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NHS RESOLUTION WEBINAR: DELAYED CANCER DIAGNOSIS IN GENERAL PRACTICE

Thursday 5 February 2026
13:00 – 14:30

Agenda

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Time	Item	Speaker
13:00	Introduction and Welcome	Ellen Nicholson, Safety and Learning Lead for General Practice, NHS Resolution
13:05	Overview, volume of Activity from primary care, National Cancer Strategy overview if published	Professor Peter Johnson, Professor of Medical Oncology, University of Southampton, and National Clinical Director for Cancer,NHS England
13:15	ELSGP Cancer report	Samantha Thomas, Safety and Learning Lead (Midlands & East), NHS Resolution
13:35	Medical Examiner/OoH GP Perspective	Dr Kathy Smith, Medical Examiner and Out of Hours GP
13:55	GP and Expert Witness	Dr Nick Swale, GP and Expert Witness
14:15	Panel discussion – Q&A	Ellen Nicholson
14:30	Summary and close	All

Overview, volume of activity from primary care, National Cancer Strategy overview if published

Professor Peter Johnson
Professor of Medical Oncology, University of Southampton,
National Clinical Director for Cancer at NHS England

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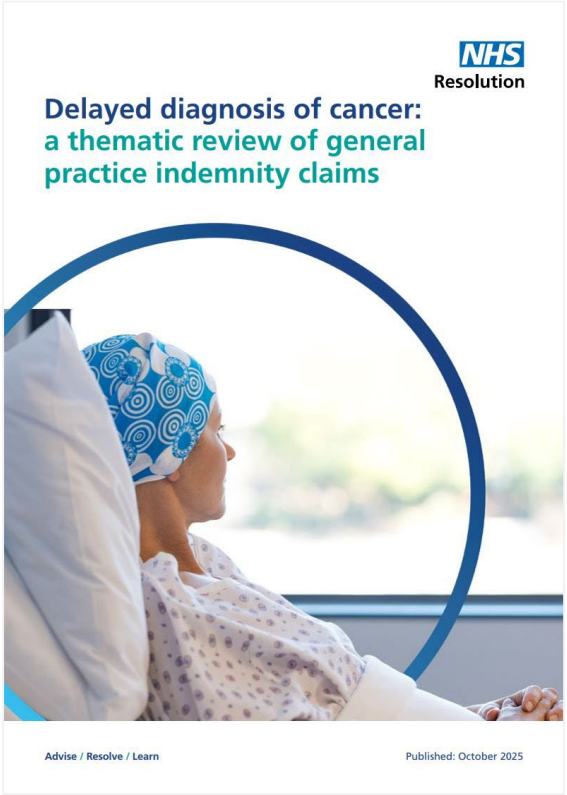
Delayed diagnosis of cancer thematic report

Samantha Thomas

Safety and Learning Lead for Midlands and East

Samantha.thomas37@nhs.net

Key findings



Analysed **105** closed, settled GPI claims over a seven-year period to March 2023.

Key findings include:

- **65.7%** of patients were diagnosed with stage 3-4 cancer, compared to national early diagnosis rates of around **54%** for stages 1-2
- **40%** of cancer diagnoses were made following routine referrals or emergency department attendance, rather than urgent suspected cancer referrals
- Remote consultations featured in **53%** of claims, highlighting the increased importance of comprehensive history taking when physical examination is not possible
- **73.5%** of claimants aged under 50 years were female, indicating potential gender disparities in early-onset cancer detection.

Background to the delayed diagnosis of cancer in general practice report

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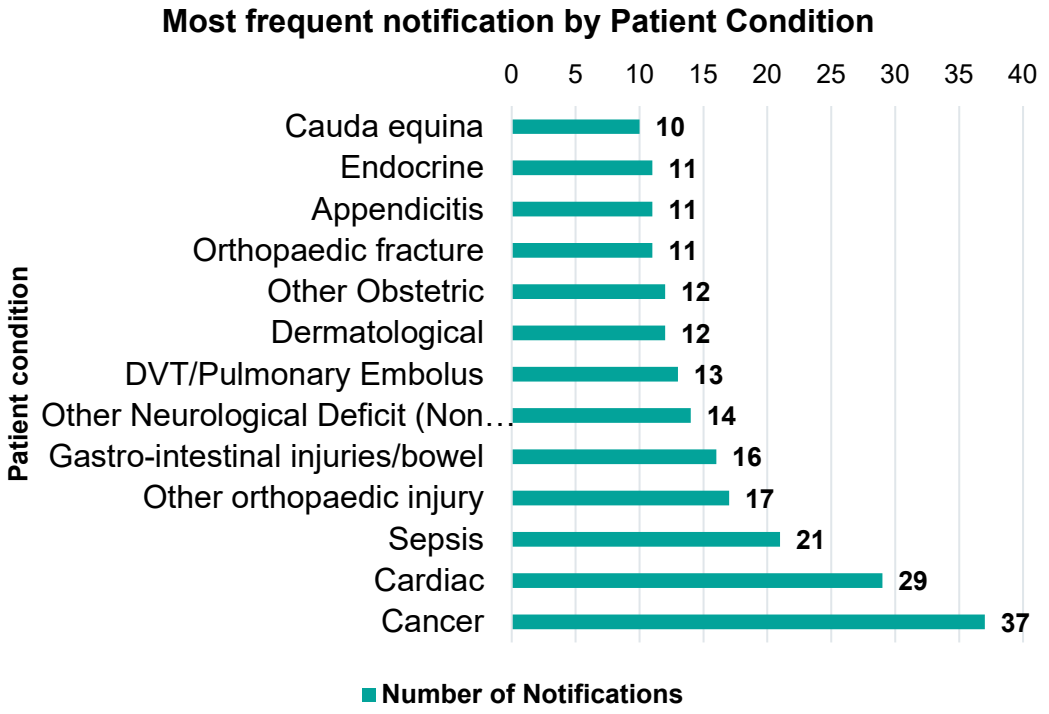
Failure to investigate, and/or diagnose, and missed, wrong and delayed diagnoses

