Rapid Colorectal Diagnostic Pathway

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CANCER CASCADE WORKSHOP

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Content

- **Harriet**
  - Why & How?
  - Examples from own practice

- **Ed**
  - An overview of the aims, delivery & learning from the ACE project
Background

- Bowel symptoms common
- 10% of GP consults for GI symptoms.
- Most is self-limiting illness or functional (IBS)
- Which patients may have bowel cancer?
- Chance of CA colon dependent on age and symptoms.
- UK = 25% of emergency presentation (Hamilton 2016, BMC Medicine)
- If patient fits 2WW criteria (therefore at increased risk) NICE recommend colonoscopy as gold standard test
Number of GP visits before referral

- 53% Once
- 26% 2-3 times
- 21% > 3 times
Colorectal cancer

- 25% patients still diagnosed via A&E – more advanced disease / worse prognosis.
- Easier access to investigations / colonoscopy service would impact on these numbers.
- Colonoscopy carries significant risks, a screening process is therefore required, direct GP referral is not appropriate.
- Differences in access to colonoscopy across England and Wales (3 fold) – possibly due to absence of national guidance on referral.
‘There’s only one way endoscopy demand is going in the UK…and it’s up’

Heather Walker
Policy Manager, Cancer Research UK
Crude colonoscopy rates per 100,000 in 2010/11 - international comparisons

- Wales
- England worst (West Midlands)
- England average
- England best (North East)
- Scotland
- Poland
- Australia
- Canada (Nova Scotia)
Historical data and projections for colonoscopy and flexisig activity

The pink line is total projected activity of colonoscopy and flexisig following Cancer Strategy commitments, awareness campaign, screening programme etc.

The purple line represents underlying colonoscopy and flexisig activity excluding screening programmes, awareness campaigns, and in the future, flexisig screening, and GP direct access diagnostic activity.
Variation in percentage waiting more than 6 weeks for a colonoscopy by CCG area
Difficulties with colonoscopy

• Overall lack of access AND inequity

• No clear guidelines

• NICE / NAEDI contradictory

• Sigmoidoscopy vs colonoscopy, surgical vs gastroenterology

• In-house variation enormous

• Capacity issues in the face of rising demand
What’s the solution?

To develop a novel pathway for patients with colorectal symptoms that is patient centred and rationalises the patient journey
Drivers from DH

- DoH - evidenced based single pathway for lower GI symptoms
- Reduce variation in approach, avoid delayed diagnosis, streamlines patient pathway
- Pressure to implement Straight to Test (STT), commissioning intention for most CCGs
- ‘DoH guidelines - telephone assessment and triage does not stop the 2 week wait clock
Straight to Test

- Standard referral route (GP to outpatient clinic) replaced with protocol-driven investigation
- Symptoms, age + initial primary care investigations are used to dictate 1st choice of test.
- Patient discharged after test or seen in clinic with results and/or to assess symptoms, agree treatment plan or discharged.

Pros

- Reduces delays by removing steps from pathway.
- Patients benefit from one stop service and get the right test first time.
- Drives improved communication between primary and secondary care
- Makes better use of scarce time and facilities in secondary care.
Straight to Test - cons

- Pts may get the wrong test
- Pts may not be mentally and physically prepared
- Pts may be at risk due to contraindications / co-morbidities
- Pts too frail for test or bowel preparation.
- Mismatch of referring symptoms and actual symptoms.
- ?leads to over investigation - ie when symptoms settle before seen

Colorectal Telephone Assessment Pathway (CTAP)

- Cons of STT can be mitigated by the introduction of CTAP
- However Telephone triage for 2 week wait referrals does not ‘stop the clock’
- Currently if vetting, validation, pre-assessment & booking is undertaken non face to face, clock does not stop until the patient attends for colonoscopy.
- High priority for providers to meet 2WW target as non-compliance leads to punitive financial penalties.
What is required from a rapid access pathway?

- Diagnose **all** patients with bowel cancer in a more timely fashion,
- Reduce wait times (2 & 18 week pathway)
- Increase capacity by avoiding unnecessary OPA
- Ensure Endoscopy waits were managed and provide a filter for patient selection and safety
- Streamline patient journey
- Manage a persistent surge in number of referrals
- Provide a flexible service that responds to peaks in demand
The Dorset Model

- Carried out a 6 month consultation period with local GP’s and patients

- GP’s want:
  - easy referral mechanism
  - compatible with Choose & Book (CAB)
  - their patients assessed, diagnosed and treated quickly

- Patients want:
  - quick assessment,
  - early diagnosis and treatment,
  - streamline journey,
  - specialist advice,
  - convenience
  - eliminate the need to find a parking space!!!
Traditional Patient Pathway

