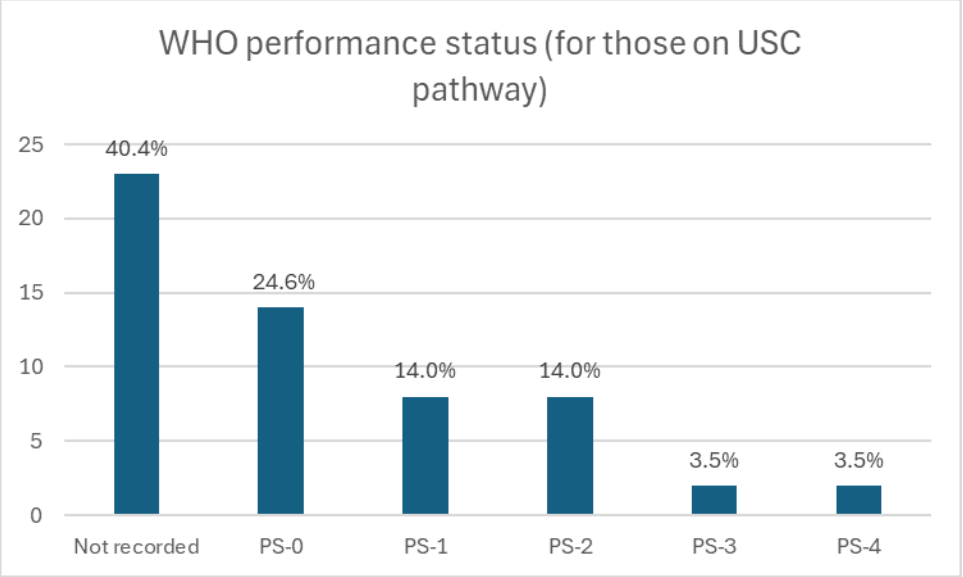
the framework of this audit. CRUK also suggests that three-fifths of cases occur in those over 75 which is also reflected in the Dorset data.

Ethnicity

Ethnicity	***Number of patients***	***Percentage***
English / Welsh / Scottish / Northern Irish / British/ Any other White	80	93%
Not Known/ not recorded	6	7.0%
	86	

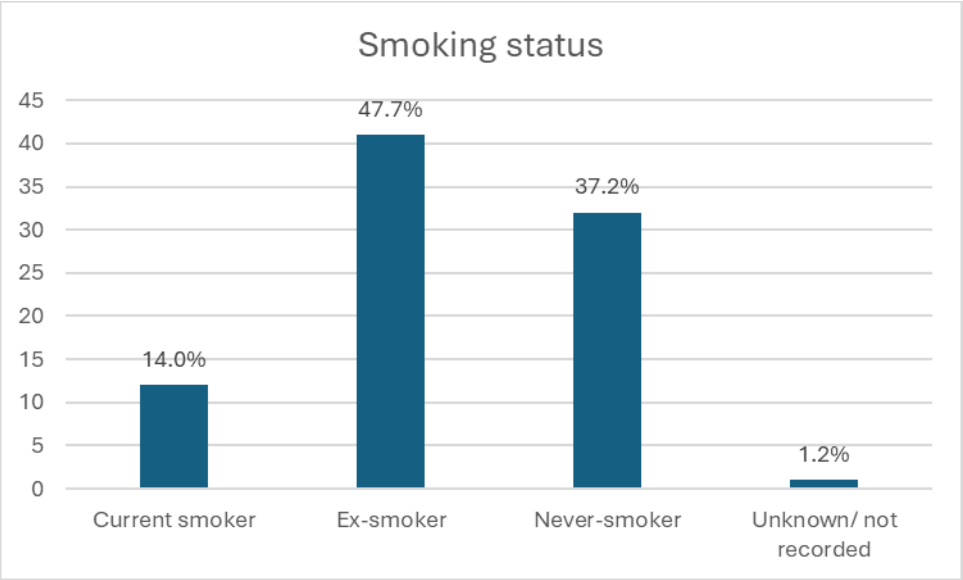
Frailty





Of note frailty was not recorded for 40.4% of patients referred on the urgent suspected cancer pathway suggesting potential need for education in primary care of importance of assessing frailty when considering further investigation. Only 7% of patients referred were recorded as Performance status 3 or 4 suggesting only a small number of frail patients are currently being referred for bladder cancer investigation.

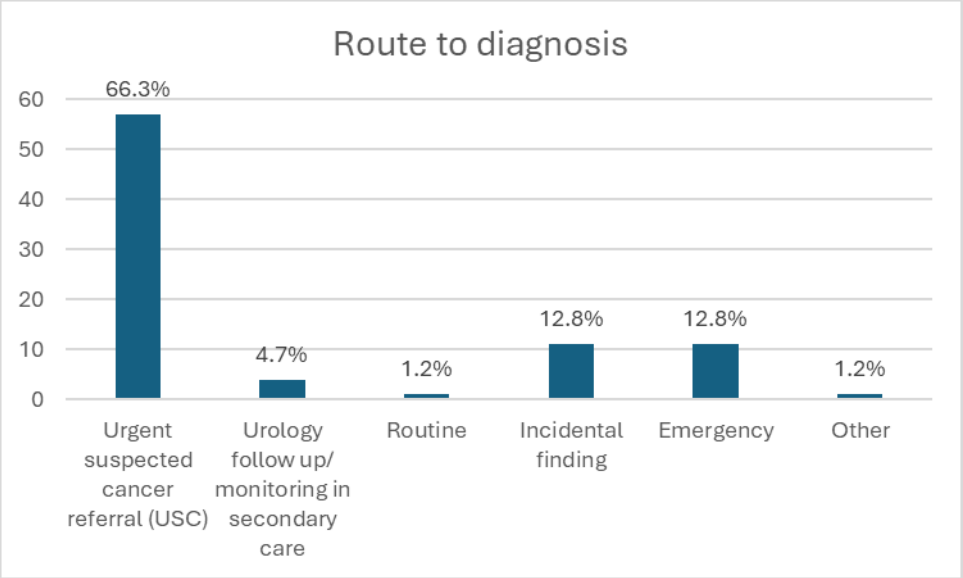
Risk factors



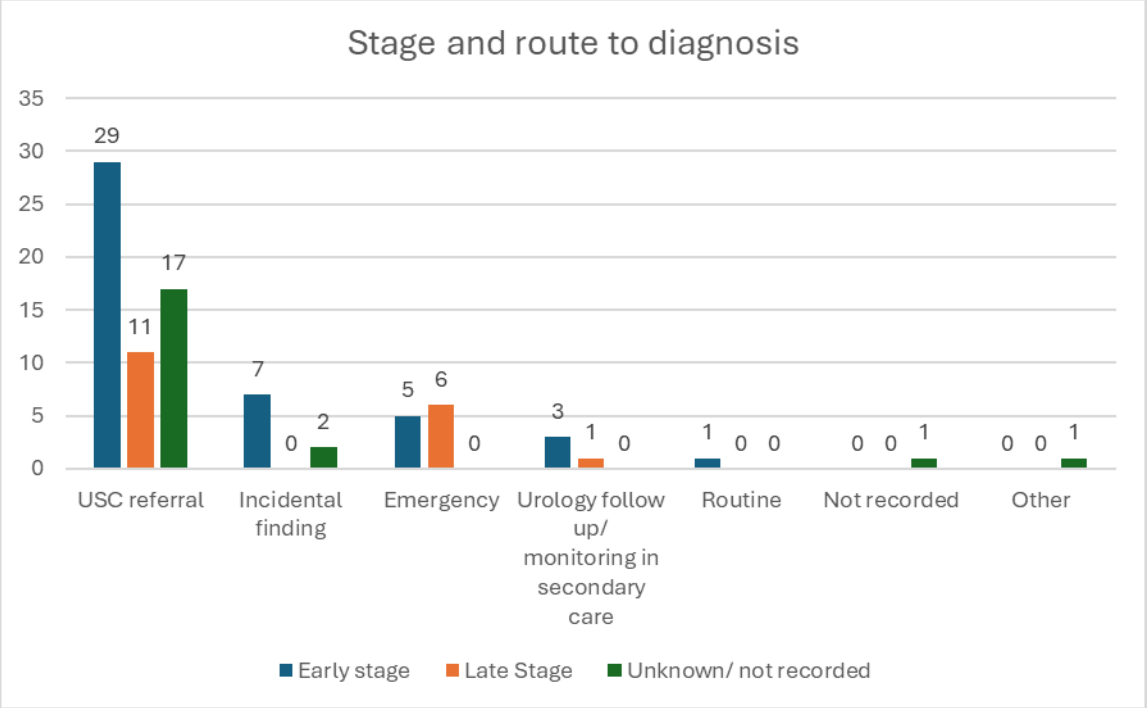
Current or ex-smokers made up 61.7% of new diagnoses. It is important that education for primary care and patients includes awareness of smoking as a risk factor. We should also continue to advocate for smoking cessation/prevention across Wessex.

Other risk factors that were looked at were occupational chemical exposure (1.2%, long term catheterisation (5.8%) and previous pelvic radiotherapy (5.8%).

