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Transforming Cancer Services for London

Best Practice Commissioning Pathway for the early detection of colorectal cancer

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All London CCGs
Integrated Cancer Systems

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This is a controlled document.

Related documents:

These documents will provide additional information.

Ref no	Document ref	Title	Version
1		A Model of Care for Cancer services: August 2010 http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/Cancer-model-of-care.pdf	
2		Lung cancer: The diagnosis and treatment of lung cancer Issued: April 2011 **NICE clinical guideline 121** guidance.nice.org.uk/cg121 http://www.nice.org.uk/nicemedia/live/13465/54202/54202.pdf	
3		Saving 1000 Lives – improving outcomes. A strategy for earlier diagnosis of cancer in London. Commissioning guidance for London PCT clusters, March 2012	
4		Best Practice Commissioning Pathway - colorectal pathway 2013/14 (for use in 2013/14 contracts) 30/01/13	1.0
5		CG27 Referral Guidelines for suspected cancer, April 2011 http://guidance.nice.org.uk/CG27/NICEGuidance/pdf/English	
6		CG131 Colorectal cancer: The diagnosis and management of colorectal cancer http://publications.nice.org.uk/colorectal-cancer-cg131	

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1 Objective of this document.

The objective of this document is to:-

(a) Define best practice for the early detection of colorectal cancer for GPs in terms of a pathway and referral guidelines;

(b) Recommend adoption of best practice to London CCGs and propose next steps towards implementation.

2 Background.

Early detection has always been a fundamental part of the work to improve cancer services both nationally and in London. The London Cancer Programme (now Transforming Cancer Services for London – TCSL - programme) set up a workstream to implement the early detection recommendations from the *Model of Care* published in August 2010, and *Saving 1000 Lives* published in March 2012.

One of the recommendations was to create best practice pathways for use by GPs to enhance the early detection of cancer. These are being agreed for 3 tumour types: colorectal, lung and ovarian cancer. The aim is to encourage GPs to lower the threshold of suspicion at which point they refer a patient for diagnosis and to ensure that a definitive diagnosis is reached as quickly as possible.

These early detection pathways will link to the Best Practice Commissioning Pathways which set out best practice for the secondary care treatment of cancer. These have been agreed for colorectal, breast, lung and brain/CNS cancers to date.

3 Early Detection of colorectal cancer.

3.1 National guidance

The guidelines for GPs for direct access to diagnostic tests for cancer published in April 2012[1] quote the following as the introduction:

Between 1971 and 2008, incidence rates for colorectal cancer have increased by 33% for men and 12% for women. In 2008, colorectal cancer accounted for 14% of all new cancer diagnoses in men (57 new cases per 100,000 population) and 12% in women in England (37 new cases per 100,000).

Five-year survival rates from cancer of the colon and cancer of the rectum are calculated separately. For colon cancer, the five-year survival rate for men is 52% and for women 54% (diagnosed between 2004 and 2008 and followed up to 2009). For cancer of the rectum, the

[1]http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_133510

five-year survival for men is 54% and for women 57% (diagnosed between 2004 and 2008 and followed up to 2009).

Colorectal cancer is most commonly diagnosed in those aged 60 and over. Cases are highest in those aged between 70-79 for men and in those aged 85 and over for women. For a number of these symptoms associated with colorectal cancer, the risk of achieving a firm diagnosis varies with age.

25% of patients diagnosed with colorectal cancer present through an emergency presentation, 26% are diagnosed through an urgent two-week referral and 24% are diagnosed through a GP referral not completed through an urgent two-week wait referral.

The NHS bowel cancer screening programme was introduced in 2006 for men and women in their 60s and achieved national coverage by 2010. The age inclusion criteria is being extended to men and women up to their 75th birthday (those aged over can self-refer) and piloting of flexible-sigmoidoscopy screening for everyone aged around 55 began in autumn 2012.

