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Accelerate, Coordinate, Evaluate (ACE) Programme

Colorectal Cancer Pathways: Interim Report

Straight to test pathways for colorectal referrals

An NHS England initiative supported by Cancer Research UK
and Macmillan Cancer Support

ACE Colorectal Cancer Pathway Cluster

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Table of Contents

1. INTRODUCTION	1
2. THE CONTEXT FOR COLORECTAL CANCER.....	2
2.1 VARIATION IN WAITING TIMES FOR LOWER GI CANCERS	5
3. SCOPE OF COLORECTAL CLUSTER AND REFERRAL APPROACHES	5
3.1 HOSPITAL-BASED TRIAGE SERVICE	6
3.2 GP DIRECT ACCESS/OPEN ACCESS TO FIRST INVESTIGATION.....	7
4. BENEFITS AND EARLY OUTCOMES.....	9
5. CHALLENGES AND RISKS TO IMPLEMENTING STRAIGHT TO TEST	10
6. CONCLUSION.....	12
7. REFERENCES.....	13
8. CONTACT ACE.....	14
ANNEX 1: STAY IN TOUCH WITH ACE.....	15

1. Introduction

The ACE Programme¹ is an NHS England initiative in collaboration with Cancer Research UK (CRUK) and Macmillan, to **Accelerate, Coordinate and Evaluate (ACE)** evidential learning to achieve the earlier diagnosis of cancer. The Programme is organised into a series of thematic clusters and the colorectal pathway cluster comprises a number of NHS projects that are focused on the implementation of a 'Straight to *first diagnostic* Test' (STT) approach following eligible GP referral.

STT is the delivery of an appropriate diagnostic service without the requirement for the patient to attend a first out-patient clinic hospital appointment. In most instances, patients will initially see their General Practitioner (GP) in a primary care setting. If the GP decides the patient's symptoms warrant further investigation and they are appropriate for a STT pathway, the GP will refer the patient to an endoscopy provider, either:

- Directly within an open access arrangement from primary care, or
- To a hospital-based triage service where a colorectal consultant will review the detailed referral or a nurse-led telephone assessment service will organise an endoscopy appointment, if considered appropriate

In streamlining referrals to the colorectal service, the ACE projects are adopting either of these models and, mindful of the current cancer waiting times standards, are focused on improving the speed of achieving a definitive diagnosis and the delivery of first treatment for those patients in whom cancer is diagnosed.

The projects are also evaluating the impact of a variety of straight to '*first diagnostic*' test approaches - flexi sigmoidoscopy, colonoscopy or CT colonography, measuring eventual time to diagnosis. The timings of these tests are being evaluated as part of the agreed data set collection and analysis of the following metrics will be undertaken by the Department of Health's Policy Research Unit (PRU):

- Is the diagnostic interval shortened in time - from GP referral to first diagnostic test
- Does the proportion of routes to diagnosis change – e.g., % of cancers diagnosed via the various referral routes – emergency presentation at A&E, GP two week wait (2WW), other GP referral etc.
- If the diagnostic interval is shortened – does this also improve the stage of cancer at diagnosis

Included in this report

The contents of this report will be of particular interest to cancer commissioners considering implementing STT/direct access pathways or in the process of doing so.

Insight into the rationale and the drivers for change should help weigh up benefits of the pathways, while links to useful resources and models in section 3 should support the design

of other pathways. Challenges and risks the ACE projects have had to overcome to sustain implementation of the redesigned pathways, highlighted in section 5, should also help inform planning. Also within section 5 is a list of recommended interventions to better understand how the endoscopy service can improve productivity and effectiveness.

2. The context for colorectal cancer

A number of factors help to set the context for including 'direct and rapid access to diagnostics' as one of the essential concepts of the ACE Programme.

Colorectal cancer is the fourth most common cancer type in the UK, with [41,112 new cases diagnosed in the UK in 2013](#)²; that's 110 cases diagnosed every day. Since the late-1970s, incidence rates have increased by more than a tenth (14%) in Great Britain and it is more common in males living in the most deprived areas. Around 16,200 people died of colorectal cancer in 2012 in the UK, that's more than 44 people every day.