Route to diagnosis

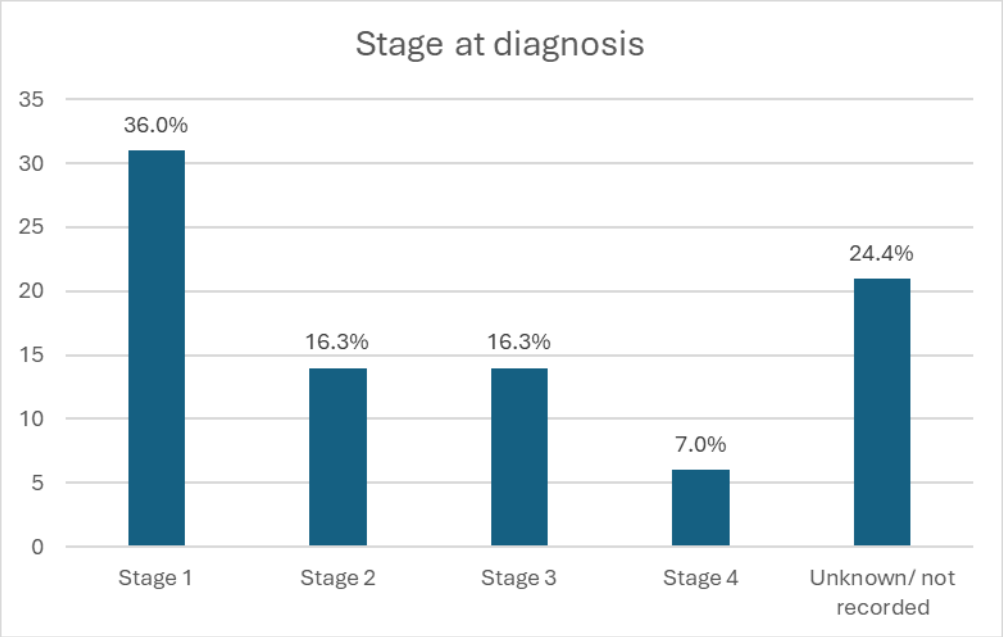


Two thirds of bladder cancers (66.3%) were diagnosed via USC referral. Incidental findings and emergency presentations each made up 12.8% of cases.

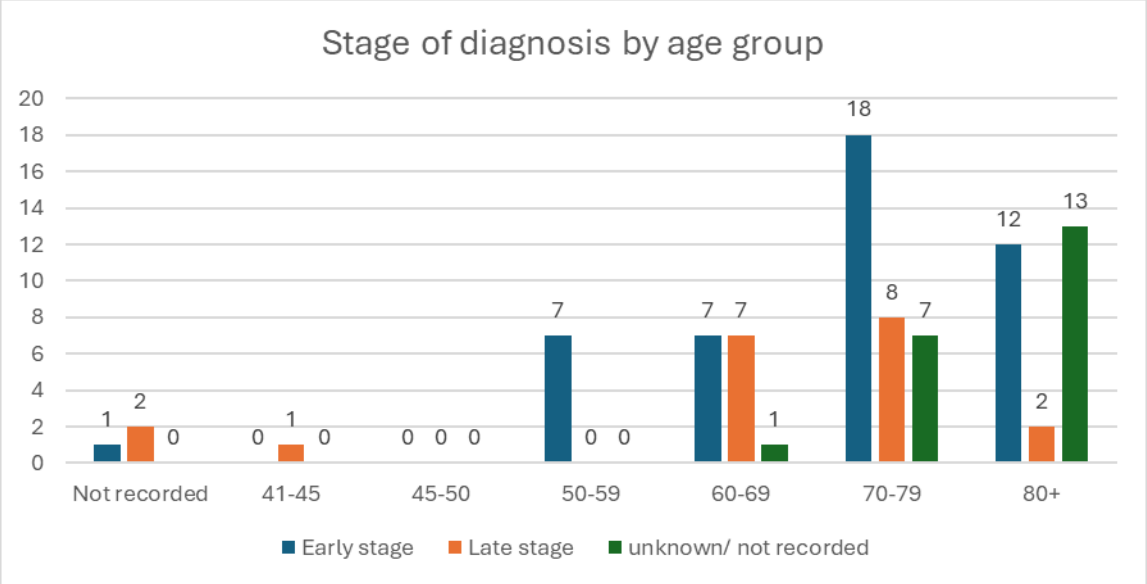


The highest risk of late-stage diagnosis was associated with emergency presentation. Though numbers of cases are small this reflects national data regarding route to diagnosis being related to stage and highlights importance of identifying patients early for referral from primary care.

Stage at diagnosis



52.3% of patients were diagnosed with early-stage disease (1-2) and 23.3% were late stage (3-4). A quarter of patients (24.4%) did not have staging recorded at diagnosis according to their primary care record.

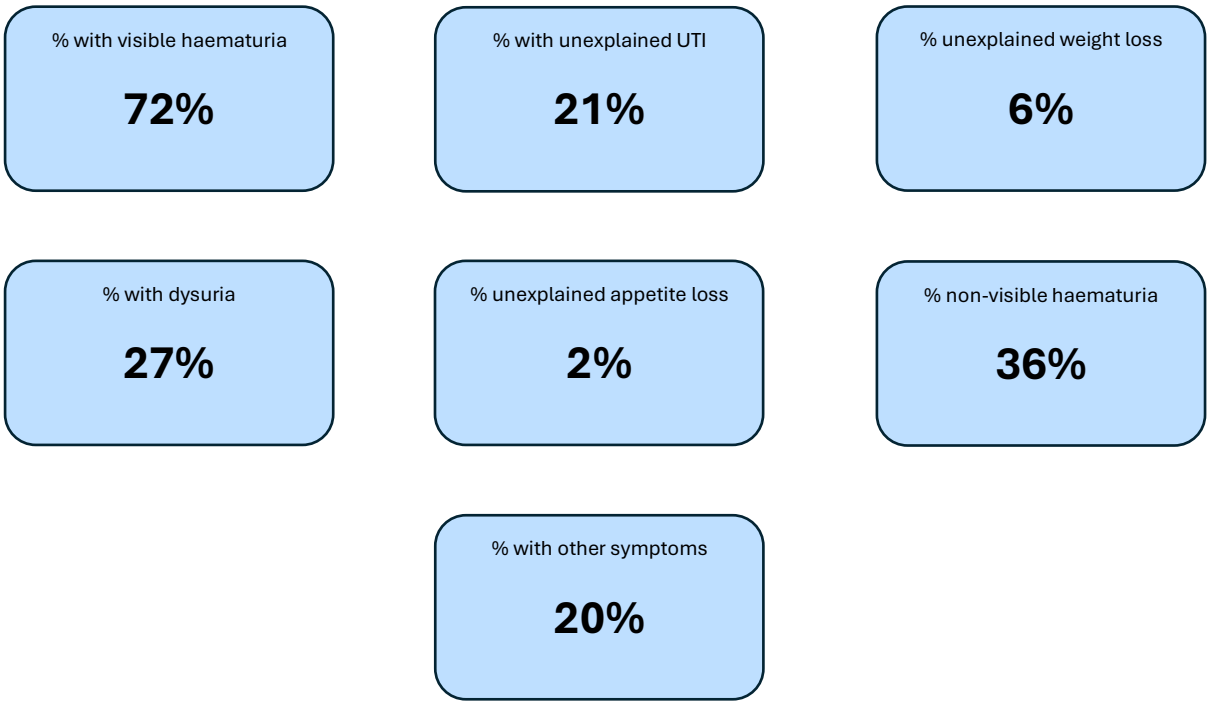


It is possible that the age of the patient at time of diagnosis correlates with staging. For example, those patients in the 60–69-year-old cohort were equally likely to be diagnosed with early or late-stage disease compared with the older cohorts where early-stage disease was much more likely. We know that there is variable guidance for management of urinary tract infection (UTI) in 60–65-year-olds. In particular, pharmacy

first guidance does not recommend testing urine in this cohort and it is possible that in some cases this could delay diagnosis.

Of note staging was less likely to be recorded in the older age groups. This could be due to frailty of patients limiting investigations.

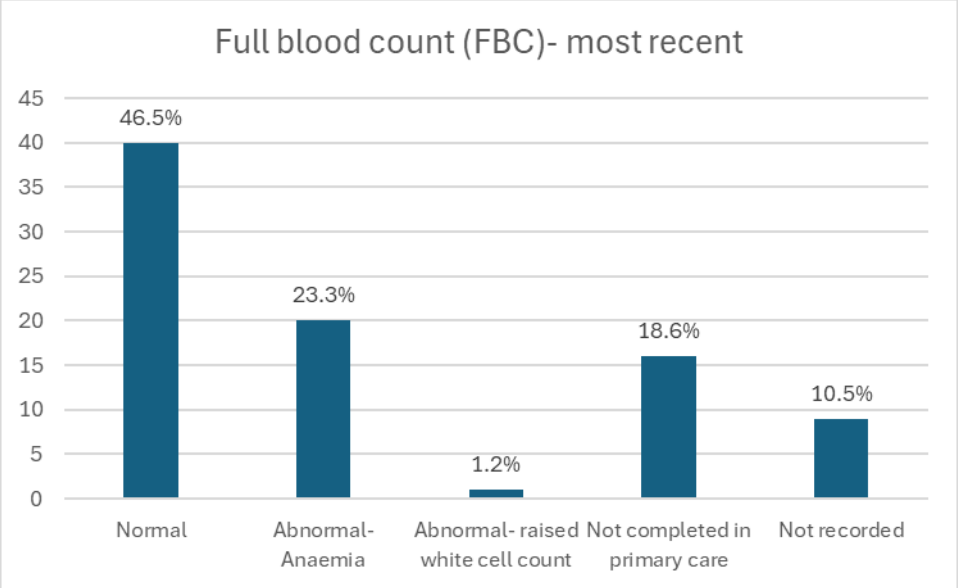
Symptoms/ Signs

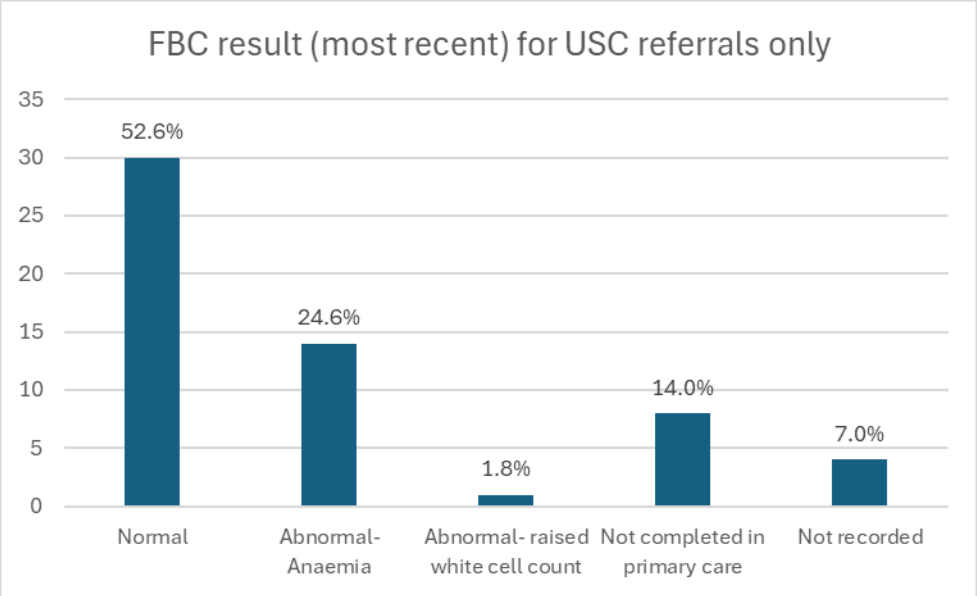


The most common symptom was visible haematuria (VH) which was present in 72% of patients, followed by non-visible haematuria (NVH) in 36% of patients. It appears that the rates of VH and NVH were similar regardless of stage, but late-stage patients were slightly more likely than early stage to present with visible haematuria (75.0% versus 68.9%) and this was also true of NVH (45% versus 37.8%).

