FIT for Symptomatic Patients in Primary Care

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Colorectal cancer: Data file

New cases of bowel cancer, 2015, UK
Cases: 41,804

Deaths from bowel cancer, 2016, UK
Deaths: 16,384

Survive bowel cancer for 10 or more years, 2010-11, England and Wales
Survival: 57%

Stage at diagnosis and survival by stage

By screening 10%
- By urgent GP: Two Week Wait referral for suspected cancer symptoms 33%
- By routine or urgent GP referral 22%
- In an emergency 23%
- Hospital outpatient referral 7%
- Hospital inpatient referral 3%
- Other 1%

Incomplete data
Source: PHE, Routes to Diagnosis, 2016
Referral Guidelines in Primary Care

NICE NG12 (2015):
• Several groups symptomatic patients – 2ww
• Certain low risk groups should have FOBt:
  ▪ Are aged 50 years and over with unexplained abdominal pain OR weight loss
  ▪ Are aged 60 years and under with changes in their bowel habit OR IDA
  ▪ Are aged 60 years and over and have anaemia even in the absence of iron deficiency
• Concerns about sensitivity / specificity guaiac FOBt so not always used

NICE DG30 (July 2017):
• Recommended use of qFIT in primary care for low risk patients including those meeting criteria for FOBt in NG12 i.e. also those not meeting above criteria
Low risk – the clinical reality...

• 56 year old man
• Speaks poor English
• Consults about shoulder and back pain
• At end of consultation says thinks he has worms because “every time I eat I need to go to the toilet”.
• Difficulties in communication in a time-pressured consultation make this hard to assess: Sounds like no rectal bleeding, abdominal pain or weight loss. But is this a change in BH? If so, for how long?
• Suggest has blood test including FBC / Fe studies and come back soon
• 1 month later – had blood tests, all normal; not returned, not contactable.
• Wait for him to return? Refer? Should have referred initially?
• Would FIT have helped??
Existing London Position on FOBt / FIT

- NICE NG12 2015: agreement to adopt a pan-London approach
- Broad concerns re FOBt so not recommended as a rule out test
- Patients meeting FOBt criteria in NG12 to be sent on 2ww
- Lowering threshold for 2ww ↑ number of patients referred
- FIT available in a limited number of pathology services
The Task

- FIT to be commissioned across 33 CCGS
- Agree a common clinical pathway
- Embed DG30 guidance in practice
- Develop resources to support delivery
- Health Equity Assessment to ensure no discrimination
- Support FIT roll out in the BC screening programme
Main challenges

• Facilitating **coherent** approach across complex health landscape

• **Addressing concerns** about:
  → Costs of implementation (kit / other)
  → Possibility of rapid rise in endoscopy demand
  → Confusing FIT for screening with symptomatic = clinical errors

• **Aligning delivery** with:
  → FIT for screening roll out
  → Timelines for emerging evidence from research / pilots
  → Expected NHSI model for pathology delivery

  and...

• **Ensuring implementation within reasonable timescales**
London’s Landscape

- 8.6 million people
- 33 CCGS
- 27 Acute Trusts
- 3 Cancer Alliances
- 5 STPs
- 2 NIHR studies
Key Milestones

1. Establish Governance
2. Agree Pathway
3. Agree Approach to Implement
4. Implement
Establish Governance

- **London Cancer Commissioning Board endorsed** set up of Pan London Symptomatic FIT Steering Group to:
  - Achieve a **pan London approach** for adopting DG30
  - Align delivery with FIT research studies London / beyond
  - Facilitate implementation across London
  - Support imperative to roll out FIT for screening in 2019/20

- **Steering group:**
  - Led by the NICE Diagnostics Advisory Group chair
  - Bi monthly meetings
  - Membership: all Cancer Alliances, STPs, research leads, GPs, gastro/colorectal/biochemistry specialists, patient reps etc.
  - Regular updates to the Cancer Commissioning Board
Agree Pathway

- Steering Group endorsed uniform implementation FIT for low risk
- Some felt should roll out for Low / High risk at start. Low / High risk pathway brought to CCB - deemed premature
- Focus moved back to details of low risk pathway, including:
  - Eligible population (NG12 low risk groups, not all low risk)
  - Who should order and provide FIT kit to patients (GPs)
  - Role of FIT re-testing in pathway (yes, now questioned)
  - Recommendations if FIT negative and ongoing symptoms
  - Expectations for safety netting
  - Appropriate patient information
- Final pathway agreed by steering group and endorsed by CCB.
- NHSI pathology network model endorsed
- There continue to a range of views...
Patient concerned about lower GI symptoms

GP appointment:
• Review symptoms
• Review history
• Examination

GP assess risk status

High Risk ≥3%

Safety net

Low risk ≤3%

Safety net

Patient Information

FIT test result

Positive

Safety net

Patient Information

Negative

Fitness test

On going monitoring

Further GP appointment:
• Review symptoms
• Review history
• Examination

Symptom changes

Persist or Worsen

Safety net

Improve

Option 1

Patient

Process

Patient Information

Option 2

Routine 18WW Process

Option 3

Patient Information

FIT test

Safety net

DG30 Criteria: Low risk ≤3%
Offer FIT to assess for colorectal cancer in adults without rectal bleeding who:
Are aged 50 years and over with unexplained:
• Abdominal pain or
• Weight loss or
Are aged under 60 with:
• Changes in their bowel habit or
• Iron deficiency anaemia or
Are aged 60 and over and have anaemia even in the absence of iron deficiency.
Agree Approach to Implement

• Who responsible for commissioning? Some debate, agreed STPs to lead.

• All 5 STPs to aim for roll out FIT for low risk symptomatic by April 1\textsuperscript{st} 2019

• Local decision on one of three out of four potential options below:
  1. Implement for low risk alone; await national guidance on high risk ✓
  2. Implement low risk; prepare actively for extension to high risk ✓
  3. Implement low and high risk FIT at the same time ✓
  4. Delay all implementation until recommendation on use in high risk ✗
Implementation

- STPs (4/5) FIT working groups with plans to launch by April 2019
- Regional (TCST) support for implementation
- Pathway integrity largely maintained
- Alignment with screening endoscopy preparedness b4 go live date
- London CCB continues to be sighted

Some implementation issues

- High / Low Risk Pathway issue continues to be controversial
- Wide variation in FIT unit pathology costs – £6.34- £16.21
- Range of approaches to commissioning
- Safety netting sometimes controversial
- Role of 2\textsuperscript{nd} FIT being reviewed
Learning

London process

• Communication is key
• Regular meetings – landscape changes quickly
• Awareness of political sensitives and individual agendas
• Endorsement of approach at high level
• Value in supportive resources e.g. business case, modelling, PIL
• Recognise inability to insulate implementation from delivery of other major agendas - endoscopy capacity; screening; research; QIPP

Wider Issues

• Early diagnosis vs managing demand – how to prioritise?
• Getting new advances into practice as evidence evolves – how to do so in safe and timely manner?
Thank you