However, survival rates of colorectal cancer are improving and have more than doubled in the last 40 years in the UK; in the 1970s, more than a fifth of people diagnosed survived their disease beyond ten years, now it's almost 6 in 10. Survival is related to the stage of the cancer disease and when diagnosed earlier, more than 9 in 10 people with colorectal cancer will survive their disease for five years or more, compared with less than 1 in 10 people when diagnosed at late stage.²

Improving survival further is a key challenge identified in [Achieving World Class Cancer Outcomes: A Strategy for England 2015-2020](#)^{3,4} with survival estimates in the UK currently below those in many European countries. The survival difference in the first 12 months after diagnosis has been partly attributed to later cancer stage at diagnosis, and also to the numbers of diagnosed colorectal cancers via the emergency route.⁴

In 2013, CRUK and the National Cancer Registration and Analysis Service (NCRAS - formerly the National Cancer Intelligence Network) [established a partnership](#)⁵ to conduct analyses that both organisations see as priorities in providing intelligence to support improved patient survival and outcomes. The partnership has enabled a better understanding of how patients use services to confirm diagnoses, how factors such as stage at diagnosis, treatment and comorbidity affect cancer survival, and how patients experience their cancer journey. To assess the impact of early diagnosis initiatives such as ACE, screening programmes and improvements in healthcare, it is important to have accurate and complete detail on the stage of a cancer at diagnosis.

NCRAS produces information that can shed light on cancers diagnosed via different routes and how survival compares across these categories. [Routes to Diagnosis](#)⁶ analysis uses routinely collected data sources (Hospital Episodes Statistics, Cancer Registry data, Cancer Waiting Times and data from the cancer screening programmes) working backwards through patient pathways to examine the sequence of events that led to a cancer diagnosis, categorising patients into one of eight routes of presentation. Exploring these routes provides yet more evidence that patients whose cancers are diagnosed at an earlier stage almost

always have improved chances of survival because treatment is likely to be more effective than it is for those diagnosed at a late stage.

Figure 1, below, taken from the NCRAS Routes to Diagnosis⁶ work, illustrates the relative survival of patients diagnosed with colorectal cancer between 2006 and 2013. Colorectal cancers diagnosed via the Bowel Cancer Screening Programme show the highest rates of survival over time with those diagnosed via the emergency route the lowest.