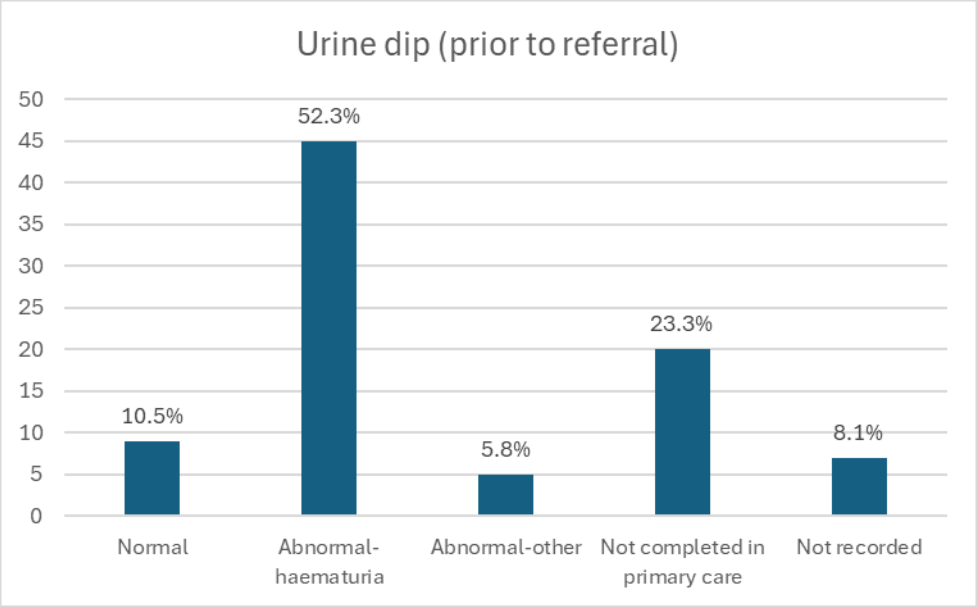
21% presented with unexplained UTI, most of these patients also had haematuria (15 out of 18 patients). This suggests a need for primary care clinicians to be vigilant when managing urinary tract infections and to ensure urine testing for blood as well as having a low threshold for advice in patients with recurrent or unexplained infections.

Investigations and examination

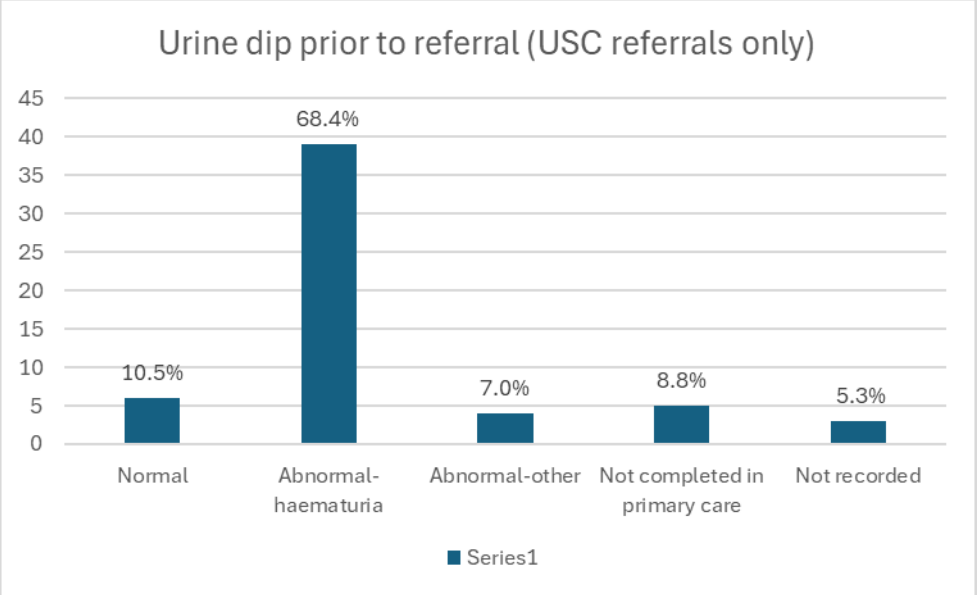




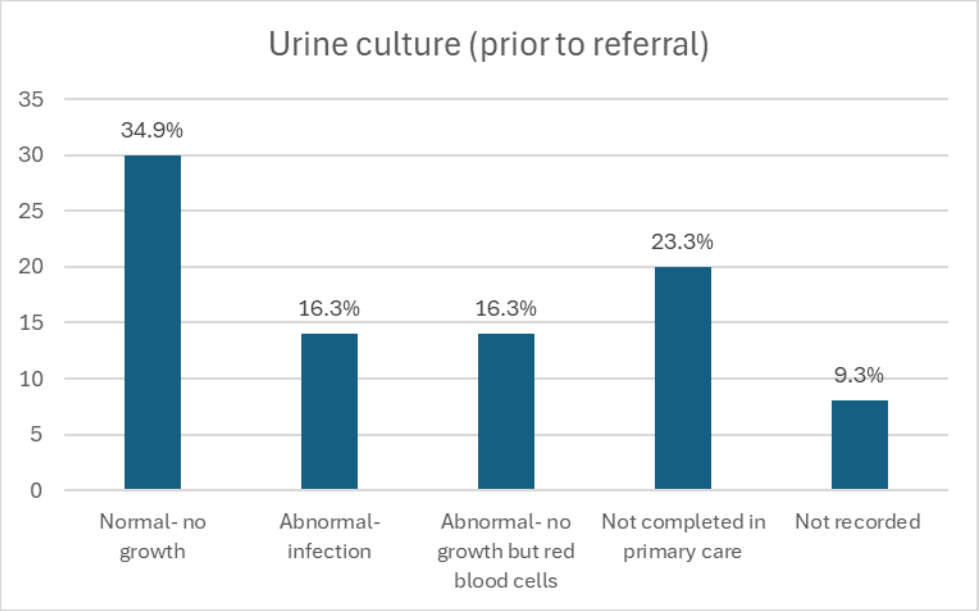
Almost a quarter (24.6%) of patients referred via urgent suspected cancer pathway had anaemia on their most recent blood test. Clinicians are all encouraged to complete FIT testing and GI cancer investigation on patients with unexplained anaemia, but it is important that we ensure all clinicians are also arranging urine dipstick testing for this cohort.



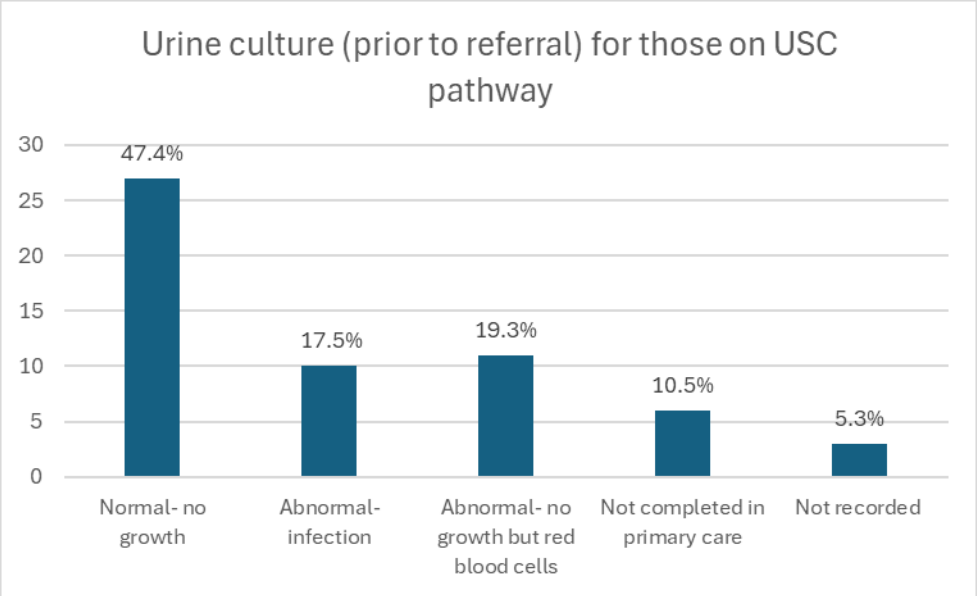
Just over half (52.3%) of all patients newly diagnosed with bladder cancer had haematuria on dipstick.



This figure rose to 68.4% of patients referred via USC route, highlighting the importance of urine dip testing as a diagnostic tool in primary care for bladder cancer.



