Implementing the NG12 NICE Guidelines for Suspected Cancer: recognition and referral
This guide aims to support GPs who are involved in implementing the updated NICE NG12 guidelines for suspected cancer: recognition and referral, which were released in June 2015 and whose remit covers England and Wales.

This guide includes top tips on how to develop local processes to implement the guidelines using relevant examples, the learning from which could apply to all four nations. It also sets out how Macmillan can support you throughout this process.

Hyperlinks to useful resources and further information are included throughout this document in purple. To find out more about this guide, please contact preventionanddiagnosis@macmillan.org.uk.
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Introduction of NG12

In June 2015, NICE published updated guidance *(NG12) for Suspected Cancer: recognition and referral.* While health economies are keen to introduce these guidelines it can be a daunting task for many. This is because:

- The new guidance includes interconnected components that need developing and implementing simultaneously to be successfully delivered;
- Many areas are currently struggling to meet cancer waiting targets;
- This new guidance comes at a time when pressures on primary care are significant;
- Direct access to the investigations discussed throughout the guidance varies significantly from one area to another;
- Even in areas where GPs have access to investigations, the new guidance will add to the strain on diagnostic departments in terms of volume and speed of turnover;
- The guidance increases the need for diagnostic testing capacity in secondary care due to the lower threshold for investigation;
- Implementing the guidelines requires a review of current referral pathways and clinics in addition to renewing existing referral forms;
- There is also a need to educate and support GPs in understanding these guidelines and the subtleties between recommendations.

December 2015 was the first time in 20 months that all cancer targets were met in England¹ as a whole. However, even within this period there remained stark variation in waiting times between different Clinical Commissioning Groups (CCGs) and acute trusts.
Background context for Two Week Wait (2WW) target

The 2WW target was developed using the NICE 2005 guidelines in response to poor performance in early cancer diagnosis and survival, leading these areas to become a focus for improvement.

The 2WW target is now included in the NHS constitution and is referenced as a measure in the CCG assurance process with NHS England. From April 2015, one-year cancer survival was also included in the assurance process. The CCG Improvement and Assessment Framework (June 2016), which replaces the assurance process, includes one-year cancer survival, 62 day wait, cancer staging and cancer patient experience.

For many cancers, one year survival outcomes in the UK are poorer than comparable European countries. This is thought to be partly attributable to current pathways in the UK healthcare system. The new guidance is based on evidence gathered using large numbers of patient records in primary care. It encourages investigation and possible referral of patients with those 'low risk but not no risk' signs or symptoms, that have now become a greater focus in terms of early cancer diagnosis.

With cancer survival in England continuing to lag behind those of mainland Europe, in June 2015 NICE published updated guidance for Suspected Cancer: recognition and referral, introducing a new, symptom-led approach alongside the existing tumour-specific approach. The addition of symptom-led guidelines was intended to reflect the way that patients often present in primary care, with particular focus on vague symptoms that may not be indicative of any one cancer.

The Cancer Strategy 2015-2021

An Independent Cancer Taskforce published Achieving world-class cancer outcomes: A strategy for England 2015–2020 in July 2015. It set out 96 recommendations within the following six strategic priorities, recognising the critical role of primary care throughout:

1. Prevention and public health
2. Earlier diagnosis
3. Patient experience
4. Living with and beyond cancer
5. Investing in modern, high quality services
6. Overhauling processes for commissioning, accountability and provision.
Secretary of State for Health has made a clear national commitment to delivering Recommendation 24 of the strategy:

By the end of 2015, NHS England should develop the rules for a new metric for earlier diagnosis measurable at CCG level. Patients referred for testing by a GP, because of symptoms or clinical judgement, should either be definitively diagnosed with cancer or cancer excluded and this result should be communicated to the patient within four weeks. The ambition should be that CCGs achieve this target for 95% of patients by 2020, with 50% definitively diagnosed or cancer excluded within 2 weeks. Once this new metric is embedded, CCGs and providers should be permitted to phase out the urgent referral (2-week) pathway.

NHS England invited applications from local areas to pilot this move to 28 day wait from first symptom to definitive diagnosis and treatment. The chosen areas will be responsible for monitoring these pilots whilst considering how practice can inform the development of this work.

The targets outlined within the Cancer Strategy have encouraged discussions at both a local and national level, regarding the development of new referral routes in an effort to ensure that these targets are met. Innovative referral routes could involve straight to test pathways, Multi-disciplinary Diagnostic Centres (MDCs) or one-stop walk in clinics, all of which are currently being piloted and evaluated through various projects within the NHS-led ACE programme. The ACE programme involves collaboration between NHS England, Macmillan and Cancer Research UK with the aim to Accelerate, Coordinate and Evaluate good practice in an effort to improve early cancer diagnosis. For further information regarding any of the ACE projects, please visit the ACE section of the Macmillan website.
Cancer survival rates

It is suggested that late diagnosis is a key factor in poor cancer outcomes and diagnosing cancer in its later stages could be accounting for 6000-7000 excess deaths a year in the UK. The UK has poor one year cancer survival rates which indicate that too many patients are presenting with cancer at a late stage. Early diagnosis is therefore imperative if the UK is to improve one year cancer survival rates in line with other European countries.

Evidence shows that delays in diagnosis are due to (i) patient delay; (ii) doctor delay; or (iii) system delay.

There is significant variation in outcomes for cancer, with clear inequalities between different patient groups.

Outcomes and access to services are generally poorer for older patients:

- Cancer patients aged 55-64 are 20% more likely to survive for at least one year after cancer diagnosis than those aged 75-99.

- There is considerable variation in treatment rates between cancers, with a large fall by age group in the percentage of patients who received a major resection as part of their treatment.

Those from more deprived socio-economic groups are more likely to experience worse outcomes than those from less deprived groups:

- It is estimated that there would be almost 20,000 fewer deaths from cancer each year if mortality rates for all socio-economic groups matched those for the least deprived.

General awareness of cancer signs and symptoms is lower in men, those who are younger and those from lower socio-economic status groups or ethnic minorities. These factors can delay patients presenting to their GP and therefore impact on the stage of their cancer at diagnosis and thus outcomes.

In order to address patient delay and improve early diagnosis, targeted awareness campaigns which aim to reach those groups at risk of late presentation are essential. The ‘Be Clear on Cancer’ programme is a nationwide embodiment of this strategy through focused campaigns that target one ‘at risk’ group at a time, for instance the ‘breast cancer in over 70s’ campaign.
The recent shift within CCGs to implement E-referrals is another way to ensure that patients are offered booked appointments at the time of referral from their GP, thereby helping to avoid patient delays in terms of booking future appointments. Additionally, another route to reduce potential patient delays or failure to attend either GP or hospital appointments, is for the GP to ensure that all information given to patients is appropriate and understandable. Patients should be informed at time of referral about why they have been referred, what it means and what they need to do. For this reason, London Cancer Alliance has produced an information leaflet for patients in several different languages.

Why is this top tips guide needed?

A full time GP is likely to see only 6-8 new cancer diagnoses a year, yet they will see many patients with signs or symptoms that could be cancer. In light of this challenge, tools and guidance are needed to aid recognition that cancer is a possible diagnosis, particularly when patients present with multiple vague symptoms, despite an absence of ‘red-flag’ symptoms that suggest more advanced disease. This guide includes top tips on how to develop local processes to implement the new 2WW guidelines, using local examples. It also sets out how Macmillan can support you throughout this process.
Macmillan supports GPs and CCGs across England to plan, design and improve services for people with cancer. More than 200 Macmillan GPs bring clinical leadership and cancer expertise to their locality. Macmillan GPs also work closely with wider primary healthcare teams across their health economy to promote a recognisable improvement in cancer care. Their work varies according to local needs and opportunities but can include:

• Pathway and service redesign, including support to achieve quality and productivity targets;

• Influencing GP peers to drive up standards of cancer care and ensure continuous improvement;

• Enhancing communication between primary, secondary and tertiary care;

• Facilitating and enabling education of primary healthcare teams;

• Providing support and clinical advice to inform CCG strategies for cancer and end of life care;

• Supporting practice nurses to take on a greater role for cancer, building on the skills they already use to support people with other long-term conditions.

If you are not aware of any Macmillan GPs in your area and you are interested in finding out more, please contact us at macdocs@macmillan.org.uk

Macmillan has updated its Rapid Referral Guidelines in response to the updated NG12 NICE referral guidelines (2015) whose remit covers England and Wales. This quick reference toolkit incorporates all recommendations in the NICE guidelines on suspected cancer: recognition and referral apart from those relating to specific childhood cancers. More information on this endorsement can be found on the NICE website. GPs located in Scotland can access the Scottish Referral Guidelines for suspected cancer online.
In addition to this toolkit, Macmillan has a range of other resources available to GPs including:

- The electronic **Cancer decision support (eCDS) tool** – this is an integrated IT tool which aims to support GPs in their clinical decision making when deciding whether to refer a patient for suspected cancer. The tool calculates and displays the risk of a patient having an as yet undiagnosed cancer based on information pulled from their patient record including read-coded symptoms from the past 12 months, medical history and demographic data, as well as using live data entered during consultation. By including not only high risk patients but also those at low risk, the tool is designed to encourage GPs to ‘think cancer’ even when presented with vague, non-red flag cancer symptoms or signs.

- 10 Top Tips Series - Macmillan GP Advisors have collaborated with members of the Macmillan primary care community to develop a ‘10 top tips’ series with practical hints, tips and information on a variety of different cancer related subjects relevant to primary care.

All of Macmillan's resources for GPs can be accessed on the ‘Resources for GPs’ section of the [Macmillan website](http://www.macmillan.org.uk).
HOW ARE MACMILLAN GPs CONTRIBUTING TO NHS OUTCOMES?

Preventing people from dying prematurely

- Raising awareness of early diagnosis and appropriate referral
- Contributing to increasing uptake of screening programmes
- Learning from late diagnosis cases
- Supporting commissioning for better clinical outcomes

Enhancing quality of life for people with long-term conditions

- Helping GPs identify cancer survivors and undertake cancer care reviews
- Raising awareness of counselling and complementary services for patients and carers
- Facilitating training for GPs and nurses in ‘cancer as a long-term condition’

Helping people to recover from episodes of ill health or following injury

- Introduction of Macmillan Recovery package
- Cancer survivorship and signposting to other services
- Increasing use of treatment summaries

Ensuring that people have a positive experience of care

- Facilitating training for GPs and nurses for ‘difficult conversations’
- Increasing communication between primary and secondary care and social care
- Improving confident delivery of end of life care and advance care planning

Treating and caring for people in a safe environment and protecting them from avoidable harm

- Supporting Gold Standard Framework accreditation
- Significant Event Audits (SEA)
- Providing NICE guidance and local guidelines summary information for practices

How do they do it?

- Training
- Awareness raising
- Campaigns
- Producing materials
- Data analysis
- Pathway redesign
- Building relationships
- Culture change
- Strategic level meetings
- GP practice visits

Source: Survey of 119 Macmillan GPs March 2015
Top tips for GPs: Implementing the NG12 NICE Guidelines for Suspected Cancer: recognition and referral

IMPLEMENTING THE NEW NICE GUIDELINES FOR SUSPECTED CANCER

The NICE NG12 guidance

Some of the major changes to the updated NG12 NICE guidelines include:

- Giving GPs more flexibility to refer or investigate patients in order to help diagnose cancer earlier;

- Lowering the symptom thresholds; the PPV risk threshold has been reduced from 5% to 3%. Additionally, the low risk threshold of integrated CDS tools allows the GP to capture those patients who may be at a low risk of undiagnosed cancer and who therefore may not fulfill the NICE criteria for referral;

- For children and young adults, the threshold has been lowered even further;

- Guidance based on signs and symptoms (including non-specific symptoms) as well as tumour site is now available, a format that more accurately reflects how patients present to primary care;

- There is guidance on the strength of recommendations with the wording “offer” for higher risk and “consider” for lower risk symptoms or signs;

- “Very urgent” referrals are now recommended for some symptoms. In these cases the patient should be seen, or investigations should be carried out, within 48 hours;

- GPs are advised to refer patients directly for tests, such as CT scans and endoscopies, for a number of symptoms. This should support more comprehensive rollout of direct access nationally;

- Specific recommendations on safety netting and guidance on supporting patients to make informed decisions are now included;

The accompanying notes within Macmillan’s Rapid Referral Toolkit include safety netting advice recommended by Macmillan GP Advisors, alongside additional ‘extra-NICE’ information where appropriate.
Implementing the NICE NG12 guidance

There are eight key interconnected components that need to be addressed in order to implement the guidance. These components are described below alongside examples of how they are being addressed across various localities, to provide insight on how this could be replicated in your area.

