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NHS England

Faster diagnostic pathways

Implementing a timed colorectal cancer diagnostic pathway

Guidance for local health and care systems

Version 3.2, April 2023

All updates to the previous version are highlighted in yellow

Contents

Best practice timed diagnostic pathways

Best practice timed pathways support the ongoing improvement effort to shorten diagnosis pathways, reduce variation, improve patient experience of care, and meet the Faster Diagnosis Standard (FDS). The guidance will support cancer alliances and constituent organisations to adopt consistent, system-wide approaches to managing this diagnosis pathway.

This guidance sets out how diagnosis within 28 days can be achieved for the suspected bowel cancer pathway. Alongside the pathway itself, resources are highlighted to support implementation of the pathways.

This colorectal pathway is part of a series, published since April 2018. From previous pathways implemented by cancer alliances, implementation guidance was shared in June 2021, identifying areas that are key to success, such as setting up with clinical and operational engagement, auditing pathways, allocating project management resources, ensuring leadership, analysing data, and sharing successes. This guidance complements and should be read alongside existing resources such as NICE guidelines (including NG12, last updated December 2021) and the joint Association of Coloproctology of Great Britain and Ireland (ACPGBI) and the British Society of Gastroenterology (BSG) guideline on faecal immunochemical testing (FIT) in patients with signs or symptoms of suspected colorectal cancer (CRC), published May 2022.

The pathway in this document was shaped by the NHS England Clinical Expert Group (CEG) for colorectal cancer. CEGs brought together clinical leaders who provided tumour specific clinical expertise. Their role included ensuring that advice on best practice cancer pathways is evidence-based and is available for anyone involved in the improvement of cancer services. The National Cancer Vanguard led and developed the best practice timed pathway. The Vanguard included Greater Manchester Cancer, Royal Marsden Partners, and the University College London Hospitals Cancer Collaborative.

For any questions about this document please email england.cancerpolicy@nhs.net.

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The Faster Diagnosis Standard

We committed in the NHS Long Term Plan to provide a faster diagnosis for people through the introduction of the Faster Diagnosis Standard (FDS). This standard will ensure people are told they have cancer, or that cancer is excluded, within a maximum of 28 days from referral. The new standard is intended to:

- reduce the time between referral and diagnosis of cancer
- reduce anxiety for the cohort of people who will be diagnosed with cancer or receive an ‘all clear’
- reduce unwarranted variation in England by understanding how long it is taking people to receive a diagnosis or ‘all clear’ for cancer
- represent a significant improvement on the current two-week wait to first appointment target, and a more person-centred performance standard.

FDS performance data, including a breakdown by suspected cancer pathway, has been published since June 2021, and faster, more streamlined pathways will be a priority.

As the key system-wide organisations for cancer services, cancer alliances will need to work across the local system to ensure that implementation is prioritised by senior stakeholders, clinical leaders, and operational colleagues, and that capacity is prioritised to enable the standard to be delivered.

The FDS has been formally performance managed since October 2021 activity, in line with cancer services recovery, with an initial threshold of 75%. Cancer alliances will need to ensure they have plans to meet the threshold. These will need to be increased in subsequent years if we are to achieve the early diagnosis ambitions in the NHS Long Term Plan.

The case for change

- Colorectal cancer is the **fourth most common diagnosed cancer** in England.
- It is the **second most common cause of death from cancer** in the UK
- For colorectal cancer patients in England diagnosed between 2014 and 2018:
  - **one-year**, age-standardised net survival for people diagnosed at stage four was **43%**
  - **five-year**, age-standardised net survival for people diagnosed at stage four was **10%**.
- In 2019, **only 37% of all colon cancers were diagnosed at an early stage**.
- There is considerable variation in routes to diagnosis:
  - Patients from the **least deprived quintile** are **less likely to be diagnosed through an emergency presentation**.
  - **More deprived** patients also have **lower survival** at given routes to diagnosis.

A **streamlined and more efficient pathway** will reduce overall waiting times, avoidable delays and the considerable variation currently seen across the country. Alongside adoption of the best practice timed pathway, cancer alliances must ensure the appropriate resources and capacity are in place to deliver high-quality services to more patients.