Medication errors

Delays in care, including speciality reviews and referrals

Problems with communication, between primary and secondary care



Claims data

105
closed settled claims with total cost of **£6,135, 218**

Cancer with most professionals seen before referral
- lung cancer
- head and neck cancer
- urological cancer (excl prostate)
- other cancer*

Highest number of successful claims
- colorectal cancer
- skin cancer
- breast cancer =
- prostate cancer =

Cancer with most visits before referral
- other cancer*
- lung cancer
- urological cancer (excl prostate)

Highest cost of successful claims
- prostate cancer
- colorectal cancer
- breast cancer

Cancer with longest GP delay to referral
- prostate cancer
- skin cancer
- gynaecological cancer

*other = haematological, pancreatic, liver cancers

Cancer subspecialties by total claims number and cost (£)

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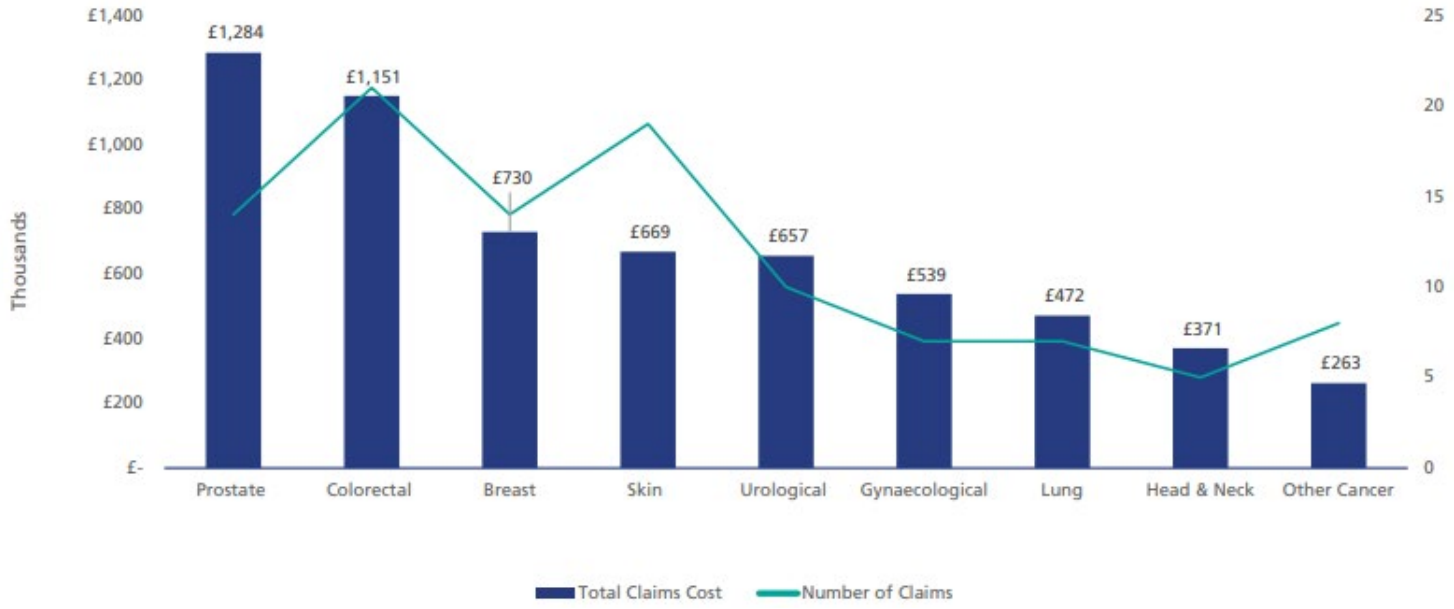
Figure 6: Cancer subspecialties by total claims cost paid and number of claims



Cancer subspecialties by average number of healthcare visits before referral

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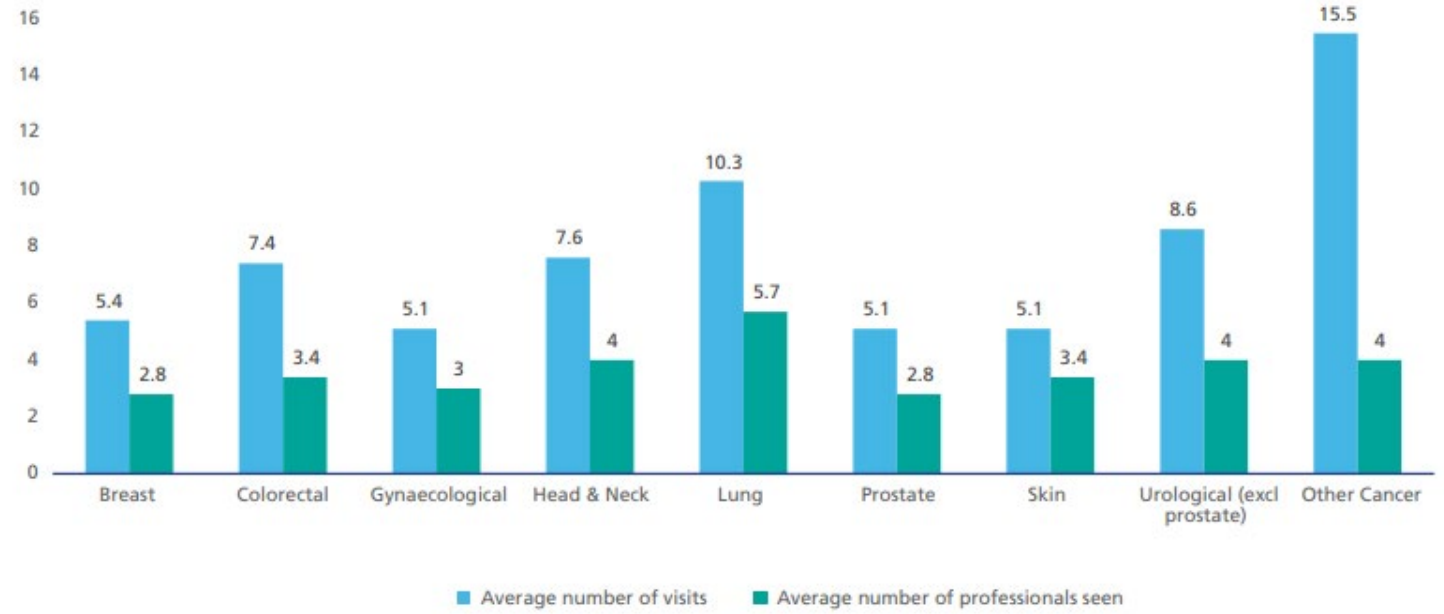
Figure 7: Cancer subspecialty by average number of healthcare visits before referral to diagnosis



