NHS
Brighton and Hove
Clinical Commissioning Group

Frequently Asked Questions on NG12 for referrers V1.2

1. General

1.1 Why was NG12 developed?

1.2 These new guidelines are designed to improve diagnosis at earlier stages of cancer and therefore better outcomes for patients.

1.3 NICE issued NG12 Suspected Cancer: Recognition and Referral in June 2015, which used evidence taken from large Primary Care studies to change referral criteria and include symptoms that correspond to a 3% positive predictive value of having cancer: this contrasts with the previous guidance from 2005 which was based on Secondary Care research and corresponded to approx. 5% positive predictive value. The new guidance will thus result in lowering the threshold for referral – meaning increasing detection of cancers.

1.4 There are other changes too: NG12 also recommends new actions for some patients – not simply referring under the 2 week wait (2WW) to outpatients. These include access to investigations, and differing urgencies of referral depending on clinical criteria. As a result, there is more focus on the clinical judgement of referrers.

1.5 What about patients who turn out not to have cancer?

1.6 Depending on the disease area, and urgency, patients may be moved onto other care pathways, or referred back to their GP for review. Depending on the outcome, they may then be referred from Primary Care onto a different (non-cancer) pathway.

1.7 Safety-netting

1.8 As NICE suggest, referrers need to ensure a process is in place for patients with any symptom with an associated increase risk of cancer but who do not meet the criteria for referral or investigation. This could be e.g. a review; either planned within a specified time-frame, or patient-initiated if new symptoms develop, the patient continues to be concerned, or their symptoms recur, persist or worsen.

1.9 How do I make a referral under NG12?

1.10 **Refer via email** - forms will be embedded in GP clinical systems with details auto-populating where possible. Completed forms should be emailed to the address on the form. In future we will be working towards implementing the e-referral system (ERS).

1.11 **Informing patients** – It is important to discuss the reason for referral - i.e. to rule out cancer - with the patient, including expected time-frames. (Clinicians may include the information that many people referred will not have a final diagnosis of cancer).

1.12 Secondary Care report many instances of patients arriving for suspected cancer assessment who apparently have no idea why they have been referred. This leads to poor outcomes: patients who don't realise the significance of their appointments may miss them, not take them

up within specified time limits, or fail to be proactive in alerting us to delays or problems. Secondary Care clinicians may be faced with distressed patients who only realise the reason for referral at an urgent outpatient review, meaning engagement and treatment planning may be more difficult.

1.13 **Appointment timing** - Tell the patient that they will receive an urgent appointment at the soonest available date. (NB some Direct Access investigations e.g. CXR/blood test have walk-in open access services available). Inform the patient that it is important they attend any appointment offered. If the patient is not available to attend e.g. on holiday you must ensure:

- they are fully informed of possible consequences of delaying investigation/treatment, and
- there is a safety-netting system in place to ensure the referral is sent when the patient becomes available to attend.

1.14 There are links to Patient Information Leaflets embedded in the referral forms to underline these conversations, and a box to tick to indicate the appropriate conversation has been had.

1.15 **Act as advocate** – especially for vulnerable groups e.g. supporting patients with cognitive difficulties who are on a cancer pathway to try to ensure the patient engages with the hospital. The referral forms 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.

1.16 Who refers under NG12?

- General Practitioners (GMP) – main referrers under NG12
- Dentists (GDP) – can refer for suspected cancer
- Nurse/Paramedic Practitioners - At present, Going Forward on Cancer Waits rules stipulate that trusts can only receive those referrals from a GP (GMP or GDP). If a patient is seen by another Practitioner and cancer is suspected, this should be discussed with the duty/usual GP to arrange referral. Also, without specific protocols,Nurses/Paramedics are not authorised to request X-rays/CT Scans (ionising radiation) under IRMER guidelines. This means that Direct Access imaging requests will need to be requested by a GP/GDP.

1.25 Where do referrals go?

1.26 Referrals to BSUH – the vast majority of suspected cancer referrals from Brighton and Hove will go to BSUH (with the exception of Bone Sarcoma – Royal National Orthopaedic Hospital - RNOH - and Head & Neck/Dermatology which have Queen Victoria Hospital – QVH - as an option). Other hospital trusts have different referral pathways/services agreed with their local CCGs - reflected in referral forms which may therefore differ. Hence if you wish to refer a patient to another hospital trust, you will need to obtain the correct referral form from their local CCG.

1.27 Useful information

1.28 NG12 Guidance – this was released back in 2015 and has been widely available since then in the medical press and on update courses and CPD modules. If you haven't already encountered it at recent GP Update and Cancer courses or via part of your CPD it is essential you familiarise yourself with it.

