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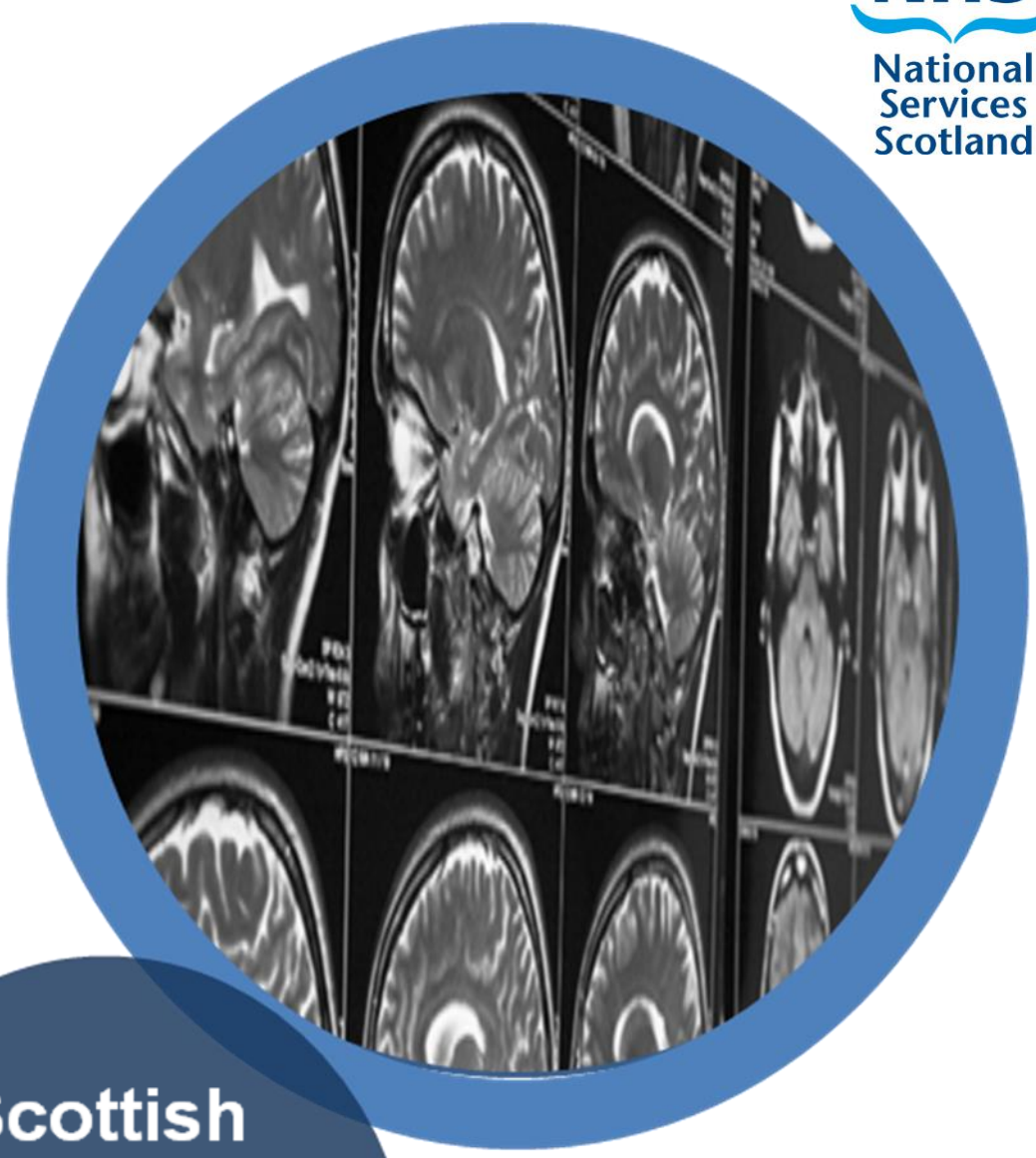

Scottish Clinical Imaging Network (SCIN)

A Scottish Imaging Pathway for Primary Care

Direct Access to CT of Chest/Abdomen/Pelvis for Patients with Unidentified Suspected Malignancy

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Introduction

The Scottish Government's Healthcare Quality Strategy lays out a blueprint for patient care in Scotland, with safety, equity, efficiency and timeliness at its heart.

