Thames Valley Cancer Alliance

Oncology Professional Care
9 & 10 June 2021, Virtual
www.oncologyprofessionalcare.co.uk

NHS

Responding to the Covid-19 pandemic – The TVCA FIT in primary care pathway

Wednesday 9th June 2021

thamesvalleycanceralliance.nhs.uk

@ThamesV_Cancer

Welcome

- Welcome & introduction – **Mrs Jennifer Graystone, Clinical Director, TVCA**
- Introducing the pathway – **Dr Anant Sachdev**
- Reviewing the evidence – **Dr Brian Nicholson**
- Pathway impact - The Frimley experience – **Mr Ian Laidlaw**
- Summary successes and key learnings – **Mrs Jennifer Graystone**
- Q & A




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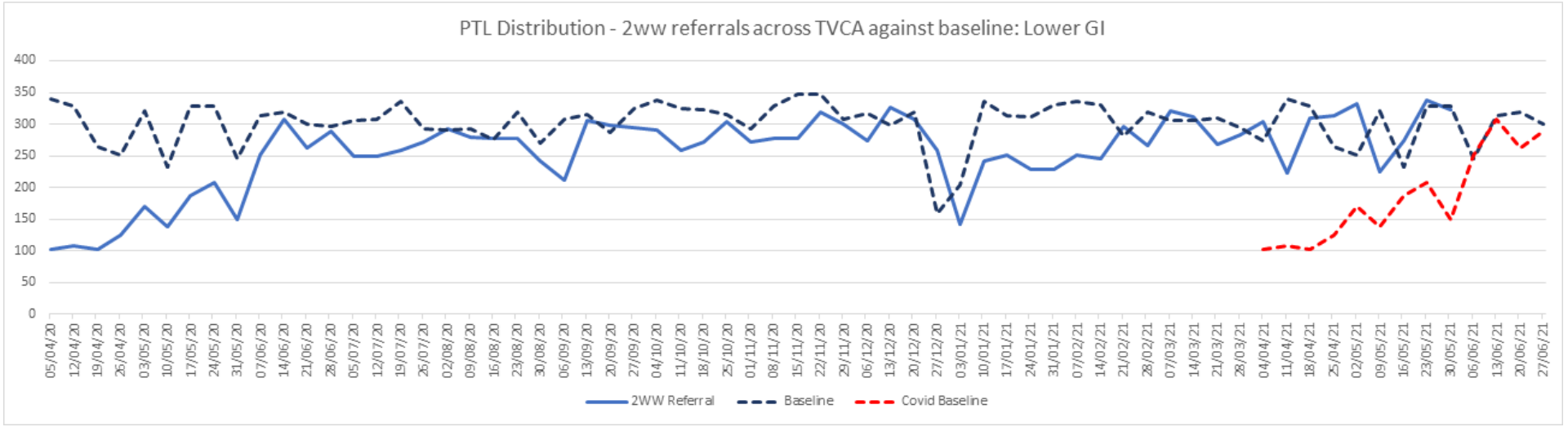
Setting the scene



- 62 day performance for lower GI cancers already challenged pre-pandemic
- March 2020 saw a 75% drop in the number of two-week wait referrals for all suspected cancers
- BSG advice on endoscopy at that point stated that only urgent cases should be investigated to ensure patient and staff safetyduring the pandemic
- Increasing evidence base around the use of FIT testing and the importance of different values in terms of risk of colorectalcancer

The Solution

FIT testing in primary care for suspected lower gastrointestinal cancers can support planning and recovery from the impact of COVID-19.

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Using FIT in primary care & Lower GI Pathway Changes during COVID-19

Dr Anant Sachdev

GP

TVCA Clinical Lead for Prevention & Early Diagnosis

CRUK Strategic GP

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NEW: Lower GI Pathway

An example of partnership working whilst responding to the pandemic

CAG & Academic Leads

The colorectal CAG leads and Oxfordshire Primary Care -FIT lab provided clinical expertise and academic rigor to ensure the **pathway is evidence-based.**

Commissioning & Trust Leads

CCG and Trust leads were pivotal in shaping the pathway.

