Centre for Sustainable Delivery

NHS SCOTLAND

Vetting of Urgent Suspicion of Cancer Referrals by Secondary Care

National Referral Regrading Guidance

Scottish Government
Riaghaltas na h-Alba

Background and Guidance Development

Regrading of Urgent Suspicion of Cancer (USC) referrals at the point of clinical vetting is currently utilised widely, but variably, across NHS Scotland. Regrading of referrals using objective criteria from the Scottish Referral Guidelines for Suspected Cancer is of utmost importance for ensuring that the right person is on the right pathway at the right time.

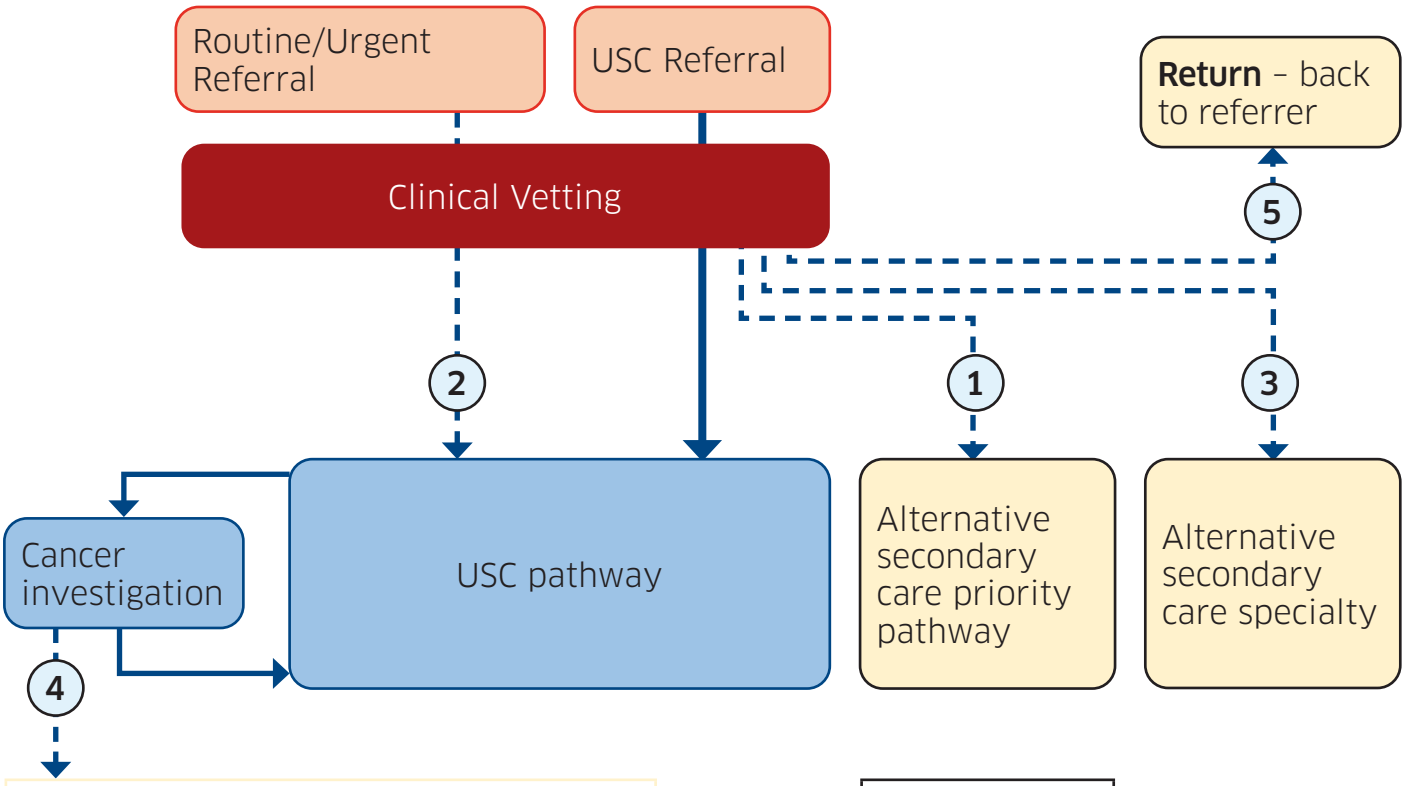
Regrading is mentioned within the Framework for Effective Cancer Management, in terms of best practice when initiating the USC pathway, and the Scottish Referral Guidelines for Suspected Cancer. However, as there is variation in its application across Boards, it was agreed by the Cancer Performance & Delivery Board to develop national guidance to provide clarity.