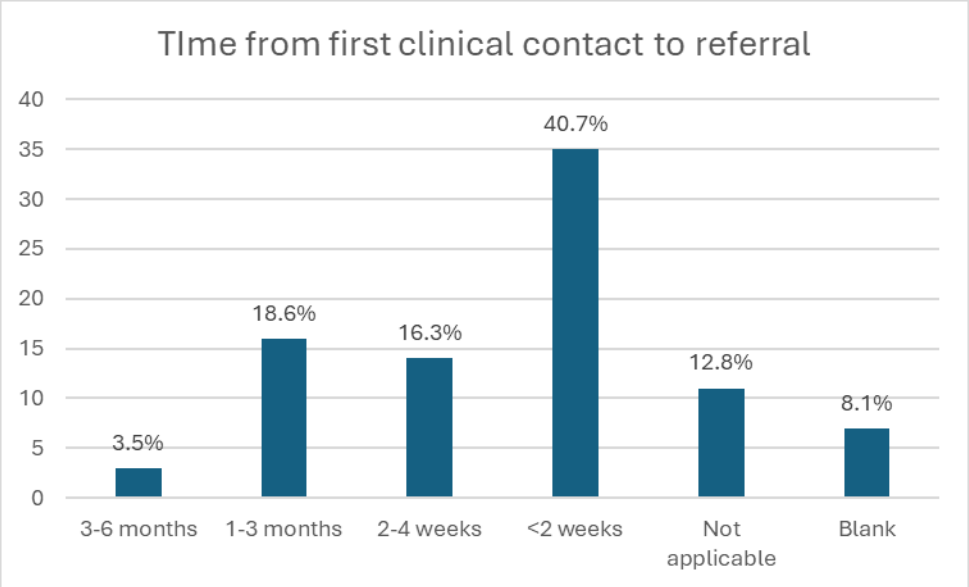
Overall, 16.3% of patients had evidence of UTI on urine culture prior to diagnosis.



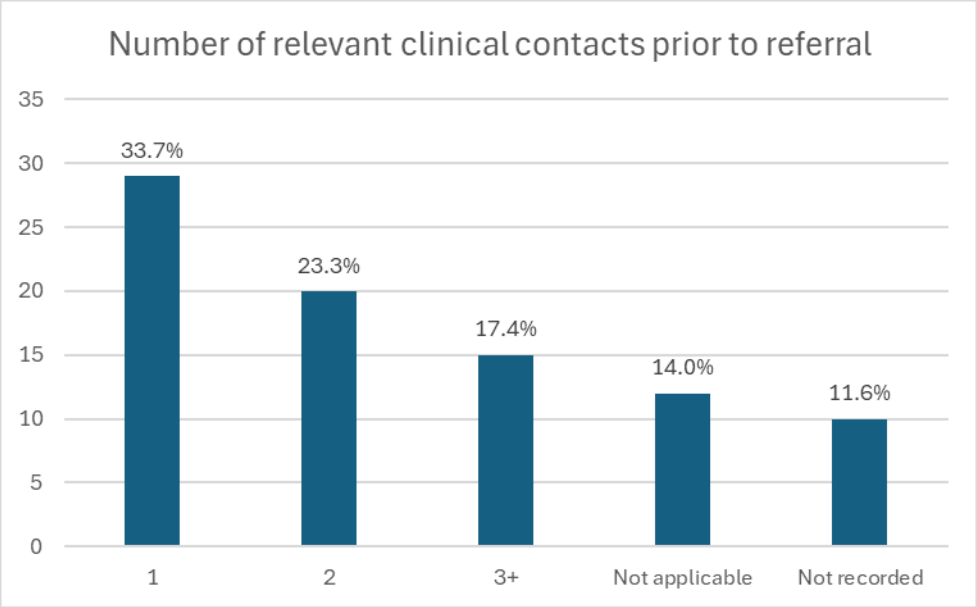
This rose very slightly to 17.5% of those referred on USC pathway. This is slightly lower than the 21% of patients who had unexplained UTI as a symptom at referral, but in some cases, infection may not have been present at the point of referral. Unexplained/recurrent UTI remains an important symptom for primary care to be aware of and consider further investigation.

Due to the small numbers within the audit, we could not draw meaningful conclusions regarding how investigation findings may relate to staging at diagnosis.

Primary care Interval



40.7% of patients were referred in under 2 weeks from first clinical contact, and a further 16.3% within 2-4 weeks. However, 22.1% waited more than 1 month, with 3.5% waiting more than 3 months. The remaining 20.9% were either not recorded or blank suggesting they likely had not been seen in primary care prior to diagnosis.



It is known that women are more likely to have 3 or more clinical contacts prior to diagnosis and have longer time intervals from presentation to referral[6]. There were only 23 female cases of bladder cancer, of which 6 had three or more clinical contacts

before referral (26.1%), compared with 9 out of 63 men (14.3%). These numbers are small but are in line with national audit data suggesting 27% of women have 3+ contacts versus 11% of men.

Delays and other qualitative analysis

There were delays identified in 23 out of 86 cases (26.7%). The majority of the delays were in primary care with a small number of patient-related or secondary care delays.

Primary care Delays (ranked in order of frequency)

1) *Haematuria* - The most common factors associated with delay involved management of haematuria and urinary tract infections (UTI's). There were cases of visible haematuria which were not referred on initial presentation, and of non-visible haematuria (NVH) where a urine sample was sent to check for an infective cause but subsequent results confirming absence of UTI were not acted upon promptly. This is in keeping with the variation in haematuria safety netting processes in primary care that practices reported. (see below)
2) *Recurrent UTI* – Delays were identified in some cases of recurrent UTI where referral was not made at an earlier stage.
3) *Anaemia* - Management of anaemia was identified as another potential source for delay with examples of urine dipstick being not forming part of the initial assessment and repeat testing in primary care before onward referral.
4) *Symptom overlap* - There were cases where overlay of gastrointestinal and known prostate symptoms contributed to diagnostic delay. These findings highlight the importance of considering bladder cancer as a differential diagnosis in patients presenting with lower abdominal pain or worsening lower urinary tract symptoms despite treatment.
5) *Administrative delay* – Delays associated with administrative processes were also identified.

Secondary Care Delays

Factors identified within secondary care included delays in diagnostic investigations and delays within the referral-to-treatment pathway.

Patient Factors

Patient-related factors that contributed to delays included:

- Delay in presenting to primary care following an initial episode of haematuria, which may reflect variation in awareness of the significance of this symptom or other barriers to seeking medical advice.
- Non-attendance at planned primary care appointments, resulting in delays to assessment and referral.
- Delaying in providing a urine sample for testing.

Safety Netting systems for haematuria

We asked PCNs to describe the system they had in place for safety-netting cases of haematuria, for example to ensure blood on dipstick had resolved following treatment for suspected urinary tract infection.

Four PCNs did not report a formal safety-netting system. Among those who did describe a process, four reported asking patients to return with a sample for repeat dipstick testing 1-2 weeks after completing antibiotics. 7 PCNs described systems involving either a task to the patient's usual GP to arrange follow up, or autogenerated/scheduled tasks or text messages generated following the initial appointment or urine result.

None of the reported systems included a process for confirming a requested repeat urine sample was received. These findings demonstrate variation in safety-netting approaches across practices and highlight an opportunity to support the development of consistent safety netting processes.

Next steps

1) Education for primary care on bladder and kidney cancer using webinar planned for Tuesday 22nd September 2026 as well as the Cancer Champions Community of Practice to include:
    a. Review of NG12/Wessex USC fast track criteria to ensure urgent referrals are being made in a timely way.
    b. Management of anaemia in primary care and need to include urine dipstick as part of investigation for these patients.
    c. Review of urinary tract infection management with focus on recurrent UTI and triaging of patients over 45 with risk factors such as smoking history as well as all patients over 60 to be managed in practice with dipstick testing and not via pharmacy first.
    d. Overlay of symptoms with gastrointestinal/gynaecological/prostate presentations.
2) Establish consensus with secondary care for management of non-visible haematuria within primary care to ensure clear pathway for urgent referral of patients who do not meet USC/NG12 criteria but may still have risk factors.

Wessex Cancer Alliance with primary and secondary care colleagues have developed a non-visible haematuria consensus statement to help ensure timely referral and investigations of these patients. This has been adopted across Hampshire and the Isle of Wight with Dorset pursuing a local pathway.

3) Review safety netting procedures within practices for haematuria, particularly in the context of repeating urine dipstick for patients with NVH and presumed urinary tract infection after completion of treatment. Consider how to support practices to develop robust procedures.
4) Given smoking history is a clear risk factor we should consider:
    a. Ongoing education for primary care in using very brief advice (VBA) for smoking cessation in consultations.
    b. Continue raising public awareness of smoking prevention and cessation.
5) Although the audit data did not reveal an obvious gender divide, national data suggests a need to improve timely referral and diagnosis of women presenting with haematuria and recurrent UTI.