Acting as a critical friend, CCG GP cancer leads and Trust leads provided important feedback to ensure the roles and responsibilities between primary and secondary care clinicians are clearly defined and **patients are managed safely.**

BBO Local Medical Committees

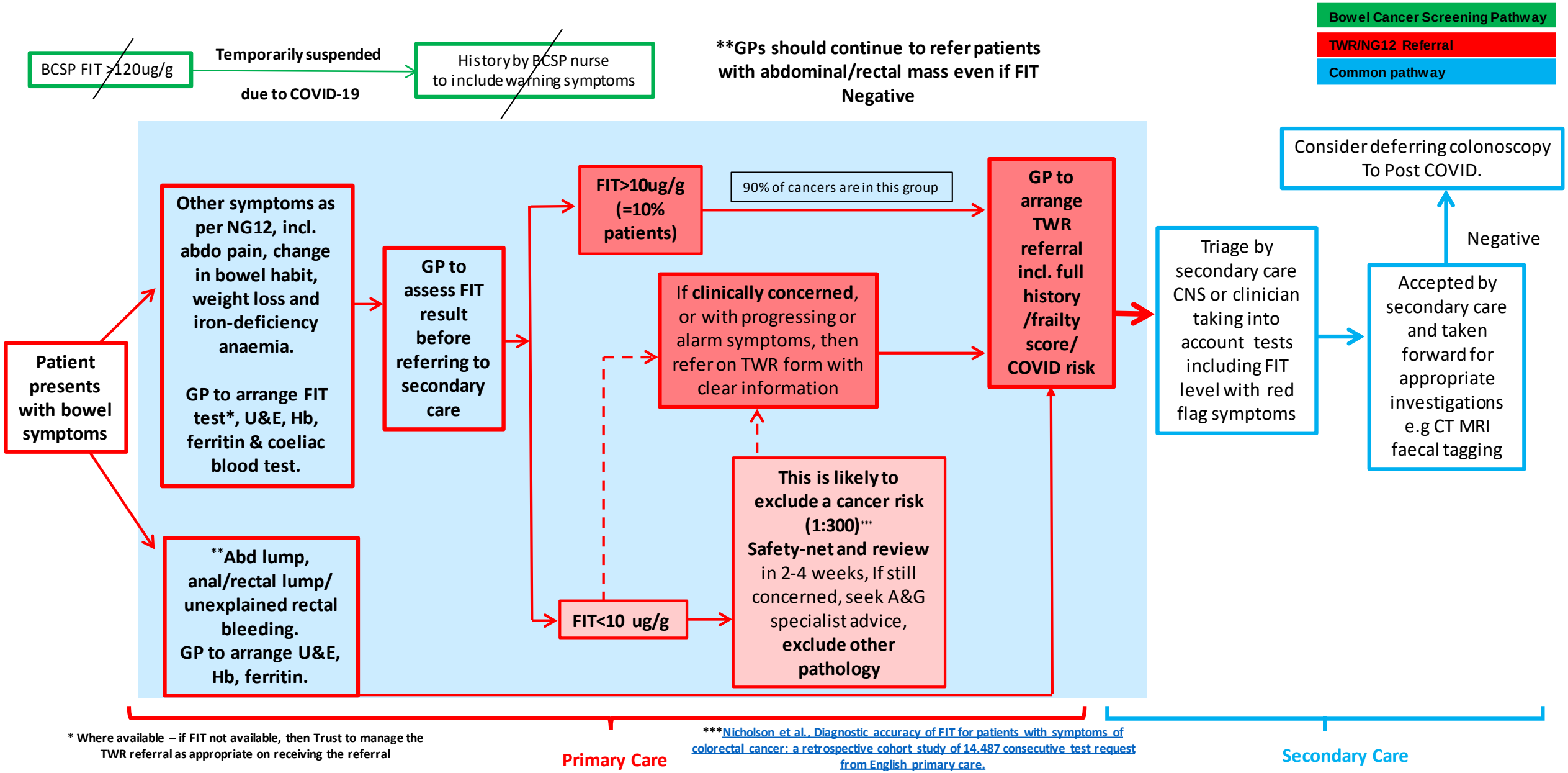
Provided additional **feedback & engagement** to support acceptance of the pathway changes within the wider GP community.

Primary Care Engagement

Continue to **provide guidance and tools** to implement the pathway.

We would also like to thank our charitable partners, CRUK and Macmillan Cancer Support for their advice and guidance.