- GP referral
- Consultant triage
- OPD appointment (8 weeks)
- Colonoscopy appointment (6 weeks)
- OPD follow up (3 months)
The Colorectal Telephone Assessment Pathway

1. GP referral
2. Nurse telephone assessment
3. Colonoscopy appointment

1 - 2 weeks
2 weeks
Patient sees GP

GP refers pt to TAC on choose and book electronically
(available within 10 days)

Referral assessed & triaged by Nurse Consultant

Patient has Telephone Assessment*

Rectal Bleed Clinic*
Coloscopy*
CT scan
Discharged
Out-patient clinic*

OPA if serious pathology found OR Discharged if normal / benign pathology with management advice – process managed by Nurse Consultant

Tests / Treatment / Discharge
Benefits of CTAP

- Enabled us to eliminate waits for non fast track referrals – was up to 13 weeks
- Pts phoned the following week and have test 2 weeks later
- Decreased wait times to investigation from 10 weeks to 3 weeks for all non fast track referrals
- Flexible due to minimal set up so able to respond to peaks ie media campaigns for bowel cancer awareness
- Quality appropriate triage
- High quality counselling of patient
- Safe assessment of patient’s suitability for colonoscopy
- Reduced DNA rates
- Frees up Surgeons to see more complex cases & operate
- Positive feedback from GP’s & patients
Disadvantages / risks

- Remuneration from commissioners variable
- Language / interpreter services
- Management of diagnostic services
- Need access to CT Colonography to support Endoscopy services
Outcomes of CTAP

- 4000 patients assessed via this route May 2008 – Sept 2012
- 87% of patients sent STT – mainly colonoscopy
- 98% patients assessed within 3 weeks of referral (unless patient choice)
- 95% patients investigated within 3 weeks following TAC (unless patient choice)
- Feedback shows high satisfaction rates from patients & GPs
Pilot via NHSIQ

- Test the transferability of the ‘Dorset Model’ (for non-2ww referrals),
- Approved by National Peer Review lead
- Guiding principles:
  - TAC undertaken by a suitably trained clinician - demonstrate core competencies
  - Results / outcomes audited
  - No patient is disadvantaged
  - Patients given choice on OPA or TAC
  - Results and progress reported to National Clinical Director for Diagnostics and GI.
STT at GSTT

- Started as a pilot due to DoH guidance for 2ww referral being assessed face to face
- Started Jan 2013 – present
- 52% improvement in time to diagnosis for 2ww
- Halved the DNA rate of 2ww referrals
- Patient satisfaction high
- Cancer yield 13%
STT at GSTT

- TAC on Choose & Book or via 2ww office

- High quality GP referrals essential:
  - Manage patient expectations
  - Pts suitability for telephone assessment
  - Pts suitability for colonoscopy / bowel prep
  - Bloods including eGFR
  - Faecal calprotectin
  - Social history
  - Co-morbidities
## GSTT referrals

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<td>2014-August</td>
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**Introduction of CTAP**
How GPs can assist

- Highlighting patients suitability for a telephone assessment:
  - Hard of hearing
  - Language barriers
  - Learning difficulties
  - Very frail and elderly
  - Pt has specifically requested a face to face appointment
  - Pt has no telephone!

- Results of all recent relevant blood test, INC: FBC, ferritin, iron studies

- eGFR & creatinine results crucial – National Patient Safety Agency

February 2009

Supporting Information

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Evidence of harm associated with weak systems for the supply and use of bowel cleansing solutions | 3
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How GPs can assist

- Results of abdominal and PR examination done in surgery
- PMH and list of all current prescription medication
- In your opinion is the patient fit enough for bowel prep at home?
- Patient’s social situation - ie do they live alone, local support
- Patient’s state of mobility / WHO status
Alternatives to Colonoscopy

- CT Colonography
  - Full bowel preparation (eg pt doesn’t want colonoscopy / sedation / invasive test)
  - Faecal Tagging (no laxatives required)

- Flex sig + CT enema
- CT scan abdo / pelvis
- Watch & wait approach
Developments

- Pilot Bowel Cancer Awareness Media campaign 2011 – referrals rose by 32%
- National Bowel Cancer Awareness campaign 2012 – 40%
- CTAP able to cope with the demand in capacity
- National Roll out / dissemination via NHSIQ initially but now continues due to high profile
- Led to projects such as ACE
Patient involvement
Summary

- Success of service was due to the focus on integrated approach with GP’s and pts – groundwork essential
- Good quality and volume of data shows pathway is safe, robust and efficient for ALL patients (not just 2ww)
- For non fast track referrals much quicker
- Preference is to receive all Colorectal referrals this way to enable earlier diagnoses and provide equality for all patients diagnosed with Colorectal cancer
Thank you!

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