Various resources have been developed by Macmillan GP, Dr Neil Smith, to support GPs with the implementation of the updated NICE NG12 guidance. These educational resources range from case studies, quizzes, videos and best practice materials, and highlight recommendations and challenges for implementing the guidance. These resources can be found on the Greater Manchester, Lancashire and South Cumbria Strategic Clinical Networks website.
(i) Demand modelling

Modelling the levels of demand for referral at CCG or trust level on the two week wait pathway (2WW) is critical. This is not an easy task as there is neither specific national guidance nor a strict formula to apply, however some national guidance and models are available from NHS England and NHS Interim Management and Support guidance. Demand modelling deals with demographic changes either from a net growth in population or increase in age. It is helpful to look back retrospectively at annual growth in referrals over the last few years and extrapolate from this to produce a potential trajectory for the near future. Demand modelling can only estimate and make best guesses for the future, however local teams may find it helpful to consider the following factors:

- The introduction of the updated NG12 NICE guidance is likely to result in increased 2WW referrals due to the reduced threshold from 5% to 3%, so this change should be taken into account when planning.

- National and local Be Clear on Cancer campaigns have been shown to increase referral activity for some tumour sites with evaluation of this including referral rates and capacity available online. Awareness of proposed campaign dates can aid capacity and demand planning. It could be assumed that certain tumour specialities may see greater increases in activity than others, in particular lower GI, upper GI, head and neck and lung as these areas have been a focus at a national level.

Please see below examples of local activity to model and manage demand and capacity increase that you could consider in your practice or local area:
Dr Neil Smith, Macmillan GP, Blackburn

**What we did**
We carried out a detailed analysis of referral and diagnostic data from the past few years with respect to suspected cancer. Following this, we set up a NICE Transformation Group which involved collaboration across 2 CCGs and one acute trust.

**How we did it**
Within our acute trust we funded a data analyst to find, summarise and make sense of the data which involved considering the difference between routine endoscopy and 2WW, for example. We then applied estimates of increasing demand based on:

- Natural growth: defined using previous trends
- Demographic changes: taking aging population into account
- Considerations given changes in the NICE guidance: taking the minor change in breast guidance into account when compared to the greater change in lower GI guidance

These considerations were then used to sense check demand projections. In addition, the acute trust undertook a risk analysis assessment for the outcome of the proposed changes.

**Who was involved?**
Myself as a Macmillan GP, CCG commissioner, cancer administrator, hospital cancer manager, data analyst, pathology consultant, radiology lead and finance managers from all organisations.

**Impact**
We successfully developed a demand model calculator which is not necessarily scientific, but which provides us with accurate estimates for our locality. This calculator has since been shared with neighbouring health economies.
Dr Martin Shelley, GP Lead for Direct Access Diagnostics, Transforming Cancer Services Team, London & Dr Anthony Cunliffe, Macmillan GP Advisor, London and South East Coast

What we did
We undertook a London-wide capacity and demand review for imaging (CT, MRI and Ultrasound scanning) and endoscopy services. This was performed to better understand the current shortfall in capacity compared with demand and to establish a baseline for forward planning. It also aimed to look for opportunities to optimise utilisation of existing capacity. This project looked at total diagnostic capacity and demand – not just cancer-related diagnostic services.

How we did it
We used the NHS Interim Management and Support demand and capacity tools in all London trusts. These tools have been designed for this purpose and have been widely tested and nationally validated. The project required a small central project team to run workshops, to support trusts in completing the tools, to analyse the data and to provide feedback. Tailored feedback was provided to trusts on their completed tools both in the form of a written report and, in some trusts, face to face feedback sessions.

Who was involved?
The project had the support of strategic commissioners and the senior management of provider organisations. Along with the small central project team, the exercise was also dependent on senior managerial and clinical engagement in each department along with some internal analytical support. Local commissioners were also engaged and required some support in interpreting the completed tools.

Impact
It is too early to know the full impact but the work has supported the development of Sustainability and Transformation Plans. For the first time commissioners and providers have a firm foundation to support their planning assumptions and a means to model a variety of scenarios going forward. The work on optimising existing capacity is important as introducing additional capacity without optimisation will result in future capacity being underutilised. It is clear that workforce issues (shortage of key skills/staff) are just as important as providing necessary estate and equipment to ensure sufficient capacity in the future.

Top tips
It is important to plan this type of project carefully. It became clear early in the project that the majority of trusts did not have expertise in capacity and demand modelling. Many trusts were not able to complete the tools without significant support and the data required was not easily available. The optimisation phase requires an awareness of the existing literature for improving diagnostic services and expertise in service improvement methodologies.
Dr Nicola Harker, Macmillan GP, North Somerset

What we did
We asked for a stock take on diagnostic provision across the region from the Strategic Clinical Network (SCN) but this is proving slow, so we are also working with Public Health England to pull information from their data. This data is proving to be incredibly interesting, such as a fall in Upper GI endoscopy provision in the past 5 years at one of our Trusts, despite the national trend for increased demand.

Bristol, North Somerset and South Gloucestershire are working very closely together on this, along with the SCN (South West). Our Site Specific Groups were tasked with reviewing their pathways and suggesting possible new pathways, which have been discussed across the region. We also have a set of forms that the SCN has produced (although inevitably some consultants want to “tweak” them).

How we did it
We formed a working subgroup including 3 Macmillan GPs, providers, commissioners and linked up with our SCN who produced draft referral forms. The subgroup is responsible for assessing impact and commissioning decisions before signing off new pathways/forms.

The SCN forms were circulated to each Site Specific Group (SSG) for input/discussion (e.g. breast, Brain, Lung etc). Macmillan GPs have attended each SSG to ensure primary care input. The finalised forms then came back to the subgroup for final decisions.

Who was involved?
Macmillan GPs representing 3 CCGs, commissioning leads, providers (cancer managers and consultants and some Cancer Nurse Specialists (CNS) at the SSGs).

Impact
In terms of implementing the guidelines, the greatest impact is predicted for colorectal and upper GI because of the need to increase capacity in secondary care for open access tests. Impact is also predicted in radiology provision, as there may be increased pressure on already stretched services. In terms of our involvement, having Macmillan GP involvement at every stage has been positively welcomed, as pathways need to be workable from Primary Care.

The new forms are nearly finalised. We are due to discuss the final forms at our next Bristol, North Somerset, & South Gloucestershire (BNSSG) cancer meeting.

See Appendix G for a Suspected Gynaecology Cancer 2 Week Wait Referral Form.

Top tips
It is important to get all the right people around the table. We found that prioritising signing off the straightforward pathways meant that time could be spent focusing on the more challenging pathways.
Dr Emma Von Bergen, Macmillan GP, Coastal West Sussex

What we did
Currently:
1. Working with providers to forecast increased capacity needs.
2. Working with providers towards offering the increased diagnostics recommended for GP access.
3. Working with providers to implement urgent upper GI endoscopy.

How we did it
This is an ongoing process and we recently experienced some issues in getting sustained engagement from our local provider to work with us and map capacity and increase diagnostics.

We organised a joint forum to try to hammer out some of these issues which was a promising first step but a number of issues, such as concerns that we may have difficulty implementing some of the recommendations under current capacity limitations, mean that the initial enthusiasm hasn’t been sustained.

We are trying to re-establish joint working towards achieving the recommendations, but at this stage we haven’t been particularly successful using the methods we have employed.

Who was involved?
The key to achieving implementation is clearly about getting the right people in the room together and in the case of our CCG we have a local steering group attended by representatives from:

CCG (Cancer and End of Life – managers and clinicians), Macmillan, Cancer Research UK (CRUK), other local charitable organisations (Brighton & Hove Albion football club have a charitable arm which works on community health projects), NHS Education England GP Tutor, Local Wellbeing Hub, Public Health England, the main local NHS provider (Western Sussex Hospitals Foundation Trust) and we have appointed a patient representative also.

We also established a senior executive level joint alliance with the CCG and our local NHS provider (this is the one which has proved difficult to get engagement with). This was in the hope that if senior executives were included in discussions that decision making could be better facilitated. We also attend SCN meetings where possible and my manager at the CCG is linked into groups across other Sussex CCGs to work collaboratively.

However, despite all this engagement, actual implementation is still some way off.

Impact
As implementation has not yet been achieved it is difficult to measure impact. We do already have routine direct access upper GI endoscopy within the CCG and have had for some time but this is already at full capacity and therefore it is looking difficult to upscale it to accommodate direct access urgent services.
**Dr Helen McCall, Macmillan GP, Great Yarmouth and Waveney**

**What we did**
We held regular meetings with secondary care and the CCG to help implement the guidance. As I am in close contact with the Secondary Cancer Care Lead and our Lead Commissioner for cancer, we were able to hold meetings to discuss implementation of the 2 week wait forms and the guidance. These meetings formed part of the hospital strategic cancer group where these types of changes are discussed.

**How we did it**
The Secondary Cancer Care Lead and Lead Commissioner were able to pass details from the meetings on to their relevant departments. All forms were then shown to the relevant clinicians. A grand round presentation was produced for all secondary care clinicians regarding the 2 week wait guidelines and all GPs were informed with good notice about the introduction of the forms.

**Who was involved?**
The forms were shown and discussed with GP clinical leads and the retained GP team prior to the approval of the SCN.

**Impact**
Not yet known.

**Top tips**
It is important to recognise the amount of time needed for IT to develop and format the forms. I allowed 2 weeks and this was not enough time.
(ii) Pathway redesign

The updated NICE guidance provides a unique opportunity to reconsider the early stages of cancer pathways. Consider the following:

• Can the 2WW booking system be improved?

• How long does it take for a patient to get an appointment?

• Have E-referrals now been implemented and accounted for?

• Can investigations and outpatient assessment be streamlined?

• Do you have access to any straight to test pathways or access to a Multidisciplinary Diagnostic Centre (MDC)?

• Are you able to review case studies of previous late presentations, to gather key learning and ideas for improvement?

• Can you organise an away day to map the current process and identify potential areas of improvement?

• Can you organise a walkthrough of the current pathway journey with patient groups to understand what changes they would value?

NICE defines 12 separate tumour types. These can be further subdivided to smooth the process, such as a jaundice pathway, based on what level of pathway specificity is required or available within your locality. Achieving World Class Cancer Outcomes has a long term aim to ensure 95% of patients receive a cancer diagnosis within 28 days of first presentation\textsuperscript{10}. Pathway redesign will help us move towards this goal.

The ACE programme (Accelerates progress; Coordinates implementation; consistently Evaluates best practice and innovation) is an NHS England led early diagnosis of cancer initiative, supported by Macmillan and Cancer Research UK. A number of initiatives are being implemented to develop a substantial knowledge base on early diagnosis, which can then be used to identify and evaluate good practice in an effort to reduce system delays and improve early diagnosis of cancer.
Wave 1 of the ACE programme involves 54 projects exploring innovative concepts such as redesigning referral pathways to allow referrals from primary care professionals other than GPs, primary care engagement to overcome barriers to cancer screening and how best to streamline lung cancer diagnostic pathways, amongst others. Published reports from these clusters can be found on the ACE Wave 1 webpage.

A number of ACE projects in wave 2 of the programme are focusing on pathway redesign by testing out models similar to the Danish model, which involves rapid direct GP access to a range of tests and also a Multidisciplinary Diagnostic Service for those patients with concerning, but non-specific symptoms. More information about these projects can be found on the ACE Wave 2 webpage.

Please see below for examples of local activity to support pathway redesign for early referral, which you could consider in your practice or local area:
Dr Neil Smith, Macmillan GP, Blackburn

What we did
We redesigned all of our local pathways for suspected cancer.

How we did it
In response to the updated NICE guidance, we arranged a joint project with our local acute trust as well as forming a NICE implementation group to oversee the process. Following the formation of this group, we underwent a series of meetings which involved all of our local tumour lead consultants. These meetings allowed us to develop drafts and redrafts of 2WW referral forms that each attendee was happy with. Within these referral forms we added local guidance for specifications about individualised pathways after which the forms were reviewed and endorsed by both GPs and consultants. From this we created pathway flowcharts to detail the agreed routes and launched the referral forms in waves. The group continues to respond to any problems, as well as providing feedback to GPs regarding the improvements.

Please see Appendix A for a jaundice pathway flowchart, which could be used as a guide for redesigning pathways within your area.

Who was involved?
Myself as a Macmillan GP, each local tumour lead consultant, acute trusts, the NICE implementation group and local GPs.