Primary Care Kidney Cancer Audit

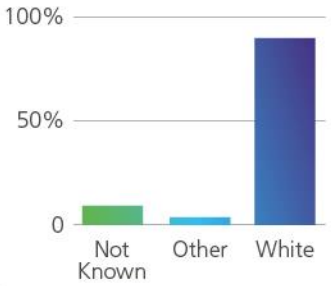
As part of a Wessex Cancer Alliance Local Improvement Scheme,
17/18 PCNs across Dorset completed a standardised audit template reviewing
kidney cancers diagnosed between 1st October 2024-31st March 2025

47

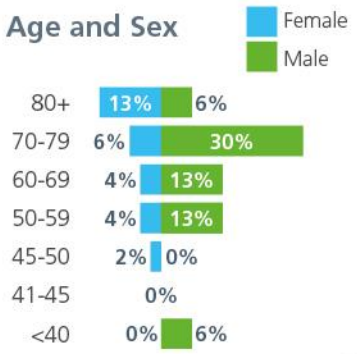
Total Patients

Demographics

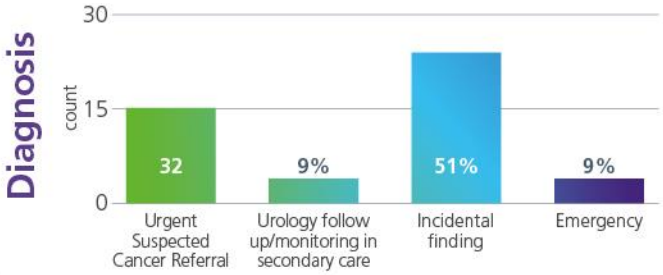
Ethnicity



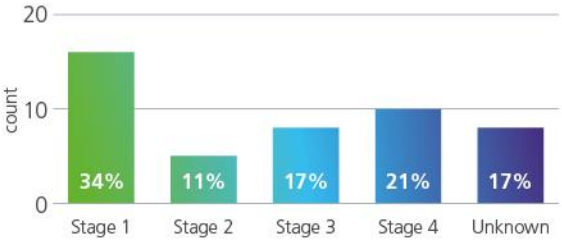
Age and Sex



Route to Diagnosis



Stage at Diagnosis

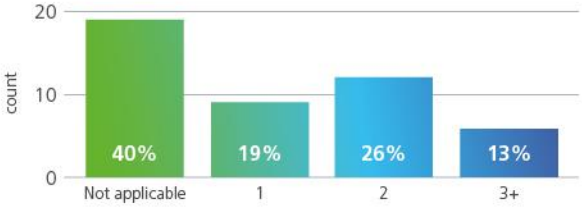


Primary Care Interval

Time from first clinical contact to referral



Number of relevant clinical contacts prior to referral



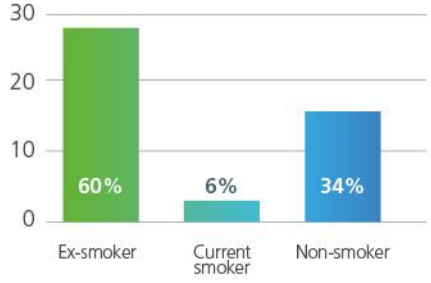
Risk Factors

% CKD
30%

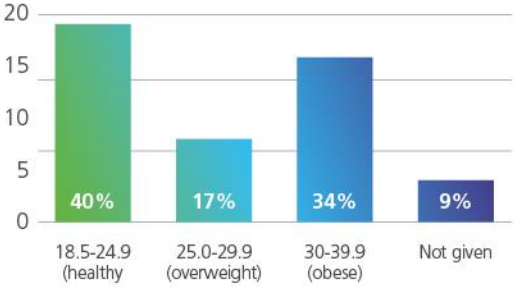
% with family history of kidney cancer
2%

% with family history of other cancer
11%

Smoking



BMI



Investigations

(excludes those not seen in primary care before diagnosis)

Full blood count (FBC)

13%

Not completed in primary care

Urine dipstick

40%

Not completed in primary care

Symptom Presentation

% with flank pain	% with visible haematuria	% with non-visible haematuria	% with no symptoms	% with mass in flank	% with unexplained appetite loss	% unexplained weight loss	% with other symptoms
2%	26%	4%	32%	2%	13%	11%	34%

Delay Themes

based on qualitative analysis of audit report (in order of frequency they occurred)

Delays

% where there was a delay

15%

1. Vague or non-specific symptoms

In some cases kidney cancer was not considered in initial differential diagnosis meaning urine dipstick testing was not undertaken

2. Interpretation of results

There were cases where initially reassuring investigation results contributed to delay giving false reassurance. Urine dipstick testing was not always caried out in assessment of anaemia

3. Continuity of care

Contributed to delays in arranging further investigation of symptoms

4. Administrative delay

***This audit focused on reviewing the primary care interval only and did not explore the pathway beyond point of referral**

Next Steps / Recommendations

- **Considerable overlap with bladder cancer recommendations**
- **Primary care education to include non-specific symptom management and risk factors (CKD, obesity)**

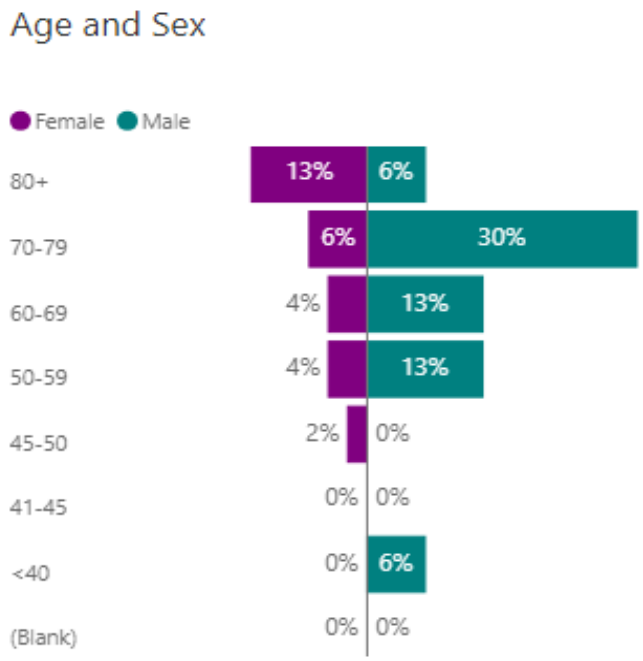
NHS Wessex Cancer Alliance

Kidney Cancer

The audit reviewed a total of 47 patients diagnosed with kidney cancer in the timeframe.

Demographics

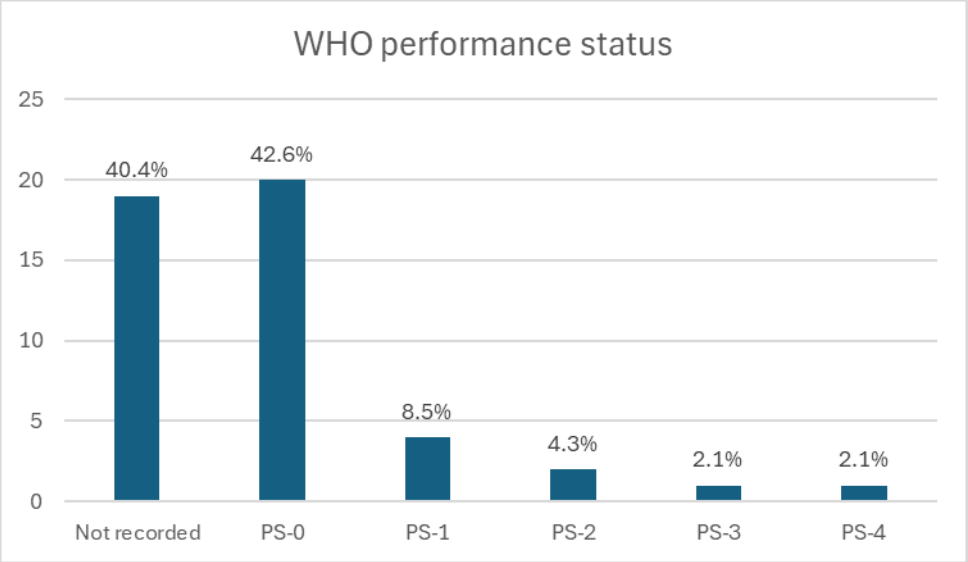
The majority of patients reviewed were male (68.1%) and were aged between 70-79 (36.2% of all cases). Most patients were over 50 (89.3%). See below for a full breakdown of age and sex.



Ethnicity

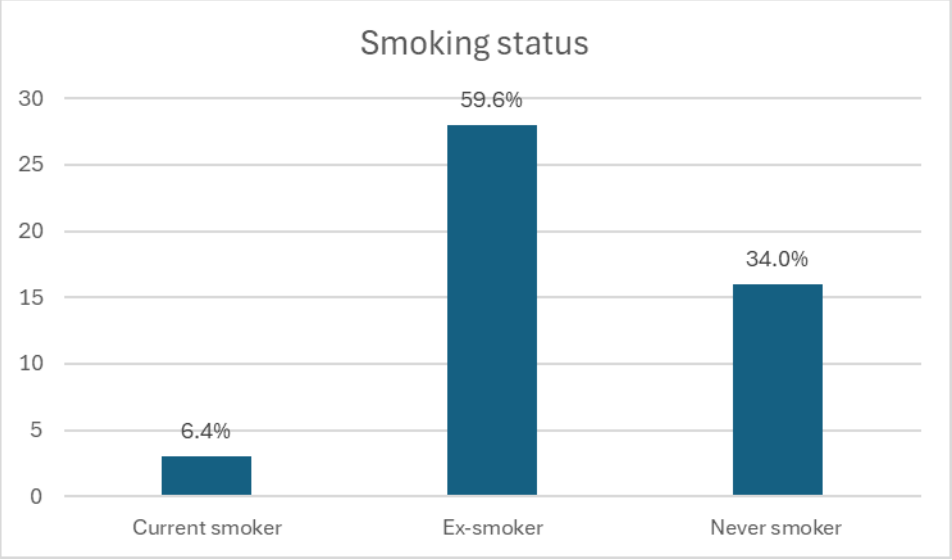
Ethnicity	Number of patients	Percentage
English / Welsh / Scottish / Northern Irish / British/ Any other White	43	91.5%
Not Known/ not recorded	4	8.5%
	47	

Frailty

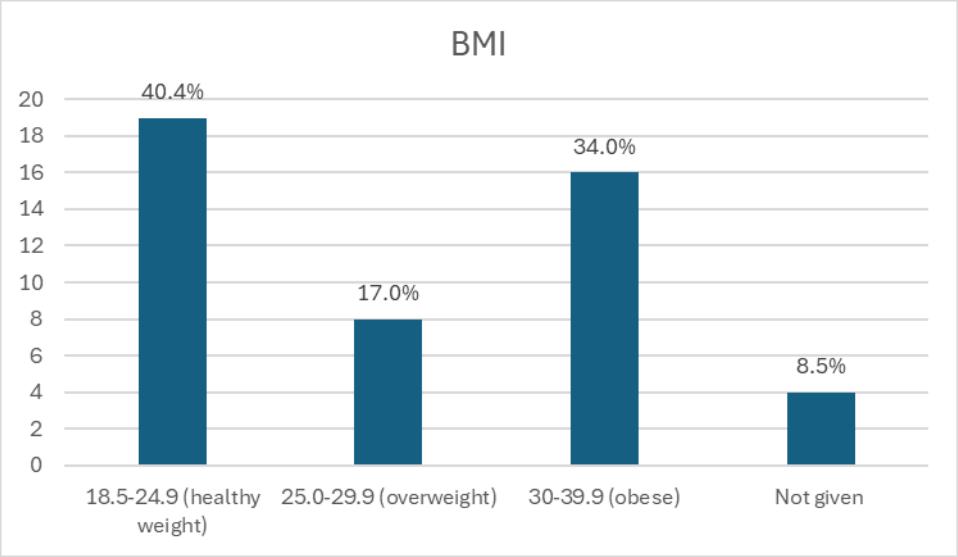


Frailty status was not recorded in 40.4% of patients, which is similar to the findings in patients with prostate and bladder cancer. There are a higher proportion of patients with Performance status 0 at 42.6% (versus 31.8% for prostate and 22.1% for bladder). This may correlate with higher numbers of patients being diagnosed incidentally and at a younger age.

