BSG position statement on a Rapid Colorectal Diagnostic Pathway

Introduction

The British Society of Gastroenterology (BSG) is a registered charity and the professional organisation for the promotion of gastroenterology and hepatology within the United Kingdom.

Gastroenterologists undertake the vast majority of diagnostic and therapeutic endoscopy in the NHS and are highly aware of the demand, capacity and financial pressures being felt in the NHS generally but specifically in endoscopy services. Straight To Test (STT) or Open Access pathways have existed in upper and lower gastrointestinal endoscopy for many years, and where used appropriately have been shown to be effective in ensuring patients get a diagnosis and appropriate treatment as quickly as possible.

Background

In the summer of 2016 the BSG responded through a consultation process to proposals from NHS England and NHS Improvement for the introduction of a Best Practice Tariff (BPT) for a STT pathway for lower GI symptoms. The BSG responded to the consultation (see response here) and engaged very actively with NHS England and the relevant Committees of the BSG. At this stage there were issues with the roll out of such a pathway that the BSG wished to discuss and engage with on behalf of members about the impact of a BPT on already pressured endoscopy services in England.

Following this engagement the National Tariff 2017/19 consultation proposed a non-mandated BPT for this pathway with a view to this becoming mandated in a future tariff round. In order to ensure the non-mandated BPT was effectively rolled out and evaluated the BSG took part in a multi-stakeholder workshop in November 2016 which resulted in broad consensus on the principles of the BPT as the **"Rapid Colorectal Diagnostic Pathway"**. These principles are set out in the following pages after significant input from the BSG.

Recommendations

The BSG recommends that members or services that are involved in the discussion of or establishment of such a diagnostic pathway follow the principles outlined for the Rapid Colorectal Diagnostic Pathway and ensure they are fully evaluated.

Wherever possible the BSG would like to be kept updated of the development of services to ensure successes and learning can be shared nationally.

Implications for members/services

Any STT pathway, including the Rapid Colorectal Diagnostic Pathway, has the potential to increase endoscopy activity and should be carefully monitored for quality and safety.

Rapid Colorectal Diagnostic Pathway

Background:

- NHS England held a workshop on the 25th November regarding implementation of the non-mandated straight-to-test (STT) best practice tariff (BPT) and to facilitate development of a 2019 mandated BPT. We also discussed the role of Faecal Immunochemical Test (FIT) in the colorectal referral pathway
- We had representation from the NHSE cancer policy team, the British Society of Gastroenterology, Association of Coloproctology GB &I, clinicians working in STT services, managers facilitating a STT service, the colorectal CRG, Macmillan, CRUK, primary care and NICE
- The actions following the workshop were as follows:
    - Rebrand Straight-to-Test as 'Rapid Colorectal Diagnostic Pathway' to acknowledge that there is a secondary-care led clinical assessment to triage patients, prior to test.
    - Agree the principles of the 'rapid colorectal diagnostic pathway' going forward as the grounding for development of a mandated BPT (See below)

The principles of a rapid colorectal diagnostic pathway

1. **Entry onto the pathway**
    a. Encourage use of a clinical decision support tool by GPs to facilitate appropriate referral of patients onto the colorectal diagnostic pathway
    b. GP engagement and education must form part of development of the pathway locally
    c. A standardised, electronic referral to colorectal services (involving the national Electronic Referral Service as outlined by the NHS Standard Contract), should include all appropriate, available information to inform a decision on further investigation. The form template must facilitate easy and comprehensive completion by GPs, ideally pulling relevant information directly from the primary care record
    d. Referral criteria should be aligned to NICE guidance (NG12)
2. **The pathway to investigation**
    a. Triage of GP referrals should be by a competent clinician (usually a Band 7+ nurse or a consultant)
    b. The decision, on which investigation/pathway is offered to a patient, should follow a locally-agreed algorithm and incorporate shared decision-making with the patient. Account must be taken of co-morbidities which could impact on the safety of various interventions e.g. chronic kidney disease
    c. It is envisaged that the triage process will likely include options such as: colonoscopy, CT (with and without pneumocolon) and outpatient clinic appointment
    d. To investigate iron deficiency anaemia, the algorithm must include provision for a 'top and tail' endoscopy for men and post-menopausal women

3. **Consent for investigation**
    a. There must be a clear process for consent; this should include appropriately comprehensive information about the proposed investigation and alternatives, and should follow the relevant guidelines
4. **What happens after investigation**
    a. There must be a clear pathway for managing patients post-investigation, this should include:
        i. Those diagnosed with cancer and provision for further staging and investigations, MDT discussion and follow-up
        ii. Those who are not diagnosed with cancer but may require secondary care follow-up e.g. inflammatory bowel disease
        iii. Those who will be referred back to their GP but have ongoing symptoms e.g. irritable bowel disease
    b. The pathway must be clear about who, how and when diagnosis of cancer/cancer rule-out is communicated to the patient
5. **Development of the pathway locally**
    a. The algorithm must be evidence-led**.** The responsibility is with the triaging clinician and pathway responsible officer to stay up-to-date on evidence about the most appropriate investigation for different groups of patients e.g. Flexi sig vs colonoscopy and the use of FIT as a triage tool
    b. The algorithm must take account of capacity in endoscopy and radiology in order to set thresholds for referral for different investigations
6. **Evaluation of the pathway**
    a. Evaluation should endeavour to include the following factors: quality of bowel prep, adequacy of consent, quality of procedure (e.g. adenoma detection rate, completion rate), patient experience and the impact on the wider service and management of non-cancer patients
    b. Trusts should monitor the demand and capacity in their endoscopy and radiology diagnostic services and in outpatients. In particular, the impact of implementing any changes in their colorectal diagnostic pathways on these services
    c. The purpose of moving to the optimal colorectal diagnostic pathway is to reduce the time taken between a patient presenting with symptoms suggestive of a colorectal cancer and that patient finding out whether or not they have a cancer diagnosis. This in turn should impact positively on the trust's performance against the 62 day cancer waiting time standard. It is also anticipated that removal of a face to face outpatient appointment, will allow for redistribution of doctors and specialist nurses away from 2ww clinics to other areas, such as theatre lists and endoscopy