Top tips
This can only be done with local dialogue, joint working and establishing trust.
Dr Achla Damania, Macmillan GP, Vale Royal

What we did
A review of the upper GI pathway is currently being undertaken and a cancer action group has been set up in our CCG.

How we did it
We worked with Macmillan and our local hospitals to look at the whole upper GI pathway to try and create better links. The group has been temporarily halted, as the project manager is off sick and there have been a few resignations within GI service, which has impacted on endoscopy services. The project is due to start again in mid-2016.

Who was involved?
Consultants. RCGP completed an audit on routes to diagnosis – 2WW investigation form (CT scans etc) with cancer lead and consultants – this was then discussed with radiology.

Impact
No impact has been identified as yet due to the project being halted. It is hoped that the group will help us to create better links within our locality.

Top tips
Getting CCG on board is vital. It is also important to maintain contact with public health and work with local consultants.
ACE Programme: Lung cancer pathway redesign

What we did
The ACE programme is divided into thematic clusters of projects; one of which is looking at the most effective and efficient lung cancer pathway from referral to diagnosis, including direct access to CT arrangements. A total of six projects within this cluster are focused on streamlining lung cancer diagnostic pathways and, through the testing of these various pathway elements, have identified barriers and ways to resolve them. Communication methods and motivation techniques are also being tested to ensure the implementation of best practice.

How we did it
The majority of projects within this cluster are trying to achieve better access to CT. One project is testing ‘GP direct access to CT’ following a normal chest X-ray (CXR), while several others are implementing ‘straight to CT’ arrangements following abnormal CXR. There is a focus on improving the interface between primary and secondary care and introducing changes to improve communications and the transfer of relevant clinical information. Other projects are re-examining processes within secondary care to ensure timeliness and best use of resources. Communication with patients is also being considered to understand how, when and by whom patients should receive information or results, including good news. Speed and length of the new pathways, clinical outcomes, patient experience and cost differences between the ‘before’ and ‘after’ pathways are all key considerations for evaluating the effectiveness of the new pathway elements.

Who was involved?
GPs, radiologists, secondary care specialists, local charities, local alliances and NHS Trusts.

Impact
As Wave 1 of the ACE programme is currently ongoing, the full impact of these projects is not yet known. However, in March 2016, an interim report was published to share some of the information and findings gathered so far, as well as defining the next phases of the process. Early findings show that there is considerable scope to improve local lung cancer pathways, which is likely to lead to a better use of expertise, scarce resources, better patient experience and more timely diagnoses. A more detailed analysis and evaluation of these projects will be undertaken by the ACE programme late-2016, and will be available on the ACE section of the Macmillan website. The aims of this pathway redesign include: reducing waiting times for investigations, improving the 2WW pathway flow, promoting collaborative working between primary and secondary care, improving the appropriateness of referrals and ultimately, improving lung cancer survival rates through early diagnosis of lung cancer. For further information on any of the projects involved in the ACE lung cluster, please visit the ACE webpage.
ACE Programme: Colorectal cancer pathway redesign

What we did
The colorectal pathway cluster within the ACE programme comprises a number of NHS projects that are focused on the implementation of a straight to first diagnostic test (STT) approach following eligible GP referral. The projects are looking to improve the speed of achieving a definitive diagnosis and the delivery of first treatment. The projects are also evaluating the impact of a variety of straight to ‘first diagnostic’ test approaches (flexi sigmoidoscopy, colonoscopy or CT colonography) measuring eventual time to diagnosis. Referral thresholds will be evaluated and information will be gathered on approaches that have already been implemented in some parts of the country to ensure there is robust evidence to drive pathway speed. There are 12 projects within the colorectal pathway cluster.

How we did it
The majority of the ACE projects have implemented their STT pathway by establishing a formal, hospital-based triage service in order to review the appropriateness of each colorectal referral. Two of the ACE projects are providing innovative access to endoscopy services, in offering the booking of flexible sigmoidoscopy and colonoscopy investigation direct from primary care. A number of projects are evaluating various interventions and pathway enhancements or the merging of pathways. Integrated models of care between primary and secondary care are being trialled as well as a system for referring patients with concerning lower GI symptoms that do not fit the NICE two week referral criteria, primarily due to age. One project is providing a ‘one-stop, GP direct access service’ for the diagnosis of rectal bleeding and other high risk symptoms to promote early detection of bowel cancer.

Who was involved?
GPs, local NHS trusts, local universities, SCNs, secondary care specialists and local cancer alliances.

Impact
In May 2016, an interim report was published to share some of the information and findings gathered so far. Early results show that the introduction of the pathway for 2WW referrals has helped to reduce the waiting time for the first diagnostic test to between 7 and 14 days, essentially by eliminating the unnecessary first out-patient appointment. For the STT pathway, no outpatient clinic rooms, clinic preparation (e.g. patient medical records) or clinic administrative or supporting nursing staff are required. This enables the service to respond flexibly to the increasing demand for a colorectal specialist opinion and the inevitable peaks in demand. 2WW referrals to the hospital-based triage are receiving an appropriate and qualitative service that GPs are becoming more familiar with. Early results from the projects indicate that STT is a faster route to diagnosis and offers an improved experience for patients. However, it would be preferable to receive all colorectal referrals via a STT pathway, developing a single queue approach, providing equity for all patients diagnosed with colorectal cancer.
A more detailed analysis and evaluation of these projects will be undertaken by the ACE programme late-2016, and will be available on the ACE section of the Macmillan website. The aim of this cluster is to reduce waiting times from referral to investigation or diagnosis, in an effort to develop a sustainable pathway for patients which encourages timely diagnosis of colorectal cancer.

For further information on any of the projects involved in the ACE colorectal cluster please visit the ACE webpage.
Dr Kay Elliot, Macmillan GP, Bedfordshire

What we did
After discussions with our local hospital – Luton and Dunstable – a new category of urgency has been introduced on the ICE requesting system for GP initiated 2WW investigation – CT/MRI/ultrasound. This will help GPs to request an investigation more promptly, and allow the hospital to audit uptake and efficacy.

How we did it
I facilitated a new indication on ICE requests for the GP access imaging which appeared in the NICE guidance. I also contacted the radiology lead and arranged a meeting to talk them through the new guidance from a radiology perspective.

Who was involved?
Practice level staff, CCG level, secondary care, other organisations, patients and myself; as a Macmillan GP and a secondary care lead clinician

Impact
We had previously had the tests available, but the new system ensures they take place within 14 days and that it is now possible to audit them.

Top tips
Talking clinician to clinician first is helpful.
**Dr Amelia Randle, Macmillan GP, Somerset**

**What we did**
We are taking a slow iterative approach aimed at culture change with improved communication between GPs, patients and hospitals. We are currently focussed on lung and breast pathways with a plan to start work on Upper GI in 2017.

**How we did it**
It was acknowledged that a redesign of the forms would not be sufficient; GPs would need access to CT, endoscopy and ultrasound. Meetings have been held to discuss pathways, including Upper GI – 1st pathway – which is dependent on access to radiology. We realised that we ordered things on paper differently but with the same clinical essence. A problem identified was access to radiology, which is largely beyond the scope of a cancer lead role.

Following upper GI, we will have an ovarian/gynae meeting. The aim is to engage all 7, but difficulties arise with so many people trying to do the same thing.

**Who was involved?**
Trusts, other CCGs (but they need to scope to further this) radiology board, different programme boards – early diagnosis is relevant to all programmes but a separate board does not exist.

New forms developed include: Breast forms, upper GI forms (1st draft – see Appendix C) and one 2WW form for all upper GI. We are developing 2WW ultrasound request forms for those seen in clinic, however it is proving difficult as ultrasound can be done anywhere. We have also developed an integrated lung form – not based on NICE guidance; more early diagnosis and straight to CT.

**Top tips**
We have found it helpful to take the NICE guidance in spirit not detail. A change in ethos is identified when it is viewed as a support document rather than a mandatory pathway.
Dr Chrissie Hunt, Macmillan GP Associate Advisor, Cumbria

What we did
We redeveloped new 2WW forms. This took a lot longer to work through than expected. The South East Coast SCN template forms were received in early 2016. We then liaised with Morecombe Bay Hospital Trust (MBHT) Cancer Managers, Consultants and Macmillan GPs to update the referral forms, which were completed at the end of March 2016.

How we did it
We used SCN templates and met with secondary care specialists to gain approval. I have also taken steps to set up meetings with my local Upper GI/Pancreatic surgeon and a consultant radiologist in my local trust (Ashford and St Peter’s). We are also looking to run a trial of direct access CT scans for suspected pancreatic cancers.

Who was involved?
St Luke's Alliance, South East Coast SCN, Macmillan GP, local upper GI/Pancreatic surgeon and consultant radiologist.

Impact
Unfortunately, I haven't been able to move things on at a pace that I would be happy with but I hope in a few months things will be progressing nicely.
(iii) Creating referral forms

The NICE guidance recommends using a proforma for referrals. Most hospitals receive large volumes of 2WW referrals on a daily basis and need a standardised system of information they can act on. Furthermore, the proforma needs to align to local pathways and take into consideration the views and advice of local clinicians. Consider the following when redesigning referral forms:

- They will need to be updated to reflect the updated guidance;
- They should be branded with the organisations that use them and be clearly identifiable by version and date;
- They should have the correct patient details and recognition that the patient has been referred on a cancer pathway;
- They can offer clinical direction as to which symptoms and signs warrant referral. A lot of clinical details can be automatically embedded into electronically completed forms (e.g. the last consultation);
- Specific additions may be made depending on local agreements; these can be adapted to allow changes to be incorporated into GP systems;
- Engage with your local Cancer Nurse Specialist (CNS), or Shared System Group (SSG) to ensure that secondary care is part of the re-design process;
- Align forms across trusts, particularly where GPs are able to refer to multiple sites;
- It is important to remove old versions and ensure all practitioners are using the most up-to-date forms;
- Include a narrative element to ensure that important aspects of the patient’s story can be included, in addition to the tick box elements;
- Referral forms should be done electronically as E-referrals; they should not be faxed or emailed. Utilise IT teams and systems to ensure consistency in terms of IT processes.
Please see Appendices D, E, F & G for copies of forms designed for different areas, which could be used as a guide for creating new referral forms within your area.

For more examples of referral forms, please email preventionanddiagnosis@macmillan.org.uk

Please see below examples of local activity on creating referral forms, which you could consider in your practice or local area:
Top tips for GPs: Implementing the NG12 NICE Guidelines for Suspected Cancer: recognition and referral

Dr Ishani Patel, GP, Transforming Cancer Services Team, Healthy London Partnership, RCGP Clinical Lead for Early Diagnosis of Cancer and QI, London & Dr Anthony Cunliffe, Macmillan GP Advisor, London and South East Coast

What we did
We created a pan-London unified approach to agreeing the criteria and creating a standard urgent suspected cancer referral form to be used by all CCGs and providers.

How we did it
The first step was to organise an event that brought together many GPs from across London and secondary care specialists from a large number of the provider trusts. A different tumour type was assigned to each group, who were then tasked with reviewing the criteria for their designated tumour type and feeding any issues back to the wider group.

This then stimulated virtual group discussions to agree the final criteria. It is worth noting that the final pan-London criteria overlapped the NICE guidelines mostly, but some criteria were changed after agreement by the different groups. These guidelines then underwent the agreed governance processes for London, finally being signed off by each CCG.

A team from the Transforming Cancer Services for London Team (TCST) then took these criteria to create standardised new urgent suspected cancer referral forms for each of the tumour types. These forms were then made compatible with each of the GP IT systems used across London, and included links to relevant educational resources. The team from TCST co-ordinated the communications and dissemination of these forms to all London CCGs.

Who was involved?
Multiple GPs from across London and secondary care specialists; covering all tumour types from multiple provider trusts across London. The Transforming Cancer Services Team for London (TCST) was also involved.

Impact
The impact of this is yet to be evaluated.

Top tips
Clear and recurrent communication to all relevant parties is vital at all stages of the process. Ensure there is robust input from both Primary and Secondary Care at all stages of development.
Dr Neil Smith, Macmillan GP, Blackburn

What we did
I created 16 new 2WW referral forms for suspected cancer; each of which included the relevant NICE guidance, as well as adhering to our updated local referral pathways.

How we did it
I arranged numerous meetings and had various discussions with healthcare professionals at all stages of the pathway. This involved a great deal of negotiating. It took roughly 10 drafts of each new 2WW referral form to reach a final, agreed version. We started trying to use CSU to translate the forms into EMIS format, however this proved too slow, therefore, a member of the cancer team trained herself to speak and write in “EMIS web”. This proved invaluable when members of the team had good ideas that we could incorporate into the form immediately.

