This search summary contains the results of a literature search undertaken by the Lincolnshire Knowledge and Resource Service librarians in **February 2012**.

All of the literature searches we complete are tailored to the specific needs of the individual requester. If you would like this search re-run with a different focus, or updated to accommodate papers published since the search was completed, please let us know.

We hope that you find the information useful. If you would like the full text of any of the abstracts listed, please let us know.

- Alison Price  
  alison.price@lpct.nhs.uk
- Janet Badcock  
  janet.badcock@lpct.nhs.uk

**Librarians, Lincolnshire Knowledge and Resource Service**

**NHS Lincolnshire**

**Beech House,**

**Waterside South**

**Lincoln  LN5 7JH**
Can a consultant refuse an urgent referral under the two-week wait for cancer (specifically intermenstrual bleeding).

Search completed by: Alison Price, 24th February 2012

Explicit clarification of the role of the GP in determining urgency is made in the following documents:

DH: Achieving the Two-week Standard: Questions & Answers – How to help you with issues arising from the two-week wait standard

Urgency of referral
It is the GP who decides whether a patient needs to be seen ‘urgently’ and requires a specialist outpatient appointment within the ‘two-week’ period. (HSC1998/242)

Q. Should referrals sent as non-urgent by GP but recategorised as urgent by the Consultant be counted against the two-week wait standard?

A No. In this case, the referral should not be monitored under the two-week standard. Audit of such cases should be undertaken and it is important that feedback processes are established between Trusts and GPs/PCG/Ts

Q. On receipt of the referral the consultant determines that the patient is not urgent and wishes to re-categorise as non-urgent. Is this permitted?

A. No. It is the GP who determines whether or not a referral should be treated as urgent under the ‘two-week standard’. All patients referred by their GP, within 24 hours of the decision to refer as urgent with suspected cancer, should be offered an appointment within 14 days of the GP’s decision to refer, irrespective of whether or not the consultant regards the referral as urgent.

The DH document is referred to in the second document below:

**National Cancer Action Team: GOING FURTHER ON CANCER WAITS (GFOCWs) A GUIDE**

3.1.27. Where is the policy/guidance that states that a consultant cannot refuse to see a patient referred via the two week wait route, no matter how inappropriate that referral?

The restriction that specifies that a consultant must see all referrals that are sent via the two week wait for suspected cancer was first introduced when the two week wait only covered suspected breast cancer.

This guidance has remained current and now applies to all suspected cancer patients referred urgently by their GP (two week wait).

Annex A of HSC 1998/242 specifies: "It is the GP who decides in the light of the new national guidelines whether a patient needs to be seen "urgently" and requires a specialist outpatient appointment within the "two week" period." This is further reinforced by the following text, which appears on page 2 of the document: 'Achieving the Two Week Wait Standard', which is available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4010373

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**Please note:** The restriction on the referral being received with 24 hours has been removed from the two week wait, to align with Choose and Book and 18-weeks. However, the restriction on the consultant's re-categorisation of these referrals remains current. http://www.nwlcn.nhs.uk/Downloads/Cancer%20Intelligence/Going%20Forward%20on%20Cancer%20Waits%20A%20Guide%20Version%206.7.pdf
Patient with suspected cervix cancer should be referred on the 2-week cancer wait form (Codes 5F/5G). All patients with intermenstrual, postcoital or postmenopausal bleeding should have a general examination, pelvic examination and cervical smear if indicated. Patients referred from colposcopy should be done so in an urgent inter-hospital manner.

www.eastmidlandscancernetwork.nhs.uk/Library/GynaeNSSGClinicalGuidelines.pdf

This document would seem to suggest that referral should be standard across the East Midlands.

7.3 The long term vision was to ensure the referral templates would be accepted at other hospitals in the surrounding areas. So far, Nottingham, Kettering, Lincolnshire, and Derby Hospitals have all agreed to accept the Leicestershire templates, which means that we do not need to keep more than one electronic form for each cancer type. We believe that this is essential if we are to be able to maintain the forms with occasional updates. There are still a couple of our surrounding Trusts who are not yet ready to receive 2WW referrals via Choose and Book, but we intend to follow the same approach as and when they are ready.

http://www.chooseandbook.nhs.uk/staff/communications/fact/2wwcancer.pdf

Dr John Holden, medicolegal adviser at the Medical Defence Union, said: 'We'd expect our members to be aware of guidelines. Ignorance would be a poor defence, but a reasoned and justifiable decision may be acceptable.' Only 70 per cent of GPs agreed with NICE that dyspepsia along with persistent vomiting would merit urgent referral for endoscopy or to a specialist. Even fewer would refer women with persistent inter-menstrual bleeding and a normal pelvic examination on suspicion of gynaecological cancer. The research also found 11 per cent of GPs did not know the maximum waiting time recommended by NICE for patients with suspected cancer was two weeks. Knowledge improved as a result of the modules and NICE is considering the results.

www.pulsetoday.co.uk/newsarticle-content/-/article_display_list/10932278/gps-risk-legal-action-over-cancer-referrals

Women presenting with symptoms of cervical cancer – such as postcoital bleeding (particularly in women over 40 years), intermenstrual bleeding and persistent vaginal discharge – should be referred for gynaecological examination and onward referral for colposcopy if cancer is suspected. Examination should be performed by a gynaecologist experienced in the management of cervical disease (such as a cancer lead gynaecologist). They should be seen urgently, within two weeks of referral.