1.29 **Resources** – there are several excellent online resources about NG12, with at least one likely to suit your learning style. Key resources include:

- Macmillan – especially their Macmillan Rapid Referral Guidelines
- CRUK – especially their 'easel' available on the Cancer Research UK Resource Page
- BMJ – their 'infographic' for Adults and Children/Young People

1.30 Important points for all disease areas

1.31 **Urgency** – not all referrals are 2 Week Wait; NG12 contains several new urgency categories including *immediate* (via A&E), *very urgent* (within 48h), *urgent* (within 2 weeks), and in some cases *routine*.

1.32 **Clinical suspicion** – NG12 puts emphasis on clinical acumen and clinical suspicion in detecting suspected cancer. Hence for any patient about which you have strong suspicion of cancer, who doesn't quite fit the referral criteria, or where signs/symptoms are unclear, you are advised to have a discussion with consultant on-call to guide next steps.

1.33 **Colour coding** – in an attempt to increase clarity, on the new referral forms, red=urgent referral, blue=direct access investigation and yellow=essential information to support referral.

1.34 **Direct Access Investigations** – NG12 responded to evidence and has suggested that GPs have direct access to specified investigations which can help to confirm or rule out suspected cancer. These include blood/pathology tests, imaging and endoscopy. Some are already accessible and part of routine practice (e.g. blood tests and CXR) with others newly accessible to GPs. Where these appear in NG12, they are noted on the new referral forms.

1.35 **Ordering Investigations** – Blood tests and imaging should be ordered via the 'ICE' OrderComms system in SystmOne/EMIS. For imaging requests, there will be a specific 'NG12' tab for relevant investigations.

1.36 **If OrderComms unavailable** – due to IT issues or e.g. Locum GP not having access- then a normal paper imaging request should be completed, ensuring it is clearly endorsed 'NG12' and including the urgency (e.g. 48h/2 weeks) and relevant symptoms on the referral form.

1.37 When GP direct access investigations are performed the GP has clinical responsibility for ensuring appropriate follow up and onward referral is arranged. In many cases positive results may be forwarded directly to the cancer team but the GP must ensure a 2WW referral has been made and that appropriate safety- netting arrangements are in place.

1.38 Where possible, for some specific areas, it has been agreed that **'Straight-To-Test'** model will supercede **'Direct Access'**. This means patients will be triaged by secondary care clinician direct to investigation or OPA as appropriate. The Trust will ensure that the patient gets the right test and is then put on to a cancer pathway if appropriate.

1.39 **Safety-netting** – referrers (for investigations) bear the ultimate responsibility for ensuring that test results are acted upon (as per BMA guidance). Work is ongoing with the trust to ensure that result reporting is timely, and where possible to achieve 'consultant upgrade' - where abnormal results will mean patients progress automatically onto timed cancer pathways. However it is important that you **review personal and practice processes for safety-netting** and ensure these are robust. (There is further work ongoing to develop reliable EMIS/SystmOne safety-netting processes which we will share when possible.) Practices need to have a policy in place to receive, record and, if appropriate, act on correspondence from hospital. This includes a practice specific plan for holidays, sickness, locums and trainees if the letters will be addressed back to the original referrer.

1.40 **Do not delay a referral** if the investigations required in 'supporting information' e.g. blood tests have not been carried out in the last 4 weeks. Instead, make the referral and arrange the test at the same time, so that results are likely to be available by the time the patient is seen.

1.41 **What happens next?** – referral pathways have been developed for all cancer sites, which set out the possible onward steps for patients up to the point that their care is taken over by Secondary Care. These pathways will mainly be of interest to clinicians, and will also be used as the basis for improving processing/waiting time performance to meet future cancer targets. For patients, links to Patient Information Leaflets are included in the referral forms.

2 Important points for specific disease areas

2.1 Brain & CNS

2.2 What are the important differences in NG12 for Brain/CNS Cancer?

- New referral criteria - 'progressive, sub-acute loss of central neurological function'.
- New urgency category - very urgent (48h) referral for 18-24y.

2.3 What about direct access MRI?

- The pathway will be 'Straight-To-Test': referrals will be triaged by consultant Neurologist and directed to MRI/OPA within 2 weeks. This is to ensure optimal pathway for patients and to secure best use of MRI resources.

2.4 Breast

2.5 What are the important differences in NG12 for Breast Cancer?

- New referral criteria – including e.g. axillary lump, skin changes, nipple changes >50y.

2.6 What about patients who don't meet the urgent (2WW) referral criteria?

- All symptomatic patients referred will be seen within 2 weeks, including those who don't meet the urgent referral criteria

2.7 Cancer of Unknown Primary

2.8 What is this form about?

- This service provided urgent review and investigation for patients with suspected metastatic cancer of unknown primary seen on imaging.

2.9 Is this included in NICE NG12?

- No: the forms and information have been included with the implementation of NG12 as this service provides an urgent service for patient with suspected cancer.