Cancer subspecialties by average General Practice professional delay to refer, in months

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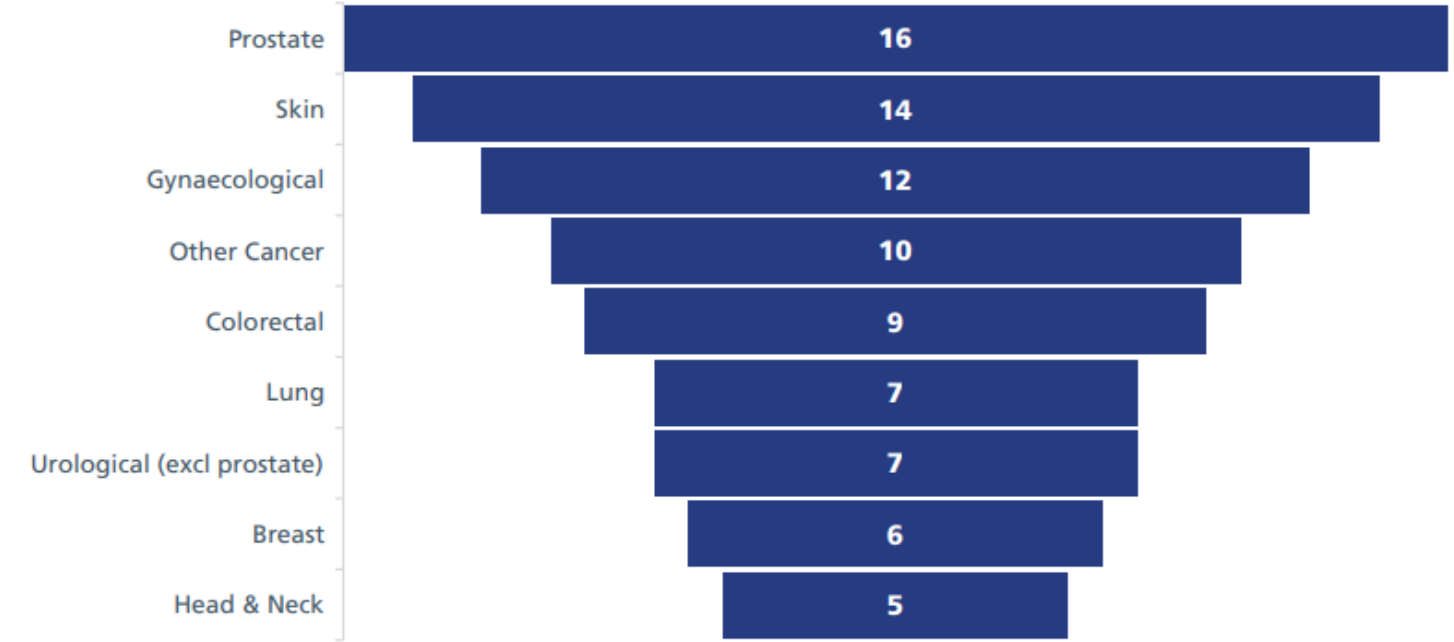
Figure 8: Cancer subspecialty by average GP delay to refer in months



Analytical highlights

No use of **2WW** in initial appointment

"A 4-week delay in cancer diagnosis can be significant". Source: Prof Peter Johnson-Westminster Health Forum Cancer next steps: March 2024.

40% cases no use of **2WW** before diagnosis

27% cases diagnosed through **routine** referral

↓

Highest in breast cancer and gynaecological cancer

13% cases diagnosed through **A&E** attendance

↓

Highest in other cancer*, urological (exc prostate) and colorectal cancer

30 % metastatic at diagnosis → Highest in gynaecological cancer, prostate cancer and other cancer*

65.7 % diagnosed with stage 3-4 cancer

Main findings

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- **7.6%** of claims showed the treatment of symptoms without a diagnosis or differential diagnosis
- Fragmented systems obscure repeat attendance. There was an average of 7.4 primary care visits before referral and diagnosis.
- In **40%** claims, cancer was diagnosed following routine referral to specialties or emergency department attendance.
- **65.7%** of patients were diagnosed at stage 3-4 cancer and many had received multiple courses of antibiotics and treatments without improvement.

In the lead up to their eventual diagnosis with cancer, patients often had multiple points of contact with the health system – including calling NHS 111, calling an ambulance, attending out-of-hours centres and visiting emergency departments. Patients who spoke to NHS 111 and attended out-of-hours services experienced increased fragmentation of care, with these visits not always reflected in GP records.