A database search revealed that research has focused upon the GP role in making referrals, including variations, rather than consultant refusal of / compliance with urgent referrals, but the following may be of interest.

Variation in number of general practitioner consultations before hospital referral for cancer: findings from the 2010 National Cancer Patient Experience Survey in England
Dr Georgios Lyratzopoulos MD a, Richard D Neal PhD b, Josephine M Barbiere MPH a, Prof Gregory P Rubin FRCPG c, Gary A Abel PhD a

Background
Information from patient surveys can help to identify patient groups and cancers with the greatest potential for improvement in the experience and timeliness of cancer diagnosis. We aimed to examine variation in the number of pre-referral consultations with a general practitioner between patients with different cancers and sociodemographic characteristics.

Methods
We analysed data from 41,299 patients with 24 different cancers who took part in the 2010 National Cancer Patient Experience Survey in England. We examined variation in the number of general practitioner consultations with cancer symptoms before hospital referral to diagnose cancer. Logistic regression was used to identify independent predictors of three or more pre-referral consultations, adjusting for cancer type, age, sex, deprivation quintile, and ethnic group.

Findings
We identified wide variation between cancer types in the proportion of patients who had visited their general practitioner three or more times before hospital referral (7.4% [625 of 8408] for breast cancer and 10.1% [113 of 1124] for melanoma; 41.3% [193 of 467] for pancreatic cancer and 50.6% [939 of 1854] for multiple myeloma). In multivariable analysis, with patients with rectal cancer as the reference group, those with subsequent diagnosis of multiple myeloma (odds ratio [OR] 3.42, 95% CI 3.01—3.90), pancreatic cancer (2.35, 1.91—2.88), stomach cancer (1.96, 1.65—2.34), and lung cancer (1.68, 1.48—1.90) were more likely to have had three or more pre-referral consultations; conversely patients with subsequent diagnosis of breast cancer (0.19; 0.17—0.22), melanoma (0.34, 0.27—0.43), testicular cancer (0.47, 0.33—0.67), and endometrial cancer (0.59, 0.49—0.71) were more likely to have been referred to hospital after only one or two consultations. The probability of three or more pre-referral consultations was greater in young patients (OR for patients aged 16—24 years vs 65—74 years 2.12, 95% CI 1.63—2.75; p<0.0001), those from ethnic minorities (OR for Asian vs white 1.73, 1.45—2.08; p<0.0001; OR for black vs white 1.83, 1.51—2.23; p<0.0001), and women (OR for women vs men 1.28, 1.21—1.36; p<0.0001). We identified strong evidence of interactions between cancer type and age group and sex (p<0.0001 for both), and between age and ethnicity (p=0.0013). The model including these interactions showed a particularly strong sex effect for bladder cancer (OR for women vs men 2.31, 95% CI 1.98—2.69) and no apparent ethnic group differences in young patients aged 16—24 years, whilst the only cancers without an apparent age gradient were testicular cancer and mesothelioma.

Interpretation
Our findings could help to prioritise and stratify early diagnosis initiatives and research, focusing on patients with cancers and sociodemographic characteristics with the largest potential for improvement.
**Title: Urgent suspected cancer referrals from general practice: audit of compliance with guidelines and referral outcomes.**

Citation: British Journal of Health Care Management, 2011, vol./is. 61/592(668-669), 1358-0574