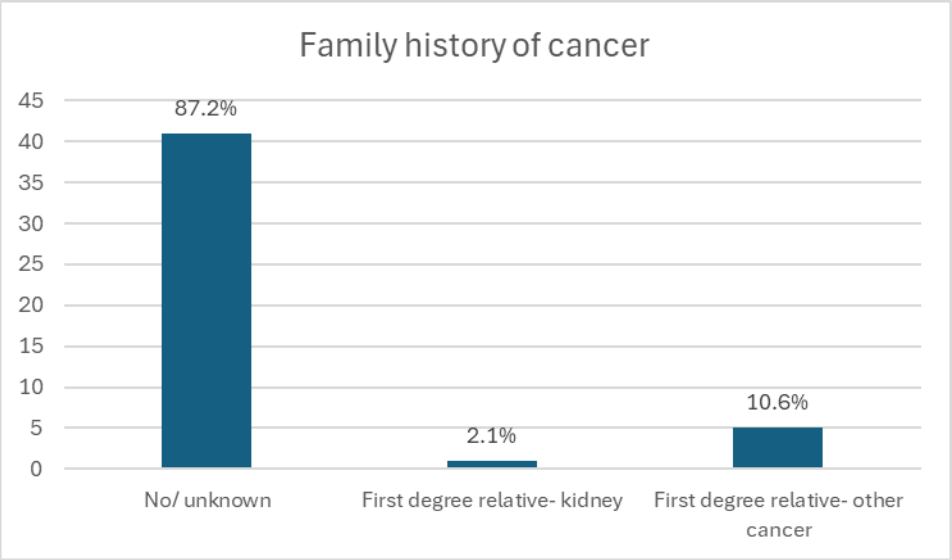
Risk factors



Similar to bladder cancer findings, two-thirds (66%) were current or ex-smoker.



51% of patients were overweight or obese and we know national data shows that the more overweight an individual is, the higher their risk of kidney cancer[7]. It may be helpful to consider urine dipstick in overweight patients presenting for chronic disease management reviews alongside those with a smoking history.

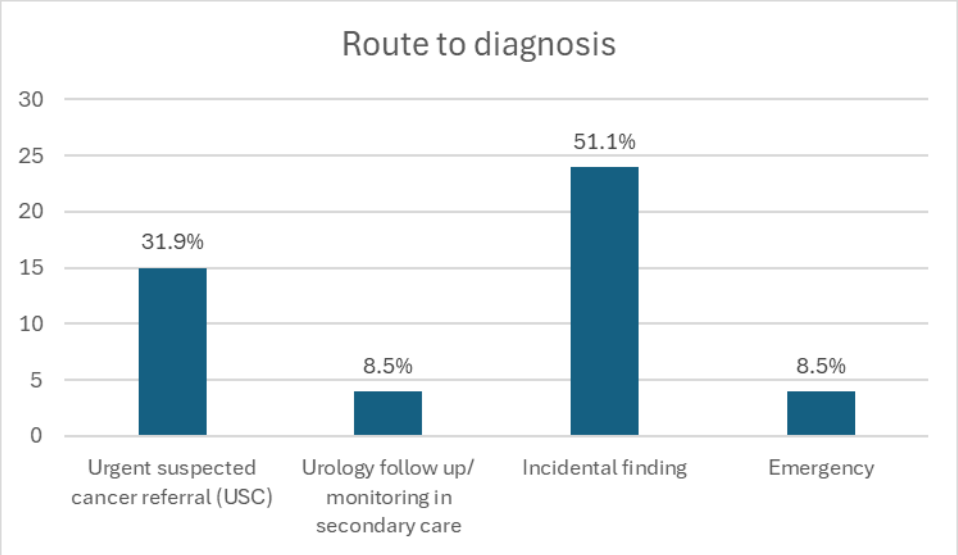


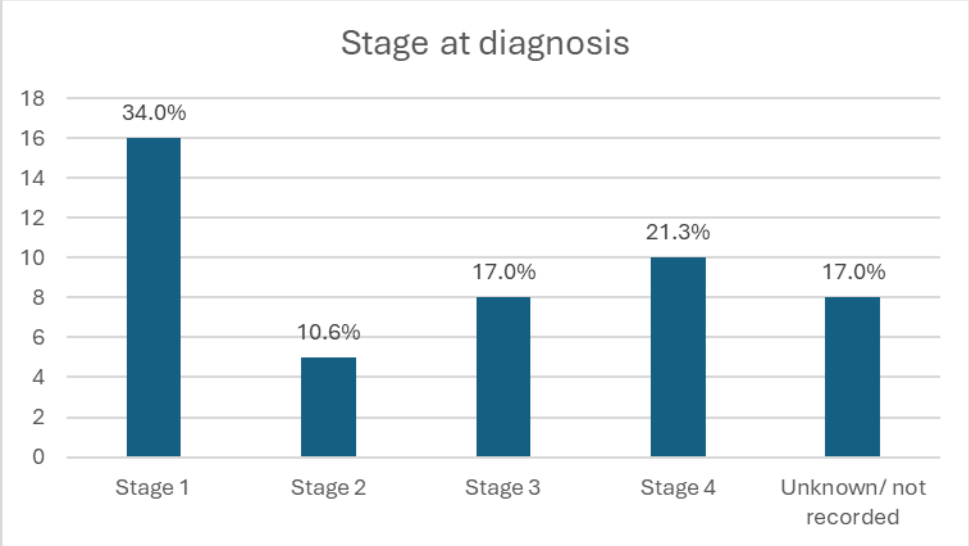
2.1% of patients had a first degree relative with kidney cancer, and a further 10.6% had a first degree relative with another cancer. As discussed above, documentation of family history in primary care is challenging and therefore it is difficult to draw conclusions from this.

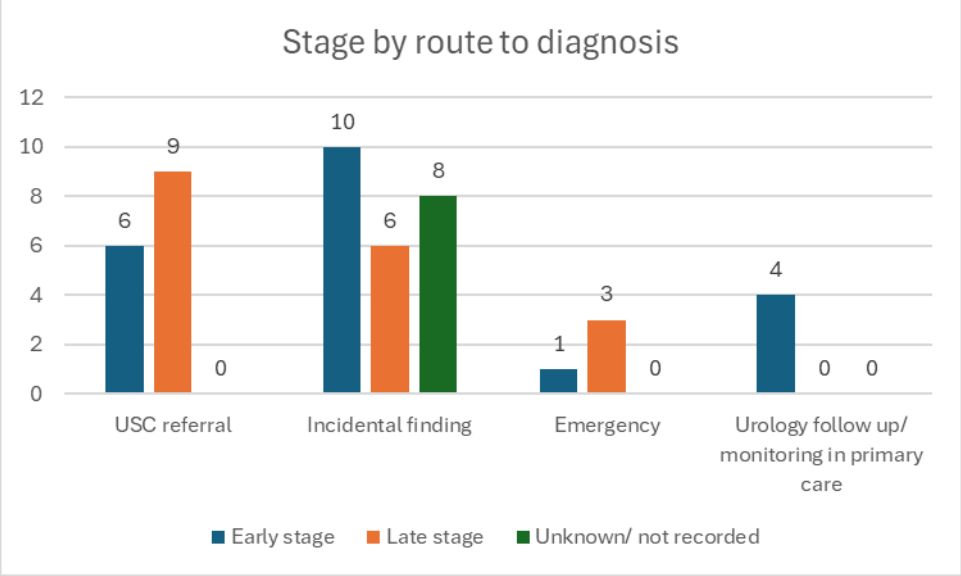
Chronic kidney disease

29.8% (14 cases) were reported as having chronic kidney disease (CKD). Potentially undertaking urine dipstick testing for haematuria for patients during annual CKD could be explored to improve early diagnosis.