Thames Valley Cancer Alliance Lower GI
Urgent Suspected Cancer Pathway during Covid-19



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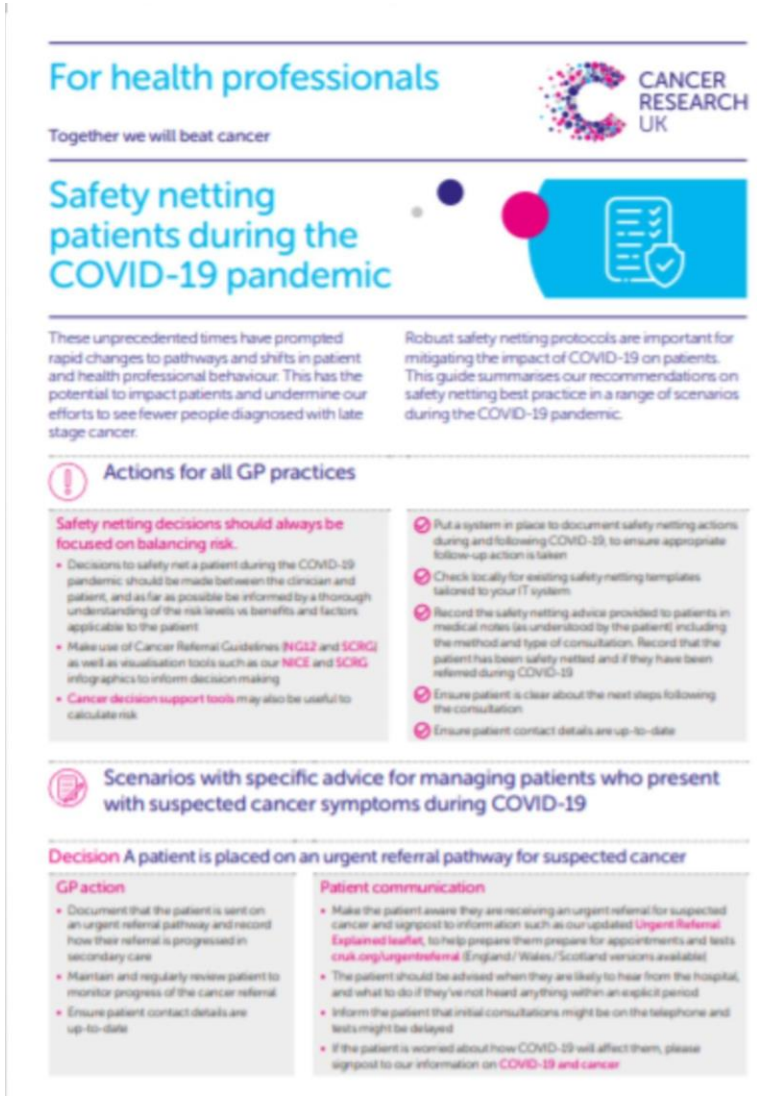
Safety Netting

Safety netting decisions should always be focused on balancing risk and made between the patient and clinician.

- Put systems in place to document safety netting actions during and following COVID
- Check locally for existing safety-netting templates tailored to your IT system
- Record the safety-netting advice provided to patients incl. method of consultation. Record that the patient has been safety netted and if they have been referred during COVID-19
- Ensure patient is clear about the next steps following the consultation
- Ensure patient contact details are up-to-date

Visit cruk.org/safetynettingtools for further resources
Further remote support may be available in your area. Contact facilitators@cancer.org.uk to find out how they can support you with safety netting in your practice.



For health professionals

Together we will beat cancer

CANCER RESEARCH UK

Safety netting patients during the COVID-19 pandemic

These unprecedented times have prompted rapid changes to pathways and shifts in patient and health professional behaviour. This has the potential to impact patients and undermine our efforts to see fewer people diagnosed with late stage cancer.

Robust safety netting protocols are important for mitigating the impact of COVID-19 on patients. This guide summarises our recommendations on safety netting best practice in a range of scenarios during the COVID-19 pandemic.

Actions for all GP practices

Safety netting decisions should always be focused on balancing risk.

- Decisions to safety net a patient during the COVID-19 pandemic should be made between the clinician and patient, and as far as possible be informed by a thorough understanding of the risk levels vs benefits and factors applicable to the patient
- Make use of Cancer Referral Guidelines (NG12 and SCRG) as well as visualisation tools such as our NICE and SCRG infographics to inform decision making
- Cancer decision support tools may also be useful to calculate risk

- Put a system in place to document safety netting actions during and following COVID-19, to ensure appropriate follow-up action is taken
- Check locally for existing safety netting templates tailored to your IT system
- Record the safety netting advice provided to patients in medical notes (as understood by the patient) including the method and type of consultation. Record that the patient has been safety netted and if they have been referred during COVID-19
- Ensure patient is clear about the next steps following the consultation
- Ensure patient contact details are up-to-date

Scenarios with specific advice for managing patients who present with suspected cancer symptoms during COVID-19

Decision A patient is placed on an urgent referral pathway for suspected cancer

GP action

- Document that the patient is sent on an urgent referral pathway and record how their referral is progressed in secondary care
- Maintain and regularly review patient to monitor progress of the cancer referral
- Ensure patient contact details are up-to-date