Who was involved?
Myself as a Macmillan GP, each local tumour lead consultant, acute trusts, the NICE implementation group and local GPs.

Impact
All of our new 2WW forms and pathways had been launched by May 2016. Our locality has plans for dermatology routes as well, but delays due to whole service redesign and decisions regarding where BCCs should fit have halted this work. The only other outstanding pathway is lower GI which we have a proposal for; however, our acute trust risk assessment has listed implementation as very high risk due to a lack of capacity in endoscopy and histopathology. We hope to overcome this and to roll out this pathway and updated 2WW referral form towards the end of 2016.

Top tips
Embed clinical information into forms e.g. last consultation and allergies.
Do not change the wording of the NICE guidance.
Add in local advice to reflect local pathways.
Top tips for GPs: Implementing the NG12 NICE Guidelines for Suspected Cancer: recognition and referral

Dr Brian Nicholson, Macmillan GP, Oxford

What we did
The Cancer lead for Oxford CCG convened a group of GPs to redesign the 2WW forms in line with the 2015 NICE guidelines.

How we did it
We first divided up the forms so that each primary care clinical member of the team was given a number of cancer sites for which to draft new forms. We then met 4 times (at least, with many emails in between) to comment on and update all the forms with the electronic communications team. The forms were then sent to the hospital MDTs for comments from each speciality. The forms were only the starting point, as for a form to be accepted the pathway – tests and specialists available for referral within the correct timeframes – had to be modified. The forms provided an educational tool for GPs so they needed to be clear and concise. We then met for final sign off.

Who was involved?
The Oxfordshire CCG Cancer lead, CCG Pathology Lead, CCG Radiology Lead, Macmillan GP Facilitator, electronic communications team, hospital specialists and hospital cancer manager.

Impact
Within the coming months, all GPs in Oxfordshire will have referral forms (and referral pathways) that adhere to the 2015 NICE guidelines for suspected cancer.

The new forms have not yet released but we expect them in the coming months.

Top tips
The specialists involved in this project jumped at the chance to improve referral pathways (and forms) for their patients. This project was perfect for improving collaboration between primary and secondary care and has set us up well for a series of educational evenings led by cancer specialists for GPs.
Dr Linda Mahon-Daly, Macmillan GP, North East Essex

What we did
We developed 2WW forms. The East of England SCN set up a working group involving Macmillan GPs to design forms for use across the entire East of England region. These forms were then shared widely with clinicians in all hospitals, as well as hospital managers, to attempt to reach a consensus based on the new NICE guidance.

How we did it
An overview approach was adopted – rather than all of us writing the forms and doing the work individually in our trusts, we decided to do it across the whole of the East of England. This saved everyone a great deal of work. This approach also allows for the clinicians and hospital managers to feel confident that the work of their peers is aligned with their work.

Who was involved?
This process was led by the SCN and arose out of our East of England cancer forum. Input from the Macmillan GPs, hospital clinicians and hospital managers was also utilised. The CCGs were not directly involved as the work was delegated to the local Macmillan GP.

Impact
The new forms have now been uploaded to all trusts across the East of England.

See Appendix E for a Brain & CNS Suspected Cancer Referral Form. See Appendix F for a Breast Suspected Cancer Referral Form (inc. Exhibited Symptoms).

Top tips
Working across an area may seem daunting, but we found that having it led centrally saves a lot of work and ensures consistency.
(iv) Access to urgent investigations

One of the main changes arising from the updated NG12 NICE guidance is greater emphasis on GPs to request urgent investigations for suspected cancer more frequently. There is already considerable variation across the country in terms of direct access to investigations for GPs. In addition to this, even if a GP currently has access, it is likely that the volume of referrals will increase which will impact on service provision. The process of organising, undertaking, reporting and acting on tests in a timely and efficient way needs to be addressed. GPs will become increasingly responsible for following up results and planning next steps as a result of the introduction of the NG12 guidance.

You will need to consider how this may impact on service provision:

- There is a pressing need for commissioning of these tests;
- GPs will need to adapt to a new method of working where they will retain responsibility for the result and subsequent actions of these tests. This may involve the need for training or educational days;
- Preliminary investigation in primary care will necessitate careful safety netting procedures and robust, standardised systems for following up results;
- Increased investigations within primary care will undoubtedly be affected by variations across different localities in diagnostic access. Local practices will need to be aware of this and consider how the issue of access to diagnostics could be navigated which will involve discussions within CCGs.

Please see below for examples of local activity to support access to urgent investigations, which you could consider in your practice or local area:
Dr Neil Smith, Macmillan GP, Blackburn

What we did
We summarised all of the diagnostics recommended in the NICE guidance, focusing on key changes. We then used this to gain agreement that, in certain circumstances, GPs could have access to urgent investigations.

How we did it
I arranged multiple meetings with local pathology leads to discuss the changes and implications of these changes. The overall progress of this work was driven by the collaborative NICE implementation group that we formed in response to the updated NICE guidance. We also arrived at a solution to limited access to Brain and CNS investigations, through implementing an agreement that the GP could speak directly to the consultant radiologist to request an urgent MRI.

Who was involved?
Myself as a Macmillan GP, the NICE implementation group, local pathology leads and local GPs.

Impact
GPs can now access urgent ultrasound scans for patients who meet the NG12 NICE criteria and have a system in place for those requiring an MRI. Several of our updated pathways now integrate the organisation of investigations with appointment bookings which has improved the process.

Within our area we now have much better access for GPs in terms of urgent ultrasound scans. This is an ongoing project which is not yet complete, due to issues with urgent CTs for suspected pancreatic cancer; however, progress is being made.
Dr Davina Solomon, Macmillan GP, Cumbria

What we did
Enabled urgent CT and MRI access for GPs in North Cumbria to enable them to follow the new guidelines. I have been working with radiologists and PRIMIS staff in North Cumbria to implement GP access for urgent imaging. Setting it up has been relatively straightforward but we will be auditing the referral to assess for quality and impact on the radiology department.

How we did it
We met with a consultant radiologist to explain the new guidelines, and PRIMIS who developed our electronic request forms. I shared the developed forms with the other Macmillan GPs and made GPs in my locality aware that the forms were coming in a cancer education event.

Who was involved?
Consultant radiologist, PRIMIS and Macmillan GPs.

Impact
Not yet known – an audit of the referral system to assess quality and impact on the radiology department is planned.

Top tips
Communicate with radiology colleagues.
**Dr Cathy Hubbert, Macmillan GP, Liverpool**

**What we did**
We have been negotiating at CCG and secondary care level for improved pathways for 2 week wait and diagnostics. We developed a slide set based on previous work undertaken by a local Macmillan GP. CCG cancer leads and Macmillan GPs presented at marketplace style events for Liverpool GPs – a webinar is available on our CCG website.

Our CCG has funded 50 places on a Red Whale GP Cancer Update course and Macmillan has funded 10 places. The event was held in April and included a half hour slot on the local perspective.

We are still working with our CCG on pathways as things tend to change slowly. We currently have direct to CT from abnormal chest X-ray and urgent ultrasound if ca125 is raised. We are working closely on straight to CT and 2WW appointments for suspected ovarian cancer on ultrasound. We are close to 2WW CT scans for suspected cancer which does not meet any other 2WW pathway. We then hope to work on 2WW upper GI to include CT as well as gastroscopy for certain symptoms. One trust has improved IDA clinic to 2WW – this was already in place in the other trust – and both trusts now have a triage for 2WW colorectal – 1 specialist nurse appointment and 1 telephone appointment so people get the best test first. Work is ongoing with our urology pathway so that appropriate patients have a CT scan performed by their first clinic appointment.

Referral forms have been developed on a network level with negotiation.

**How we did it**
For the work on colorectal initiatives – secondary care led with CCG collaboration.

The other aspects were undertaken by a dedicated team led by our manager, CCG leads, and Macmillan GPs meeting with secondary and tertiary care colleagues. Our CCG cancer team also includes project leads (healthy lung and survivorship), patient representatives, Public Health England and CRUK facilitators. We have also been working with neighbouring CCG Cancer Leads and Macmillan GPs through formal and informal meetings and lots of emails.

**Who was involved?**
CCG cancer team, local trusts secondary and tertiary, local CCG leads, network support and CRUK facilitators. The local authority hosts our LAEDI group.

**Impact**
Educational events have been well evaluated. Pathways change slowly but we are optimistic and have many more projects ongoing.
Dr Linda Mahon-Daly, Macmillan GP, North East Essex

What we did
We redesigned the initial stages of our lung cancer pathway to speed up the process of implementing the guidance. GPs already have open access to chest X-rays from Monday to Friday. We set up a system so that if a GP-requested chest X-ray raised suspicions of cancer, a CT scan was automatically organised by the radiology department without the GP having to request this. If the CT result was abnormal, this was automatically forwarded to the cancer hub to book an appointment with the chest clinician, and the GP was asked for a 2WW referral form.

How we did it
This process was carried out by having a range of clinical discussions, which included chest physicians, the radiology department and the Macmillan GP representing primary care. Clinical and managerial discussions between the Macmillan GP, chest physicians, radiology department and the cancer managers at the trust followed.

Who was involved?
Hospital clinicians, Macmillan GPs and local managers.

Impact
The pathway is now up and running and working well.

A flowchart for the lung pathway can be found in Appendix B.

Top tips
Working with clinicians and managers to redesign the pathway ensures buy in from everyone and means that the pathway is owned and will work in practice.
Dr Pauline Love, Macmillan GP Advisor, North Derbyshire
What we did
We developed a new system for managing patients with suspected lung cancer, by which there would be direct access to CT. The system essentially ensures that if an abnormal X-ray (where there is a suspicion of lung cancer) is seen by a radiographer, they have direct access to a CT scan. This is followed up by an email being sent to the GP practice for our information saying that a CT scan has been arranged.

Impact
This system appears to be working well. Our data has shown that numbers of cancer diagnoses being made in A&E had fallen considerably; only 3 in a 6 month period – with the remaining patients being directly referred on 2 week wait or investigated in practice then referred on 2 week wait.
(v) Patient Engagement

Patients need to be put at the centre of redesign stimulated by the introduction of the updated NG12 guidelines. The underlying aim of this update is to make the system more effective and efficient, to increase early diagnosis and to speed up care processes. It is important that patients are made aware of being on a suspected cancer pathway by their GP whilst emphasising the need to attend future appointment(s).

Additional support should be given to vulnerable groups in particular. It is recommended that patients are given information, ideally produced in collaboration with patient groups, on what their referral means (London Cancer Alliance 2015). Patient satisfaction and feedback should be integral to pathway redesign. One essential component is communication between the responsible clinician and patient or carer at every stage of the process.

The Be.Macmillan website has several patient information leaflets available for GPs to order free of charge for their practice and patients.

Please see below examples of local activity to support patient engagement, which you could consider in your practice or local area:
Dr Neil Smith, Macmillan GP, Blackburn

What we did
We included a patient representative in all of our local action groups with two patient representatives attending the cancer steering group for our locality. We also hosted an information workshop which considered how to best develop an information service from a patient perspective. Additionally, we developed patient participation group and involved a breast cancer patient support group in the redesign of our local breast pathway.

How we did it
We linked with other members of the Macmillan family through the Macmillan Information Service, physical activity team and solutions team as well as recruiting patient representatives early on in the process. We also mapped out all cancer support groups in the area to ensure an even spread.

Who was involved?
Myself as a Macmillan GP, the NICE implementation group, members of the general public who formed patient experience groups, secondary care specialists and local GPs.

Impact
We were able to involve patients in producing patient information leaflets about the 2WW process, allowing those in our area to be informed of the changes we were making. GPs hand these patient leaflets out when making a suspected cancer referral. We are also involved in an ongoing project with our patient group to produce tumour specific patient information leaflets as a result of the successful collaboration so far.

From this work, we have demonstrated an increase in patient engagement and as a result have reduced DNA appointments for suspected cancer.
Dr Catherine Crocker, Macmillan GP, Birmingham

**What we did**
We utilised local forms which encourage information giving when referring patients on a 2WW pathway. We found that local 2WW forms work well and some specialities have a tick box on the 2WW form to confirm that the nature of the referral has been explained to the patient and the information sheet has been given out. Locally, we have also moved to emailing rather than faxing the referrals. The written explanation should alert the patient to act if no appointment is received in 2 weeks and also to keep, or remake, the appointment.