Route to diagnosis and stage at diagnosis

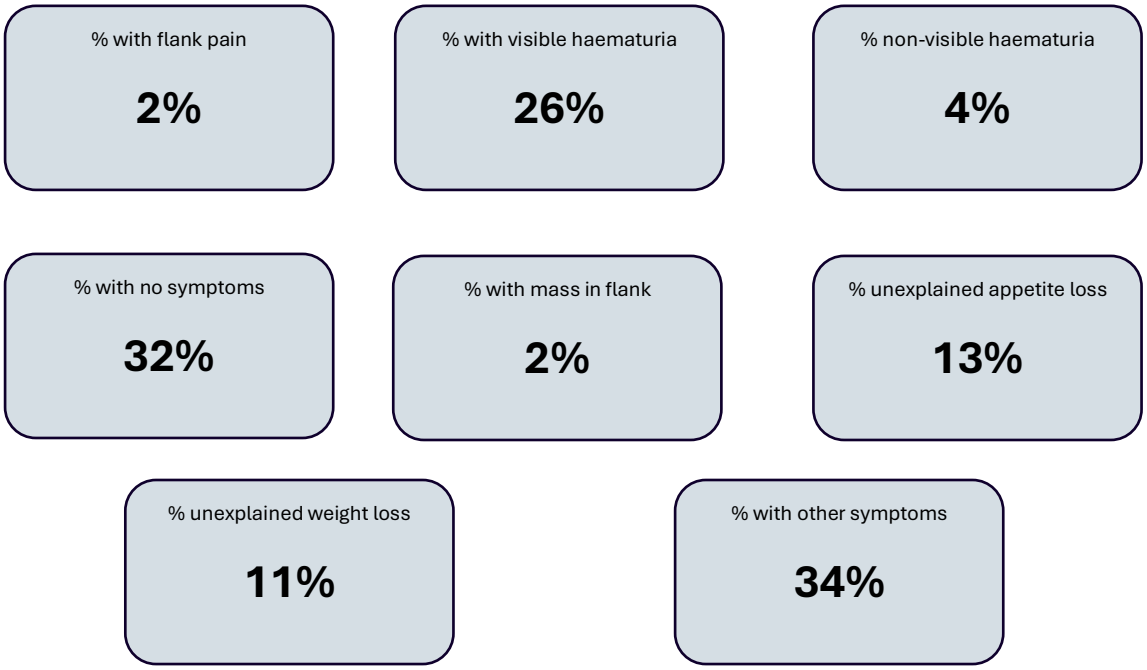






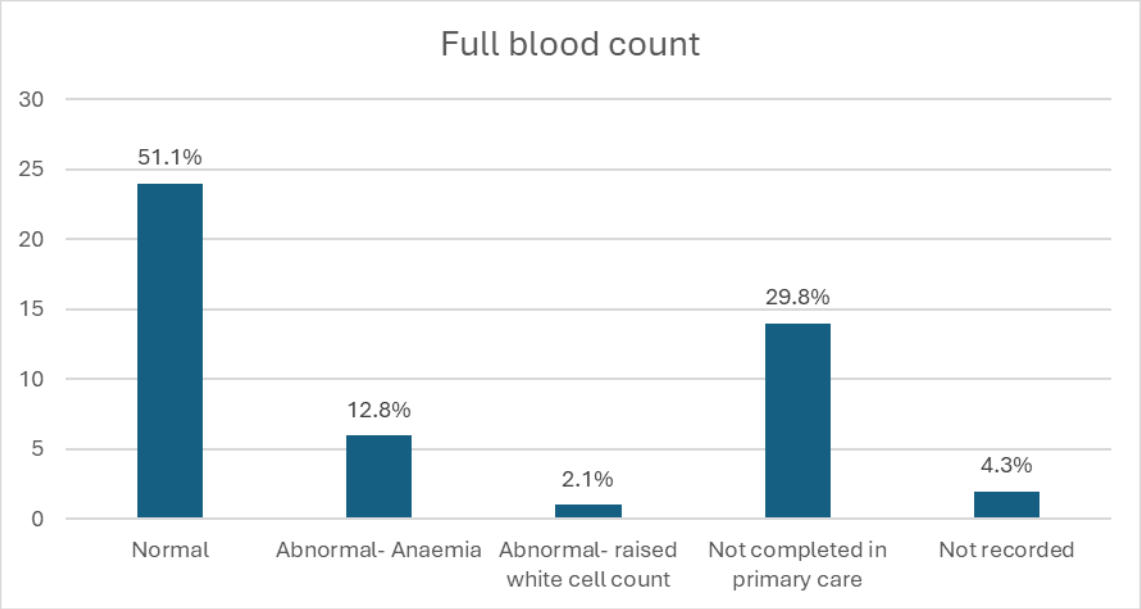
51% of patients were diagnosed by incidental finding on investigation for other reasons. These patients had a higher chance of being diagnosed at early stage than those patients referred on USC referral or emergency presentation.

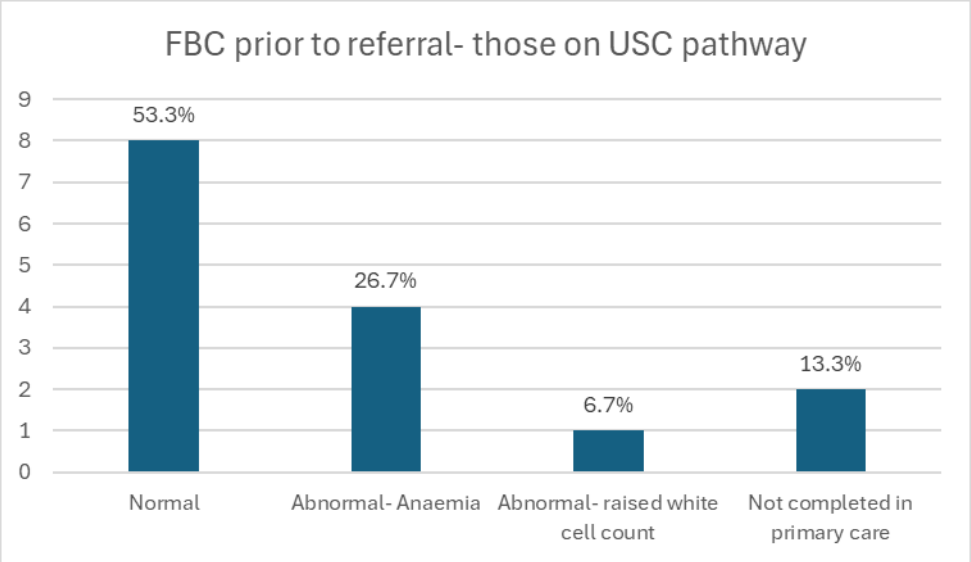
Symptoms/ Signs



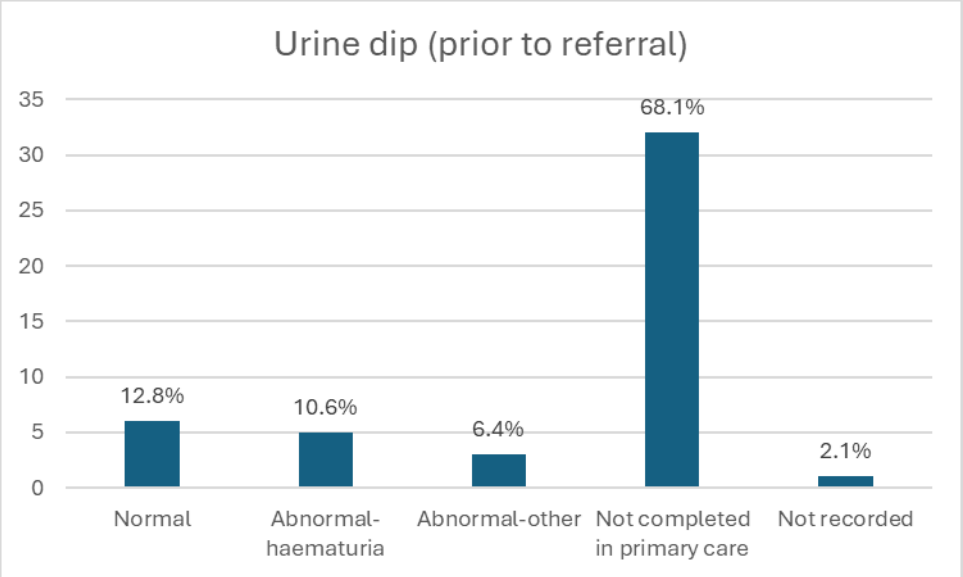
Of the 24 patients diagnosed incidentally, 11 had no symptoms. However, many with incidental diagnosis also had a range of symptoms recorded. This may indicate that they may have had scans done for symptoms suspected to be due to another cause. In particular, we know that patients with non-specific symptoms such as weight and appetite loss may be appropriately referred to the rapid investigation service for CT imaging.