Patient communication

- Make the patient aware they are receiving an urgent referral for suspected cancer and signpost to information such as our updated Urgent Referral Explained leaflet, to help prepare them prepare for appointments and tests cruk.org/urgentreferral (England/Wales/Scotland versions available)
- The patient should be advised when they are likely to hear from the hospital, and what to do if they've not heard anything within an explicit period
- Inform the patient that initial consultations might be on the telephone and tests might be delayed
- If the patient is worried about how COVID-19 will affect them, please signpost to our information on COVID-19 and cancer

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Safety Netting

1. Ensure that other non-Gastrointestinal pathology is excluded e.g. renal, gynaecological etc.

2. When FIT is <10ug/g, this suggests an extremely low probability of LGI cancer

3. Lower GI cancer needs to be excluded when there is:
a) the presence of a palpable mass
b) iron deficiency anaemia

4. Safety-netting includes reviewing the patient at an interval of no more than 4 weeks

Safety Netting

5. If patient continues to display concerning signs/symptoms, refer regardless of the FIT result

6. There is currently no data to support repeating a FIT test, if patient has persistent or worsening symptoms, refer regardless of FIT result

7. **Never ignore gut feeling!** If there is still concern or uncertainty about fulfilling the pathway criteria, seek advice and guidance, refer to local RDC or refer on via LGI urgent suspected referral pathway (even if FIT < 10ug/g)

Using FIT to improve outcomes in colorectal cancer patients1

The context:

The COVID-19 pandemic has caused disruption across cancer pathways for diagnosis and treatment. In England, 32% of colorectal cancer (CRC) is diagnosed via urgent symptomatic referral from primary care, the “2-week-wait” (2WW) pathway.

Access to routine endoscopy is likely to be a critical bottleneck causing delays in CRC management due to chronic limitation in capacity, acute competition for physician time, and safety concerns.

How can FIT help?

To avoid significant numbers of avoidable deaths from CRC, normal diagnostic and surgical throughput must be maintained. An accrued backlog of cases will present to primary care following release of lockdown, supranormal endoscopy capacity will be required to manage this without undue delays.

FIT-triage of symptomatic cases provides a rational approach by which to avoid patient delay and mitigate pressure on capacity in endoscopy. This would also reduce exposure to nosocomial COVID-19 infection, relevant in particular to older patient groups.

90% of the life years lost to delayed cancer diagnostics can be “recouped” by use of FIT triage.

[1]Quantifying and mitigating the impact of the COVID-19 pandemic on outcomes in colorectal cancer

What are the benefits of this approach?

For Patients…

- **Improved patient experience and quality of referral.**
- FIT provides a high level of reassurance to patients with negligible results and improved access to services for patients who are at high risk of colorectal cancer.
- Alternative pathology is not missed.

For GPs…

- **Better patient prioritisation and triage during COVID-19**.
- National guidance (incl. BSG) cite FIT as an effective and key diagnostic test by which patients can be prioritised according to their results and symptomology.
- There are a number of patients who have had their 2ww referral suspended due to COVID-19, FIT will enable those at high risk to be brought in to the trust for urgent investigations where required.
- Alternative pathology is not missed.

Patient Feedback FIT

- 'My experience of the kit was swift and effective in getting referred to the Endoscopy unit for colonoscopy. After the positive result of the stool sample I was anxious and worried to find out what was wrong, but the quick referral was received. The whole process was quick, effective and transparent'

- 'The FIT test was easy and self explanatory to use. I didn't mind doing it as I knew it would help with my speedy referral/ diagnosis.'

Faecal Immunochemical Testing (FIT) for patients with colorectal cancer symptoms

Dr Brian D Nicholson MRCGP DPhil
NIHR Academic Clinical Lecturer
Nuffield Department of Primary Care Health Sciences
University of Oxford