Main findings cont'd

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- Insufficient history taking and safety netting advice was a feature in both face to face and remote consultations. **53%** of claims contained remote consultations.
- **73.5%** of claimants under 50 years old were female and were noted to have higher rates of metastasis at diagnosis.
- Risk of cancer recurrence was not recognized in the **10.5%** claimants who had a prior history of cancer.
- Patients who had multiple morbidities , were under several specialties or who had recently seen a specialist experienced increased delays.

Patients have limited avenues to access secondary care without GP support. Patients who were initially reassured delayed return to their GP. Those who were unsatisfied sought escalation via NHS 111, ambulances or emergency departments.

Positive practice example

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Good practice

The patient was seen by the practice nurse and at the appointment. The previous consultation history and urological investigations were checked. They noted that the previous high PSA results had not been acted on. They shared this information with the patient, and the nurse demonstrated full transparency by discussing the actions, which should have taken place.

The nurse made a 2WW referral to urology and took blood tests to check PSA levels. When received, the nurse called the patient to update them on the extremely high result and updated urology of this information ahead of their first appointment.

Additionally, the duty of candour and complaint response showed that the practice raised the issue with the electronic patient health record company to request a change to prevent this type of error from happening in the future, therefore, recognising the incident had a potential risk of recurrence within a larger system design error.

Jess's Rule - 3 Strikes and we rethink

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'reflect, review and rethink'

Jessica Brady had 20 consultations with her GP practice In the 5 months leading up to her death, and her cancer was not diagnosed. Jess was then admitted to hospital and found to have stage 4 adenocarcinoma. Jess passed away in December 2020 at the age of 27.

Reflect: Think back on what the patient has said and consider what has changed or been missed. Offer ongoing **episodic** continuity of care for future direct patient care. 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.

Recommendations

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01

Improving diagnostic processes

02

Strengthening communication within consultations and across the system

03

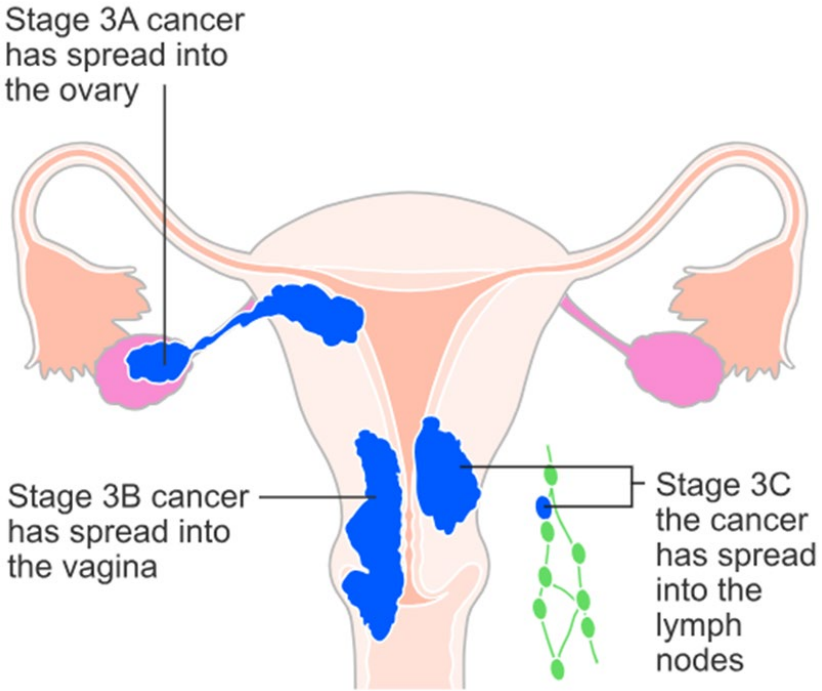
Empowering patients with clearer pathways for self-referral and escalation