The 2005 NICE guidelines highlight criteria for 'high risk' patients who should be referred under an urgent two-week wait. Nevertheless, it is known that only 50% of colorectal cancers ever have this 'high-risk' symptom pattern that would qualify for an urgent NICE referral with the remaining 50% having no obvious symptom complex. These patients take longer to be diagnosed and also have a worse mortality. As such, detecting cancer early in these patients will yield most benefit.

The national guidance goes on to suggest the definition of the cohort of patients for whom direct access to flexi-sigmoidoscopy may be of benefit. This is a change from NICE CG27 Referral for suspected cancer (2005)[2], published for use in primary care: this document recommends urgent referral to secondary care for a cohort of patients but not the use of diagnostic tests.

NICE Clinical guideline CG131[3] deals with the investigation of patients with suspected colorectal cancer in secondary care and recommends the use of colonoscopy to make a definitive diagnosis.

3.2 The recommendations for best practice in London

The early detection workstream of the TCSL programme convened a small group to consider the early detection of colorectal cancer. Input was sought from primary care, secondary care and screening services.

Considerable discussion was held about the risks of flexi-sigmoidoscopy missing cancers which could have been detected using colonoscopy. The group also discussed the role of the GP in choosing the right test, or referring to a specialist unit, which would decide which was the most appropriate test to reach definitive diagnosis quickly.

[2] http://guidance.nice.org.uk/CG27/NICEGuidance/pdf/English
[3] http://publications.nice.org.uk/colorectal-cancer-cg131

A draft early detection pathway was created in June 2012, but it was not fully supported and was not presented through the TCSL programme governance process for ratification. The pathway and referral guidelines contained here supersede that guidance.

4 The pathway and referral guidelines.

The narrative attached as appendix A represents the pathway that the group is recommending as best practice for London

It principally covers the group of patients who do not meet the criteria for urgent referral, setting out the symptoms clearly for which referral to a diagnostic service should be made. It proposes the reduction of the threshold age for referring new onset colorectal symptoms from 60 years of age in 2013-14 to 55 in 2014-15 and 45 in 2015.

It also aims to increase participation in the bowel cancer screening programme. 40% of patients identified with bowel cancer through the National Bowel Cancer Screening programme have stage I disease with a 95% 5 year survival rate. Only 5% of symptomatic patients are found to have stage I disease demonstrating the opportunities that are presented by the bowel cancer screening programme to detect cancer earlier and to improve colorectal cancer outcomes.

With the aim of investigating symptoms appropriately to reach a rapid definitive diagnosis, the group recommends best practice for London should be referral by the GP to a 'Diagnostic Service', a designated referral centre which will triage referrals and assign the most appropriate diagnostic test which will be booked directly with the patient. It should be noted that barium enema is not considered to be an appropriate first diagnostic test.

5 Process for agreeing the definition of best practice.

This paper will go to the following meetings for discussion and ratification:

Cancer Programme Executive	19th February 2013
Cancer Clinical Leadership Advisory Group	26th February 2013
Cancer Commissioning Board	1st July 2013

It will also be reviewed by service users through the London User Partnership group and with the Early Detection group in early March 2013.

This pathway has now been agreed as best practice for London by all three of these groups.

6 Adoption and implementation of best practice.

It is recognised that the definition of best practice set out on in this paper will have implications for CCGs in terms of referrals for diagnostic tests (numbers of colonoscopy or flexi-sigmoidoscopy) and the introduction of a diagnostic service, which will also impact on the way in which secondary care provider’s work.

There will therefore be a process of work with CCGs during the first quarter of 2013/14 -, April – June 2013 - to discuss the implications and to analyse what agreement to best practice would mean for each CCG. This will include activity volume and cost analysis. It will need to include reference to primary care systems (decision support software), and primary care education to ensure that all GPs are aware of and follow best practice at all times. This will be linked through primary care commissioning and contracting.

Following the agreement to commission best practice on a CCG basis, this will be built into Commissioning Intentions for 2014-15 in September 2013, for implementation from April 2014.

Appendix A – Best practice early detection pathway and referral guidelines

The following two page document is being recommended as best practice for the early detection of colorectal cancer in London.