**How we did it**
- *Information sheets* are given to patients, but in particularly busy surgeries I tend to print the information sheet off and post it.

**Who was involved?**
Primary Care, and patients.

**Impact**
Not yet known.
(vi) **GP education**

The changes introduced by NICE may appear overwhelming and confusing to some GPs. Some areas have already carried out GP educational events on this topic which have helped GPs to understand what practical changes could occur as a result of the updated guidance. It is important to provide guidance that is practical, which focuses on the common issues and considers the main changes that may arise. A wide range of resources and educational events are readily available. Some of these are listed below:

- **Macmillan’s Early Diagnosis Webpage** hosts various resources and tools which aim to support GPs in diagnosing cancer early;

- **Macmillan’s Rapid Referral Guidelines** can also be downloaded from our webpage. This NICE endorsed resource can be used during education events. To request a hard copy please email preventionanddiagnosis@macmillan.org.uk;

- **Macmillan’s Resources for GPs** webpage hosts additional resources for GPs and the wider primary care team including commissioners;

- GPs can attend **GP Cancer Update Courses** to refresh their knowledge of cancer signs and symptoms and various aspects of the cancer pathway from early diagnosis to end of life;

- **Cancer Research UK** hosts various resources to help GPs diagnose cancer early as well as giving further information on national initiatives that could encourage collaboration between CRUK facilitators and GPs;

- The **Royal College of General Practitioners** have developed various toolkits in order to support GPs at all stages of the cancer journey. A range of quality improvement resources, including revalidation and Significant Event Analysis (SEA) tools, can also be found on the [RCPG website](#).

Please see below for examples of local activity to support GP education, which you could consider in your practice or local area:
**Dr Neil Smith, Macmillan GP, Blackburn**

**What we did**
Organised and carried out numerous education events based on the NG12 NICE guidance as well as producing an educational resource pack to be shared with others.

**How we did it**
I arranged our annual local multidisciplinary cancer education event, which looked at the changes within the NG12 NICE guidance. This event was attended by 250 GPs across three sites and will be replicated at Macmillan’s 2016 Primary Care Conference with support from other GPs and radiologists. In line with this, I arranged multiple nurse training events for cancer based on the updated guidance and pathways. I also worked with the RCGP to develop and cascade educational events for GPs specifically on the NG12 NICE guidance and delivered a programme on this to 150 GPs. Resources have been circulated to the Macmillan GP community to enable them to replicate these events in their locality.

**Who was involved?**
Myself as a Macmillan GP, cancer commissioners, cancer managers, consultants, RCGP and the SCN.

**Impact**
I have now produced and delivered an education package for other GPs to use. From these events we received a high degree of GP satisfaction and have positive feedback for all sessions. Education for both GPs and nurses is an essential step in implementing new local guidance and pathways, and has allowed me to develop a whole range of resources which can be shared with peers.
Dr Helen McCall, Macmillan GP, Great Yarmouth and Waveney

What we did
We organised a Red Whale Cancer GP Update course which was attended by 50 GPs; 2 from each local practice. The event was a success and we received good feedback from attendees. I also presented the new guidelines at a grand round at the hospital so that staff were made aware of them. I arranged for frequent emails to be sent to local GP practices in order to inform them of the new 2WW forms before they were posted on the ‘Knowledge management website’. These forms were up and running at the start of February 2016. I am currently collecting feedback from GPs and secondary care consultants to assess how it is going.

How we did it
The Red Whale course was funded by Macmillan and advertised well in advance. I also asked Red Whale for a copy of their 2WW guidance summary booklet for each clinician in the area and have circulated these to all practices. There have been frequent meetings between the Lead Cancer clinician at the hospital, our CCG and myself to ensure that these forms are accessible to all local GPs, along with arranging a helpline to deal with any queries about the new forms and guidelines.

Who was involved?
CCG, Manager for End of Life and Cancer, Cancer lead clinician at the local hospital, Managers at the hospital, and the SCN for East of England; which produced the new forms.

Impact
There has been a huge increase in referrals but some confusion about the Upper GI 2WW referrals as this has changed considerably. Radiology is having some difficulties adapting to the increased number of requests for CT scan, ultrasound and Chest X-rays.

An example of this new 2WW form can be found in Appendix D.
Dr Sinead Clarke, Macmillan GP Advisor, Central Cheshire
What we did
Two local Macmillan GPs looked at the updated NICE guidance with the cancer lead consultant at our local District General Hospital and started to work on adapting our existing 2WW forms to the new NICE guidance.

How we did it
About halfway through the adaptation process, we got sight of the new draft forms for Greater Manchester Network and decided to adopt these instead, as they seem efficient and a lot of our patient flows are into Manchester. We are still in the process of getting our local Cancer Leads to agree to this. Once they do we plan to launch these forms at Protected Learning Time GP Events in 2016.

Who was involved?
Two Macmillan GPs, local cancer commissioner and cancer leads at local hospital.

Impact
It is not yet possible to measure any impact, this should be easier once the new forms have been launched and GPs have begun the adoption process.
**Dr Peter Long, Macmillan GP, Southend**

**What we did**
Our local SCN produced new site specific urgent referral forms for suspected cancer. These were incorporated into the IT system in primary care and the acute trust. Education was provided to local GPs about the new forms and the NICE 2015 suspected cancer referral guidelines.

**How we did it**
As the Macmillan GP for the area, I worked with the local CCG whilst our acute trust ensured that the IT was in place. This took a number of meetings with IT support from the CSU in order to make sure the forms were adapted properly. I trialled the new forms at my own surgery to troubleshoot any problems.

I met with the acute trust alongside the director of integration from the CCG to make sure the adoption of the new forms would fit with the hospital’s cancer strategy. I also hosted an educational session attended by GPs from across the area in order to explain the new forms and how they fit into the broader cancer strategy for our locality.

**Who was involved?**
Myself as a Macmillan GP, our acute trust and our local CCG. I worked in close partnership with a commissioning manager at the CCG throughout the process. At a broader level, I also met with the local SCN and had discussions with CRUK about the forms.

**Impact**
The new forms went live in April 2016. I will continue to work with locals GPs, the acute trust and the CCG to work through any problems that arise.

**Top tips**
It is important not to underestimate the amount of time needed for IT solutions to be found. This was probably the key challenge that we experienced in this process.
(vii) Financial and workforce planning

It is impossible and potentially unsafe to make substantial changes in GP referral behaviour and activity without considering the impact on the wider health economy. Certainly, there may be increased costs and increased activity. Clinical Commissioning Groups need to be informed and able to plan for this so initiating these discussions early on is essential for smooth progress. There are workforce, training, equipment and other resource implications that need to be factored into planning. Consider the following:

• Can primary care actually cope with these changes? If not what extra funding is needed? This could involve;
  – utilising a more experienced GP or clinical assistant to review or triage referrals or,
  – supporting a local practitioner with a specialist interest in this area to provide clinics aimed at their peers;

• Implications for medications funding will need to be considered. Will GP budgets fund any prescribed medication or will this be funded by secondary care? This could be something which is discussed within wider CCG meetings,

• What are the risks to the hospital department, such as diagnostic services?

• Could these changes be detrimental to some patients?
  – May need to consider the emotional impact of an urgent referral for suspected cancer. Are practice staff trained and confident to manage this?
  – Need adequate patient information and time to be able to talk through informed decision making.

Please see below for examples of local activity to support GP education, which you could consider in your practice or local area:
Dr Neil Smith, Macmillan GP, Blackburn

What we did
We used the demand modelling insights we had gained for our locality and projected this on to our finance and workforce planning.

How we did it
Using our demand modelling insights, I projected our local predictions onto our finance spreadsheet to consider the possible implications in terms of finance and workforce planning. Using these predictions, I facilitated meetings between our CCG and acute trust finance managers to discuss the changes and potential ramifications on finance and workforce planning within our area. I then presented the possible implications during local CCG boards.

Who was involved?
Myself as a Macmillan GP, the NICE implementation group, CCG finance managers, acute trust finance managers and local CCG boards.

Impact
We have come to a general agreement which allows us to move forward with this planning. Specific areas of development include agreeing an endoscopy business case including extra investment for building, equipment and staff. As well as this we have plans to recruit more histopathologists and are considering a 7 day diagnostics unit and tariff changes.
Dr Prue Mitchell, Macmillan GP, New Devon

What we did
We set up a working party to look at implementation of the new NICE guidelines with a focus on whether to commission faecal occult blood test (FOBT) or faecal immunochemical test (FIT).

How we did it
Meetings were held monthly to discuss planning and implementation.

Who was involved?
The working party was comprised of myself as a Macmillan GP, the Clinical Effectiveness Team from our CCG, a CRUK facilitator, GP clinical leads, representatives from the 4 acute trusts in our area, a locality contracting representative, a service design manager and an South West cancer clinical network representative.

Impact
There has not yet been a definite decision on the process. As far as we know, no other CCG is commissioning either test.

The recommendation by NICE Clinical Guideline NG12 for faecal occult blood testing by primary care for selected groups of patients with clinical features associated with colorectal cancer was discussed by the Devon Clinical Policy Committee on 24th February 2016. The decision taken by the committee was that faecal occult blood testing in the groups defined by NICE for suspected colorectal cancer should be recommended in the local health community. Implementation needs further work and will be guided by the evidence and the laboratories work up in consultation with the consultants who carry out colonoscopies. The general consensus seemed to favour FIT with patient advantages and imminent adoption by the screening programme. Implementation of this new test will require proceeding with caution. To our knowledge other areas are yet to decide on this issue and the SW Cancer Network is interested in how Devon is progressing. We intend to liaise with SW Cancer Network Manager regarding next steps. This is likely to involve some local pilot work to inform a final decision on implementation with data on costs and service impacts. This would take the form of a service evaluation. We will be sending a paper to SW cancer network manager which outlines the initial points to be considered in a service evaluation of faecal occult blood testing for the patient groups recommended by NG12.

NHS England have been approached for support. It is thought that the national screening program is changing from FOBT to FIT. NICE is going to review FOBT in low-risk patients and report in 2017. The next plan is to develop a pilot proposal and find a laboratory willing to take part in the project.

Top tips
Be patient and don’t underestimate the complexities behind what may appear to be a relatively simple NICE recommendation.
(viii) Capacity increase

A clear strategy needs to be developed to expand capacity for assessing cases of suspected cancer. It may be wise to use a phased approach by agreeing priorities for implementing this guidance as a practice or locality and focusing on only one challenge at a time. Some adaptations may be easier than others and worthwhile focusing on initially (e.g. breast referrals). Others may be more challenging and take longer to implement (e.g. lower GI investigations and referrals). Systems need to be in place to monitor expansion including the ability to respond to concerns in both primary and secondary care, at all stages of the implementation process.

Please see the demand modelling section (i) for examples of local activity to support capacity planning, which you could consider in your practice or local area.
None of these challenges can be solved in isolation. You cannot create forms without designing pathways. You cannot make financial and workforce plans without modelling demand. You cannot inform GPs of how they should change their management without ensuring that there is the capacity to deliver this change.

It has been impossible to produce a national ‘one size fits all’ solution. Specific practical changes need to be based on local needs, priorities and resources. This can only happen through collaboration between CCGs, Acute Trusts and primary care. The areas that have so far been successful in moving forward are those where a close working relationship has already been established. Relationships need to function on multiple levels: clinician to clinician, commissioner to provider, manager to manager, chief executive to chief executive.

Strategic Clinical Networks or Cancer Alliances can help to facilitate these changes whilst there remains a growing opportunity to share good practice and seek advice amongst your peers. Macmillan and Cancer Research UK are both committed to supporting the implementation of the new NG12 NICE guidance for recognition and referral of suspected cancer. By addressing these eight components we may be able to improve cancer care and save lives.


3. Abdel-Rahman M, et al. What if cancer survival in Britain were the same as in Europe: how many deaths are avoidable?. British Journal of Cancer. 2009; 101: 115–124.


8. Positive predictive value (PPV) is the probability that subjects with a positive screening test truly have the disease. Negative predictive value is the probability that subjects with a negative screening test truly don’t have the disease.


Appendix A: Proposal for referrals for patients with jaundice

Day 0
Patients present at GP with jaundice
GP checks Blood – if raised bilirubin* and abnormal LFT’s refer to Radiology for Ultrasound Scan Ensure patient has had an EGFR within last 3 months

* A raised bilirubin alone can be a normal finding in a patient with Gilbert’s syndrome

Day 28
Patient seen in clinic, informed of diagnosis, treatment options discussed and plans made.