Read the full report online

Local innovation

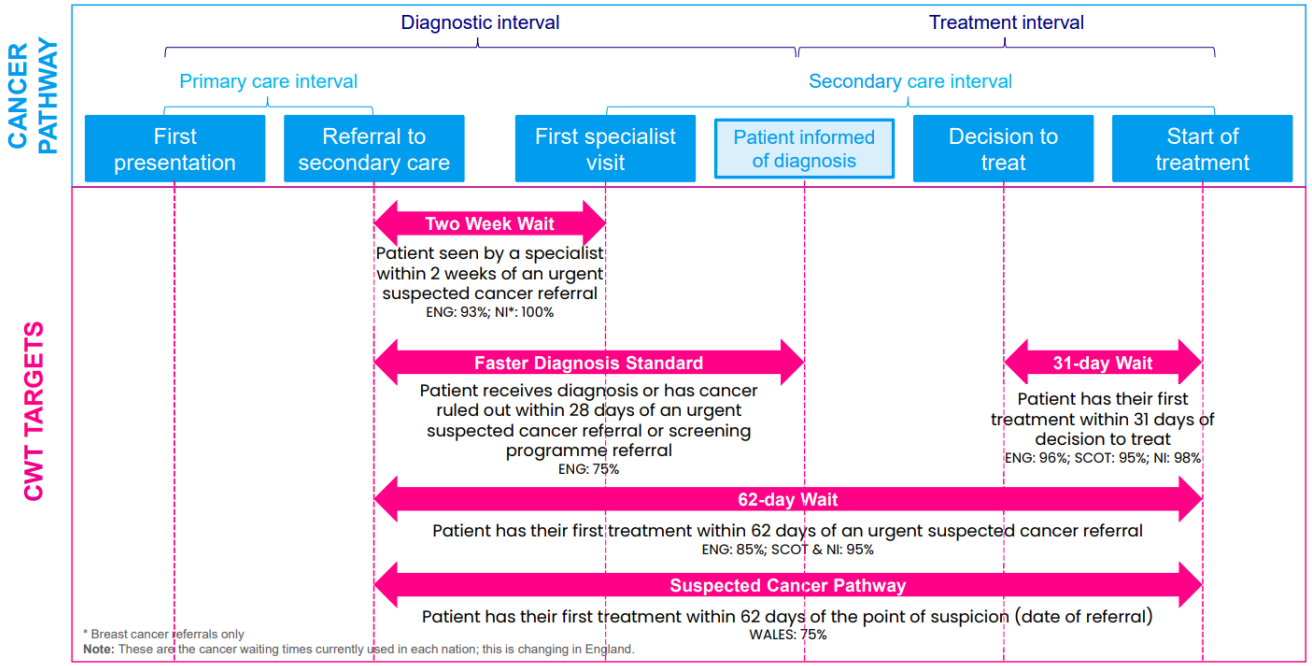
Somerset NHS Foundation Trust

After noticing a year-on-year (30% in 2023) increase in the number of women with post-menopausal bleeding referred to its gynaecology service, Somerset NHS FT launched a ‘first of its kind’ service, allowing women who are experiencing vaginal bleeding or unusual discharge (after the menopause) to complete a self-referral (via the website or by telephone) to the gynaecology booking team in order to reduce avoidable delays.



Summary

Cancer waiting times targets



The timeline between first presentation until referral to secondary care is a key point in the cancer pathway. This report highlights key themes contributing to delayed diagnosis of cancer in general practice claims.

Source: Cancer intelligence team, Cancer UK - Performance measures across the cancer pathway Key Stats(2023)

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Safety and Learning

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Medical Examiner/OoH GP Perspective