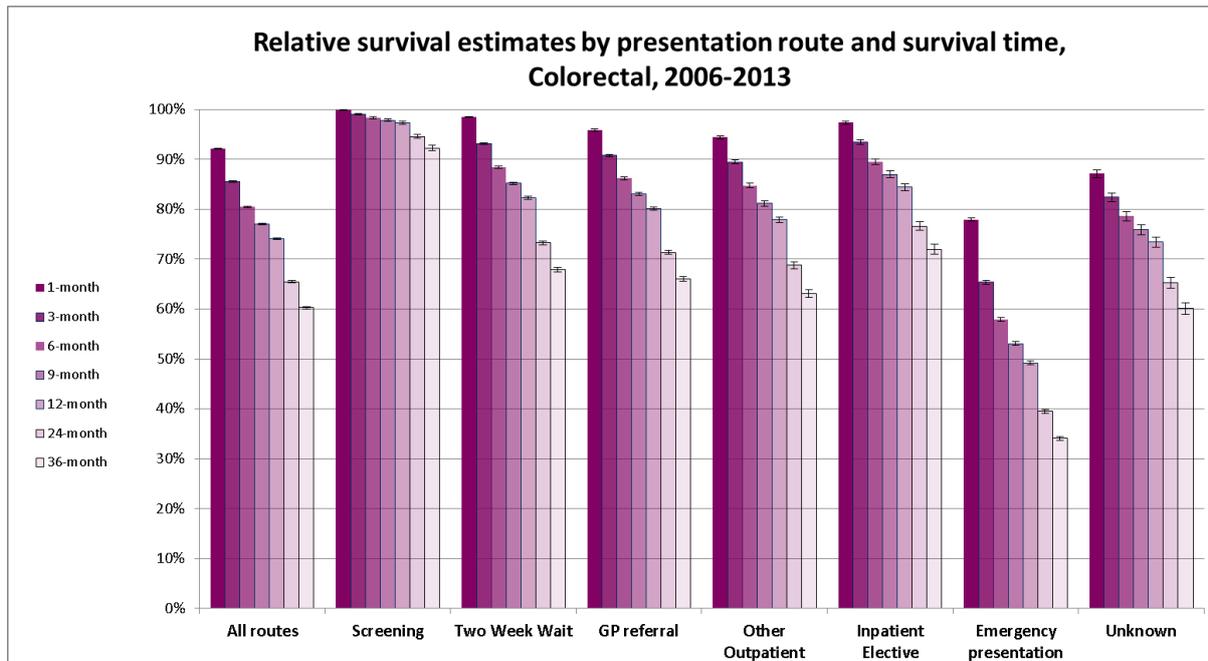


Figure 1: Relative survival estimates by route, persons, for time-period post colorectal cancer diagnosis, 2006–13

Since the introduction in 2000 of the mandatory standard for patients with suspected colorectal cancer to be first seen by a specialist within two-weeks, there has been a steady increase in the number of patients referred.⁷ Compliance with the standard is achieved when the patient is first seen in an outpatient setting by a consultant (or member of their team), or seen in a diagnostic clinic, or goes ‘straight to the diagnostic test’ such as colonoscopy. The 2WW referral aims to accelerate any resulting cancer diagnoses and is based on the very latest 2015 referral guidelines (NG12) endorsed by the National Institute of Health and Care Excellence (NICE).⁸

There have been concerns that the number of cancers diagnosed via this referral route is low. Colorectal cancer conversion rates for NHS Trusts in England (the percentage of cancer diagnoses resulting from a 2WW referral) vary from 2% to 9% among 137 Trusts. Although this variation is narrow the conversion rate indicates a low yield for diagnosing colorectal cancer, and unless the 2WW referral conforms to the NICE referral guidelines, this practice could have a negative impact on the waiting times of patients with colorectal cancer who present via less urgent routes.

Error! Reference source not found. overleaf, produced from the recently published Routes to Diagnosis data⁹, illustrates the percentage of colorectal cancer diagnoses presenting through each of the eight distinct routes.

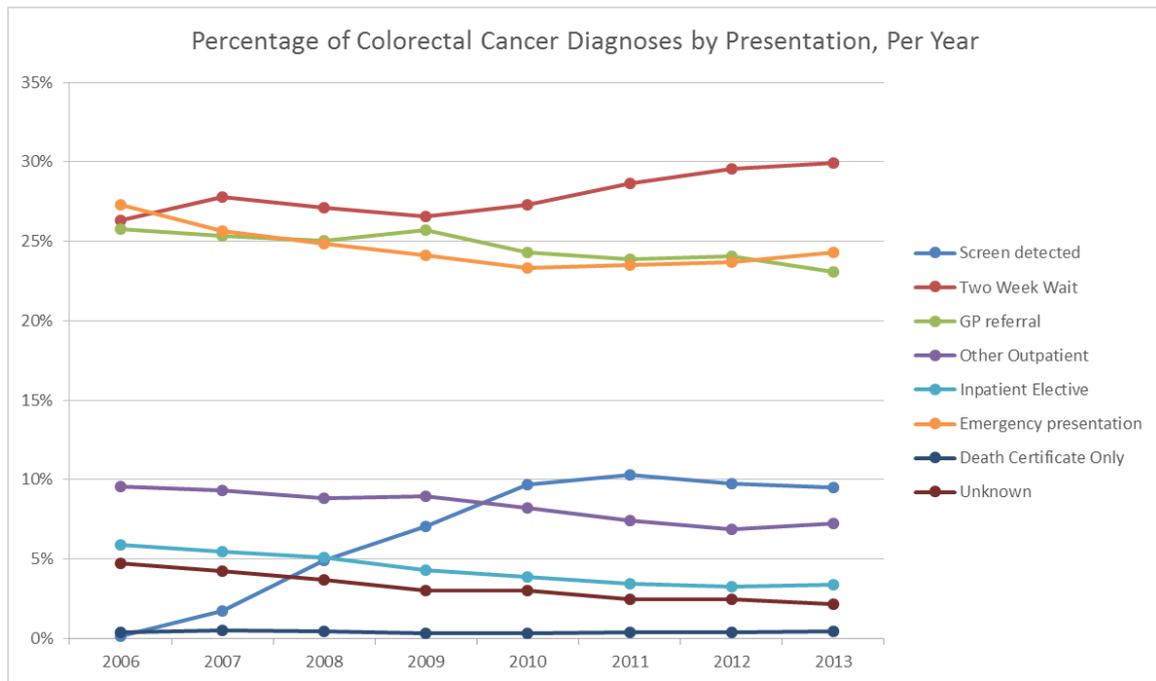


Figure 2: Percentage of colorectal cancer diagnoses by presentation route, by year of diagnosis, 2006 - 2013