Figure 1: Percentage of early staged (stages 1 and 2) colon cancers, by CCG, in 2019

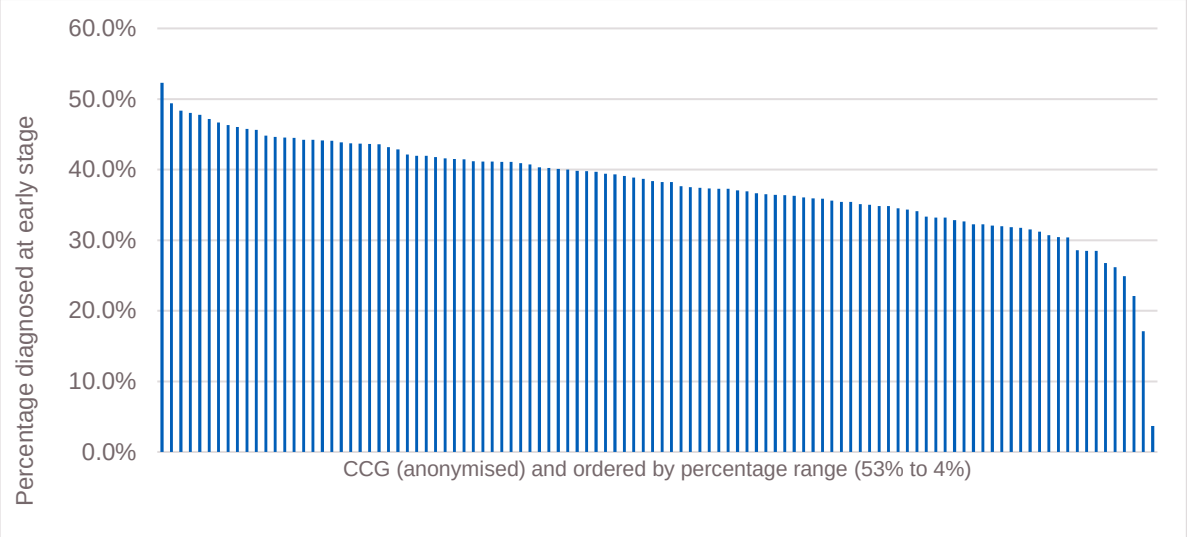
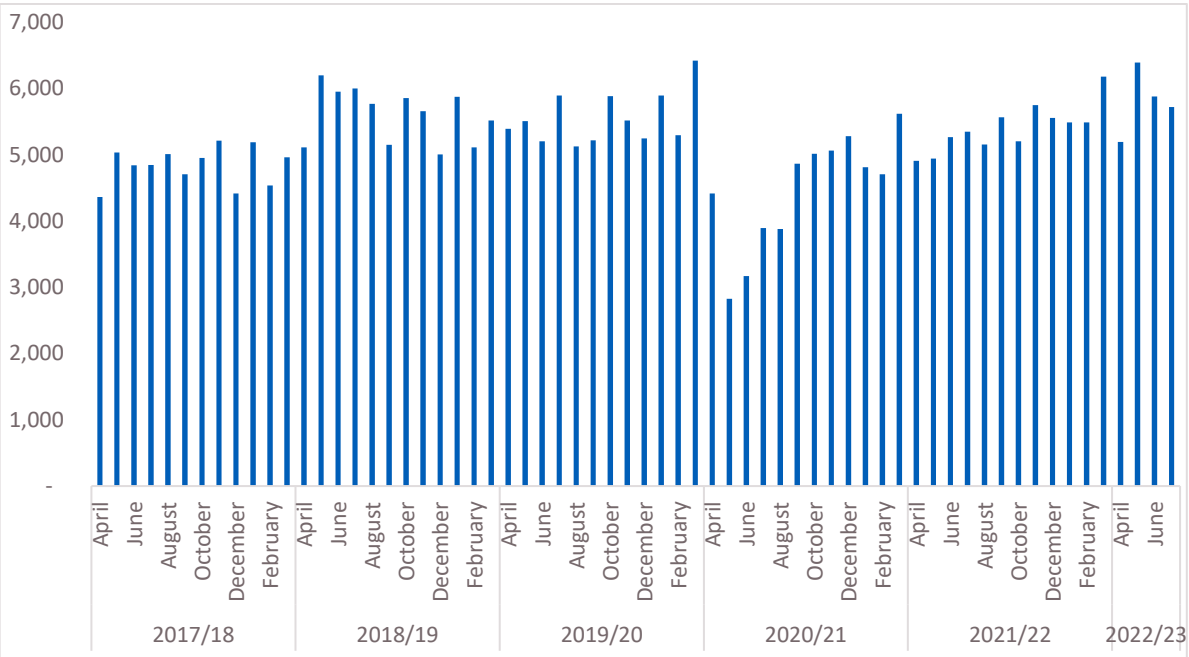