Dr Kathy Smith

Medical Examiner and Out of Hours GP

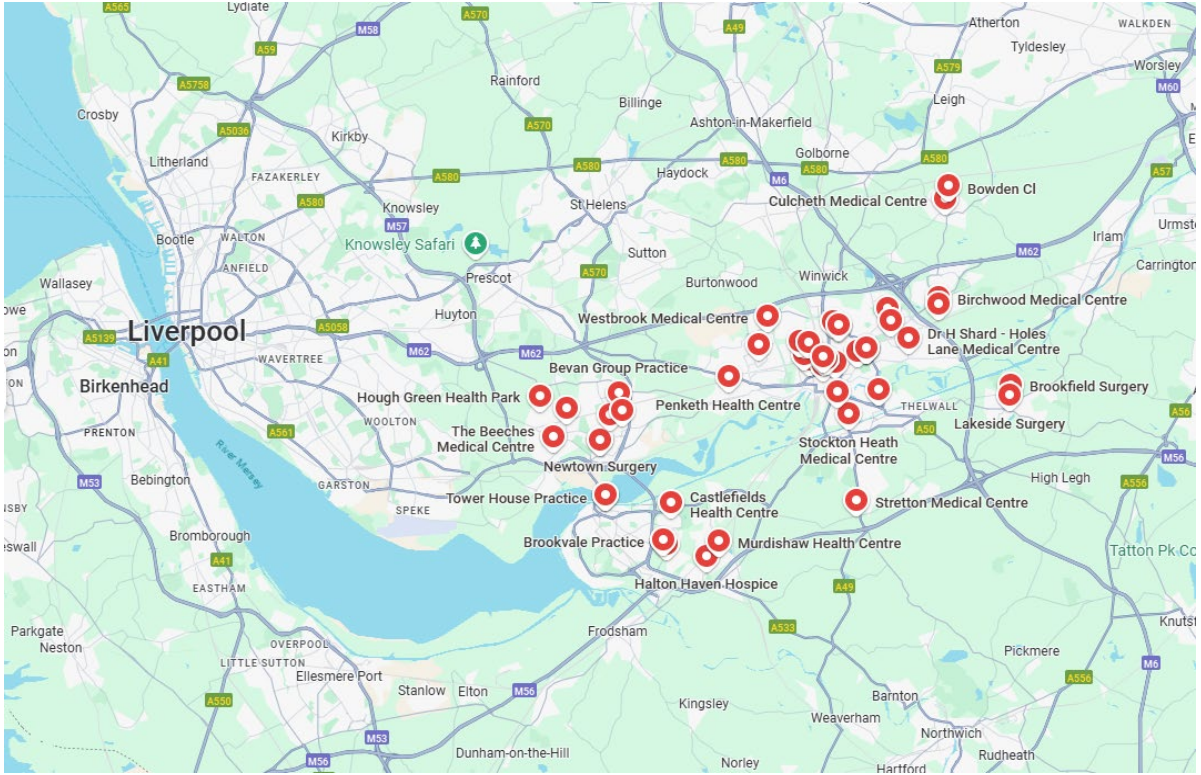
Declaration of interests

Warrington and Halton Teaching Hospitals NHS Foundation Trust

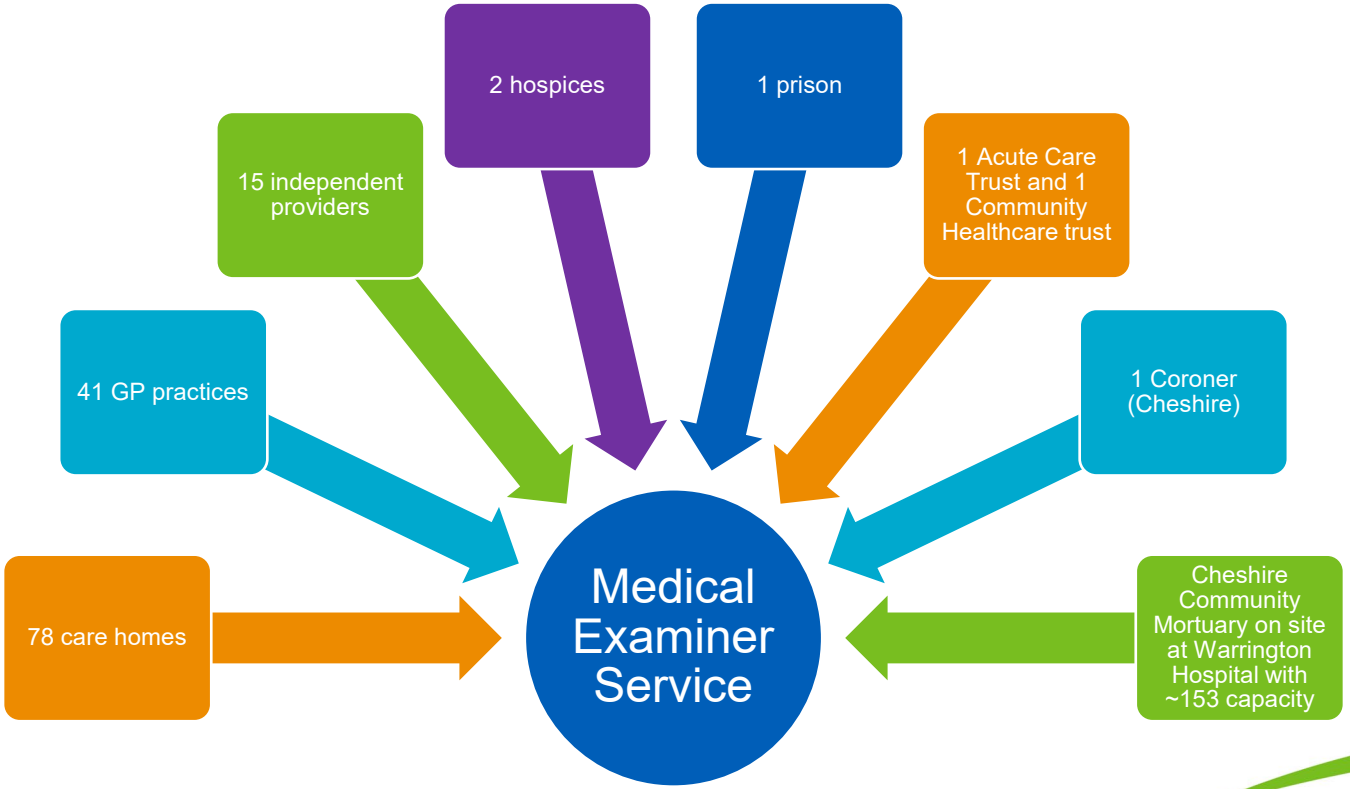
- Portfolio GP
- Medical Examiner at Warrington Hospital
- Medical Lead at NHS South Central and West Commissiong Support Unit
- National Improvement Coach for National Neighbourhood Health Implementation Programme (NNHIP)
- Visiting Lecturer and Tutor at Chester Medical School
- RCGP Mersey local faculty board