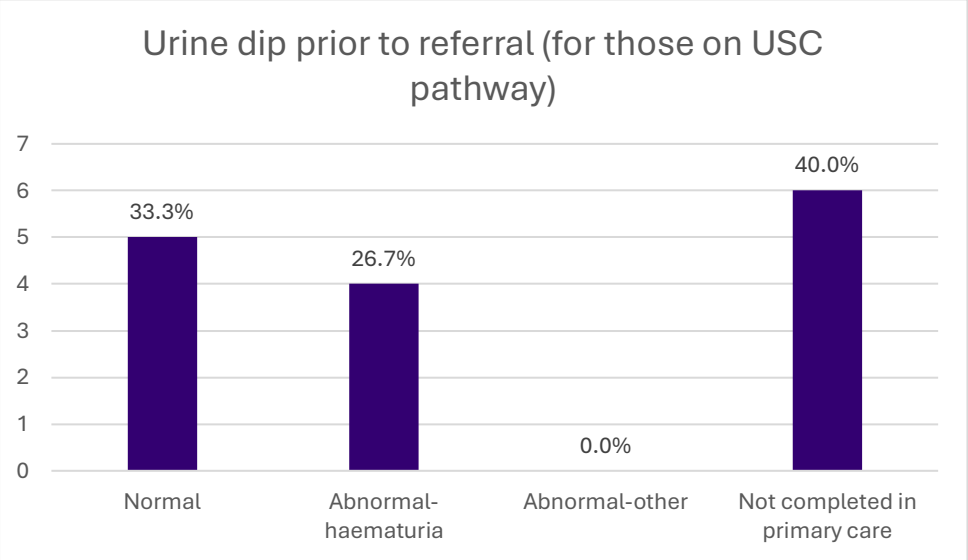
Investigations and examination



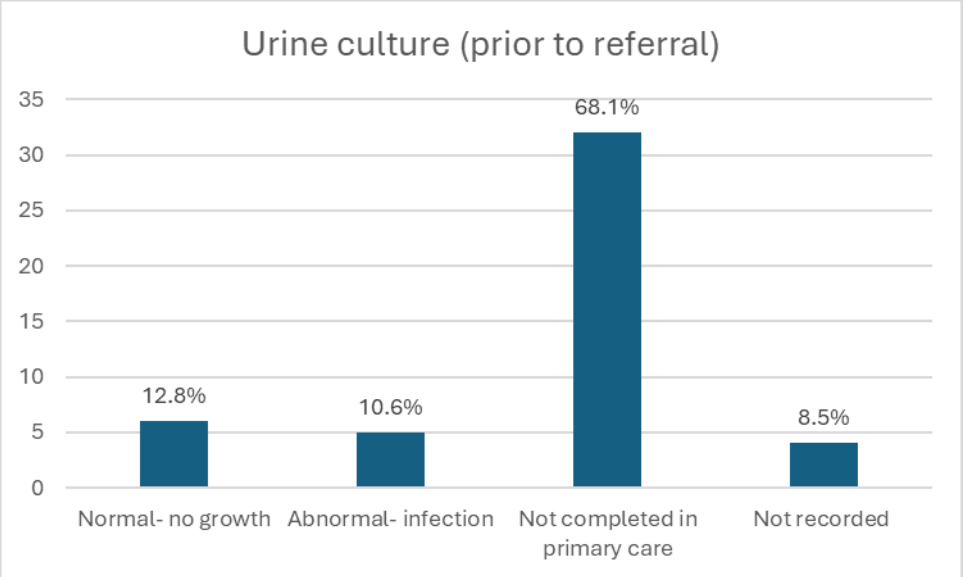


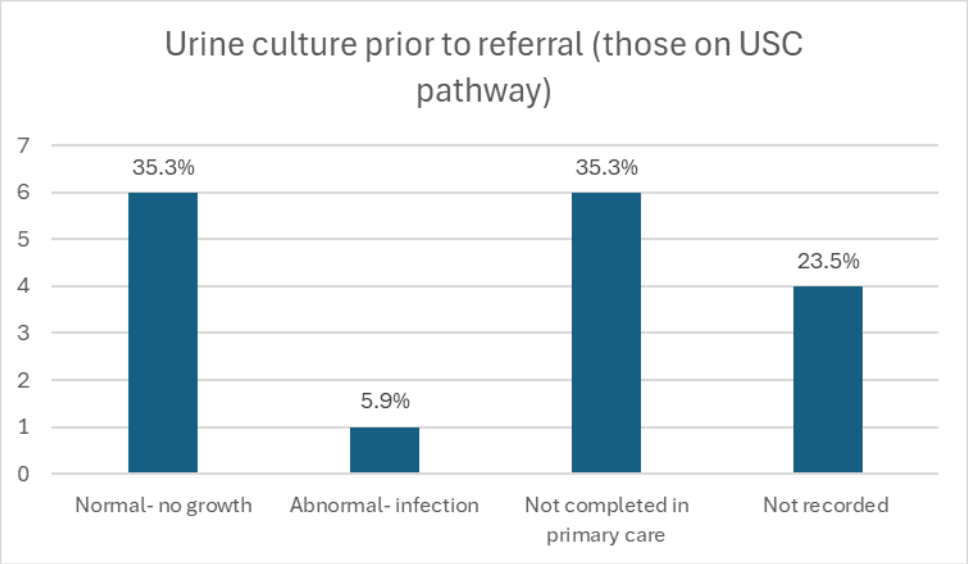
5 out of 15 patients referred on the USC pathway had an abnormal full blood count with either anaemia or elevated white cell count.





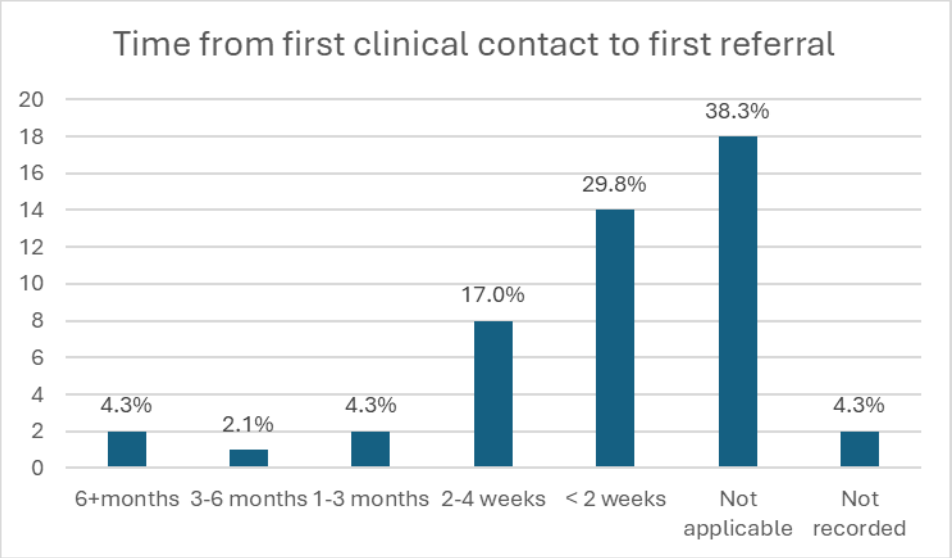
Though numbers were small, a significant portion of patients referred on USC pathway did not undergo urine dipstick testing. 9 patients had testing and 4 of these had haematuria.



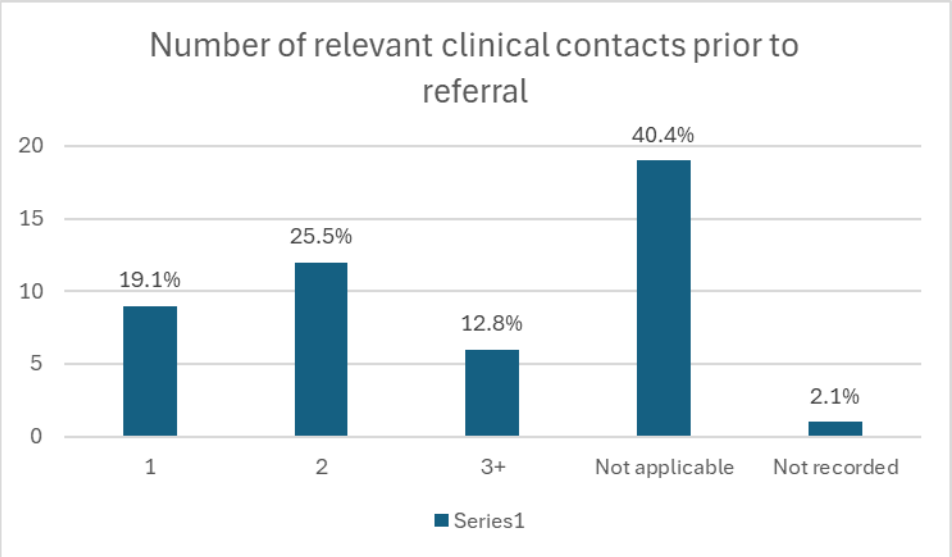


Only one patient referred on USC pathway had confirmed urinary tract infection, but notably several patients were not tested.

Primary care Interval



29.8% of patients were referred within 2 weeks of first clinical contact. A further 17% were referred within 2-4 weeks. 10.7% of patients waited over a month. It is not clear due to the small numbers of kidney cancer in the audit whether this impacted stage of diagnosis.



Delays and other qualitative analysis

There were delays identified in 7 out of 47 patients diagnosed with kidney cancer (14.9%).

Primary care Delays

Vague or non-specific symptoms – In some cases, kidney cancer was not considered in the initial differential diagnosis, meaning urine dipstick testing was not undertaken at the first presentation.

Interpretation of results – There were cases where initially reassuring investigation results contributed to delays, highlighting the importance of recognising that false negative results can occur. There were also examples where urine dipstick was not part of the initial assessment of anaemia, in keeping with findings from the bladder cancer audit.

Continuity of care - On occasion limited continuity of care contributed to delays in arranging further investigation of symptoms.

Secondary Care Delays

The PCN who analysed delays following fast track referral noted a delay from referral to treatment. As mentioned above, this was only reviewed by one PCN as it was outside the scope of the audit.

Next steps

There is considerable overlap between the recommendations regarding bladder cancer audit data and kidney cancer. In addition to the bladder recommendations, we would also suggest that primary care education should include importance of considering urine dipstick in patients presenting with non-specific symptoms as well as refresher on risk factors such as obesity and CKD.

Overall Conclusion

Urological cancers were chosen to review for this year's audit in Dorset to explore possible reasons for the discrepancy in late-stage diagnosis. Our audit did not find explicit primary care delays to account for this; however, we did generate several areas for primary care education and system wide improvement which have been detailed in the next steps section for each tumour type. In addition to the site-specific recommendations highlighted in the report we also identified some general themes to address in future work:

- Targeting groups at high risk of urological cancer– For example those with family history or black ethnicity for prostate cancer, females and current or ex-smokers

for bladder and kidney cancer, and obesity and CKD for kidney cancer. We also suspect that within Dorset deprived and rural populations also need to be targeted for early diagnosis.

- Frailty – this was not documented in approximately 40% of USC referral in all urological cancers. Since August 2025 all USC forms in Wessex have been updated with the Rockwood clinical frailty score instead of the WHO performance status. Given the increase in patient triage ‘straight-to-test' it is important we ensure primary care clinicians are documenting frailty in referrals and understand the importance of this.
- Across all three urological tumours there was a theme of potential delay for patients with non-specific symptoms or symptoms which overlapped with other tumour types. For urological cancers this was seen in patients with potential gastrointestinal or gynaecological symptoms. It is important that we consider the possible differential diagnosis of symptoms across tumour sites when designing training or guidance for primary care clinicians in future rather than narrow site-specific advice.

Acknowledgements

Thank you to all the PCNs across Dorset who took part in this audit for their time and dedication given to providing data, reflections and learning points.

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Appendices

Appendix A



Wessex Cancer Alliance Urology Audi