This guidance should be supported by locally devised processes to aid in effective communication following clinical triage, regardless of the outcome. A supporting toolkit of best practice examples has been developed and is hosted on Turas (NHS Education for Scotland's platform) to aid Health Boards to utilise the Regrading Framework within their existing pathways.

Principles for Regrading Referrals

1. Right person, right pathway, right time.
2. Regrading is a clinical decision made at the point of clinical vetting.
3. Good communication is key.

Regrading Summary



1. If the clinical information is complete but does not comply with the Scottish Referral Guidelines for Suspected Cancer, and there is no additional information to justify such referral, it should be **regraded** and considered for another priority (routine or urgent). The referrer should be informed of the regrading decision.

   - It is recommended that each Health Board develops local processes for clear communication, such as the use of standardised regrading letters from secondary care, which should include space for a clear explanation for regrading to an alternative pathway.
   - Where the person's understanding of being referred onto a USC pathway is explicitly stated in the referral, a sensitive, reassuring communication directly to the person, to inform them of the regrading decision, is recommended as good practice.

Example Case: A 20-year-old woman presents to their Primary Care Clinician with a new discrete breast lump, but no other suspicious features. They are referred to the Breast Service as USC priority. The vetting clinician ascertains that there are no features that meet the Scottish Referral Guidelines for Suspected Cancer, and regrades the person to a routine clinic pathway. The vetting clinician writes to the Primary Care Clinician to inform them of the regrading decision. As the referral letter advised that the person was aware of a USC referral being made, the vetting clinician writes to the person to inform them that it is extremely unlikely that the breast lump is cancerous, that they will be seen in the Breast Clinic within 12 weeks, and to contact the department if any new symptoms develop while they wait for their appointment (with contact details clearly included).

2. If a person is referred for routine investigation but has clinical information compliant with the Scottish Referral Guidelines for Suspected Cancer, the referral should be **regraded** to a USC pathway. The referrer should be informed.

   - It is recommended that clinical documentation in secondary care is updated to include the revised referral priority, and that during the person's first contact with secondary care, they are provided with an explanation of the clinical concern to justify earlier review.

Example Case: A 40-year-old woman presents to their Primary Care Clinician with a new breast lump. From the history and examination, the Primary Care Clinician suspects a benign pathology, and refers to the Breast Service as routine priority. The vetting clinician upgrades the referral to USC priority, in accordance with the Scottish Referral Guidelines for Suspected Cancer. The vetting clinician sends an explanatory letter to the referrer to inform them of the reason for the upgraded priority (age 30 years or over) and places a note on the person's secondary care electronic record so that reasons for the prioritised appointment at the Breast Clinic can be sensitively discussed with the person at first review.

3. If the clinical information is complete but the referral information aligns to an alternative USC pathway, rather than the one it was submitted to, the referral should be **redirected** within secondary care. The referrer and person should be informed at the point of redirection.

   - It is recommended that referrals between different secondary care specialties are undertaken through local electronic referral systems, such as SCI Gateway or Patient Administration System (PAS), to ensure prompt action and tracking.
   - Where the person's understanding is explicitly stated in the referral, sensitive communication directly to the person to inform them of redirection to another specialty is recommended as good practice.