Figure 2: Colorectal cancers referred for urgent suspected cancer and commencing treatment (62-day standard) by volume, 2016/17 to 2022/23



Actions for cancer alliances

In 2023/24, **all systems** are asked to develop plans to:

- Implement and maintain priority pathway changes.

- Increase and prioritise diagnostic and treatment capacity, including ensuring that new diagnostic capacity, particularly via community diagnostic centres (CDCs), is prioritised for urgent suspected cancer.
- Maximise the pace of roll-out of additional diagnostic capacity, delivering the second year of the three-year investment plan for establishing Community Diagnostic Centres (CDCs) and ensuring timely implementation of new CDC locations and upgrades to existing CDCs.
- Deliver a minimum 10% improvement in pathology and imaging networks productivity by 2024/25 through digital diagnostic investments and meeting optimal rates for test throughput.
- Increase GP direct access in line with the national rollout ambition and develop plans for further expansion in 2023/24.
- support implementation of FIT in primary care in line with ACPGBI/BSG guidance and make sure processes are in place in secondary care so that the clinical triage is informed by the FIT result and appropriate action taken as outlined in NHS England guidance on FIT implementation.

NHS England provides support, funding and guidance to help cancer alliances improve outcomes and reduce variation. The following support is available:

- Funding and programme management to support delivery to achieve the FDS and best practice timed pathway milestones.
- Implementation guidance for achieving pathways.
- Collaboration and networking events to share best practice.

> "Early diagnosis confers the best chance of cure. Lowering the threshold of referral for patients with colorectal symptoms to scaled up and streamlined diagnostic services should impact the unwarranted national and international variation in outcome."
>
> **Mr Michael Machesney MD FRCS**
> Clinical Lead for Clinical Advisory Group, NHS Cancer Programme

Faecal immunochemical test (FIT)

The Association of Coloproctology of Great Britain and Ireland (ACPGBI) and British Society of Gastroenterology (BSG) have produced new joint guidance on use of FIT in patients with signs or symptoms of suspected colorectal cancer. It is recommended that all GPs implement the recommendations in full. In particular, the guidance recommends the use of FIT in primary care for patients presenting with all NG12 suspected colorectal cancer symptoms except those with an anal/rectal mass or anal ulceration. The guidance also recommends that those with fHb <10ug Hb/g a normal full blood count, and no persistent unexplained symptoms are not referred on a lower GI urgent cancer pathway but are managed in primary care or referred on a non-urgent pathway to secondary care for definitive diagnosis.

Where patients with a FIT <10 are referred to secondary care, for example where a GP has ongoing clinical concern, for evaluation, there should be a clinical assessment. If there are no persistent unexplained signs or symptoms of suspected colorectal cancer, the patient should either be discharged back to their GP or rerouted on to an alternative pathway for definitive diagnosis.

Comprehensive use of FIT in NG12 patients is currently critical to using available colonoscopy capacity in the most effective way.