In spite of the identified low conversion rates, this data illustrates that the 2WW route continues to yield the highest incidence of colorectal cancer diagnoses (at 30%), recently attributable to the Be Clear on Cancer Campaigns, run in 2012 and 2013, to raise awareness of colorectal cancer symptoms and encouraging patients to attend their GP sooner. The proportion of patients diagnosed from the Bowel Cancer Screening Programme increased steadily between 2007 – 2010, but has since plateaued, despite the age extension to screening invitation (all 70 to 74 year olds was introduced in 2009). Between the years 2006–2010, there was a steady decrease in the number of patients diagnosed with colorectal cancer through emergency presentation routes, from 28% to 23% respectively, with a slight increase to 24% since then.

If patients present in primary care with recognised colorectal symptoms and referral to a hospital based specialist is required, GPs are encouraged to use either the recognised urgent suspicious cancer referral 2WW route following the latest NICE referral guidelines; a more routine referral route if the presenting symptoms are not suspicious of cancer; or through a more direct ‘open access’ referral route for the appropriate diagnostic tests if this service is locally available.

2.1 Variation in waiting times for lower GI cancers

A document with analysis on variation in waiting times for lower GI cancers has been produced by Gemma Luck, ACE’s data analyst, to support this report and can be viewed [here](#)¹⁰. Included in the document are findings and methodology on the variation across trusts in England for the 62 day wait for treatment and 2WW referrals.

The document reports a range of between 7 and 13 days among 139 trusts for patients seen by a specialist after referral for 2WW, as well as lower GI cancer conversion rates among 137 trusts.

A range of between 49 and 64 days from urgent GP referral to start of treatment, outlined in the document, also demonstrates wide variation found between trusts in England.

3. Scope of colorectal cluster & referral approaches

The scope of the ACE clustered projects remains consistent in that all are aiming to diagnose patients via a STT route, reducing waiting times **FROM** referral **TO** the appropriate diagnostic investigation(s) and onto a confirmed diagnosis. All want to increase capacity by eliminating unnecessary outpatient appointments, streamline the patient journey, manage the continued increase in the rate of 2WW referrals and provide a flexible and responsive specialist service.

The referral processes for the ACE projects are similar in that patients will initially see their GP with recognised colorectal symptoms. If the GP decides the patient requires further investigation, an onward referral to a hospital based specialist is made. GPs use either the recognised urgent suspicious cancer 2WW referral route following the latest 2015 NICE referral guidelines; or alternatively a more routine/less urgent referral route if the presenting symptoms are not suspicious of cancer.

With clear referral symptom criteria there are opportunities to establish STT pathways, where a diagnostic procedure is arranged as the first episode of care, in place of an initial out-patient hospital appointment. If the GP considers the patient fits the STT criteria they will refer the patient to an endoscopy provider, in most circumstances via:

- a hospital-based triage service where a consultant or nurse-led assessment service will organise the endoscopy appointment if considered appropriate, or
- through a more direct 'open access' referral route to the most appropriate diagnostic test if this service is locally available

In order to ensure the STT pathway was acceptable for patients and GPs, the ACE Project teams have worked hard to include what improvements each wanted from a redesigned referral process. In consultation with GPs as principal referrers and CCGs, they identified the benefits of improving integration between primary and secondary care by improving the quality and criteria for STT referral, documented in clear, symptomatic guidelines. The GPs also insisted on patients being assessed, diagnosed and treated within the agreed cancer waiting times standards and improved communication systems via the Choose and Book electronic referral system. Likewise patient groups wanted to accelerate the speed of a confirmed diagnosis following referral to a specialist and onto the start of hospital treatment without any unnecessary delay.