Author(s): Baughan, Paul, Keatings, Jennifer, O'Neill, Bill

Abstract: BACKGROUND: Late diagnosis contributes to the UK having poorer cancer survival than many countries in Europe. Cancer referral guidelines help GPs decide which patients to refer urgently for further investigation. AIM: To examine primary care referral patterns, compliance with referral guidance, and eventual outcome for patients. DESIGN AND SETTING: Prospective audit within general practice in Scotland. METHOD: GPs in Scotland reviewed all urgent suspected cancer referrals over a 6-month period. They noted the final diagnosis and assessed whether the referral was in accordance with agreed referral guidelines. RESULTS: A total of 18 775 urgent suspected cancer referrals were analysed from 516 GP practices. The referral rate ranged from 3.7 to 24.0 per 1000 per annum; 30.8 per cent of referrals were for patients aged under 50 years, yet this age group accounts for only 11.1 per cent of all diagnosed cancers; 10.3 percent of all urgent cancer referrals were for suspected melanoma, despite this cancer accounting for only 4.1 per cent of new cancers. The proportion of patients subsequently diagnosed with cancer was greatest for leukaemia (61.7 per cent), prostate (52.6 per cent), and lung cancer referrals (39.7 per cent), and lowest for melanoma (11.8 per cent), oesophago-gastric (11.2 per cent), brain (10.6 per cent), and laryngeal cancer referrals (7.8 per cent). Compliance with referral guidelines was 90.9 per cent. A large proportion of referrals considered to be outside the guidelines still had a cancer diagnosed (urological 15.9 per cent, lung 8.8 per cent, colorectal 8.4 per cent, and breast 6.4 per cent). CONCLUSION: There is wide variation in GP referral rates for suspected cancer with a greater than expected proportion of referrals for younger people. Many referrals considered to be outside the national guidelines were diagnosed with cancer, suggesting factors other than those in referral guidelines alert GPs to the possibility of cancer. [Abstract]

**Title: Implementation of national cancer guidance: the experience of a primary care trust.**

Citation: Quality in Primary Care, 2006, vol./is. 14/3(185-192), 1479-1072

Author(s): Rhydderch, Melody

Abstract: In 1999 national cancer guidance was circulated to primary care organisations and looked to build on the work undertaken through the Calman Hine programme. More recently, we have received N.I.C.E. guidance on primary care referrals for patients with suspected cancer. Within NE Lincolnshire locality our approach has been to utilise the national cancer guidance as an opportunity to 'localise' or practically integrate the current evidence to develop locality guidance within care pathways. The localisation of national cancer guidance has been implemented by a three-stepped process by which we have looked to engage the local health community. Within the establishment of the care pathways we have looked to utilise a number of key characteristics for the various areas of cancer considered. The guidelines were developed over a three to four year period and we focused on the areas for which the development of referral guidelines would be most appropriate. What has been the value of the work to date? - from audits, as well as anecdotal feedback, there is a high level of awareness and utilisation on locality guidelines. One practical reflection of this is the high level of utilisation of referral proformas where they have been developed. The work to date has also led to significant sharing of experiences and outcomes across practices within the primary care trust,
facilitated by the Primary Health Care Team structure. The above were desirable as we looked to reflect on the value of the implementation of locality guidelines. However, the most important factor is what positive impact there is on service delivery. A potential independent indicator is that of conversion rates of urgent two week wait (2WW) referrals to cancer. The paper considers the potential impact of localisation on conversion rates. It then highlights the potential quality assurance framework for the development of effective care pathways. 1 table 5 refs. [Abstract]

Title: Urgent GP referrals for suspected lung, colorectal, prostate and ovarian cancer.
Citation: British Journal of General Practice, 2006, vol./is. 56/526(355-362)
Author(s): Allgar, Victoria
Abstract: BACKGROUND: The UK urgent cancer referral guidance was introduced between 1999-2000. There is a dearth of literature relating to the effectiveness in detecting cancer of urgent suspected cancer referrals and general practitioners’ compliance with the guidance. AIMS: This paper aims to determine the diagnostic yield from urgent referrals for suspected colorectal, lung, ovarian and prostate cancer, and the proportion of patients with cancer who were urgently referred. Secondary aims are to determine the association of these findings with age, ethnicity, sex and marital status, and to determine the proportions of patients who fulfilled the urgent referral criteria.
DESIGN: Detailed notes analysis of all urgent referrals and all cancer diagnoses.
SETTING: One hospital trust in England. METHOD: Data regarding all urgent referrals and all cancer diagnoses were obtained from one hospital trust over a two-year period. Data analysis was undertaken to determine, diagnostic yields and their association with sociodemographic factors, trends over time and fulfilment of the guidance. RESULTS: The percentages of urgent referrals diagnosed with cancer were colorectal 11 per cent, lung 42 per cent, ovarian 20 per cent, and prostate 50 per cent. The percentages of patients with cancer referred urgently were colorectal 21 per cent, lung 23 per cent, ovarian 24 per cent and prostate 32 per cent. Patients who were urgently referred without cancer were younger than those with cancer for all but prostate. There were no significant differences by sex, marital status or ethnicity. For patients with cancer there were no differences for any sociodemographic factors in whether or not they were referred urgently. CONCLUSIONS: The predictive power of the referral guidance as a marker for cancer is low, resulting in significant numbers of patients being urgently referred without cancer. A large majority of patients not diagnosed with cancer through the urgent referral route did fulfil the criteria for urgent referral, suggesting that with more widespread use of the guidance the diagnostic yields will be higher. This has implications for patients, on hospital diagnostic systems, and for patients presenting through other pathways. 2 figs. 2 tables 26 refs. [Abstract]