Benefits of pathway change

For patients and unpaid carers

- Reduced anxiety and uncertainty of a possible cancer diagnosis, with less time between referral and receiving the outcome of diagnostic tests.
- Improved patient experience from fewer visits to the hospital, particularly to specialist centres if possible, and avoiding emergency admission.
- Potential for earlier recognition and initiation of pre-optimisation for treatment that could reduce complications and adverse outcomes.

For systems

- Reduced demand in outpatient clinics with increased straight to test provision and use of pathway navigators.

- Resources can be targeted at patients with cancer by removing non-cancer patients earlier in the pathway.
- Improved quality, safety, and effectiveness of care with reduced variation and improvement in outcomes.

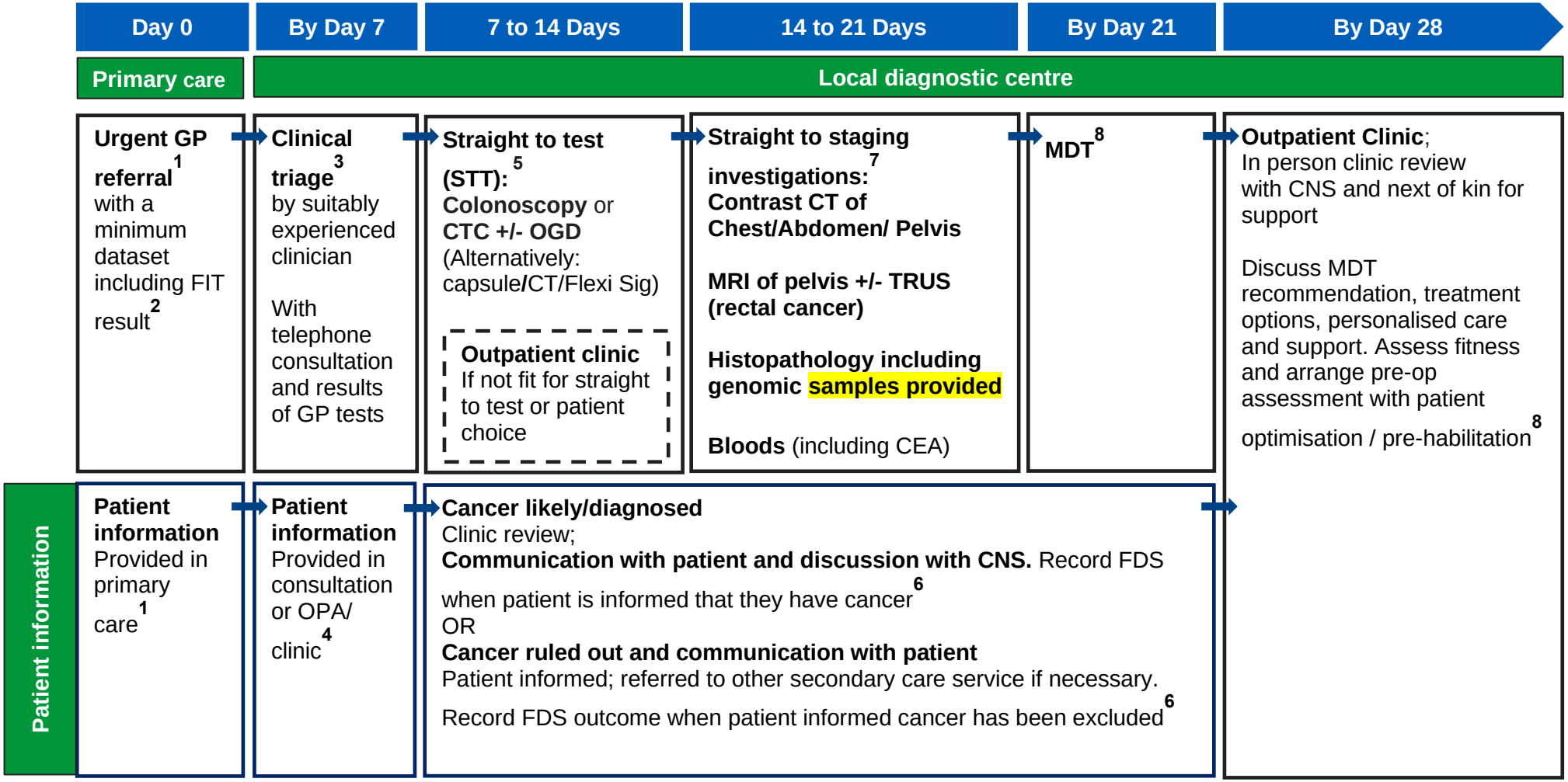
Experience of care

- Patients and carers know they are urgently referred for investigation of suspected cancer and should expect diagnosis within 28 days.
- Patients and carers' ability to attend appointments can be taken into account with additional support offered where necessary.
- Patients are communicated with clearly, understand the information provided, and are given additional support, such as access to a clinical nurse specialist (CNS) or navigator, psychological support, buddy system, where necessary.

For clinicians

- Using a nationally agreed and clinically endorsed pathway to support quality improvement and reconfiguration of colorectal cancer diagnostic services.
- The use of predetermined diagnostic algorithms and standards of care to streamline clinical decision-making and reduce delays for multidisciplinary team (MDT) discussion.
- Improved ability to meet increasing demand and ensure best utilisation of the highly skilled workforce.

28-day best practice timed pathway



Detailed information on pages 10 to 13

Detailed information

1. **Urgent GP referral pathway** should be used for patients who meet NG12 criteria for suspected cancer pathway referrals. In line with the ACPGBI/BSG FIT guidance, all patients except those with anal/rectal mass or anal ulceration should be offered a FIT. Those with fHb <10ug Hb/g, a normal full blood count, and no persistent unexplained symptoms should not be referred on the lower GI urgent cancer pathway but managed in primary care or referred on an alternative non-urgent pathway for definitive diagnosis. Where patients are not referred, appropriate safety netting must be in place as outlined in NHS England guidance on implementing FIT. For those referred on an urgent cancer pathway, it is essential that the FIT result alongside full blood count result is included on the referral form so that it can be used by lower GI triage teams to determine the appropriate onward pathway for the patient.