3.1 Hospital-based triage service

The majority of the ACE projects have implemented their STT pathway by establishing a formal, hospital-based triage service in order to review the appropriateness of each colorectal

referral. The referral criteria has been focused initially on the 2WW cohort of patients - those presenting patients that fit the NICE referral guidance (NG12) that the GP considers are suspicious of having cancer. The ACE projects have adopted either one of two hospital-based triage models that have developed over recent years:

- a 'virtual' clinic held daily either by a consultant colorectal surgeon or a colorectal nurse specialist (under the supervision of the consultant), who use a detailed GP referral form and an agreed protocol to triage each patient directly to the most appropriate diagnostic test (colonoscopy/flexible sigmoidoscopy/CT virtual colonography)
- a colorectal telephone assessment pathway (CTAP) where a colorectal nurse specialist (CNS) makes contact with each patient and using a detailed telephone protocol script, reviews the patient's presenting condition and symptoms prior to the arrangement of the most appropriate diagnostic test as above

The [virtual clinic model](#)¹¹ relies on the completion of a decision based customised referral form agreed between the referring GPs and hospital-based colorectal team. Each day the nominated duty consultant/CNS reviews the GP referral documentation and further assesses each patient as to the most appropriate diagnostic test. Endoscopy pre-assessment is then followed up separately by the endoscopy unit via a telephone call with each patient. This includes a full risk assessment of each patient's ability to take the required bowel medication at home prior to the booked investigation date. The prescribed bowel preparation medication is then posted directly to each patient's home address.

To comply with patient safety guidelines a patient group directive has been agreed locally by each of the ACE projects hospital trust's drugs and therapeutic committees for the supply and administration of the required bowel medication and each relevant member of staff is competency trained.

The [CTAP model](#)¹² is based on a clinical assessment of the GP referral and further questions and prompts by the CNS during the telephone clinic appointment. This also includes the first stage of the endoscopy pre-assessment, completed by the endoscopy team via a second telephone call. Patients with comorbidities that are deemed high risk are advised when to stop other medication and any management of anticoagulation therapy. The most appropriate outcome/test for the patient is then agreed by the colorectal team and booked, in accordance with the [protocol](#)¹³. Harriet Watson, Colorectal Consultant Nurse at Guy's and St Thomas' NHS Foundation Trust, London, has produced a helpful 'How to Guide' on the introduction of a CTAP service for the triage and assessment of colorectal referrals (available [here](#)¹⁴).

Having direct access to the electronic endoscopy booking system has enabled the colorectal teams to manage the dedicated colonoscopy slots and ensure the immediate booking of available slots, giving the CTAP patients a planned date for their diagnostic investigation at the time of their telephone appointment.

One of the more innovative ACE projects is based at the University Hospitals of Morecambe Bay, who are testing the use of a hospital-based administrative triage in directing appropriate patients STT. On receipt of a GP 2WW referral, administrative staff at the Trust are using

clinically agreed guidelines to triage patients straight to endoscopy test or out-patient clinic appointment as appropriate. The triage criteria for Morecambe Bay can be found [here](#)¹⁵. It is essential the new GP referral proforma (found [here](#)¹⁶) is accurately completed in primary care; this reflects both the latest NICE referral guidance for GP's (NG12) and the STT pathway. This is being rolled out gradually to allow the local endoscopy service to adjust to any increases in the number of referrals received. It is also critical that the administrative staff are fully conversant with the agreed clinical guidelines though clinical advice is always available via the Trust colorectal team if there are any doubts in interpretation. Feedback via the Macmillan GP's has been very positive and supportive of the triage service, as is evidence gathered from investigated patients.

If a patient is deemed **unsuitable** for any hospital-based triage either for complex clinical reasons (perhaps other long term conditions), are frail and elderly, hard of hearing or have other disabilities, they are offered an outpatient clinic appointment in reserved slots within the maximum 2WW standard.

3.2 GP direct access/open access to first investigation

Two of the ACE projects based at the Homerton and Croydon University Hospitals in Greater London are providing innovative access to endoscopy services in offering the booking of flexible sigmoidoscopy and colonoscopy investigation **direct** from primary care. These open access services are being provided for those patients whose symptoms do not fit the NICE referral guidance (NG12) that the GP considers are suspicious of having cancer, yet present in primary care as 'low risk, but not no risk'.