Primary care guidance for colorectal referral (aim to increase referrals for diagnostics)

Background: There has been a modest improvement in the outcome of patients with bowel cancer since the Cancer Plan. However, the UK still has 10% fewer survivors from bowel cancer than Australia and Canada. GPs have a key role in early diagnosis. The following guidelines build on those for the two week wait pathway and the direct access guidelines for GPs and are expected to result in an increase in referrals to secondary care for diagnostic tests (see below). The threshold age for referring new onset colorectal symptoms is 60 years of age for 2013-14. The threshold age should be reduced to 55 years of age in 2014-15 and to 45 years of age in 2015 to enable CCGs to meet their commissioned goal to prevent avoidable deaths.

Patients with bowel symptoms (change in bowel habit, rectal bleeding & anaemia) **attending GP**:

Examine abdomen and do a rectal examination

Questions to consider:

1. Do symptoms fit with the two week NICE criteria: **Yes** Refer to a diagnostic service under the two week rule
   If No ask 2nd question
2. Is the patient 60 years or over: **Yes** Refer to diagnostic service irrespective of duration of symptoms
   If No i.e. patient is 59 or younger

Check the following:

a. Change in bowel habit to loose stools: >40 years & > 6 weeks symptoms: Refer to diagnostic service
b. Rectal bleeding: >40 years & > 6 weeks symptoms OR >55 years any duration symptom: Refer to a diagnostic service
c. None of the above: do a FBC (if not done already): if anaemia < 10 females, < 11 males: refer to diagnostic service under 2 week rule
   if anaemia > 10 females, > 11 males: refer to diagnostic service

d. If none of the above, arrange a follow-up appointment with the patient within the next four weeks to check the symptoms have resolved, and/or refer to a colorectal/lower GI diagnostic service.

Bowel awareness (aim to increase participation in screening programmes)

Background: 40% of patients identified with bowel cancer through the National Bowel Cancer Screening programme have Stage I disease with a 95% five year survival rate. Only 5% of patients with symptoms are found to have Stage I disease.

GPs are encouraged to promote bowel cancer screening to patients with FOB attending the surgery for a other purposes if > 60 years of age (here patients will be receiving an invitation from the NBCSP to participate in FOB screening every two years). GPs are encouraged to respond to the letters informing them their patients have not taken up the opportunity to have bowel screening by contacting their patients and explaining the benefits of screening. Concerned patients over the age of 75 (70 in areas where the age extension has not yet happened) years may self-refer for screening by calling 0800 7076060 and requesting an FOBT kit.

GPs to promote bowel cancer screening with Flexible Sigmoidoscopy to patients attending the surgery for standard a check-up if 55 years (here patients will be receiving an invitation from the NBCSP to participate in a one off Flexible Sigmoidoscopy)

Diagnostic Service (aim to investigate patients efficiently & appropriately)

Principles:

1. Referral received to a designated referral centre ideally using a standardised pro-forma (designed in conjunction with Local CCGs). Referrals will faxed to dedicated fax, email address or to a Choose and Book telephone consultation clinic (for triage)
2. Once received, referrals are triaged by a trained specialist nurse (patients may be contacted by telephone to check presenting symptoms and fitness) according to local policy (building on existing local experience) agreed with local CCGs to one of the following:
    a. Direct access Colonoscopy (+ OGD if anaemia)
    b. Direct access Flexible Sigmoidoscopy
    c. Direct access CT Colonography
    d. Out-patient consultation
3. Normal examinations, Haemorrhoids, diverticulosis, IBS, functional constipation sent back to GP with advice on self-care and primary care medical management.

Patient with Polyps to be entered into surveillance managed at the acute trust level in accordance with the BSG guidelines. Where trusts discharge the patient back to the GPs with advice on future plans to have colonoscopic screening, trust letters must state that the need to enter "colonoscopic screening for polyps" as an active problem in the GP record so that any interval presentations can be assessed with this information.

4. Patients with cancer and IBD: treated in secondary care within Cancer and IBD MDTs and followed up as per local policy agreed with local CCG