4. There are a number of possible outcomes for a person on a USC pathway who, after initial clinical assessment or investigation, are found not to have cancer. They could be:

   - **discharged** from secondary care's responsibility, back to primary care, with reassurance that cancer is not causing their symptoms;
   - **regraded** to an alternative priority (routine/urgent) and managed through a secondary care pathway, if incidental findings or ongoing concerns have been identified which require treatment/care in the specialty they were initially referred to;
   - **redirected** to an alternative specialty (as routine or urgent) if incidental findings or ongoing concerns have been identified which require treatment/care in a different specialty than that to which they were initially referred.

Regardless of the outcome, the person and initial referrer should be informed timeously.

- Where secondary care specialties utilise evidence-based symptom questionnaires or similar pre-clinic processes to aid their vetting decisions, this should be considered a clinical assessment. The outcome of such assessments will help support justification of any regrading decisions and should be communicated to the referrer.
- Where an incidental finding relates to a different secondary care specialty than that of the initial USC referral, the referral should be redirected using internal secondary care processes and not be returned to the initial referrer, or the person's Primary Care Clinician, to re-refer back into secondary care.
- Where a person is redirected to an alternative specialty, it is recommended that local electronic referral systems, such as SCI Gateway, are used to ensure prompt action and tracking.

Example Case: A person with a chronic cough is referred to the Respiratory Service as USC priority. A CT scan performed as part of the USC pathway shows no evidence of lung cancer, but an incidental large thyroid goitre is reported. The Respiratory Clinician in the lung cancer clinic notices that recently performed Thyroid Function Tests were abnormal. In the clinic, the person is reassured that there is no evidence of lung cancer and advised of the incidental finding. After determining that there are no acutely concerning clinical features, the Respiratory Clinician redirects the person by referring directly to the Endocrinology Department's Thyroid Clinic. The person's Primary Care Clinician is advised of the person's discharge from the lung cancer clinic and subsequent redirection to Endocrinology.

5. USC referrals should only be **returned** to the referrer in exceptional circumstances. Referrals that do not have the required clinical information for effective vetting should be returned, in accordance with the Cancer Waiting Times (CWT) Data & Definitions Manual. The referrer should be informed and advised to resubmit the referral with additional information.

   - Referrals should only be returned in the rare instance where there is insufficient information for vetting to occur.
   - Referrals that are returned to the referrer should be accompanied by a clinical letter or electronic communication with an explicit statement of the additional information required for vetting of the referral to occur.
   - If the referral includes symptoms or clinical features which meet the threshold for investigation, based on criteria from the Scottish Referral Guidelines for Suspected Cancer, the referral should not be returned for additional information, and the person should be managed on a USC pathway accordingly. If further assessment or investigation is indicated to evaluate the presenting symptoms or clinical features, this should be performed as part of, or concurrently to, the USC pathway such that cancer assessment and investigations are not delayed.
   - Where a USC referral is sent from one secondary care specialty to another, details of the reasons for return of the USC referral and requests for additional information should be communicated to the initial secondary care referrer. They would retain responsibility to supply any further relevant information or re-referral. In addition, the person's Primary Care Clinician should receive a copy of correspondence for information.
   - In some cases, additional information may be available at vetting which excludes a diagnosis of cancer, such as recent investigations performed in secondary care. If the person's symptoms do not meet criteria for another non-USC pathway, then the referral should be returned to the referrer with an explanatory communication and, where the person's understanding is explicit from the referral, the person should be informed.

Example Case: A 65-year-old ex-smoker presents with a 4-week history of a cough. A chest x-ray is performed and reported as normal. Their Primary Care Clinician refers them to the Respiratory Service as USC priority. The vetting clinician in secondary care can see that they had a normal CT Pulmonary Angiogram performed two months previously when the person self-presented to the Emergency Department, with no evidence of a lung malignancy. The referral is returned to the Primary Care Clinician with an explanatory electronic letter. As the referral stated that the person was aware of the possibility of lung cancer, the vetting clinician writes to the person to advise them that the recent CT scan is sufficient to exclude lung cancer at this point, and to contact the department if the cough persists for investigation on the Chronic Cough Pathway (Patient Initiated Review).

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Any enquiries regarding this publication should be sent to us at

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