   The National Cancer Waiting Times Monitoring Dataset Guidance v11.0 sets out consultant upgrade rules, including from non-GP scenarios such as A&E and acute settings. Cancer alliances may agree local arrangements to facilitate patient self-referral, community diagnostic hub and other referral routes, to access the FDS pathway.

   It is noted with the implementation of community diagnostic centres that referral pathways may be subject to change. **Primary care should inform the patient** that they are being referred for an urgent suspected cancer pathway, although stating that vast majority of referrals result in non-cancer diagnoses. Primary care should also make the patient aware of their responsibilities to make themselves available for the first four weeks for full diagnostic testing. i**A minimum dataset should be agreed locally with GPs**, to accompany the referral and facilitate straight to test, which includes: patient demographics, patient symptoms (in line with NG12), past medical history (including previous colorectal investigations and co-morbidity), family history, anticoagulant status, WHO performance status, smoking status and alcohol intake, prescribed medication (when auto-populated if possible in practice IT system), need for interpreter, mental capacity to consent, primary care investigation results (FBC, ferritin, CRP, MCV, U&E / eGFR, FIT), and digital rectal examination findings.

2. **Clinical triage** for straight to test investigation can be done by a suitably experienced clinician. This may be a supervised Clinical Nurse Specialist. If patient is assessed as medically unfit by GP or hospital triage raises concerns,

the patient should be assessed in person in clinic. If deemed medically fit, the appropriate first line investigations should be performed and reported within 7 to 14 days so that this cohort can progress on the pathway in the same timeframes. Patients should have same day investigations to reduce repeat visits and improve patient experience.

Telephone or video consultation should be used to determine suitability for straight to test and pre-assessment, if it would not delay the pathway. Preparation for any tests can be communicated to patients at this stage. Bowel prep can be arranged during triage or by primary care depending on local arrangements.

3. **Patients and carers should be asked** what information they require about the pathway, provided with standard leaflets about investigations when sending confirmation of appointment, confirmation of next step(s) and any patient needs required to prepare for the day (for example, can they eat and drink before), and whether they have any disabilities or language barriers.