Day 7
Radiology book Ultrasound Scan within seven days on to a Consultant List
Patients contact details including preferred telephone number are confirmed
Consultant will inform patient of findings and next steps

Day 10
Ultrason reported same day and copy on ICE for review by GP. ELHT are responsible for patient communication and management. Further appointment booked for the following before leaving X-ray Department
• Mass, multiple lesions in liver CT to be arranged
• No gallstones and biliary dilatation triphasic CT to be booked
• Gallstones with biliary dilatation MRCP to be arranged

Day 14
Radiologist sends copy of report to HPB MDT via MDT co-ordinator
Report to GP via ICE system

Day 21
HPB MDT initiates appropriate next step & telephoned with patient within 24 hours to book clinic within 1 week
G.P. informed via letter within three days.

Day 28
Patient seen in clinic, informed of diagnosis, treatment options discussed and plans made.

Appendix A: Proposal for referrals for patients with jaundice

Day 0
Patients present at GP with jaundice
GP checks Blood – if raised bilirubin* and abnormal LFT’s refer to Radiology for Ultrasound Scan Ensure patient has had an EGFR within last 3 months

* A raised bilirubin alone can be a normal finding in a patient with Gilbert’s syndrome

Day 28
Patient seen in clinic, informed of diagnosis, treatment options discussed and plans made.

December 2014
Appendix B: Straight to Test Lung Pathway

1. **GP Requests CXR**
   - **CXR abnormal**
     - CT scan requested by automatic Radiology trigger
       - CT scan suspicious of cancer
         - Radiology contact Cancer Hub
           - Cancer Hub contacts GP for 2ww referral or notification referral not clinically appropriate
             - GP contacts patient and sends referral
   - **CXR normal**
     - Result back to GP

2. If referral not received in 2 working days, Cancer Hub to ring GP surgery to remind
   - If referral not received by GP within 2 working days, (ie total 4 working days) Cancer Hub to contact Lead Cancer Manager/ADO for escalation
     - Cancer Hub to raise
   - Result back to GP

January 2016
Appendix C: Lung Suspected Cancer Referral Form

**LUNG SUSPECTED CANCER REFERRAL FORM**

Date of GP decision to refer: No. of pages sent:

IF NHS E-REFERRAL IS UNAVAILABLE, COMPLETE FORM AND EMAIL TO THE REFERRAL TEAM WITHIN 24 HOURS.

If your patient does not meet NICE suspected cancer referral criteria, but you feel they warrant further investigation, please disclose full details in your referral letter.

**PATIENT DETAILS – Must provide current telephone number**

<table>
<thead>
<tr>
<th>Last name:</th>
<th>First name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender:</td>
<td>DOB:</td>
</tr>
<tr>
<td>NHS No:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
</tbody>
</table>

Telephone (Day):

Telephone (Evening):

Mobile No.:

Patient agrees to telephone message being left? Y N

Transport required? Y

Email: Y

Interpreter required? Y

Language/Hearing: Y

Learning difficulties? Y

Mental capacity assessment required? Y

Known safeguarding concerns? Y

Mobility requirements (unable climb on/off bed)? Y

**It is mandatory to arrange an urgent CXR before referral**

- Pleural effusion (STOP: refer on fast-track to pleural service)
- Normal
- Suspicious (inc. slowly resolving consolidation)

**SYMPTOMS & CLINICAL EXAMINATIONS** (usually ≥40 yrs)

- Stridor or Superior Vena Cava Obstruction: medical emergency*

| Chest X-ray suspicious of lung cancer/mesothelioma [All ages] |
| Unexplained haemoptysis |
| Persistent or recurrent chest infection |
| Chest signs consistent with lung cancer |
| Chest signs of pleural disease [2015] |
| Finger clubbing |
| Persistent cervical lymphadenopathy |
| Supraclavicular lymphadenopathy |
| Thrombocytosis [2015] |
| 2 of the following; OR |
| 1 if EVER: |
| Cough |
| Fatigue |
| Shortness of breath |
| Dysphasia |
| Wheeze |
| Chest/shoulder pain |
| Hoarseness |
| Unexplained loss of appetite [2015] |
| Unexplained weight loss |
| Other primary cancer (specify): |

Please attach a Patient Summary including:

- Referral letter (if applicable)
- Investigation results
- PMH
- Up-to-date medications list and indications

WHO PATIENT PERFORMANCE STATUS KEY

| 0 | Fully active, able to carry on all pre-disease performance without restriction |
| 1 | Restricted in physically strenuous activity but ambulatory and able to carry out light/sedentary work, e.g. house/office work. |
| 2 | Ambulatory and capable of self-care, but unable to carry out work activities. Up and active > 50% of waking hours. |
| 3 | Capable of only limited self-care. Confined to bed or chair >50% of waking hours. |
| 4 | Completely disabled. Cannot carry out any self-care. Totally confined to bed or chair. |

**GP DETAILS**

| GP name: |
| Practice Code: |
| Address: |
| Tel: |
| Fax: |
| Practice email: |

**INVESTIGATIONS REQUIRED TO SUPPORT REFERRAL**

Most patients will go straight to diagnostic test. The following tests are essential:

- FBC
- LFT
- U&E
- Clotting
- Glucose
- CRP
- eGFR
- Creatinine
- Bone profile

**PATIENT MEDICAL HISTORY**

Existing conditions & risk factors (inc. smoking status):

Current medication (attach list & indications):

- Allergies Y
- Anticoagulants/Antiplatelets Y
- Immunosuppressants Y
- Diabetic Y

WHO Patient Performance status (see below for key)

- 0
- 1
- 2
- 3
- 4

**ADDITIONAL INFORMATION**

DISCUSSIONS WITH PATIENT PRIOR TO REFERRAL

- Cancer needs to be excluded
- Patient given referral information leaflet
- Date(s) unavailable next 14 days:
Top tips for GPs: Implementing the NG12 NICE Guidelines for Suspected Cancer: recognition and referral

Appendix D: Lower GI Urgent Suspected Cancer Referral Form (Page 1)

LOWER GI URGENT SUSPECTED CANCER REFERRAL FORM
Date of GP decision to refer: / /20  No. of pages faxed:

IF CHOOSE & BOOK IS UNAVAILABLE, COMPLETE FORM AND FAX TO URGENT REFERRAL TEAM WITHIN 24 HRS.
NOTE: This form is NOT for use for patients aged < 16 years.

PATIENT DETAILS – Patient must provide a current telephone number they can be contacted at between 08:00 - 17:00.
Last name:  First name:
Gender:  M □  F □  DOB:  / /
BMI (assists diagnostics):
NHS No:
Address:
Email:
Telephone (Day):
Telephone (Evening):
Mobile No.:
Patient agrees to telephone message being left?  Y □  N □  Transport required?  Y □

Language/Hearing:  Interpreter required?  Y □
Learning difficulties?  Y □
Mental capacity assessment required?  Y □
Known safeguarding concerns?  Y □
Mobility requirements (unable climb on/off bed)?  Y □

SYMPTOMS & CLINICAL EXAMINATIONS
☐ IF ≥ 60 yrs and IRON-DEFICIENCY anaemia
   (≤11g men, ≤10g non-menstruating women)
   MUST CONDUCT INVESTIGATIONS IN SUPPORT OF REFERRAL
☐ Rectal mass upon examination [2015]
☐ Right sided abdominal mass [2015]
☐ Occult blood in faeces
☐ IF ≥ 40 yrs WITH rectal bleeding AND change in bowel habit
☐ IF ≥ 40 yrs AND abdominal pain AND unexplained weight loss
☐ IF <50 AND rectal bleeding AND any:
   ☐ Abdominal pain  ☐ Change in bowel habit
   ☐ Unexplained weight loss  ☐ Iron-deficiency anaemia [2015]
☐ IF ≥ 50 yrs AND unexplained rectal bleeding
☐ IF ≥ 60 yrs AND changes in bowel habit
☐ IF ≥ 60 yrs AND unexplained anal mass/ulceration [2015]

NB: Constipation alone is not sufficient for 2WW referral

ADDITIONAL INFORMATION
☐ Other primary cancer
   Please specify:

GP DETAILS
GP name and initials:
Practice Code:
Address:
TEL:
FAX:
Practice email:

INVESTIGATIONS IN SUPPORT OF REFERRAL
Most patients will be sent straight to diagnostics. Please indicate that the following tests have been carried out to support this referral:

☐ FBC  ☐ Ferritin  ☐ eGFR  ☐ S. Creatine
Other:
☐ Faecal occult blood test  ☐ Coeliac testing

PATIENT MEDICAL HISTORY
Existing conditions and risk factors:
Had colonoscopy in last 3 years?  Y □  N □

Current medication:
☐ Anticoagulants/Antiplatelets  Y □
☐ Immunosuppressants  Y □
☐ Diabetic  Y □

Patient Performance status
☐ 0  ☐ 1  ☐ 2  ☐ 3  ☐ 4
See below for key

DISCUSSIONS WITH PATIENT PRIOR TO REFERRAL
Cancer needs to be excluded  □
Patient given urgent referral information leaflet  □
Date(s) unavailable next 14 days:

Please attach a Patient Summary including:
☐ Referral letter (if applicable)  ☐ Investigation results  ☐ PMH  ☐ Up-to-date medications list and indications

If your patient does not meet 2WW criteria, but you feel they warrant further investigation, please disclose full details in your referral letter.

PERFORMANCE STATUS KEY
0  Fully active, able to carry on all pre-disease performance without restriction
1  Restricted in physically strenuous activity but ambulatory and able to carry out light/sedentary work, e.g. house or office work.
2  Ambulatory and capable of self-care, but unable to carry out work activities. Up and active > 50% of waking hours.
3  Capable of only limited self-care. Confined to bed or chair >50% of waking hours.
4  Completely disabled. Cannot care out any self-care. Totally confined to bed or chair.

FOR FURTHER GUIDANCE ON LOW RISK SYMPTOMS & HOSPITAL CONTACT DETAILS, SEE REVERSE OF THIS FORM.
Appendix D: Lower GI Urgent Suspected Cancer Referral Form (Page 2)

<table>
<thead>
<tr>
<th>ALL AGES</th>
<th>≥ 40 YEARS</th>
<th>&lt; 50 YEARS</th>
<th>≥ 50 YEARS</th>
<th>&lt; 60 YEARS</th>
<th>≥ 60 YEARS</th>
</tr>
</thead>
</table>

WITHOUT rectal bleeding

- Abdominal pain OR - Weight loss

AND

- change in bowel habit OR - iron-deficiency anaemia [new 2015]

Anaemia EVEN in absence of iron-deficiency [new 2015]

Positive result ONLY

Primary care: Test for occult blood in faeces

URGENT REFERRAL WITHIN 14 DAYS

<table>
<thead>
<tr>
<th>Anglia</th>
<th>Beds &amp; Herts</th>
<th>Essex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addenbrookes</td>
<td>East &amp; North Herts</td>
<td>Basildon &amp; Thurrock</td>
</tr>
<tr>
<td>FAX: 01223 217927</td>
<td>FAX: 01438 284503</td>
<td>FAX: 01268 598066 <a href="mailto:cancer.2wwreferrals@btuh.nhs.uk">cancer.2wwreferrals@btuh.nhs.uk</a></td>
</tr>
<tr>
<td>TEL: 01223 217923</td>
<td>If you have not received acknowledgement within 48hrs (Mon-Fri) contact the 2WW supervisor on 01438 285206</td>
<td></td>
</tr>
<tr>
<td>Bedford Hospital</td>
<td></td>
<td>Colchester Hospital University FT <a href="mailto:twoweek.waitreferral@nhs.net">twoweek.waitreferral@nhs.net</a></td>
</tr>
<tr>
<td>FAX: 01234 792133</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hinchingbrooke</td>
<td>Luton &amp; Dunstable</td>
<td>Mid Essex Hospitals FT</td>
</tr>
<tr>
<td>TEL: 01480 847557</td>
<td>FAX: 01582 497910</td>
<td>FAX: 012455 16751</td>
</tr>
<tr>
<td>FAX: 01480 416312</td>
<td>FAX: 01582 497911</td>
<td></td>
</tr>
<tr>
<td>Ipswich Hospital</td>
<td>QEH, King’s Lynn</td>
<td>Southend University Hospital FT</td>
</tr>
<tr>
<td>FAX: 01473 704120</td>
<td>FAX: 01493 453325</td>
<td>FAX: 01702 508174</td>
</tr>
<tr>
<td>James Paget</td>
<td>FAX: 01553 613473</td>
<td></td>
</tr>
<tr>
<td>FAX: 01493 453325</td>
<td></td>
<td></td>
</tr>
<tr>
<td>QEH, King’s Lynn</td>
<td>Norfolk &amp; Norwich</td>
<td></td>
</tr>
<tr>
<td>FAX: 01493 453325</td>
<td>FAX: 01603 286876</td>
<td></td>
</tr>
<tr>
<td>FAX: 01553 613473</td>
<td>West Herts Hospitals</td>
<td>West Herts Hospitals</td>
</tr>
<tr>
<td>FAX: 01702 508174</td>
<td>FAX: 01727 897492</td>
<td>FAX: 01702 508174</td>
</tr>
<tr>
<td>Peterborough &amp; Stamford</td>
<td>Peterborough &amp; Stamford</td>
<td></td>
</tr>
<tr>
<td>FAX: 01733 678562</td>
<td>FAX: 01603 286876</td>
<td></td>
</tr>
<tr>
<td><a href="mailto:2wwreferrals@pbh-tr.nhs.uk">2wwreferrals@pbh-tr.nhs.uk</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Suffolk Hospital</td>
<td>West Suffolk Hospital</td>
<td></td>
</tr>
<tr>
<td><a href="mailto:wsh-tr.RapidAccess@nhs.net">wsh-tr.RapidAccess@nhs.net</a></td>
<td><a href="mailto:wsh-tr.RapidAccess@nhs.net">wsh-tr.RapidAccess@nhs.net</a></td>
<td></td>
</tr>
</tbody>
</table>
Appendix E: Brain & CNS Suspected Cancer Referral Form (Page 1)