2.10 Children and Young People

2.11 What are the important differences in NG12 for Children and Young People?

- **New pathway – ALL suspected cancer in <18y to be discussed with Paediatrician on-call the SAME DAY and email the referral form within 24h to ensure patient enters timed cancer pathway.**
- New cancer types included – including e.g. Wilm's tumour, Neuroblastoma, Sarcoma, Retinoblastoma.
- New referral criteria – including parental concern; all detailed on referral form.
- New urgency categories – including immediate referral via A&E, very urgent (48h) referrals.
- Direct Access investigations – (after discussion with Paediatrics) possible outcome of referrer requesting Direct Access investigations. Abnormal results will be subject to 'consultant upgrade' and placed on cancer pathway by the reporting Radiologist.

2.12 What about patients 18-24y?

- There are specific differences for patients aged 18-24y for Brain & CNS, Haematology, Sarcoma – Soft Tissue and Sarcoma – Bone. These are specified on the respective 'adult' referral forms.

2.13 Gynaecology

2.14 What are the important differences in NG12 for Gynaecology?

- New cancer included – Vaginal Cancer; see referral form.
- New referral criteria – see referral form.
- Direct Access Investigations – comprising CA125 and/or Ultrasound in specified circumstances – see referral form.

2.15 Haematology

2.16 What are the important differences in NG12 for Haematology?

- New referral criteria – including e.g. unexplained lymphadenopathy, specific criteria for patients 18-24y.
- New urgency categories – including immediate referral via A&E, very urgent (48h) referrals.
- Direct Access Investigations – comprising very urgent (48h) blood tests and details of when to request them – see referral form.

2.17 Head and Neck

2.18 What are the important differences in NG12 for Head & Neck?

- New referral criteria – including some that have been **removed** i.e. unexplained sore throat, unilateral head/neck pain (still indication for urgent referral not via 2WW); see referral form.
- New urgency categories – including immediate referral via A&E.

2.19 Lower GI

2.20 What are the important differences in NG12 for Lower GI?

- New referral criteria – including e.g. abdominal pain, removing duration for rectal bleeding/change in bowel habit, and new age cut-offs; see referral form.
- Direct Access Investigations – Faecal Occult Blood (FIT) testing for specified circumstances; see referral form.

2.21 Lung

2.22 What are the important differences in NG12 for Lung?

- New referral criteria – including e.g. shoulder/chest pain.
- New urgency categories – including immediate referral via A&E for specified indications; see referral form.
- Direct Access Investigations – requesting Chest X-ray (via ACE pathway for BSUH), Currently, the radiology department will automatically book a CT scan for patients if CXR findings are suspicious. Clear advice to Primary Care regarding next steps will be included in the CXR report

2.23 Sarcoma – Bone

2.24 What are the important differences in NG12 for Sarcoma – Bone?

- New referral criteria – see referral form
- New urgency categories – very urgent (48h) referral for 18-24y patients; refer using referral form
- Direct Access Investigation – X-ray with varying urgency including via A&E, very urgent (48h) and routine; see referral form. For BSUH, (non-A&E) X-ray to be requested via Order Comms. Patients with abnormal X-ray results to be referred to RNOH using referral form.

2.25 Sarcoma – Soft Tissue

2.26 What are the important differences in NG12 for Sarcoma – Soft Tissue?

- New referral criteria – see referral form.
- New urgency criteria – very urgent (48h) referral for 18-24y patients; refer using referral form.
- Straight-to-test – in BSUH, patients will be seen in clinic with a diagnostic ultrasound investigation and referred onward for further imaging/biopsy/MDM discussion as appropriate. There is a link to an information leaflet with more details about this process included in the referral form.

2.27 Skin

2.28 What are the important differences in NG12 for Skin?

- New referral criteria – including e.g. dermatoscopy finding for Melanoma, referral for BCCs (only in certain specific situations); see referral form.

2.29 Upper GI

2.30 What are the important differences in NG12 for Upper GI?

- New referral criteria – including e.g. new alert symptoms/signs e.g. abdominal pain, new onset diabetes, back pain, raised platelets; see referral form.

2.31 What about Direct Access?

- The pathway will be ‘Straight-To-Test’: referrals will be triaged and directed to endoscopy/OPA within 2 weeks. This is to ensure optimal pathway for patients and to secure best use of resources.
- Non-urgent referral will go through existing routine pathway whilst non-urgent direct access endoscopy is developed

2.32 Urology

2.33 What are the important differences in NG12 for Urology?

- New referral criteria – including WCC, raising age threshold for some symptoms; see referral form.
- Direct Access Investigation – including PSA blood test with Digital Rectal Examination and instructions on when to undertake, USS Testes for unexplained or persistent testicular symptoms.

2.34 For abnormal imaging/blood test results: how should I proceed?

- Refer patients using referral form.