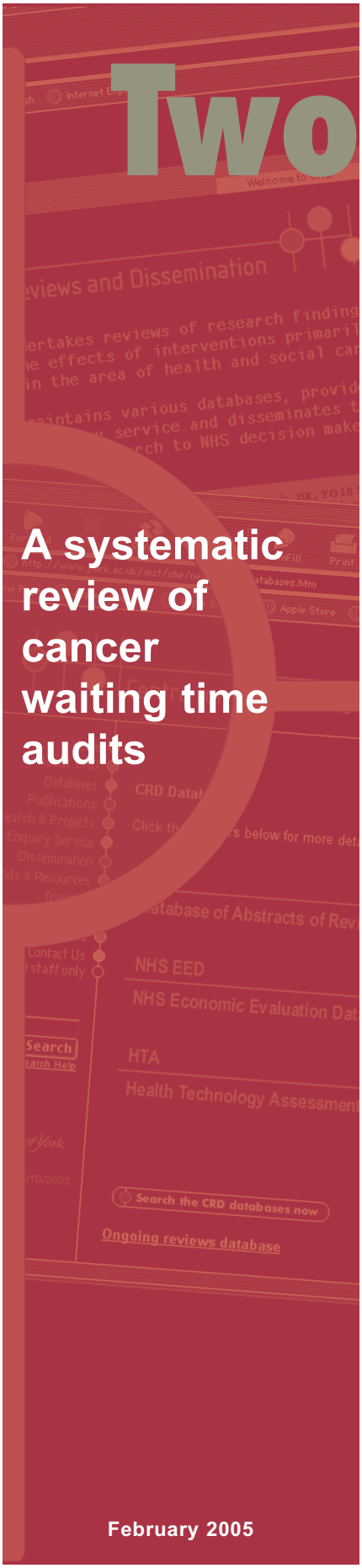
Two-week wait

for cancer referrals



- This systematic review of clinical audits assessed the implementation and effectiveness of the NHS two-week waiting time policy for cancer referrals in England and Wales.
- Most included clinical audits were poorly reported and their results demonstrated a wide variation in compliance with the guidelines.
- Fewer than half of included audits provided sufficient detail on the methods used for the audit to be reproducible. Less than a fifth provided details outlining any recommended changes to service delivery.
- Audit reports should be written up in sufficient detail to allow the reader to ascertain how the audit was conducted and to assess the validity of the results and how these will be used to improve existing practices and procedures.
- The methods by which clinical audits assessing the two-week waiting time policy are conducted and reported should be standardised across the NHS.

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Identifying clinical audits

Many clinical audits are only documented internally, therefore in order to identify them emphasis was placed on systematically contacting relevant people across the NHS. All NHS organisations were contacted via the CRD Single Contact Point (SCP) network. CRD has developed and maintains a network of some 650 key individuals within NHS Trusts and Strategic Health Authorities (SHAs). Most SCPs have roles and responsibilities connected with clinical audit, effectiveness or governance. These SCPs use their local knowledge and experience to communicate the findings of CRD outputs within their organisation. A letter was sent to each SCP asking whether they or their organisation had conducted any cancer waiting time audits since 1st April 1999.

We did not think that by contacting a single representative in every NHS organisation we would identify all potential audits. As such, additional contacts were made with a number of key individuals and organisations across the NHS. These included:

- PCT Cancer Leads
- Cancer Service Collaborative (CSC) National Clinical Leads
- Chairs of the Referral Guideline Working Parties
- Cancer Network Managers
- Cancer Network Service Improvement Leads
- Cancer Registry contacts
- Professional Societies (see full report for complete list)
- Cancer Screening Services
- Relevant Sections of the DoH
- Audit Commission
- Commission for Health Improvement
- The Welsh Assembly

Any leads arising from these contacts were followed up by a combination of telephone calls and emails.

In addition, we also searched the websites of key organisations, posted requests for unpublished audits on relevant email discussion lists, conducted hand searches of conference proceedings and searched electronic databases (including grey literature databases and those that record abstracts submitted to conferences).

To be considered for inclusion, minimum details of the methodology used had to be reported, which constituted some sort of description of the included participants or a description of the data source. Any type of evaluation that measured the effectiveness (including timeliness and appropriateness) of the two-week wait policy was considered. If an audit appeared to be relevant, but we were unable to confirm this because information was missing, attempts were made to contact the authors for more information.

Audits undertaken prior to April 1999 (when the first two-week wait policy was introduced for breast cancer) were excluded. Furthermore, for audits restricted to a specific cancer site, those performed prior to the relevant introduction dates were also excluded. Clinical audits started before but completed after guideline implementation were included if more than 50% of the participants were seen after the implementation of the guidelines. Summary reports of the Cancer Waiting Times Datasets routinely collected by all NHS trusts to inform a national database, were excluded.

Results

We received a total of 624 clinical audits via correspondence with various individuals, which included 576 identified via the CRD SCP network, and 48 identified through contact with other individuals and organisations. In many instances several follow-up contacts were necessary before we actually received any audits from some of the hospital trusts, PCTs, SHAs and other contacts.

Table 1: Number of included single and multiple site audits

Cancer site	Number of audits
Brain	1
Breast	43
Children's	1
GI Lower	39
GI Upper	23
Gynaecology	16
Haematological	5
Head and Neck	8
Lung	15
Sarcoma	0
Skin	38
Urological	16
Multiple Sites	35
Site Not Stated	1
Total	**241**

Two hundred and forty-one clinical audits met the review inclusion criteria. The number of single and multiple site audits included is given in Table 1. A summary of all the included audits can be found on the Internet, http://www.york.ac.uk/inst/crd/waittime.htm

Table 2 provides an overview of the quality assessment for all the included audits. The majority of included studies were poorly reported. Fewer than half (44%) provided sufficient detail on methodological aspects for the audit to be reproducible. Less than 20% provided an action plan outlining any recommended changes to service delivery or how any changes would be implemented.

