A Colorectal Telephone Assessment / Straight to Test Pathway (CTAP) for the Initial Assessment of Colorectal Referrals

Harriet Watson - Colorectal Nurse Consultant

December 2014
Aim

To introduce a novel pathway for patients with colorectal symptoms that is patient centred and rationalises the patient journey

Right test, right time
Evolution of CTAP

- Colorectal symptoms are common in the population
- How do we determine which pts referred have cancer?
- The 2 week wait (2ww) referral criteria gives a low yield of cancer (7 - 10%)*
- 54% of 2ww do not meet referral criteria*
- Carve out of non 2ww patients
- Most cancers diagnosed via non fast track route (82%) some were taking up to 6 months from referral to diagnosis

- Idea came from patients
  - Issues of parking
  - Wanting less visits to hospital
  - The ides grew from their feedback

*DCH data from 01/09/10 to 31/08/11
What used to happen

- GP referral
- Consultant triage
- Out-patients
- Lower GI investigation
- Out-patients
- 8 weeks
- 6 weeks
- 3 months
What will now happen

GP referral

Nurse telephone assessment

3 days

Lower GI investigation

2-4 weeks

Discharged or OPA review if pathology found
How does it work?

• Nurse assessment and triage
  • Given as a ‘choose and book’ appointment or via 2ww office
  • Clinical assessment plus first stage pre-assessment for Colonoscopy
  • Algorithm to follow / protocol driven
  • Able to direct book for a colonoscopy appointment
  • Bowel prep sent in post
  • Second stage telephone pre-assessment for high risk patients (anti-coag / diabetes etc.)
Colorectal Telephone Assessment / Straight to Test Pathway

1. Patient sees GP
2. GP refers pt to TAC on choose and book electronically (available within 7 days)
3. Referral assessed & triaged by Nurse Consultant
4. Patient has Telephone Assessment*
   - CT Colonography or scan
   - Colonoscopy*
   - Flex sig
   - Discharged
   - Out-patient clinic*

* All appointment / investigation dates and times are chosen by patient at the time of the telephone assessment

OPA if significant pathology found OR Discharged if normal / benign pathology with management advice – process managed by Nurse Consultant via a Virtual Clinic

Tests / Treatment / Discharge
Post procedure / Follow up

• Results are assessed by a Consultant in virtual clinic
• Decision made by them following investigations regarding patient follow up
• Database/audit ongoing
## The assessment algorithm

<table>
<thead>
<tr>
<th>Condition</th>
<th>Investigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anorectal</td>
<td>OPA or Rectal Bleed Clinic</td>
</tr>
<tr>
<td>Bright red rectal bleeding &lt;40 yrs</td>
<td></td>
</tr>
<tr>
<td>Change in Bowel Habit</td>
<td>Colonoscopy or CT Colonography</td>
</tr>
<tr>
<td>Dark/ altered blood</td>
<td>Colonoscopy</td>
</tr>
<tr>
<td>Bright red rectal bleeding &gt;40</td>
<td>Colonoscopy</td>
</tr>
<tr>
<td>Previous polyps/ FHx CRC</td>
<td>Colonoscopy</td>
</tr>
<tr>
<td>Weight loss</td>
<td>CT scan</td>
</tr>
<tr>
<td>Anaemia</td>
<td>Colonoscopy &amp; OGD</td>
</tr>
</tbody>
</table>

CT Colonography is offered to patients considered unfit for Colonoscopy. Inpatient Colonoscopy is avoided.
Dorset - Results

• 4000 patients 2008 - 2012
• 98% assessed within 3 weeks, 95% had colonoscopy within 3 weeks of telephone assessment
• 87% referrals diverted down ‘STT’ route
• High patient and GP satisfaction – 85% ‘very satisfied’
• Time to assessment reduced - from 23 weeks (max), 13 (average) to 3 weeks
• Time to diagnosis 3 weeks for all patients (2 & 18ww referrals)
• Estimated savings £40,665 per annum
But… Dorset is a small, rural, close knit healthcare environment

Could these data be replicated?
Guys & St. Thomas’ - Results

• Started as a pilot due to DoH guidance for 2ww referral being assessed face to face
• November 2013
• 87% patients sent for Colonoscopy
• 34% improvement in time to diagnosis for 2ww
• 61% patients sent back to GP (after tests)
• Halved the DNA rate of 2ww referrals
• Patient satisfaction high
• Cancer yield 13%
# Out-patient data

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of referrals</th>
<th>Average time to date of first contact</th>
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</thead>
<tbody>
<tr>
<td>April 2013</td>
<td>97</td>
<td>12</td>
</tr>
<tr>
<td>May 2013</td>
<td>88</td>
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<tr>
<td>November 2014</td>
<td>136</td>
<td>5</td>
</tr>
</tbody>
</table>

Introduction of the TAC clinic
Benefits of CTAP

- Decreases and in some cases eliminates waits for Colorectal 2ww referrals
- Frequently pts phoned the following week and have within 2 weeks later
- Decreased wait times to investigation from 10 weeks to 3 weeks for all non 2ww referrals (Dorset)
- Flexible due to minimal set up so able to respond to peaks ie media campaigns for bowel cancer awareness
- Continuity for GP’s
- High quality, appropriate triage and counselling of patient
- Safe assessment of patient’s suitability for colonoscopy
- Positive feedback from GP’s & patients
- Frees up Surgeons to see more complex cases & operate
Dissemination of practice

- Barts - Whipps Cross
- UCLH
- Imperial
- Liverpool
- Colchester
- Peterborough
- Taunton
- Northumberland
- Stoke on Trent
Conclusion

• Successful implementation of pathway so far
• Reduced waits,
• Financial savings
• Excellent patient feedback
• Needs better routine data collection and analysis
• Formalised patient feedback