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NHS England

GP direct access to diagnostic services for people with symptoms not meeting the threshold for an urgent suspected cancer referral

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A number of organisations were consulted during the development of this guidance, including:

- The Royal College of Radiologists
- Society and The College of Radiographers

The following contributed to the development of this guidance:

- NICE clinical lead for Referral for suspected cancer guideline (NG12)
- National Clinical Director for Cancer
- National Specialty Advisor for Imaging
- Regional Radiology Leads
- Head of Imaging Transformation
- NHS England Primary Care Group
- NHS England Cancer Programme

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Introduction

Many GPs are currently able to refer patients straight to test for several imaging modalities, including ultrasound, X-ray, computerised tomography (CT), and magnetic resonance imaging (MRI). However, variability in testing capacity and access to a convenient mechanism for ordering a test directly has limited GPs' use of direct referral in some areas of the country.

NHS England is working to open Community Diagnostic Centres (CDCs) so that they provide up to 3 million tests within 2022-23 and up to 9 million per year by the end of 2025. By combining this increase in diagnostic capacity with existing diagnostic resources, we will ensure GPs have increased and swifter access to more diagnostic imaging tests.

We recognise that systems are facing workforce challenges. NHS England and Health Education England are working together to support systems to mitigate those challenges as far as possible by supporting opportunities to optimise the existing workforce now while also growing the workforce over time. We are providing funding to ensure that each CDC has the right workforce in place and we are supporting systems to make the most of CDCs and diagnostic networks as opportunities for upskilling and cross-boundary working. We are also working to ensure that GPs have digital tools to conveniently order appropriate diagnostic tests

at local testing centres and we are working to enhance digital connectivity across the NHS to enable results to flow more seamlessly.

A phased approach

The increase in use of direct access tests will be phased. Beginning in November 2022, our focus is on increasing the use of specific direct access tests for adults who have concerning symptoms, but **do not** meet the threshold for referral under the urgent suspected cancer diagnosis pathway. Currently over 20% of cancer diagnoses are made in people referred for investigation on non-urgent pathways[1] – often because their symptoms did not indicate a significant risk of malignancy.

Our aims in phase one are to reduce:

- the time it takes for adults who have concerning symptoms but do not meet the criteria for urgent referral to receive a cancer diagnosis
- the number of GP and specialist attendances before investigations are requested for these patients.

These aims support the implementation of the NHS Long Term Plan ambition for 75% of people with cancer to be diagnosed at an early stage (stage 1 or 2) by 2028 and the Elective Recovery target for 95% of patients needing a diagnostic test to receive it within 6 weeks by 2025.[2]

To measure progress against these aims, we have developed a set of data metrics to monitor progress and measure outcomes. Regular Diagnostics Data Hub collections will enable us to monitor rates of GP direct access uptake by ICS and region.

The second phase begins in 2023 and will support systems to make a wider range of direct access tests available.

About the guidance

This guidance provides advice on the use of direct access referrals to specific diagnostic tests where the threshold for referral under the urgent suspected cancer referral process is not met.

The guidance supports the first phase of delivery and is aimed at and of interest to healthcare professionals in primary care, secondary care and service commissioners. It builds on Direct Access to Diagnostic Tests for Cancer (2012)[3] and is not a clinical guideline.

It covers the following diagnostic tests, which all GPs should have access to as a minimum:

- X-ray
- CT chest
- CT abdomen and pelvis
- ultrasound abdomen and pelvis
- brain MRI.

It also details expectations around wait and turnaround times for direct access referrals made for this cohort.

[1] Routes to Diagnosis, 2018 - NHS Digital
[2] https://www.england.nhs.uk/coronavirus/publication/delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care/
[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216503/dh_133511.pdf

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Using the guidance

GPs should consider direct access tests where they consider an urgent referral to be required, but do not think an urgent suspected cancer referral is appropriate.

They should use their clinical judgement and consider a direct access test as part of a set of wider investigations that explore the common causes of presenting symptoms. This should include a full history and appropriate examination.

We recommend that this Guidance is viewed alongside the Clinical Decision Support (CDS) tool iRefer[4], which can help guide GPs to the most appropriate test, including any sequence of tests that may be required before a GP direct access referral.

We will allocate funding to providers throughout 2022/23 (and 2023/24 if required) to implement the iRefer-CDS system and make licences available to primary care. We will also provide support to ensure that all GP order comms systems are compatible with iRefer-CDS. This aims to ensure best practice in GP referrals for imaging tests, so that patients receive the most appropriate tests and diagnostic capacity is managed.

