Practical perspectives on implementing the NICE Guideline
Suspected cancer: recognition and referral
NICE Guideline NG12, published in 2015, has been developed against a backdrop of increasing cancer incidence, and cancer survival figures in the UK that lag behind those of mainland Europe. These revised guidelines take a symptom-led approach designed to empower primary care to recognise and appropriately refer people with suspected cancer.

Key updates to the guidelines
The group were positive about the approach and the new inclusions to the guidelines.

- For the first time the recommendations have been organised by symptom rather than the site of suspected cancer, to better reflect how patients present in primary care. The inclusion of non-specific features of cancer is also an important evolution of the guidelines.
- There is a lowering of the threshold of risk of urgent cancer referral from 5% to 3%. This lower threshold is lowered further in two instances: for children and for those instances where good primary care tests are available and inexpensive.
- With the exception of smoking, individual risk factors have been removed from the guidelines. This is due to the higher positive predictive value of symptoms relative to patient risk factors. One member of the group did raise concern over this change.
- NG12 does not replace the clinician’s responsibility to exercise professional judgement. Should a GP suspect that a patient needs an urgent opinion, that decision should be acted upon, and local systems need to be in place to accommodate these referrals.

Key themes from the discussion
The new guideline stresses the responsibility of the GP to exercise their clinical judgement. The group felt that it was a great strength of NG12 that the importance of a GP exercising their clinical judgement is stressed. If a GP does not follow guidance, but has a good clinical reason for choosing a different path, then they can justify themselves. NG12 is guidance, not policy. The clinical judgement of clinicians who know their patients was considered to be highly reliable, if not quantifiable.

One example cited within the discussion related to the recommendations for colorectal cancer, where not everyone aged 50 years and over with rectal bleeding is recommended for referral.
The wording is specifically ‘unexplained rectal bleeding’, unequivocally placing the decision in the hands of the GP.

There was little concern on who should be referred under the new criteria. The greater concern was how to access direct diagnostics as they are set out in the recommendations, and specialist advice from secondary care.

Better engagement and communication between primary and secondary care is fundamental to the implementation of NG12. ‘Money is not the answer. We need a longer term vision within the NHS, and the interface between primary and secondary care has to significantly improve.’ – Shahnawaz Rushed

A number of the delegates expressed a view that GPs and consultants may lack appreciation of the parts of the cancer care process that do not fall within their area of the pathway. Engagement across both primary and secondary care, to come together and consider the implications of the guidelines on local cancer services is key to implementing them successfully. One of the practical examples raised as a way to improve shared understanding was shadowing exchanges, where a GP shadows a consultant for a half or whole day and then they reciprocate and share learnings with relevant colleagues.

Another example highlighted in the discussion was a local workshop where, once commissioners had set their outcomes targets, they stopped back to allow primary and secondary care and public health to work together to achieve these outcomes. Through a series of meetings to define pathways and update referral forms, a joint understanding of what was needed to align care pathways with the guidance was reached, as well as better ways to communicate to and manage expectations of their patients.

One of the challenges identified by some of the participants was around the current complexity and the time taken to access some secondary care services. One suggestion to improve communication was that a specialist nurse might be on hand to take calls from GPs unsure of whether or not to refer. This was reported here to have worked well in other specialties such as cardiology and neurology. Another was that a mobile number, direct line or e-mail might simply be added to referral forms and letters, with details of the best time to call and discuss next steps.

The regional variation in access to tests and diagnostics, and the people trained and qualified to conduct them, are major barriers to implementation of NG12, requiring close collaboration and strong commissioning of local services. ‘There is the problem of how one brings together commissioners and providers in a joined-up way, across more than just one CCG and one provider. It is possible that the suggestion that cancer alliances be formed to address this may be of help. NG12 implementation will be put on our agenda … bringing together senior leadership representation from those organisations should help us to address that more readily.’ – Matthew Hayes

There was a general concern from the group about lack of capacity in diagnostics services. One delegate shared their view that there is a lack of demand and capacity planning across more than individual CCGs and providers.

While it can be challenging to bring commissioners and providers together in a joined-up way, gathering these stakeholders together is a good start to evolving the pathway and implementing the new recommendations.

And there is no doubt that the guidance has been successful in sparking discussion between all the people who are involved in diagnosing cancer. It has brought together networks, cancer managers, GPs and clinicians from the community.

Conversations are needed to address regional variations in access to tests and diagnostics, but regional variation is only part of the problem. At heart is a resource issue – having enough people qualified to do the tests.

Thinking pan-region rather than for one hospital or CCG, capacity can often be found. Having an operational framework that identifies your gaps, and where you can utilise any additional capacity is key.

‘When there is so much variation between areas, careful attention must be paid to avoid losing the positivity and proactivity essential for implementation. But overall, the guidance has served to focus commissioners’ minds on diagnostics.’ – Shahnawaz Rushed

Commissioners have to be asking themselves what they need to be doing to be able to provide direct access to diagnostics, keeping in mind that savings will be forthcoming from a decrease in appointments for those whose problems are picked up earlier.

It was thought to be helpful if the NICE Quality Standards explicitly listed all diagnostic tests that should be directly accessible to GPs to ensure that they are universally commissioned.

There is an anticipated increase in referrals due to the lower threshold, in a system which is already under pressure. ‘The misunderstanding is that GPs are charged with reducing the number of referrals. What we are actually saying is that we need to increase the number of referrals that are of a quality for the right patients. From a commissioning point of view, we want to see an increase in the number of referrals.’ – Anant Sachdev

It was noted that there is a need to ensure the right people are getting through the system. One of the delegates highlighted that local capacity modelling had been undertaken and suggests that endoscopies may increase by up to 79% between 2013/14 and 2019/20 and this poses significant questions about the capacity to deliver on these recommendations.

