Integrated Lower GI Pathway

Lower GI Symptoms

LOW RISK Colorectal Cancer Does not fulfil NICE Guidance (NG12)

Age <50 yrs

Worrying Symptoms

Reassure and Consider performing FCP Fulfils NICE guidance (DG11)

Age ≥50 yrs with fresh rectal bleeding, no other symptoms

Refer for Flexi Sigmoidoscopy or as per trust guidance

Age ≥50 yrs

Reassure, follow up as required Consider FCP NICE Guidance DG11

2WW

Perform FIT Test

FIT +ve

FC <100

FC ≥100

Repeat FCP

FC <100 mcg/g

Routine Gastro Referral

FC 100-250 mcg/g

FC >250 mcg/g

Urgent Gastro Referral

These patients fulfil low risk NICE guidance (DG30)
Background – case for change

Support patients to have the right test in the right place at the right time

System Wide Lower GI Pathway

Improve early diagnosis of cancer and IBD

Variation in diagnostic testing – standardising practice

Efficient utilisation of resources
### How & when are people diagnosed

<table>
<thead>
<tr>
<th>How</th>
<th>Early stage</th>
<th>Late stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening</td>
<td>10%</td>
<td>37%</td>
</tr>
<tr>
<td>GP 2WW referral</td>
<td>31%*</td>
<td>15%</td>
</tr>
<tr>
<td>Routine GP referral</td>
<td>23%*</td>
<td>22%</td>
</tr>
<tr>
<td>Emergency presentation</td>
<td>23%**</td>
<td>7%**</td>
</tr>
<tr>
<td>Hospital inpatient</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>3%</td>
<td></td>
</tr>
</tbody>
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* GPs need a better way to assess “risk” than the current guidance
** We need to reduce the number presenting as an emergency
NG12 defined referral of high risk patients

For the ‘low risk’ but not no risk patients...(DG30)

Patients without rectal bleeding who:
- Aged $\geq 50$y with abdominal pain or weight loss
- Aged $< 60$y and have a change in bowel habit or IDA
- Aged $\geq 60$y or over and have anaemia, even in the absence of iron deficiency

......Offer them a FIT
What is Faecal Calprotectin FC?

- It’s a biomarker like D-dimer and troponin
- Lacks sensitivity or specificity unless used within a defined protocol/pathway
- Targeted use increases its predictive value
- NICE guidance DG11 – it is an option for adults with recent onset of lower GI symptoms when cancer is not suspected but in whom specialist investigations are being considered
- Used to support the diagnosis of IBD and IBS
- Normal FCP has a high negative predictive value for IBD of >95%
- One third of high tests “normalise” on repeating the test
What is FIT?

• FIT = Faecal Immunochemical Test
• Performed on a single sample of faeces
• FOBt detects Heme, the iron containing component of Hb and unfortunately false positive associated with quite a lot of foods, supplements and medication
• FIT uses antibodies to detect human haemaglobin
• FIT is more specific and sensitive to bleeding in the lower part of the GI tract
• FIT can be used in both screening and symptomatic patients BUT the level assayed is set differently in the screening group
• FIT has >95% negative predictive value for cancer in the low risk group
Recognising the Challenges to Roll Out

• Governance- being clear about where responsibility lies when cutting across a number of work-streams

• Clinical leadership- strong clinical input with financial representation for the business case and then a local implementation group which engages CCGs and Primary Care ensuring good communication across the whole system

• Dedicated project management support

• System approach with peer support and mutual accountability

• Evaluation – it’s never too early to think about this in order to support the specification for contracts and to ensure you can demonstrate impact
Data for first 6 months

Total number of tests = 4726

248 out of 251 practices have sent at least one test so far

Tests turn around time = 99.85% 1-5 days

Tests non-resulted = 15.85% (749)

Average positivity across 7 CCGs March-May = 20.2%

Average positivity across 7 CCGs June-August = 20.1%

FCP (Sheffield only) Jan’18-Sept 19 = 9257 of which 1731>100 but only 419 (41%) repeated
Review – what’s gone well, lessons

What’s gone well?
• Engaging Primary Care - GPs have embraced the tests, particularly FIT
• Single centralised pathology model
• Choice of test kit

What could have gone better?
• Underestimated number of FIT requests
• FCP still appears to be relatively under-used
• GP interpretation of FIT criteria
• Better if roll out of symptomatic FIT had been well in advance of screening roll out
Going forward

- Full evaluation locally
- Use of FIT in high risk patients?