There is currently highly variable direct access for CT scanning for Primary Care Practitioners in Scotland. There are some areas which provide this access for General Practitioners for specific indications and others that do not. The Scottish Clinical Imaging Network (SCIN), which is one of 4 National Managed Diagnostic Networks under the auspices of National Services Division (NSD), set up a subgroup in 2014 to look specifically at this issue.

This group, with Imaging and Primary Care representation, concentrated on a subset of patients with unidentified suspected malignancy, who the GPs felt were most difficult to manage without wider access to CT scanning. This was felt to be due to the lack of a defined pathway for this group of patients leading in some cases to delays in referral to the correct specialty.

Direct access for GPs to CT scanning of chest/abdomen/pelvis for this group of patients could enable a cancer diagnosis to be made directly from primary care and aid more appropriate onward secondary care referral. In other cases it could guide the GP how best to manage the patient within a primary care setting.

This document outlines the pathway developed by the group for this specific group of patients, through consultation with Imaging and Primary Care colleagues from across Scotland. It also makes recommendations for its implementation. The group has developed a paper and an electronic referral form, for services to use for this pathway. It is hoped that this pathway will be successfully adopted across Scotland and lead to a more streamlined service for patients across Scotland.

The pathway has been based on the principles outlined in the document ***Quality Imaging Services for Primary Care: A Good Practice Guide (2012)*** which was produced in collaboration between the Royal College of General Practitioners, the Royal College of Radiologists and the Society and College of Radiographers.

Underlying Principles

1. There should be equity of access in relation to this pathway for GPs across Scotland

2. All Imaging should be undertaken in compliance with the Ionising Radiation (Medical Exposure)Regulations 2000 (IR(ME)R) and subsequent amendments

3. The service delivered should be of the same quality to that of secondary care imaging

4. Referrals for this specific patient group should have the same turnaround times for acquisition and reporting as equivalent secondary care scans.

Recommendations for Implementation of the Pathway

1. Details of the pathway is communicated to all GP practices and Imaging services

2. The pathway is piloted across all Health Boards in Scotland, following a six month set up, period for a period of 6 months. This will be undertaken by National Services Division and reviewed by SCIN.

3. There is audit of the demand, resources required and impact on the current imaging service throughout the pilot period.

Referral Criteria

a. Clinical assessment of patient by General Practitioner leading to very strong suspicion of suspected underlying malignancy with, for example, unexplained significant weight loss of > 10% body weight.

b. If there is any indication of localising signs, symptoms or laboratory tests to suggest malignancy in a specific system, direct referral to secondary care should be made using the appropriate established pathway without ordering a CT scan.

c. Prior to requesting a CT scan of chest/abdomen/pelvis the GP must ensure the following has been completed.

- History,
- Examination including depression screening
- Relevant biochemical and haematological testing (including eGFR if not done within the last 2 months)
- CXR

d. CXR - no evidence of primary intrapulmonary malignancy.

e. If CXR report shows metastatic disease with no known primary then this CT pathway can also be used, for all age groups.

f. If the patient is < 40 years of age, discussion with the duty radiologist must take place in the first instance prior to requesting a CT scan. In this group of patients, an urgent ultrasound of abdomen/pelvis may be more appropriate as the next test.

Communication with Imaging

a. Dialogue with the local radiology department should not be routinely necessary if the patient fulfils all the criteria for this pathway. It is, however, recommended if there is uncertainty as to the suitability of their patient for a CT scan

b. Local arrangement within Health Boards will dictate whether this is via

- Email contact to a specific manned radiology inbox
- Dedicated phone line into radiology department to speak with duty radiologist.

c. If using an email process to request dialogue/scan, response should be within 2 working days.