One delegate spoke about how the volume of local referrals had been increasing year on year and that this needs to be actively managed to prevent overloading the system. There are capacity and resource issues not just in secondary care but across the whole pathway, including in primary care. It was felt to be important that we are careful to support patients to resolve their symptoms and are mindful of balance of risk and harm when advising patients.

Safety netting and engaging with patients to discuss the best course of action is key to managing patients in primary care. ‘The guidance supports the GP to safety-net, rather than refer. Establishing safety netting as an alternative to a low-risk investigation is an important part of how we are going to manage this implementation.’ – Amelia Randle
Safety netting is about supporting GPs not to overload the system with referrals for low-risk, possibly unnecessary investigations, and was considered to be an important part of how implementing NG12 is going to be achieved.

The alternative is a consistent reduction of referral thresholds, with more people being referred and feeling concerned about a possible cancer diagnosis, with as many as 97% of people having cancer ruled out. As such, we must be considerate of the support and education needed by the large number of people undergoing a suspected cancer referral.

The reference to safety netting in the guidance has also focused the minds of GPs. For example, a symptom, such as a mole, would not necessarily trigger a referral, but it is important to engage and reassure the patient as to why they need to come back and see if there is any change, and to understand the importance of attending these appointments.

Some would suggest booking in a review and to understand the importance of coming back and see if there is any change, to reassure the patient as to why they need to be referred, but it is important to engage and encourage direct access for some.

Patients can present with symptoms, which may be caused by many other common conditions. The lowering of the referral threshold is a positive step and, coupled with the national screening programme for asymptomatic patients, can positively impact patient outcomes.

When the guidelines were prepared, there was apparently not yet a convincing body of scientific evidence to support an evidence-based recommendation of faecal immunochemical tests (FIT), regardless of any cost considerations. Therefore, the recommendations clearly suggest testing for occult blood in the faeces, while not stipulating whether the test is to be FIT or FOBT. It was noted that this may cause difficulties in commissioning services.

One problem with faecal occult blood tests is the high risk of false negatives, which can provide patients and clinicians with unwarranted reassurance through a false negative result. There is also a risk of false positives providing patient anxiety due to the low specificity of FITB.

A number of delegates thought that the inclusion of non-site specific symptoms was beneficial and that there was awareness of unexplained weight and appetite loss. However, it was felt that there was less recognition of deep vein thrombosis as a non-site specific symptom requiring further assessment for additional symptoms or consideration of an urgent referral for suspected cancer.

Conclusion

Much progress has been made in identifying practical tips to enable those cultural, structural and operational changes that will be necessary for the timely and game-changing implementation of NG12.

The firmly held belief that primary and secondary care, working together, can make a difference in cancer mortality figures will underwrite its impact.

Focus on recommendations for colorectal cancer

Part of the discussion focused on the recommendations for suspected colorectal cancer.

‘If we are serious about making an impact on the health of the nation with respect to premature cancer mortality, colorectal cancer is very significantly up there.’ - Matthew Hayes

Key points from the discussion of NG12 with regard to colorectal cancer included:

- Refer people using a suspected cancer pathway referral for an appointment within 2 weeks for colorectal cancer for patients aged 40 years and over with unexplained weight loss and abdominal pain, or patients aged 50 years or over with unexplained rectal bleeding, or for patients aged 60 years and over with iron-deficiency anaemia or changes in their bowel habit.

- A referral should be considered for patients with a rectal or abdominal mass.

- A referral should be considered in aged 50 and over with rectal bleeding and any unexplained symptoms or findings including, abdominal pain, change in bowel habit, weight loss, or iron deficiency anaemia.

- Testing for occult blood in faeces should be offered for patients without rectal bleeding who are aged 50 years and over with unexplained abdominal pain or weight loss. Or are aged under 60 with changes in their bowel habit or iron deficiency anaemia. Or are aged 60 and over and have anaemia even in the absence of iron deficiency.

- GPs should consider other relevant investigations in patients presenting with symptoms other than rectal bleeding.

Last word

The new NICE suspected cancer referral guidance has huge potential for improving outcomes for cancer patients in England, Wales and Northern Ireland. The new guidance has lowered the risk threshold for referral, takes a symptom-led approach, and encourages direct access for some diagnostic tests. The intention is to contribute to a shift in the stage at which people are diagnosed, so that more patients are diagnosed at an early stage when treatment will be potentially curative.

There has been a steady increase in urgent referrals for suspected cancer over time. For some pathways there may be little impact of the NICE guidance beyond the existing trend. However, implementation of other recommendations will require additional service provision, or create above trend impact on demand. It is vital that primary and secondary care services are equipped and resourced to support implementation of the guidelines.

Tools and resources

- Watch videos of the delegates giving their thoughts on this topic www.pulsetoday.co.uk/NG12
- Complete the module on NICE implementation www.pulsetoday.co.uk/NG12
- Access the full NICE suspected cancer: recognition and referral guideline www.nice.org.uk/guidance/ng12
- Access updated NICE Summaries and resources www.nihr.org.uk/nice
- Get involved with the RCGP and CRUK Cascade events www.pulsetoday.co.uk/RCGP
- Access local support through Health Professional Engagement Facilitators www.hpf.org.uk
- CPD accredited resources www.doctors.net.uk/UC

www.cruk.org/RCGP