<table>
<thead>
<tr>
<th>BRAIN &amp; CNS SUSPECTED CANCER REFERRAL FORM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of GP decision to refer: No. of pages sent:</td>
</tr>
</tbody>
</table>

IF NHS E-REFERRAL IS UNAVAILABLE, COMPLETE FORM AND EMAIL TO THE REFERRAL TEAM WITHIN 24 HOURS

NOTE: This form is NOT for use for patients aged < 16 years.

FOR GUIDANCE ON SYMPTOMS & URGENT REFERRALS: SEE REVERSE OF THIS FORM.

<table>
<thead>
<tr>
<th>PATIENTDETAILS – Must provide current telephone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last name: First name:</td>
</tr>
<tr>
<td>Gender: DOB:</td>
</tr>
<tr>
<td>NHS No: Address:</td>
</tr>
<tr>
<td>Telephone (Day): Telephone (Evening):</td>
</tr>
<tr>
<td>Mobile No.:</td>
</tr>
<tr>
<td>Patient agrees to telephone message being left? Y N</td>
</tr>
<tr>
<td>Transport required? Y</td>
</tr>
<tr>
<td>Email:</td>
</tr>
<tr>
<td>Interpreter required? Y Language/Hearing:</td>
</tr>
<tr>
<td>Learning difficulties? Y</td>
</tr>
<tr>
<td>Mental capacity assessment required? Y</td>
</tr>
<tr>
<td>Known safeguarding concerns? Y</td>
</tr>
<tr>
<td>Mobility requirements (unable climb on/off bed)? Y</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MALIGNANCY SUSPECTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brain tumour Previous cancer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SYMPTOMS &amp; CLINICAL EXAMINATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>IF &lt; 25 yrs WITH newly abnormal cerebellar or other central neurological function, call consultant direct to request an urgent appointment WITHIN 48 hours AND complete this form [2015].</td>
</tr>
</tbody>
</table>

Symptoms of CNS disease
- Progressive neurological deficit
- Cranial nerve palsy
- New onset seizures
- Recent behavioural change

Recent, first presentation of headache with features that could suggest raised intracranial pressure
- Worsened by lying/coughing
- Nausea/vomiting
- Double vision
- Intermittent drowsiness
- Focal neurological symptoms
- Recent behavioural change

Examination findings
- Impaired higher mental functions. That is: Alert/ oriented/ attentive/ forgetful **delete as appropriate**
- Facial weakness
- Extraocular muscular palsy
- Unilateral deafness
- Hemisensory loss
- Dysphasia
- Limbs – Ataxia
- Hemiparesis
- Cranial nerves – Papilloedema
- Other neuro examination
- Other primary cancer
- Please specify:

**Suspected metastatic spinal cord compression: refer as a medical emergency**

Please attach a Patient Summary including:
- Referral letter (if applicable)
- Investigation results
- PMH
- Up-to-date medications list and indications

If your patient does not meet NICE suspected cancer referral criteria, but you feel they warrant further investigation, please disclose full details in your referral letter.

<table>
<thead>
<tr>
<th>GP DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP name:</td>
</tr>
<tr>
<td>Practice Code:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Tel:</td>
</tr>
<tr>
<td>Fax:</td>
</tr>
<tr>
<td>Practice email:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INVESTIGATIONS IN SUPPORT OF REFERRAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where MRI or CT scan was requested before referral, please indicate result and attaches copies of report(s) if available.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PATIENT MEDICAL HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing conditions &amp; Risk factors (inc smoking status):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current medication (attach list and indications):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
</tr>
<tr>
<td>Anticoagulants/Antiplatelets</td>
</tr>
<tr>
<td>Immunosuppressants</td>
</tr>
<tr>
<td>Diabetic</td>
</tr>
</tbody>
</table>

WHO Patient Performance status (see reverse for key)
- 0
- 1
- 2
- 3
- 4

<table>
<thead>
<tr>
<th>ADDITIONAL INFORMATION</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>DISCUSSIONS WITH PATIENT PRIOR TO REFERRAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer needs to be excluded Y</td>
</tr>
<tr>
<td>Patient given referral information leaflet Y</td>
</tr>
<tr>
<td>Date(s) unavailable next 14 days:</td>
</tr>
</tbody>
</table>

61
Appendix E: Brain & CNS Suspected Cancer Referral Form (Page 2)

WHO PATIENT PERFORMANCE STATUS KEY

<table>
<thead>
<tr>
<th></th>
<th>Status Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Fully active, able to carry on all pre-disease performance without restriction</td>
</tr>
<tr>
<td>1</td>
<td>Restricted in physically strenuous activity but ambulatory and able to carry out light/sedentary work, e.g. house or office work.</td>
</tr>
<tr>
<td>2</td>
<td>Ambulatory and capable of self-care, but unable to carry out work activities. Up and active &gt; 50% of waking hours.</td>
</tr>
<tr>
<td>3</td>
<td>Capable of only limited self-care. Confined to bed or chair &gt;50% of waking hours.</td>
</tr>
<tr>
<td>4</td>
<td>Completely disabled. Cannot carry out any self-care. Totally confined to bed or chair.</td>
</tr>
</tbody>
</table>

2005 NICE Guidance

- **Signs or symptoms that may cause concern:**
  - progressive neurological deficit;
  - headaches;
  - mental changes;
  - cranial nerve palsy;
  - Headaches of recent onset accompanied by features suggestive of raised intracranial pressure:
    - vomiting;
    - drowsiness;
  - posture-related headache;
  - pulse-synchronous tinnitus; or
  - other focal or non-focal neurological symptoms, such as blackout or change in personality or memory.

- **Consider immediate referral – first calling the consultant – with patients with rapid progression of:**
  - sub-acute focal neurological deficit;
  - unexplained cognitive impairment,
  - behavioural disturbance or slowness (or a combination of these); or
  - personality changes confirmed by a witness and for which there is no reasonable explanation even in the absence of the other symptoms or signs of a brain tumour.

- **A ‘normal’ scan**
  - A normal investigation does not preclude the need for ongoing follow up, monitoring and further investigation. A seemingly ‘normal’ MRI may give false reassurance in pts who have neurological pathology that MRI is unable to detect.
  - Approximately 10% of patients may be unsuitable for, or unable to tolerate an MRI brain scan, e.g. patients with pacemakers in-situ or those with severe claustrophobia. In these patients a CT scan may be more appropriate.

- **Incidental findings**
  - A small percentage of MRI scans may yield abnormalities in otherwise healthy individuals. This may impact on these patients in a number of ways including further investigation and the potential impact on health insurance premiums. As incidental findings are not an infrequent result of MRI scanning, patients should have prior counselling and information to make them aware of the potential for such findings as a consequence of their investigation. *(Macmillan Rapid Referral Guidelines, 2015)*

<table>
<thead>
<tr>
<th>Anglia</th>
<th>Beds &amp; Herts</th>
<th>Essex</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Addenbrookes</strong></td>
<td><strong>East &amp; North Herts</strong></td>
<td>Basildon &amp; Thurrock</td>
</tr>
<tr>
<td><a href="mailto:Add-tr.nhsoutpatientreferrals@nhs.net">Add-tr.nhsoutpatientreferrals@nhs.net</a></td>
<td>FAX: (no longer advised)</td>
<td><a href="mailto:btu-tr.cancer2wreferrals@nhs.net">btu-tr.cancer2wreferrals@nhs.net</a></td>
</tr>
<tr>
<td><strong>Bedford Hospital</strong></td>
<td></td>
<td>Colchester Hospital University FT</td>
</tr>
<tr>
<td><a href="mailto:bhn-tr.registration@nhs.net">bhn-tr.registration@nhs.net</a></td>
<td>ON-CALL (switchboard): 01234 355122</td>
<td><a href="mailto:twoweek.waitreferral@nhs.net">twoweek.waitreferral@nhs.net</a></td>
</tr>
<tr>
<td><strong>Ipswich Hospital</strong></td>
<td></td>
<td>Mid Essex Hospitals FT</td>
</tr>
<tr>
<td><a href="mailto:ihn-tr.2WWreferrals@nhs.net">ihn-tr.2WWreferrals@nhs.net</a></td>
<td></td>
<td>FAX: (no longer advised)</td>
</tr>
<tr>
<td><strong>James Paget</strong></td>
<td>Luton &amp; Dunstable</td>
<td>Southend University Hospital FT</td>
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<td>FAX: (no longer advised)</td>
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<td>FAX: (no longer advised)</td>
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<tr>
<td><strong>Norfolk &amp; Norwich</strong></td>
<td>West Herts Hospitals</td>
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<td><a href="mailto:nnu-tr.2ww@nhs.net">nnu-tr.2ww@nhs.net</a></td>
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<tr>
<td><strong>Peterborough &amp; Stamford</strong></td>
<td></td>
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</tr>
<tr>
<td><a href="mailto:pen-tr.2WWreferralsphb@nhs.net">pen-tr.2WWreferralsphb@nhs.net</a></td>
<td></td>
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<tr>
<td><strong>West Suffolk Hospital</strong></td>
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<td><a href="mailto:wsh-tr.RapidAccess@nhs.net">wsh-tr.RapidAccess@nhs.net</a></td>
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</tr>
</tbody>
</table>
## Appendix F: Breast Suspected Cancer Referral Form (inc. Exhibited Symptoms) (Page 1)

### BREAST SUSPECTED CANCER REFERRAL FORM (INC. EXHIBITED SYMPTOMS)

<table>
<thead>
<tr>
<th>Date of GP decision to refer:</th>
<th>No. of pages sent:</th>
</tr>
</thead>
</table>

**IF NHS E-REFERRAL IS UNAVAILABLE, COMPLETE FORM AND EMAIL TO THE REFERRAL TEAM WITHIN 24 HOURS.**

**NOTE: This form is NOT for use for patients aged < 16 years.**

### PATIENT DETAILS – Must provide current telephone number

- **Last name:**
- **First name:**
- **Gender:**
- **DOB:**
- **BMI (assists diagnostics):**
- **NHS No.:**
- **Address:**
- **Telephone (Day):**
- **Telephone (Evening):**
- **Mobile No.:**
  - **Patient agrees to telephone message being left?**
    - Y
    - N
  - **Transport required?**
    - Y
  - **Email:**
  - **Interpreter required?**
    - Y
  - **Language/Hearing:**
  - **Learning difficulties?**
    - Y
  - **Mental capacity assessment required?**
    - Y
  - **Known safeguarding concerns?**
    - Y
  - **Mobility requirements (unable climb on/off bed)?**
    - Y

### GP DETAILS

- **GP name:**
- **Practice Code:**
- **Address:**
- **Tel:**
- **Fax:**
- **Practice email:**

### INVESTIGATIONS IN SUPPORT OF REFERRAL

- **Please describe lump**
- **Size (cm):**
- **Transport required?**
  - Y
  - N
- **Interpreter required?**
  - Y
- **Language/Hearing:**
- **Learning difficulties?**
  - Y
- **Mobility requirements (unable climb on/off bed)?**
  - Y

