



PAN-LONDON SUSPECTED CANCER REFERRAL SUPPORT GUIDE

1. INTRODUCTION

The pan-London suspected cancer referral forms, referral criteria and supporting clinical information have been developed by the Transforming Cancer Services Team, Healthy London Partnership, London Cancer and London Cancer Alliance. The pan-London position includes is based on the following:

- NICE guidelines NG12, *Suspected cancer: recognition and referral* (2015)¹ using primary care symptoms data
- Retention of some symptom criteria from CG27 *Referral Guideline for Suspected Cancer* (2005)²; CSG9 *Improving outcomes for people with sarcoma* (2006)³; CG122 *Ovarian Cancer* (2011)⁴.
- The positive predictive value (PPV) of symptom criteria for referral has been reduced from 5-10% to 3%.
- Lowered age thresholds in some tumour groups based on London demographics and activity.
- Oversight by the pan-London two-week wait operational group working closely with London CCG cancer leads, Macmillan GP advisors and tumour group pathway directors.
- Pan-London tumour specific clinical reference groups (CRGs) who continue to provide expert advice during the implementation and roll-out of the referral forms and educational support.

While guidelines assist the practice of healthcare professionals, they do not replace their knowledge, skills or clinical judgement. NG12 also supports clinicians to refer patients appropriately where cancer is suspected even if the patient does not meet NG12/pan-London referral criteria. Referrers should include as much clinical and patient sensitive information as possible to enable swift triage and processing.



2. PRIMARY CARE AND EDUCATIONAL SUPPORT

Each pan-London tumour-specific suspected cancer referral form has a hyperlinked web-based clinical support guide to assist primary care physicians and dentists to understand the new referral criteria and indications for direct access diagnostics. NG12 (2015) has retained recommendations from CG27 (2005) and the pan-London position supports the following as good practice:

- Discussion with a specialist (for example, by telephone or email) should be considered if there is uncertainty about the interpretation of symptoms and signs, and whether a referral is needed. This may also enable the primary healthcare professional to communicate their concerns and a sense of urgency to secondary healthcare professionals when symptoms are not classical.
- Take part in continuing education, peer review and other activities to improve and maintain clinical consulting, reasoning and diagnostic skills, in order to identify at an early stage people who may have cancer, and to communicate the possibility of cancer to the person.

Local educational workshops to support the needs of primary and secondary care across London including the locum workforce are important for engagement. Please contact your CCG Cancer lead/Macmillan GP/CRUK facilitator for further information. An e-learning course to support and enhance clinicians' understanding of the updated pan-London referral criteria is available at:

3. THE DIAGNOSTIC PROCESS AND DIRECT ACCESS

NG12 (2015) aims to lower the threshold for investigation where there is a suspicion of cancer and for some diagnostic pathways the responsibility for undertaking investigation has been moved wholly or in part to primary care. This will involve all GPs having direct access to a series of urgent and non-urgent investigations (for example, upper GI endoscopy, non-obstetric ultrasound, abdominal CT scan, brain MRI scan) and this has been included within 2016/17 pan-London commissioning intentions. The process of diagnosing cancer generally spans both primary and secondary care. It is important that the pathway from primary to secondary care is as smooth as possible.

Direct access means that GPs will request these investigations and retain clinical responsibility for acting on the results and it is anticipated that this will help to free up outpatient capacity. GPs may already have direct access to some of these investigations but the NICE guidance specifies that for urgent investigations to diagnose or exclude cancer the investigation must be reported within two weeks. Further work to support implementation of direct access investigations is underway.



4. TOP 10 TIPS FOR PRACTICE SAFETY NETTING FOR DIRECT ACCESS TESTS AND REFERRALS

The pan-London team recommend the following as part of the GP practice **safety netting system**. Further information can be found in the London Cancer & Macmillan safety netting guide and the CRUK safety netting guide (see resources section below)

Setting up a practice safety netting system:

- Offer a timely review and action after investigations have been requested
- Actively monitor symptoms in people at low risk (but not no risk) to see if their risk of cancer changes
- Where appropriate reassure people who are concerned that they may have cancer that with their current symptoms their risk of having cancer is low.
- Explain to people who are being offered safety netting which symptoms to look out for and when they should return for re-evaluation. It may be appropriate to provide written information.
- Ensure that results are reviewed and acted upon promptly and appropriately; the healthcare professional who ordered the investigation taking or explicitly delegating responsibility for this. Be aware of the possibility of false negative results for chest X-rays (NG12, 2015).
- Consider a review for people with any symptom that is associated with an increased risk of cancer, but who do not meet the criteria for referral or other investigative action.
- The review may be planned within a time frame agreed with the person or be patient-initiated. If new symptoms develop, the person continues to be concerned or their symptoms recur, persist or worsen
- Read code suspected cancer referrals and direct access diagnostics e.g. *fast track suspected (breast) cancer referral, referral for ultrasound investigation*
- Track patient attendance and outcomes for blood tests/imaging/endoscopy/suspected cancer outpatient appointments using the relevant software, e.g. ICE software, tQuest list management or other robust electronic safety netting system
- Pro-active recall to review patients who do not attend their appointment for diagnostics/two week wait clinic within the time frame agreed
 - EmisWeb: A coded **Diary entry** within the 'follow up' component of the consultation where a regular search is conducted to track patients in their suspected cancer/diagnostics journey
 - SystemOne: If using a Referral Wizard please ensure a practice safety netting system is established