Warrington Medical Examiner Service

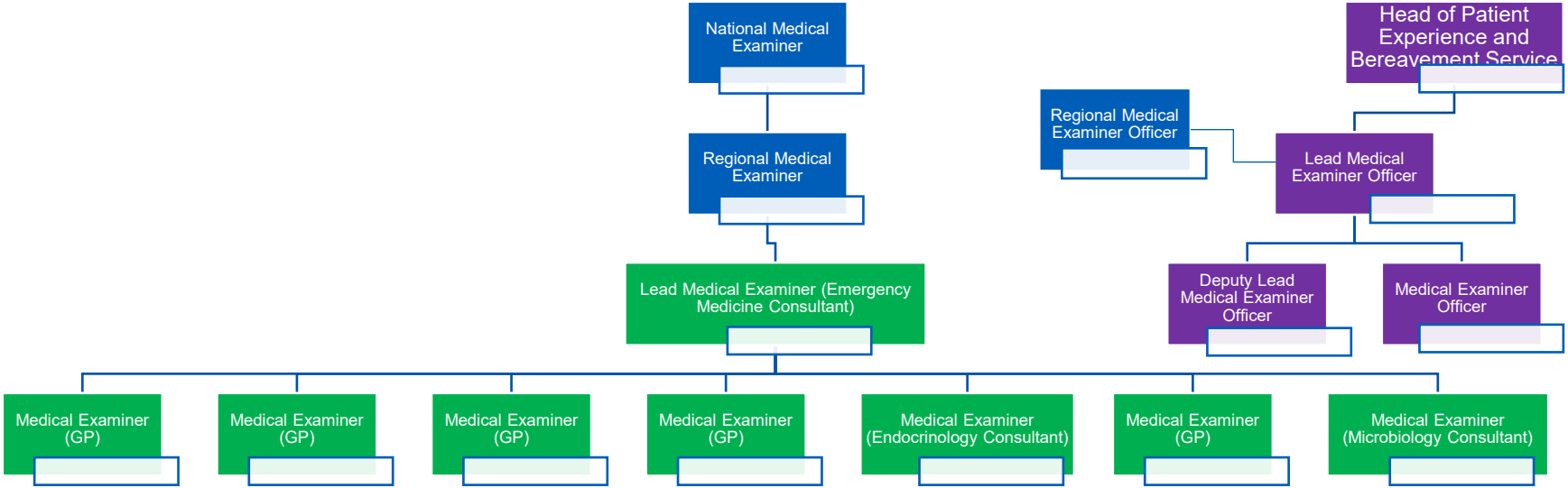
About us – Location



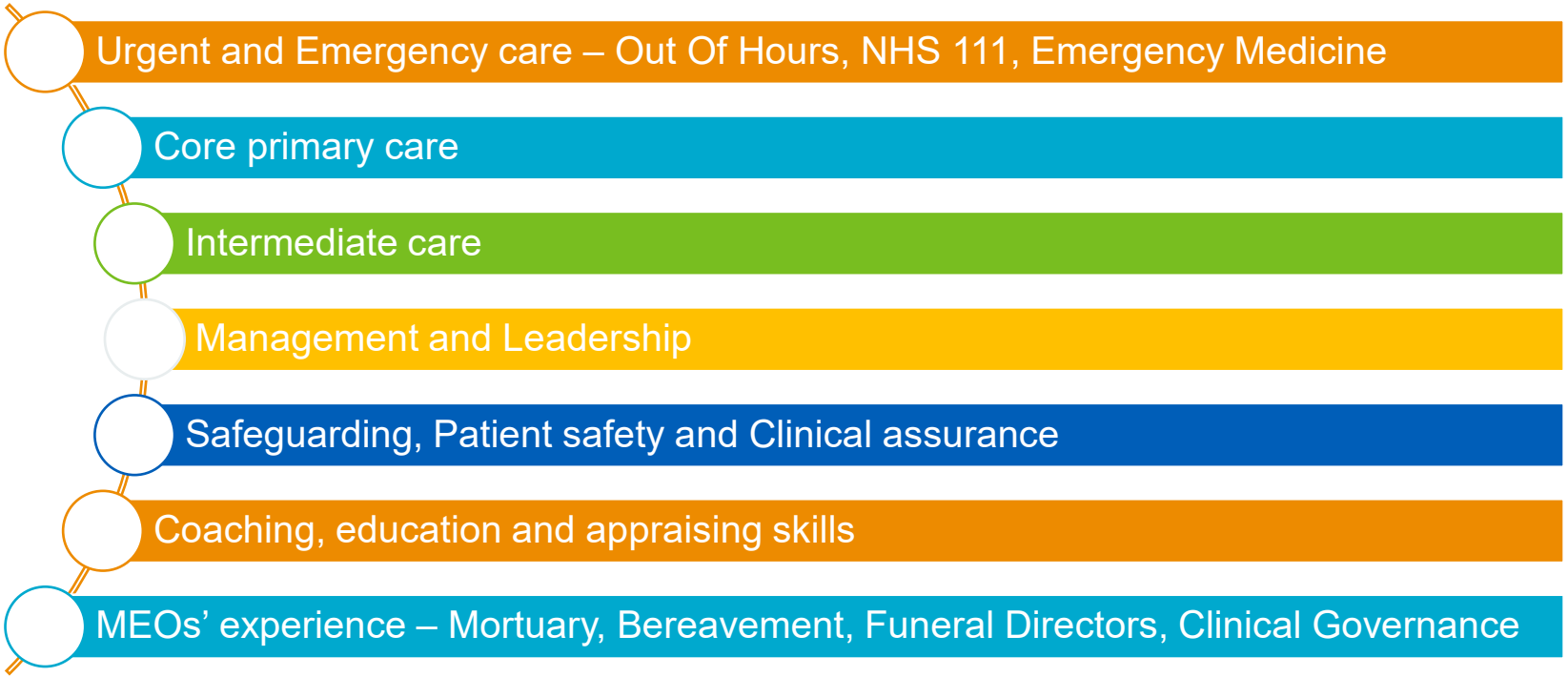
About us – Some of our partners



About us - Our service



About us – Expertise within the team



About us – Our process

MEO = Medical Examiner Officer
MCCD = Medical Certificate of Cause of Death
AP – Attending Practitioner

About us – Benefit of GPs as Medical Examiners

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Contributing the GP perspective from the outset

Collaborative approach

Inform clinical quality thresholds i.e. **What does good look like in primary care?**

Experienced in Electronic Patient Record navigation

Insight into patient pathway challenges

Face validity – who is scrutinising who?

Constructive peer feedback approach

Values-driven approach

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Feedback

Feedback

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Quantitative measures

- Quarterly reporting and audits
- Pattern recognition locally, regionally, nationally
- Focus on delays and barriers

Qualitative measures

- Feedback from providers
  - What has gone well?
  - An important source of professional and peer validation
  - Areas for improvement and learning
  - Sense checking - is it ok to write…?
- Feedback from the bereaved
  - Structured conversation
  - Independent scrutiny
  - Role in empowering and signposting

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Challenges

Challenges so far

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- Managing Provider level FAQs: GP practices report family members often ask about the time scale for the death certification and registration process
- Managing NOK expectations – what is the MCCD for?
- Managing negative press and misconceptions about delays
- Managing a wide spectrum of workplace cultures across our stakeholders
- Managing defensive medical peers who feel scrutiny is a negative process
- Managing medical peers reluctant and/or resistant to change
- **Managing safety or quality concerns identified following reviews – how do you articulate this constructively and kindly through a range of reporting channels; from DATIX incident reporting to email dialogue (primary and community care)**
- **Managing safety or quality concerns identified such as delayed or missed cancer diagnoses in primary care**
- Collating themes and patterns on areas for improvement in the community