   Preferences for amount of information and when it is provided will vary, and therefore it will help to provide caseworker/navigator telephone contact details to provide support throughout the pathway and outside of clinic times, provide signposting to charities and support services, provide information about carers attending appointments, and offer follow-up if patients do not receive confirmation of appointment in expected timescale.

   Where possible, continuity of caseworker/navigator should be provided to enable familiar contact and to build trust. Patients should also be informed that they may receive one or more procedures and/or diagnostic tests on the same day, at the first face-to-face appointment.

4. **Straight to test should be carried out within seven days of triage.** Following tissue sampling results, confirmed cancer tumours for all colorectal diagnosis should be tested for all molecular markers required to determine onward management, including Lynch syndrome as per NICE Guidance (DG27). For metastatic patients, molecular testing should be delivered by the Genomic Laboratory Hub, preferably by gene panel analysis to include all relevant gene markers. Results from initial tumour tests should be discussed at MDT as diagnosis may impact treatment options.

5. **Patients should be informed about cancer being ruled out, or diagnosed** at the earliest face-to-face opportunity, unless the patient has expressed an alternative preferred method of communication to speed up communication. In this timed pathway, this can be done at a straight to test clinic, a follow-up testing or results outpatient appointment. Early consideration of patient's fitness for radical therapy and requirements for pre-habilitation should be addressed as soon as possible in the pathway to minimise delays in expediting treatment.

   All patients diagnosed with cancer should have a referral to relevant allied health professionals within seven calendar days of diagnosis, and where required, will also be involved during treatment planning. Local protocols and initiatives should be developed in collaboration with perioperative medicine, elderly care and specialist dietitians.

   When colorectal cancer is ruled out, but other cancers are not ruled out it may be appropriate, following initial investigation, to refer the patient on to an alternative tumour site specific pathway, or a pathway where non-specific or vague symptoms can be assessed.

   Where cancer is ruled out, but symptoms suggest further diagnostic tests are necessary, it may be appropriate to request them before onward referral to a non-cancer routine pathway. Where cancer is excluded, the FDS 'clock stop' can be completed at this point of communication with the patient. Most commonly this will be immediately following a colonoscopy when they should also be provided with a copy of the report.

   When colorectal cancer is diagnosed it is best explained to the patient in person with the support of a CNS and next of kin. At this point the FDS 'clock stop' is also completed, but the 62-day standard from GP referral to treatment commencement continues. **Cancer waiting time rules** (including 'clock start', 'adjustments' and 'clock stop') are set out in the National Cancer Waiting Times Monitoring Dataset Guidance v11.0.

6. **Staging investigations should be requested 'straight to staging'** when the straight to test results or colorectal cancer diagnosis is available. They should be completed in seven days.

7. **The core roles at the specialist colorectal cancer MDT** (to be carried out with diagnostic and staging investigation results) are lead clinician, colorectal surgeons, specialist radiologist, specialist pathologist, clinical and medical

oncologists, palliative physician, expert colonoscopist, CNSs and pathway navigator/MDT coordinator.

The capacity required to deliver these core roles should be reflected in job plans. National guidance on how to maximise effectiveness of MDT meetings is available. Locally agreed, criteria for referral to the specialist multidisciplinary team (sMDT), for example when there is an unexpected finding of CRC from another clinical team, can also support with efficient pathway management.

8. **Personalised care and support planning** should be based upon the patient and CNSs completing a holistic needs assessment (HNA), usually soon after diagnosis. The HNA ensures conversations focus on what matters to the patient, considering wider health, wellbeing, practical issues and support in addition to clinical needs and fitness. This enables shared decision-making regarding treatment and care options.

Additional information

Audit tool

Can be used to undertake a baseline audit of services being delivered and whether sufficient capacity is in place to routinely deliver, identify areas for improvement, select measurements for improvement, and conduct re-audits as part of continuous improvement.