One hundred and seventy three audits (and research studies) reported details on how included patients were identified or gave their data source. The results of these studies demonstrated that under the two-week wait system, there was wide variation in the proportion of site specific cancer referrals that were seen within two weeks, in the proportion of referrals that were found to be in accordance with the symptoms listed in the guidelines, and in the proportion of two-week wait referrals deemed by consultants to warrant an urgent appointment.

Quality of included audits

As stated above, the majority of included audits were poorly reported. Poor reporting seriously compromises the integrity of the audit process. Many trusts do not appear to write up their audits in full. The reasons why they are not always formally documented may include the fact that clinical audits are often not published, and the audit process may be considered so familiar to those undertaking them that reporting methodological aspects is considered unnecessary. Audit reports should be written up in sufficient detail for a reader (who did not conduct the audit) to be able to ascertain how the audit was conducted.

Most included audits chose to examine outcomes relating to the proportion of patients seen within two weeks and cancer detection rates among two-week wait referrals, when data on both of these outcomes are routinely collected as part of the monthly monitoring process. Other outcomes that could be considered pertinent include:

- Proportion of non two-week wait referred patients that had symptoms in line with the guidelines.

Table 2: Quality assessment of included audits

Quality element	Cancer site													
	Brain	Breast	Children's	Lower GI	Upper GI	Gynaecology	Haematology	Head & Neck	Lung	Sarcoma	Skin	Urology	Multiple	Not Stated
Number of Audits	1	43	1	39	23	16	5	8	15	0	38	16	35	1
Involved those providing the service?	1	23	1	18	11	9	4	3	9	0	21	12	18	1
Motive for audit given?	1	34	0	19	9	6	3	3	5	0	18	11	24	1
Clear project plan used?	1	28	0	18	6	7	3	1	5	0	12	5	20	1
Integrity of the population source tested?	0	3	0	0	0	0	2	0	0	0	1	1	6	0
Sample population appropriate?	1	37	0	31	13	12	5	6	10	0	28	13	28	1
Explicit inclusion criteria used?	1	27	0	24	10	7	3	1	6	0	22	6	26	1
Data source checked?	0	5	0	1	0	0	0	0	0	0	0	0	5	1
Data collection tool carefully designed and tested?	0	4	0	3	0	3	0	0	0	0	3	0	3	0
Validity and reliability of data collection considered?	0	3	0	2	0	0	0	0	0	0	0	0	1	0
Time frame justified?	1	4	0	5	3	0	0	0	0	0	7	1	9	0
Process of applying criteria unbiased and robust?	0	4	0	6	0	1	0	0	0	0	1	1	3	0
Adequate data reported	1	29	0	22	8	7	4	4	8	0	19	8	21	1
Data analysed appropriately?	1	27	0	29	14	11	4	4	11	0	26	9	27	1
All patients accounted for?	0	29	0	26	13	5	4	3	5	0	21	9	20	1
Interpretation fair?	1	27	0	26	12	9	3	4	7	0	26	10	29	1
Action plan reported?	0	8	0	9	1	4	3	1	1	0	6	4	7	1
Reaudit planned?	0	5	1	10	1	5	2	2	1	0	10	4	7	0

- Cancer detection rates for two-week wait referrals that were in line with the guidelines
- Cancer detection rates for two-week wait referrals that were not in line with the guidelines
- Cancer detection rates for non two-week wait referrals that were in line with the guidelines
- Proportion of two-week wait referrals that were not in line with the guidelines, but were deemed clinically appropriate
- Proportion of two-week wait referrals that were in line with the guidelines, but were deemed clinically inappropriate.

Are trusts making appropriate use of clinical audit?

Where clinical audits indicate the need for changes to the process, procedure or the delivery of services, this involves ensuring that such changes are implemented and that further monitoring is used to confirm improvement in healthcare delivery.

In this review, 70% of included audits provided no details on whether the results were or would be fed back to individual GPs and PCTs. Less than 20% of included audits provided details of an action plan outlining any recommended changes to service delivery or how any changes would be implemented. Additionally fewer than 20% of included audits reported any plans to re-audit.

It is possible that owing to poor reporting, documentary evidence of action plans exist elsewhere and that any necessary changes to processes and procedures are being acted upon. Making such information available would make it easier for those not directly involved in the audit to assess if and in what ways the audit findings are being acted upon.

Conclusions

Most included clinical audits were poorly reported and their results demonstrated a wide variation in compliance with the guidelines.

Audit reports should be written up in sufficient detail to allow the reader to ascertain how the audit was conducted and to assess the validity of the results and how these will be used to improve existing practices and procedures.

The methods by which clinical audits of site specific cancers are conducted and reported should be standardised across the NHS.

Acknowledgements

We would like to thank all the NHS staff that took the time to respond and help us identify and obtain potential clinical audits.

This summary article is based on a recent CRD systematic review of clinical audits undertaken to assess the implementation and effectiveness of the NHS two-week waiting time policy for cancer referrals in England and Wales.

The systematic review was commissioned to inform the ongoing National Institute for Clinical Excellence (NICE) review of the Cancer Referral Guidelines. The revised Cancer Referral Guidelines are due to be issued in March 2005. It was hoped that the results of the review would provide valuable information on the impact of the current referral guidelines as well as show whether the guidelines are having an impact on service delivery.

The full text of CRD Report 27 can be downloaded free of charge from the CRD website at: www.york.ac.uk/inst/crd/crdpublications.htm For more information about obtaining copies of CRD Report 27, contact the CRD publications office (crdpub@york.ac.uk).

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