Patient safety and quality themes

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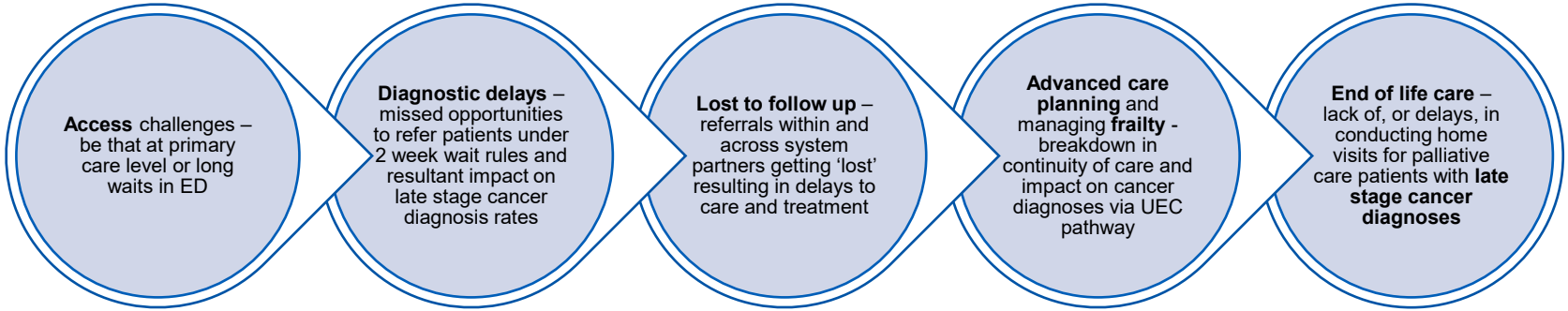

Areas for improvement

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Consider gaps and areas of risk across the patient pathway

Jess's rule - working with primary care to highlight opportunities

Develop clear communication channels for flagging quality or safety concerns with General Practice – primary and secondary care interface

Think about how we work with existing system partners

Think about how we routinely share ME insights with wider system partners

Thank you

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Delayed cancer diagnosis in General Practice: Learning from negligence claims

Dr Nick Swale
GP and Expert Witness

Learning from claims

- Delayed cancer diagnosis GP negligence claims are common
- Simple avoidable errors are commonly seen in such claims
- Knowledge of what goes wrong & simple changes to practice may help to avoid claims
- Most of this information will not be a surprise..
- Yet primary care cancer claims still occur..

Why do cancer claims occur?

Assessment

- Inadequate assessments (history & examination)
- Failure to elicit or recognise red flags

Diagnosis

- Failure to consider cancer within a differential diagnosis
- Failure to reassess adequately & reconsider the working diagnosis

Management

- Failure to investigate or refer adequately
- Inadequate safetynetting

Assessment

- Take a good history
- Examine when needed
- Consider differential diagnoses
- Know the red flags and assess for them
- Be aware that cancer:
  - may mimic other conditions
  - may present with vague or atypical symptoms
  - may present repeatedly before the eventual diagnosis
- Be aware of a past history of cancer

Assessment: Red flag examples

- Bowel symptoms: rectal bleeding, weight loss, abdo pain, bowel habit
- Respiratory symptoms: haemoptysis, weight loss
- Urinary symptoms: haematuria
- Upper GI: dysphagia, weight loss, abdo pain, vomiting
- Back pain: thoracic pain, night pain, weight loss, history of cancer

- Past history of cancer: consider recurrent / metastatic disease
  - (eg if presenting with new bone pain, cough, weight loss)

Inadequate examination examples

- Prostate / bowel cancer: rectal exam (DRE)
- Gynaecological cancer: pelvic exam (PV)
- Melanoma: 7 point score

Differential diagnosis

3d approach: consider at least 3 differentials for every presentation

Examples:

- Change of bowel habit: IBS, cancer, IBD
- Urinary symptoms: UTI, prostate enlargement, prostate cancer
- Haemoptysis: infection, cancer, PE

Reassessment

- Cancer often presents repeatedly in primary care before eventual diagnosis
- Common to see initial working diagnosis not questioned
- If the patients reattends:
  - question the initial working diagnosis, particularly if there are odd symptoms, or poor response to treatment, or progression
- Reassess in more detail (not less!)
- Be aware of fragmentation effect – multiple clinicians / services
- Be aware of cognitive bias

Cognitive bias

- Common
- May be subconscious
- May lead to ignoring symptoms that don’t fit (confirmation bias)
- False reassurance of common benign conditions in general practice
- Horses vs Zebras
- Don’t necessarily just go with the (apparently) obvious diagnosis
- Hypochondriacs may still get cancer
- Avoiding bias requires disciplined, systematic, logical thinking

Investigation examples

- Investigate to exclude differentials:
  - PSA, Ca125, FIT, CXR
- Beware false negatives:
  - Chest Xrays
- Anaemia needs careful assessment:
  - Iron deficiency anaemia may be a red flag
- IBS: a diagnosis of exclusion – consider FIT & Ca125 etc

Example - Patient W

- 76-year-old, past history of breast cancer 5 years ago
- New presentation with thoracolumbar back pain & night pain
- Gradually worsened until severe
- Lumbar spine XR normal
- Eventually admitted, MRI scan = metastatic breast cancer

Failure to assess, elicit red flags, consider differential diagnosis, investigate, reassess

Example - Patient X

- 60-year-old, fit & well, no PMH
- Presented with abnormal thumb nail
- Progressed to discoloured, then weepy, then skin (Hutchinson's sign)
- Treated for fungal then bacterial infection
- Multiple re-presentations
- Eventually referred as non-2WW, diagnosed as melanoma

Failure to consider differential diagnosis, reassess, refer 2WW

Example - Patient Y

- 42-year-old female
- Intermittent bowel symptoms – diarrhoea, bleeding, then weight loss
- Diagnosed as IBS & haemorrhoids
- Blood tests normal
- No DRE, no FIT
- Eventually diagnosed as low rectal cancer

Failure to assess, elicit red flags, consider differential diagnosis, investigate, reassess, safetynet

Example - Patient Z

- 78-year-old, exsmoker
- Presented over several months with repeated chest infections
- Treated with antibiotics, partially resolved, but recurred
- COPD considered, no CXR
- Eventually admitted, CXR = lung cancer

Failure to consider differential diagnosis, investigate, reassess

Key learning from claims

- Take a good history
- Consider differential diagnoses
- Assess for red flags
- Re-presentations: reassess and question the diagnosis