Day	Pathway Step	Service in place?	Capacity in place?
0	GP referral – local agreements made ensure minimum dataset (as detailed in pre-referral information) can facilitate straight to test provision. Primary care provision of FIT testing prior to referral for all patients with NG12 symptoms except those with anal/rectal mass or anal ulceration.		
	Patient information resources developed for primary care – ensure patient engagement and empowerment		
7	Clinically led triage – should be consultant supervised and delivered by appropriately trained clinician (eg CNS) using FIT result for risk assessment – ensure local protocols in place & bowel prep arrangements agreed. Consider early opportunities for pre-habilitation or symptom control if necessary.		

14	Straight to test provision for all eligible patients – develop local protocols for appropriate first test ideally matched to resource provision between radiology (CTC) and endoscopy (colonoscopy). Consider parallel booking of other relevant tests, eg OGD		
	OPA – Ensure provision for outpatient consultation, no more than 14 days from GP referral, for patients unsuitable for straight to test for clinical assessment		
21	Staging investigations – Develop local arrangements for staging investigations (such as a standardised diagnostic bundle), ideally should be straight to staging booked at time the initial definitive investigation is completed. Can include same-day/one-stop model (see OSCARS example).		
	MDT with some patients on clear and agreed cancer protocol pathways that may not need formal discussion. These patients need to be recorded on the MDT agenda with their treatment plan. Regular audits of patients on protocol pathways should be conducted to ensure the plan was delivered.		
28	Clinic review – Ideally a consultant surgeon or oncologist supported by a CNS leads a discussion regarding diagnosis and treatment options in person with the patient supported by next of kin. Consideration of fitness for treatment, prehabilitation and symptom control should be included. Appropriate communication and contact with CNS should be encouraged throughout the pathway (eg at endoscopy, telephone consultation, etc)		

Guidance from the NHS England Clinical Expert Group on colorectal cancer

- Clinical Advice to cancer alliances for the Commissioning of the Whole Bowel Cancer Pathway provides guidance to support the commissioning of best practice services.

Other resources for colorectal cancer pathway improvements

- ACE Wave 1 report on Improving diagnostic pathways for patients with suspected colorectal cancer.
- Straight-to-test colonoscopy for 2-week-wait referrals improves time to diagnosis of colorectal cancer and is feasible in a high-volume unit is an evaluation of straight to test in shortening time to diagnosis.
- Public Health England Return on investment tool: colorectal cancer (to help local commissioners understand the economic case for early diagnosis of bowel, colon and rectal cancers).
- Association of Coloproctology of Great Britain and Ireland (ACPGBI) and British Society of Gastroenterology (BSG) FIT in patients with signs or symptoms of CRC guidelines.

NHS England resources

- The Change Model is a framework for any project or programme seeking to achieve transformational, sustainable change (refreshed on 4 April 2018).
- The Improvement Hub provides useful resources that can support service improvement including guidance, modelling tools, and webinars.
- The Delivering Cancer Waiting Times - A Good Practice Guide sets out good practices to achieve and sustain CWT performance.
- Supporting the use of Faecal Immunochemical Testing (FIT) letters.

Cancer alliance workspace

Cancer alliances access this workspace for national guidance, resources, and to share learning. Please use this space to upload materials you have developed locally and that you think would be useful for colleagues implementing this pathway across the country.

Acknowledgements

This guidance was developed by the NHS Cancer Programme (with Mr Arun Takhar as former Clinical Fellow and Professor Christopher Harrison as former National Clinical Director) and builds on experience and expertise provided by the Clinical Expert Group for Colorectal Cancer (Mr Michael Machesney as Chair, Mr John Griffith as Vice Chair, and Beating Bowel Cancer and Bowel Cancer UK as secretariats), the National Cancer Vanguard (Dominic Cunnane, Lisa Galligan-Davies, Jacob Goodman, Nicola Hunt, Prof Kathy Pritchard-Jones, Mr David Shackley, and Dr Nicholas van As), and other exemplar sites (Mr Muti Abulafi, Mr Ayan Banaerjea, Dr David Burling, Mr Rai Sajal and Harriet Watson).

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