GPs can continue to use existing direct access workflow, but our expectation is that practices with compatible order comms systems will migrate to iRefer-CDS as soon as licences become available.

Clinical indications by imaging test

Detailed below are the symptoms that may warrant an urgent direct access referral to the tests being recommended in this guidance, to guide decision-making.

GPs should continue to use their clinical judgement to decide whether a direct access, routine or urgent cancer referral will deliver the best outcomes for their patients. In doing so they should also consider the sequence of tests needed to investigate the common causes of these symptoms, having conducted a full history and appropriate examination.

GPs should be mindful of health inequalities.

We recognise that diagnostic testing can have wider implications. Incidental findings can impact on the individual patient and healthcare resources. When considering referral of a patient for diagnostic testing GPs may wish to discuss the risks with the patient and are advised to consult iRefer-CDS.

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Symptoms that may warrant an urgent direct GP referral for Chest X-ray or CT Chest

A CT scan has greater sensitivity than chest X-ray for detecting lung cancer.[5] In most instances CT is a more accurate test, and some people are still considered high risk even when the chest X-ray is normal and so will need a CT.[6]

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[4] https://www.irefer.org.uk/
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4553249/
[6] https://www.hsib.org.uk/investigations-and-reports/missed-detection-of-lung-cancer-on-chest-x-rays-of-patients-being-seen-in-primary-care/missed-detection-of-lung-cancer-on-chest-x-rays-of-patients-being-seen-in-primary-care/

GPs should carefully consider the risk profile of patients when referring for chest imaging and CT should be considered in patients with:

- haemoptysis
- unexplained persistent cough (over 3 weeks)
- worsening spirometry
- cervical lymphadenopathy

For lower risk patients, which will include never smokers and those under the age of 40, X-ray should be considered as an initial investigation.

GPs can consider further investigation, imaging (including CT) and referral for people who have a normal chest X-ray result but continuing undiagnosed symptoms, regardless of their risk level.

Symptoms that may warrant an urgent direct GP referral for CT abdomen and pelvis or ultrasound abdomen and pelvis

GPs should consider patients' risk profile and request investigations for the common causes of presenting symptoms. These can be done either prior to or alongside a direct access test.

Where GPs consider an urgent direct access test to be warranted, they should consult iRefer-CDS to decide whether to refer for ultrasound or CT for the following symptoms:

- pelvic or abdominal pain
- persistent abdominal distension “bloating'
- increased urinary urgency and/or frequency.
- new onset altered bowel habit (particularly in those over the age of 40)
- weight loss
- feeling full (early satiety) and/or loss of appetite.

These non-specific cancer symptoms can reflect several different intra-abdominal cancers including those of the pancreas, colon, urological tract or lymphoma.

Symptoms that may warrant an urgent direct GP referral for Brain MRI

Most patients with brain tumours have seen their GP before diagnosis, often several times, however over 50% are diagnosed following emergency presentation. Fewer than 5% of brain tumours are diagnosed following an urgent suspected cancer referral. GP access to brain MRI is essential to support the earlier and faster diagnosis of brain tumours in primary care.

GPs should consider whether a brain MRI is warranted for:

- new onset headache in patients aged over 50, ***excluding*** patients where a primary diagnosis is made i.e. migraine, tension headache, cluster headache, trigeminal neuralgia and importantly temporal arteritis
- headaches causing patients to wake from sleep
- new headaches in a patient with a history of immunocompromise
- a history of headaches but reporting a recent significant change in frequency or intensity
- headaches that have been present for some time but have changed significantly, particularly with a rapid increase in frequency.

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Wait times

An urgent direct access referral will aim to be completed, including report, in no more than 4 weeks. This will be achieved through work to increase capacity and enhance digital connectivity across the NHS, to enable results to flow more seamlessly.

Results management

Results indicative of malignancy should trigger a consultant referral onto the urgent suspected cancer pathway, via a referral to the MDT.

Where malignancy is suspected, the MDT should assign a secondary care clinician to contact the patient to explain that their results have revealed something that needs further investigation and offer them an appointment. The follow up conversation to discuss next steps should also be had with a secondary care clinician.

Results should also be communicated to primary care through existing channels.

Incidental and equivocal findings

Local systems should have Standard Operating Procedures, Significant Findings Policies and / or pathways in place to deal with unexpected and significant incidental findings.

The reporting of results should make specific recommendations for any action required by primary care. The patient should have their results explained by a clinician.

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