### TYPE OF 2WW REFERRAL

- **Suspected cancer**
- **Exhibited breast symptoms**

### HORMONAL STATUS

- **N/A: Patient is male**
- **Premenopausal**
- **Postmenopausal**
- **On HRT**
  - **Type of HRT:**
- **Hormonal contraceptive**
  - **Please specify:**

### SYMPTOMS (SUSPECTED CANCER REFERRAL)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Left</th>
<th>Right</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unexplained lump with or without pain (&gt;30 yrs)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Focal or diffuse nodularity</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Ulceration</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Abscesses/infection NOT responding to Antibiotics</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>IF ≥50 yrs with one nipple inversion/retraction</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>IF ≥50 yrs with one nipple discharge (blood-stained)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>IF ≥50 yrs with one other nipple change</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Skin changes: dimpling/tethering</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Skin changes such as eczema/rash</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>which is NOT responding to topical treatment</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>IF ≥30 yrs WITH unexplained lump in axilla [2015]</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>IF &lt; 30 yrs WITH lump persisting after period AND strong family h/o breast cancer</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>MEN: IF &gt;40 yrs AND unilateral firm subareolar mass NOT thought to be skin lesion or lipoma</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

### PLEASE INDICATE SITE OF CONCERN

(Use left/right above for nipple symptoms)

Please attach a Patient Summary including:

- Referral letter (if applicable)
- Investigation results
- PMH
- Up-to-date medications list and indications

**If your patient does not meet NICE suspected cancer referral criteria, but you feel they warrant further investigation, please disclose full details in your referral letter.**
Appendix F: Breast Suspected Cancer Referral Form (inc. Exhibited Symptoms) (Page 2)

WHO PATIENT PERFORMANCE STATUS KEY

<table>
<thead>
<tr>
<th>Status</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Fully active, able to carry on all pre-disease performance without restriction</td>
</tr>
<tr>
<td>1</td>
<td>Restricted in physically strenuous activity but ambulatory and able to carry out light/sedentary work, e.g. house or office work.</td>
</tr>
<tr>
<td>2</td>
<td>Ambulatory and capable of self-care, but unable to carry out work activities. Up and active &gt; 50% of waking hours.</td>
</tr>
<tr>
<td>3</td>
<td>Capable of only limited self-care. Confined to bed or chair &gt;50% of waking hours.</td>
</tr>
<tr>
<td>4</td>
<td>Completely disabled. Cannot carry out any self-care. Totally confined to bed or chair.</td>
</tr>
</tbody>
</table>

PATIENT PRESENTS WITH

Unexplained lump with or without pain

Any of the following:
- unilateral nipple discharge, retraction or other change
- Skin or nipple change which doesn't respond to topical treatment/ suggests cancer
- Previously benign breast symptoms
- Previous breast cancer, plus lump or suspicious symptoms

NOTES: 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. [2005]

Unexplained lump in the axilla [2015]

Lump persisting after period AND strong family h/o breast cancer

IF MALE AND > 40 yrs WITH unilateral firm subareolar mass, with or without nipple distortion or associated skin changes (not thought to be skin lesion or lipoma).

UNDER 30 YEARS

Unexplained lump with or without pain

CONSIDER NON 2WW REFERRAL

SUSPECTED CANCER REFERRAL WITHIN 14 DAYS

<table>
<thead>
<tr>
<th>Anglia</th>
<th>Beds &amp; Herts</th>
<th>Essex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addenbrookes</td>
<td>East &amp; North Herts</td>
<td>Basildon &amp; Thurrock</td>
</tr>
<tr>
<td><a href="mailto:Add-tr.nhsoutpatientreferrals@nhs.net">Add-tr.nhsoutpatientreferrals@nhs.net</a></td>
<td>FAX: (no longer advised)</td>
<td><a href="mailto:btu-tr.cancer2wwreferrals@nhs.net">btu-tr.cancer2wwreferrals@nhs.net</a></td>
</tr>
<tr>
<td>Bedford Hospital</td>
<td></td>
<td>Colchester Hospital University FT</td>
</tr>
<tr>
<td><a href="mailto:bhn-tr.registration@nhs.net">bhn-tr.registration@nhs.net</a></td>
<td></td>
<td><a href="mailto:twoweek.waitreferral@nhs.net">twoweek.waitreferral@nhs.net</a></td>
</tr>
<tr>
<td>Hinchingbrooke</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TEL: 01480 847557</td>
<td></td>
<td></td>
</tr>
<tr>
<td><a href="mailto:hch-trCancerMDT@nhs.net">hch-trCancerMDT@nhs.net</a></td>
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<tr>
<td><a href="mailto:nnu-tr.2ww@nhs.net">nnu-tr.2ww@nhs.net</a></td>
<td>TEL: 01727 897199</td>
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<td><a href="mailto:Wherts-tr.twowreferrals@nhs.net">Wherts-tr.twowreferrals@nhs.net</a></td>
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<td>West Suffolk Hospital</td>
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<tr>
<td><a href="mailto:wsh-tr.RapidAccess@nhs.net">wsh-tr.RapidAccess@nhs.net</a></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix G: Suspected Gynaecology Cancer 2 Week Wait Referral Form (Page 1)

Suspected gynaecology cancer 2 week wait referral

<table>
<thead>
<tr>
<th>Date of decision to refer</th>
<th>Date referral received at Trust</th>
</tr>
</thead>
</table>

**Patient Details**
- Surname: 
- First Name: 
- Title: 
- DOB: / / 
- NHS Number: 
- Transport required: 
- Ethnicity: 
- Language: 
- Interpreter required: 
- Patient Address: 
- Postcode: 
- Contact numbers: 
- Home: 
- Mobile: 
- Email: 
- Usual GP Name: 

**Practice Details**
- Practice Name: 
- Practice Address: 
- Practice Code: 
- Direct line to the practice (Bypass): 
- Main: 
- Fax: 
- Email: 
- Referring Clinician: 

**SPECIFIC 2WW INFORMATION**

**Ovarian cancer**
- ☐ Physical examination identifies ascites &/or a pelvic or abdominal mass (which is not obviously uterine fibroids)
- ☐ Ultrasound raises suspicion of ovarian cancer
  Please arrange CA 125 so results are available when the patient is seen.

**Endometrial cancer**
- ☐ Post-menopausal bleeding (Unexplained vaginal bleeding more than 12 months after last menstrual period).
- ☐ If ultrasound raises suspicion of cancer
- ☐ Irregular bleeding that persists 6 weeks after stopping HRT. (If patient wishes to continue HRT, refer for USS)
- ☐ Bleeding on tamoxifen after significant amenorrhea.

**Cervical**
- ☐ If cervix appears on examination to be consistent with cervical cancer (destructive lesion or obvious growth on or replacing the cervix)

**Vulval**
- ☐ If unexplained vulval lump, ulceration or bleeding

**Vaginal**
- ☐ If unexplained palpable mass in or at the entrance to the vagina

**Investigations**
Please ensure the following recent blood results are available (less than 6 weeks old):
- ☐ FBC
- ☐ U&E

Anticoagulation and / or antiplatelet medication – please state indication and medication taken:
Please provide details and the latest INR if applicable:

**Recommendations (if not suspected cancer referral)**

**Arrange URGENT CA125, especially if the patient is over 50 years old for any of the symptoms following persistent or frequent episodes for over 12 months**
- Persistent abdominal distension
- Increase urinary urgency and / or frequency
- New onset symptoms suggestive of IBS
- Early satiety and / or loss of appetite
- Pelvic or abdominal pain

**Consider CA125 at any age for:**
- Unexplained weight loss
- Changes in bowel habit
- Fatigue

**Arrange URGENT Ultrasound for:**

<table>
<thead>
<tr>
<th>Any age</th>
<th>CA125&lt;35iu/ml</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 55 yrs</td>
<td>Unexplained PV discharge and any of:</td>
</tr>
<tr>
<td></td>
<td>First presentation</td>
</tr>
<tr>
<td></td>
<td>Thrombocytosis</td>
</tr>
<tr>
<td></td>
<td>Haematuria</td>
</tr>
<tr>
<td></td>
<td>Low HB</td>
</tr>
<tr>
<td></td>
<td>Thrombocytosis</td>
</tr>
<tr>
<td></td>
<td>High blood glucose</td>
</tr>
</tbody>
</table>
Appendix G: Suspected Gynaecology Cancer 2 Week Wait Referral Form (Page 2)

Patient name __________________ Date of birth ________________ NHS number _____________

Further information:
(Clarification &/or further information provided will help ensure patients receive the most appropriate first line management; please include the following: significant & relevant medical history, including use of HRT, co-morbidities, current medication and allergies)

Please indicate if a hoist or other mobility aid is required.
(If available please ask patient to bring their own sling to the appointment.)

WHO Performance Status (please circle)

- 0 Fully active
- 1 Restricted in physically strenuous activity but ambulatory and able to carry out light work
- 2 Ambulatory and capable of self-care, unable to carry out work activities, up & about 50% of waking hours
- 3 Capable of only limited self-care, confined to bed/Chair 50% of waking hours
- 4 No self-care, confined to bed/Chair 100%

☐ This case has been discussed with the secondary care clinical team, please specify with whom and when:

I confirm that I have:
☐ discussed the possibility that the diagnosis may be cancer
☐ discussed the 2 week wait (2WW) process with the patient
☐ provided the patient with the 2WW referral leaflet
☐ told the patient the appointment will be within the next two weeks, and attendance is advised
Please note any dates the patient is NOT available for an appointment in the next 2 weeks.

Fast track referral Information:

An administration team at the trust receives this referral. Based on the information you provide, some patients will go straight to diagnostics before they see a member of the clinical team. Providing information such as WHO performance and renal function will help decide if an endoscopy or further imaging could be tolerated or possible.

If your patient cannot attend in the next two weeks, please consider the timing of the referral, as the trust is obliged to offer an appointment within two weeks.

Useful websites: e-CDS  Genetics and Family History  Q-Cancer  RAT

<table>
<thead>
<tr>
<th>Trust</th>
<th>Phone</th>
<th>FAX</th>
<th>Electronic</th>
</tr>
</thead>
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<tr>
<td>Basingstoke</td>
<td>01256 486798</td>
<td>01256 313430</td>
<td>No</td>
</tr>
<tr>
<td>Bournemouth</td>
<td>01202 704741</td>
<td>01202 704470</td>
<td>E – Referral</td>
</tr>
<tr>
<td>Chichester</td>
<td>01903205111 ext 84997</td>
<td>01903 285098</td>
<td><a href="mailto:Cancer.appointments@nhs.net">Cancer.appointments@nhs.net</a></td>
</tr>
<tr>
<td>Dorchester</td>
<td>01305 255849</td>
<td>01305 255646</td>
<td>E – Referral</td>
</tr>
<tr>
<td>Frimley</td>
<td>01276 526400</td>
<td>01276 604506</td>
<td>No</td>
</tr>
<tr>
<td>IoW</td>
<td>01983 534018</td>
<td>01983 552434</td>
<td>No</td>
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<tr>
<td>Poole</td>
<td>01202 442823</td>
<td>01202 442824</td>
<td>E- Referral</td>
</tr>
<tr>
<td>Portsmouth</td>
<td>023 9268 1700</td>
<td>023 9268 1701</td>
<td>No</td>
</tr>
<tr>
<td>Royal Surrey</td>
<td>No</td>
<td>01483 464848</td>
<td>No</td>
</tr>
<tr>
<td>Salisbury</td>
<td>01722 336262 ext 4235</td>
<td>No</td>
<td><a href="mailto:Shc-tr.salisbury-rapidreferralcentre@nhs.net">Shc-tr.salisbury-rapidreferralcentre@nhs.net</a></td>
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<tr>
<td>Southampton</td>
<td>02381 201019</td>
<td>No</td>
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<tr>
<td>Winchester</td>
<td>01962 825925</td>
<td>01962 825695</td>
<td>No</td>
</tr>
</tbody>
</table>

Referral forms developed February 2016 by Wessex Cancer Clinical Network
Cancer doesn’t just affect the people you support physically. It can affect everything – their relationships, finances and careers.

We want to work with you to help you provide the best support possible for people affected by cancer and their families. So as well as offering resources for your role, we can provide information to the people you support, so they know they’ll never have to face cancer alone.

Together, we can help make sure people affected by cancer get the support they need to feel more in control – from the moment they’re diagnosed, through treatment and beyond.

To find out more about all the ways we’re here for you and the people you support, visit macmillan.org.uk/primarycare