5. TOP 10 TIPS FOR PATIENT/CARER INFORMATION AND SUPPORT

The following represents good practice in relation to patient/carer information and support

Good practice

- Please ensure each patient that is referred to a suspected cancer service is given the **pan-London suspected cancer patient information leaflet**. A hyperlink to access this leaflet is at the bottom of each referral form.
- Please provide information that is language/culturally appropriate. The **pan-London suspected cancer patient information leaflet** is available in 11 languages.
- Discuss with people with suspected cancer (and their carers as appropriate, taking account of the need for confidentiality) their preferences for being involved in decision-making about referral options and further investigations including their potential risks and benefits.
- When cancer is suspected in a child, discuss the referral decision and information to be given to the child with the parents or carers (and the child if appropriate).
- Explain to people who are being referred with suspected cancer that they are being referred to a cancer service. Reassure them, as appropriate, that most people referred will not have a diagnosis of cancer, and discuss alternative diagnoses with them.
- Give the person information on the possible diagnosis (both benign and malignant) in accordance with their wishes for information
- When referring a person with suspected cancer to a specialist service, assess their need for continuing support while waiting for their referral appointment. This should include inviting the person to contact their healthcare professional again if they have more concerns or questions before they see a specialist. If the person has additional support needs because of their personal circumstances, inform the specialist (with the person's agreement).
- Inform the patient/carer where they are being referred, what type of tests may be carried out, and what will happen during diagnostic procedures
- Inform the patient/carer how long it will take to get a diagnosis or test results
- Advise the patient who to contact if they do not receive confirmation of an appointment



6. ELECTRONIC REFERRALS

Once the decision to refer has been made, make sure that the referral is sent within 24 hours. We advise e-Referrals (formerly known as Choose and Book) or to email the hospital using their designated two-week wait service email address. Include all appropriate information in the referral and ensure local arrangements are in place to identify people who miss their appointments so that they can be followed up.

The Health and Social Care Information Centre recommend **removing paper fax method** from all providers. The NHS Mail fax service is now closed as it is not a secure or efficient method of transferring sensitive data. To maximise patient safety and confidentiality all Trusts will have an email address for suspected cancer referrals.

7. ADULT & CHILD SAFEGUARDING

The pan-London referral forms provide an opportunity for clinicians to share safeguarding concerns in order to support safety-netting and communication between the primary and secondary care interface. Safety netting, shared decision making, patient choice and including patient specific information on the referral form to evidence the importance of attending appointments for diagnostics have been shaped as a result of these representatives. It is essential to consider the information needs of patients (and their carers or families) when cancer is suspected. This is relevant both for patients in whom investigation is being considered and in those who are being monitored for possible cancer in primary care.

In addition a Macmillan Expert Reference Group has recommended specific measures are in place for potentially vulnerable patients, the forms will also include information about sensory, cognitive and mobility impairment along with a free text box for the GP to include any additional narrative or relevant information.



8. REFERENCES

¹ NG12 *Suspected cancer: recognition and referral*. NICE (2015) <https://www.nice.org.uk/guidance/ng12>

² CG27 *Referral guideline for suspected cancer*. NICE (2005)

<http://webarchive.nationalarchives.gov.uk/20060715141954/http://nice.org.uk/nicemedia/pdf/cg027niceguideline.pdf>

³ CSG9 *Improving outcomes for people with sarcoma*. NICE (2006) <https://www.nice.org.uk/guidance/csg9>

⁴ CG122 *Ovarian cancer: recognition and initial management*. NICE (2011) <https://www.nice.org.uk/Guidance/CG122>

9. RESOURCES

- CRUK Safety Netting Guide: http://www.cancerresearchuk.org/sites/default/files/16_safety_netting.pdf
- London Cancer & Macmillan Safety Netting Guide: http://www.londoncancer.org/media/126626/150708_Guide-to-coding-and-safety-netting_report_Dr-A-Bhuiya_V3.pdf