Both ACE projects have benefited from strong clinical leadership in primary and secondary care in promoting the innovative pathway changes, and have worked collaboratively with commissioning colleagues from their respective City & Hackney and Croydon Clinical Commissioning Groups (CCG), to ensure these redesigned services are a sustained referral option for referring GPs. The pathways are also a definitive link to Best Practice Commissioning for early diagnosis of colorectal cancer recommended by the Transforming Cancer Services for London programme and further endorsed in the Five Year Commissioning Strategy for London (2014, NHS England).¹⁷

The key rationale for direct access is that both primary and secondary care sectors act as one unified service for the patient. The clinical assessment that normally takes place in secondary care regarding appropriateness of referral and the type of diagnostic test required is undertaken in primary care by GPs who are trained to do so, who then provide a detailed referral assessment including all the information needed by the secondary care clinicians. This makes it easy for the secondary care clinicians to proceed direct to the test with minimal and brief discussion with the patient on the day of the test.

One of the most significant drivers for this pathway change has been the intent to improve the patient experience in reducing the routine waiting time to the first diagnostic test, and for those patients where a colorectal cancer is diagnosed, to promote early diagnosis by increasing the proportion of patients diagnosed with stage I & II with good clinical outcomes.

The NCIN Routes to Diagnosis data confirm that a significant proportion of colorectal cancers are diagnosed via the routine GP referral route at 25% in 2013⁹.

Both Trusts have agreed strict referral criterion to the direct access diagnostic service involving GPs, CCGs as direct commissioners of the service, and representatives from the colorectal and endoscopy clinical teams. Inclusion criteria are based on presenting symptoms of rectal bleed at Croydon (Croydon rectal bleed pathway can be found [here](#)¹⁸) and at the Homerton, patient age, symptom presentation of bowel habit, rectal bleeding, level of anaemia, and familial history of colorectal cancer (Homerton direct access colonoscopy/flexi sig pathways can be found [here](#)¹⁹). Other medical issues are considered at the initial consultation in primary care including existing prescribed medication, insulin dependent diabetes, bloods etc. Equally an explicit exclusion criterion has been agreed based on other potential conditions - mental health, dementia, obesity, recent myocardial infarction or cerebrovascular accident etc.

Similarly, direct access referral proformas for both flexible sigmoidoscopy (Homerton flexi sig referral proforma can be found [here](#)²⁰) and colonoscopy have been agreed and it is essential that referred patients meet the specified criteria and the proformas are appropriately completed. The receiving hospital merely performs a check that the referring GP practice has completed the proforma correctly, and that each patient conforms to the agreed criteria (e.g. age, symptoms), though importantly no recognised hospital triage takes place at this stage.

If a patient is considered appropriate for direct access referral, the GP books the most suitable diagnostic endoscopy slot via the NHS e-Referral Service, which replaced Choose and Book in June 2015. During the consultation in primary care the referring GP explains the appropriate procedure to each patient and provides a [patient information leaflet](#)²¹. The leaflet further describes the planned procedure in detail, and importantly highlights the required dietary changes each patient will need to adhere to, two days prior to the investigation date. Appropriate bowel preparation is prescribed and given to the patient, with further instruction for administration contained in the patient information leaflet.

Following the planned direct access investigation, any patients who are diagnosed with cancer are immediately added to the hospital cancer register and referred for discussion at the next colorectal multidisciplinary team meeting. Any adenomatous polyps that are detected are removed if they are of a certain size during the investigation otherwise they will be brought back for a dedicated operative list to remove larger polyps. The patient is then added to the polyp surveillance register and reviewed again in 1, 3 or 5 years' time depending on risk stratification of the polyp.

Most other patients are referred back to the care of the referring GP, though if biopsies are taken these are reviewed by the colorectal team in a virtual clinic setting and the results are communicated back to the patient and the GP with advice and guidance on future management.

4. Benefits and Early Outcomes

All of the ACE project initiatives will be subject to robust evaluation led by the DH Policy Research Unit (PRU), ensuring that evidential learning is collated and shared across the wider NHS. Early outputs from the projects to date are practical and descriptive, including materials for sharing (protocols and good practice guidance) with data for analysis by the PRU now starting to emerge. This is in line with the ACE Programme's evaluation plan where early outputs are *formative* and later outputs (from June 2016) are *summative*, comprising conclusions and cancer outcomes impacts.

