# Overview of General 2ww referral management

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This paper relates to adult patients only. Children, teenage and young adult cancers should be managed in accordance with normal protocol.

**Initial management of 2ww referrals**

1. On receipt of a 2ww referral, providers should decide the most appropriate action. This will include triage of the referral to decide most appropriate management.
2. Patients may either be prioritised to be seen (clinic or test), put on a deferral list or discharged after a telephone appointment or face-to-face appointment
3. Patients may be deferred if
	1. They are assessed as lower risk and the infection risk of attending a hospital outweighs the benefit
	2. The provider is unable of provide the clinic or test at this time but patients must have a harm review completed using local harm review documentation if this option is chosen
	3. If the provider has not been able to assess the referral at all, this should be communicated back to the referrer and options for assessment discussed
4. Where patients have been assessed by telephone or face-to-face appointment and either found to not be requiring investigations or to be managed on routine pathway only, this will be communicated to GPs and patient and removed from the cancer pathway, as in line with current process. Telephone appointments can now be counted as ‘first seen appointment.’
5. Where GP has not performed bloods and patient is unable to attend their GP practice, patients will be asked to attend the drop-in phlebotomy service to prevent delays to investigations.

**Management of patients who do not attend**

1. If patient is assessed for investigation (remaining on the 62-day pathway as cancer not yet ruled out) but the patient is not willing to attend for investigations or appointments for the foreseeable future due to COVID, the GP will be informed that the patient has opted out of the cancer pathway. They will be advised to return to their GP and the GP will be informed. If they subsequently wish to attend or symptoms progress further, the GP will be required to re-refer with up to date information (including bloods etc).
2. If a patient is unable to attend for investigation for a set period of time due to self-isolation, these remain on the cancer pathway and appointments are booked at the earliest appropriate date.

**Management of deferred patients**

1. Patients who are deferred either at point of referral or thereafter should be tracked by the receiving provider. RCHT will be collecting and monitoring this via the Somerset Cancer Registry.
2. Patients on this list are the collective responsibility of primary and secondary care (deferred patients may not have been physically seen by either).
3. Patients who are deferred will receive a standard letter and advice to contact their GP if their symptoms worsen. GP to be sent copy of letter and if a patient re-presents before the provider is able to see them, the GP can flag to the provider to escalate review.
4. When services can resume normal care deferred patients will be reviewed and prioritised. This will be a joint task between the provider and patients’ GPs. The exact process is to be determined and may very between tumour sites.

**Dr B Pottinger / L Hunt – based on Alliance guidance**

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