Booking of scan

a. Request a CT of chest, abdomen and pelvis using normal booking system for Imaging for primary care within your board area.

b. All types of request should include details of a robust communication mechanism, either practice email and/or phone number for the radiology department to contact the primary care referrer if there are any problems with the request and to communicate urgent significant results.

c. Referrer must include all relevant history, CXR, ultrasound if appropriate and relevant abnormal blood results on the referral form to demonstrate compliance with the referral criteria

d. Ensure that it is flagged as urgent suspicion of cancer in order to qualify for a 2 week turnaround time.

e. Ensure that a current (within 2 months) eGFR result is included in the request or the request may be refused or delayed. Contrast CT scans can further compromise impaired renal function.

Receipt of Report

a. Obtain report from Radiology via normal method for your board

b. Contact Radiology by phone or email, depending on local protocol if any queries with the report

c. Responsibility for reading and acting on the results lies with the referring GP

d. Responsibility for onward referral lies with the referring GP

e. Each radiology service should have a process in place for the communication of urgent unsuspected results.

f. Each Radiology service should have a process in place for the communication of critically urgent findings which require action that day. This would normally be via a telephone call to the GP surgery during normal working hours or to the GP out-of-hours service at other times.

g. If the scan is positive for malignancy, the reporting radiologist should activate a cancer tracking mechanism, if available, in order to ensure that the results are acted upon. The recommendation is that communication to primary care regarding a positive cancer scan should be via the GP practice generic email box in addition to the usual method of conveying results.

Recommendations for Radiology Services and for Primary Care

a. Each radiology service should ensure that adequately staffing and resources are in place or are put in place to support this new pathway to avoid adverse impact on the existing service

b. Radiology services should consider the institution of a Duty Radiology system to support this pathway if not already in place.

c. All requests for this service should be vetted – the request should be queried or refused if deemed inadequate information or not meeting referral criteria and this information fed back to the referrer in a timely fashion.

d. Radiology services should consider appointing a Primary Care Lead radiologist as the liaison between radiologists and general practitioners. This individual would have responsibility for coordinating contact between these two groups of professionals, audit and education.

e. Each radiology service should set up a regular meeting with GP representation to follow up on issues with this service

f. Each Radiology service should audit the referral patterns for this pathway

g. Each radiology service should engage in regular training sessions for local GPs on referral for complex imaging

h. Radiologists should specifically word their reports to aid the referring GP

   - By emphasising what issues would require onward referral and to which specialty.

   - By give guidance on relevance of benign radiological findings

i. If trainee Radiologists are available within your board area (post exam years 3/4/5) they should be involved in the local system of dialogue with primary care referrers as part of their training.

j. Larger Health Boards with multiple acute hospitals should consider setting up a single centralised point of contact into Radiology for Primary care colleagues if this is deemed a more efficient use of resources

Appendix 1

Web link **Paper referral form available at www.scin.scot.nhs.uk**

Web link **SCI gateway referral form available at www.scin.scot.nhs.uk**

Subgroup membership

Mrs Lynn Ross (chair)	General Manager Imaging, NHS GG&C
Dr Anne Marie Sinclair	Lead Clinician Scottish Clinical Imaging Network
Mr Jonathan Serhan	Consultant Radiologist, NHS Fife
Mr Jim Embleton	NMDN Clinical Imaging Lead, NHS GG&C
Dr Stuart Ballantyne	Consultant Radiologist, NHS GG&C
Dr Leighton Walker	Consultant Radiologist, NHS GG&C
Dr Barbara Macpherson	Consultant Radiologist, NHS Lanarkshire
Dr Stephen Glancy	Consultant Radiologist, NHS Lothian
Dr Kenneth Fowler	Consultant Radiologist, NHS Tayside
Dr Peter Hutchison	General Practitioner, NHS Dumfries & Galloway
Dr John Dudgeon	General Practitioner, NHS Greater Glasgow & Clyde
Dr Neil Pryde	General Practitioner NHS Fife
Mrs Betty McVean	Superintendant Radiographer NHS GG&C
Mrs Alexandra Speirs	Network Manager, National Network Management Service
Miss Mary Adams	Network Support Officer, National Network Management Service

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