Early results from those ACE projects introducing the pathway for the 2WW referrals has helped to reduce the waiting time for the first diagnostic test between 7 and 14 days, essentially by eliminating the unnecessary first out-patient appointment. Inevitably this reduction is making a timely contribution to the achievement of the overall 62 day cancer waiting times standard and will consequently become an enabler for the new metric recommended in the latest Cancer Strategy, Achieving World Class Cancer Outcomes 2015 - 20, in that all suspicious cancer referrals should have a confirmed definitive diagnosis – cancer or not - within four weeks of a GP referral⁴.

Both the Homerton and Croydon Trusts confirm that introducing their GP direct access pathway has reduced waiting times for non-2WW referrals from the date of the referral to the date of the first investigation; previously some patients had been waiting over and above 13 weeks. This was the main lever for the implementation of the change and where many of the patients with the risk of a colorectal cancer were waiting undiagnosed.

First sets of data gathered from front runner ACE projects are starting to be analysed by the local analytical teams and the PRU; the initial response is to report on common elements consistently, for example, the % of clinic first; % first diagnostic test breakdown by route and association of diagnostic intervals and stage at diagnosis. The following data for the first few months show the early results of the STT service:

STT Diagnostic Time Intervals	
% of 2WW referrals suitable for STT	55%
Time from 2WW referral to first consultation	Median 10 days (range 6 – 21)
Time from 2WW referral to colonoscopy	Median 10 days (range 6 – 21)
Time from colonoscopy to biopsy result	Median 15 days (range 4 – 23)
Time from referral to decision to take off TWW	Median 10 days (range 6 – 21)
Time from non-2WW referral to colonoscopy	Median 3 weeks (range 21 – 24 days)

The STT pathway has provided an extremely flexible model as there is minimal operational set up required. No outpatient clinic rooms, clinic preparation (e.g. patient medical records) or clinic administrative or supporting nursing staff are required. This enables the service to respond flexibly to the increasing demand for a colorectal specialist opinion and the inevitable peaks in demand.

2WW referrals to the hospital-based triage are receiving an appropriate and qualitative service that GPs are becoming more familiar with. Patient suitability for colonoscopy is a prerequisite of the triage service and incorporating safe pre-assessment has improved to include questions on additional comorbidities, social support, sedation risk and management of bowel preparation. The CTAP referrals are additionally benefitting from an indirect counselling service as the agreed telephone script includes information on wider health determinants such as health promotion, diet, lifestyle advice, risks and symptom management.

In eliminating the first outpatient appointment it has freed up consultant and associated clinical and nursing staff time to see either more complex cases in clinic, or readjust job plans to include other sessional arrangements, providing a real financial benefit and incentive to sustain the pathway changes.

One of the most positive benefits the ACE projects have reported has been the high satisfaction experience and feedback from referring GPs and patients. Analysis of patient satisfaction on over 300 cases at the Wirral University Hospital Trust indicate that over 90% of patients are very satisfied with the STT service offered.

5. Challenges and risks of implementing STT

Inevitably the projects face many challenges including ‘professional protectionism’ in holding on to traditional first out-patient consultation settings, capacity and demand constraints within endoscopy services and whether the patient’s first encounter with the specialist colorectal service is more effective being face to face, virtual or from a telephone assessment service.

If a STT pathway is considered appropriate for the 2WW referrals, the relevant diagnostic test must still be performed within the mandated two week waiting (2WW) period. The current national Cancer Waiting Times Monitoring Guidance²² states that the 2WW standard is only achieved when the patient is first seen and not first ‘assessed’ at either a ‘virtual’ clinic setting or via the telephone, so introducing the STT pathway for 2WW referrals has been extremely challenging.

Some of the ACE projects have reported that triaging patients to radiology has been more challenging than endoscopy from a clinical perspective. Local radiologists are keen for patients to attend an out-patient clinical assessment prior to booking any radiological investigation. In those instances where a CT scan or CT colonography is considered the most appropriate first investigation, then an initial out-patient appointment may be required first. Local protocol to be agreed by the colorectal multi-disciplinary team will determine this arrangement.

As discussed, the STT service is reliant on high quality GP referrals and inevitably this requires considerable resource in both time and energy to agree appropriate referral criteria, train all the GP staff in how to both understand and apply the criteria and use any required technology such as electronic booking systems.

Perhaps the biggest challenge ACE projects have identified is the issue of available endoscopy capacity and rising demand with waiting lists for diagnostic tests constantly increasing and exceeding acceptable waiting times standards.

[Scoping the Future](#)²³ – an evaluation of endoscopy across the NHS in England, is a report recently published by CRUK, providing national evidence to back the expressed concerns of endoscopy staff, struggling to cope with increased demand and a lack of trained workforce. The report shows the NHS will need to carry out close to a million more endoscopies per year by 2020 from approximately 1.7 million per year now, to around 2.6 million. This represents a huge challenge and urgent action is required now if the NHS is able to respond and provide positive solutions.

ACE recommends a unified approach is taken across the NHS, working in collaboration with the NHS National Cancer Team and the newly created Transformation Board to develop the required endoscopy capacity and workforce. The Cancer Strategy identifies some promising solutions, including additional investment, Health Education England developing a new national training scheme for non-medical endoscopists, and a pledge to train an additional 200 more endoscopists by 2018. The ACE Programme endorses these commitments, acknowledges that the pace and scale will be determined by the available budget, yet reiterates it is vital the strategy recommendations are implemented without delay.

In working closely with endoscopy staff to implement STT, the ACE projects have suggested the following key interventions to better understand how the endoscopy service can improve productivity and effectiveness:

- Responsibility for the endoscopy unit can straddle medical and surgical teams, often with no clear accountability or leadership, so time is required to establish clear managerial and operational responsibilities including accountability, delivery roles e.g., scheduling & booking, and communication
- Undertake a capacity and demand exercise to appreciate when STT patients can be best booked and arranged. The NHS Interim Management & Support (IMAS) Intensive Support Team²⁴ has developed a demand and capacity simulation tool and can also provide expert support with managing waiting lists.
- Agree on any required additional data collection, particularly if starting with a STT pilot – this can provide the evidence to support a business case for any required additional capacity, workforce and future development
- Ensure the endoscopy booking team are fully conversant with all STT operational procedures for scheduling direct booking, patient communication and pre-assessment

6. Conclusion

Given that late diagnosis is one of the major reasons often cited in explaining our poor cancer outcomes, the ACE projects are exploring opportunities to create STT pathways, where a diagnostic procedure is arranged as the first episode of care within two weeks, in place of an initial outpatient appointment.

Based on clear primary care referral criteria, the ACE projects are aiming to provide an earlier assurance of diagnosis by reducing the time interval from referral to diagnosis, enabling earlier treatment and improving patient experience by reducing the number of hospital attendances required.

As the ACE projects progress they are developing a clearer understanding of their colorectal clinical pathways, enabling the development of referral criteria to identify more patients suitable for STT pathways.

At its heart, Achieving World-Class Cancer Outcomes⁴ sets out a vision for what cancer patients should expect from the health service including prompt and accurate diagnosis. The strategy suggests this will require, 'a shift towards faster and less restrictive investigative testing, quickly responding to patients who present with symptoms, by ruling out cancer or other serious disease'. The strategy also acknowledges achieving this vision will require a significant increase in diagnostic capacity, giving GPs direct access to key investigative tests, alongside the testing of new models which could reduce the burden and expectation on GPs.

STT is a purposeful initiative that can support colorectal teams deliver the ambition declared in the strategy that by 2020, 95% of patients referred for testing by a GP are definitively diagnosed with cancer (or cancer is excluded) and the result communicated to the patient within four weeks.

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8. Contact ACE

If you have any queries about ACE, please contact the team at: ACEteam@cancer.org.uk
In addition, you can visit our webpage: www.cruk.org/ace where we will publish news and reports.

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The ACE Programme
Accelerate, Coordinate, Evaluate

Stay in touch with ACE

Annex 1

Name:		
Email address:		
Organisation:		
Role:		
		Yes/No
1.	I am interested in the ACE Colorectal Pathways cluster and would like to receive a soft copy of any further reports produced.	
2.	I would be willing to assist the ACE Programme by completing questionnaires, sharing information about our local service or by receiving visits from the ACE team.	
3.	If an opportunity were to arise, I would be interested in working with ACE to improve our local colorectal cancer pathways.	
4.	Comments/Questions/Areas of interest regarding this Interim Report:	

Please return this form to Brian.Knowles@cancer.org.uk