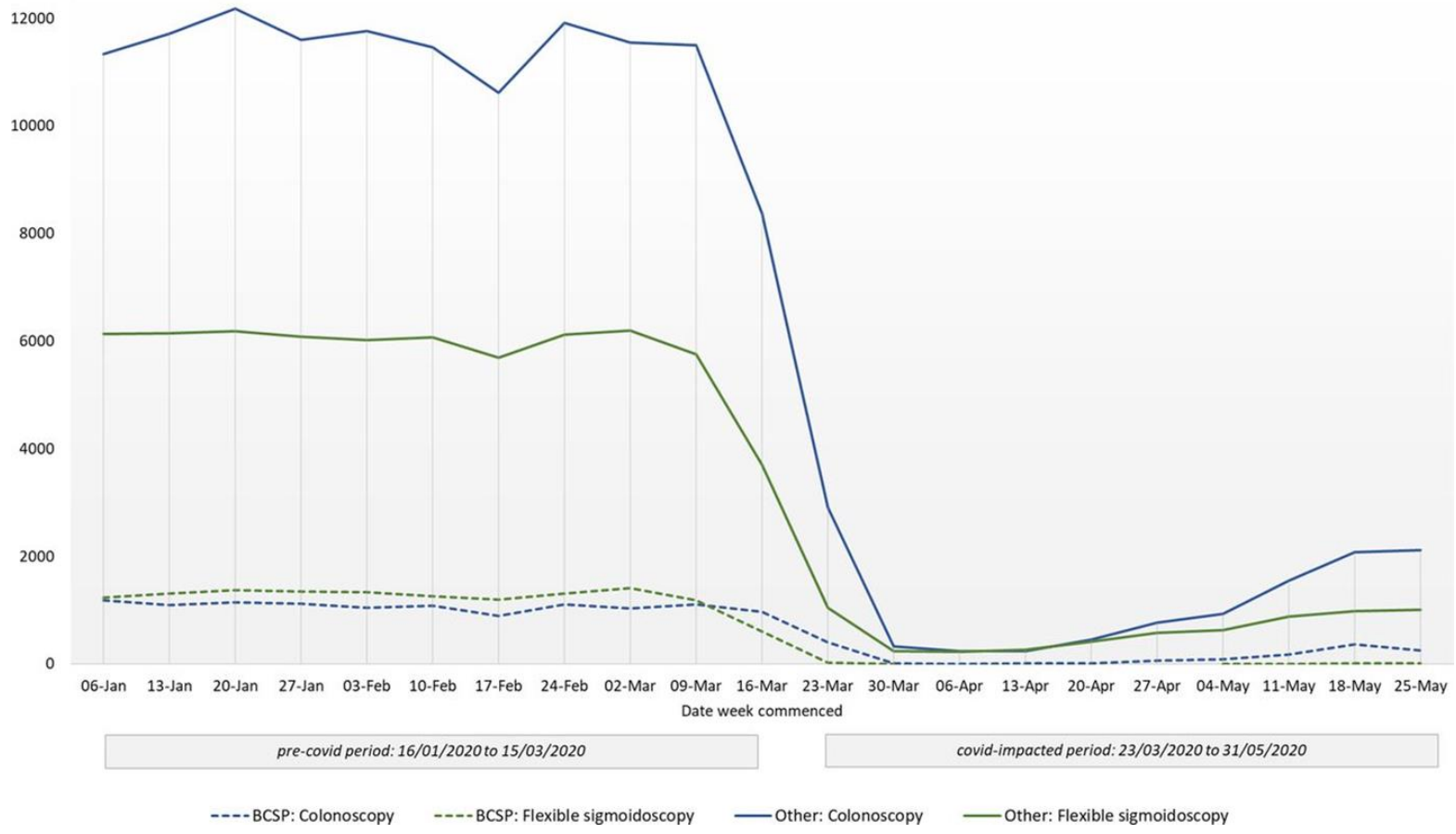
NUFFIELD DEPARTMENT OF
PRIMARY CARE
HEALTH SCIENCES
Medical Sciences Division

Colonoscopy and sigmoidoscopy procedures

Impact of COVID-19

UK's National Endoscopy Database (NED)

The average weekly number of procedures, cancers, proportion of missing cancers and cancer detection rates were calculated.



Rutter (2020) Gut doi:10.1136/gutjnl-2020-322179

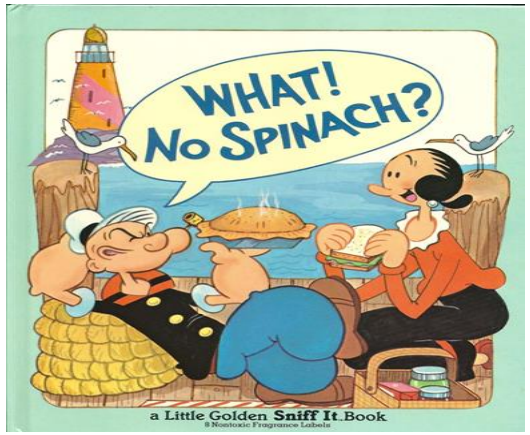
NICE 2015 – Faecal Occult Blood Testing (FOBT)

>50 yrs

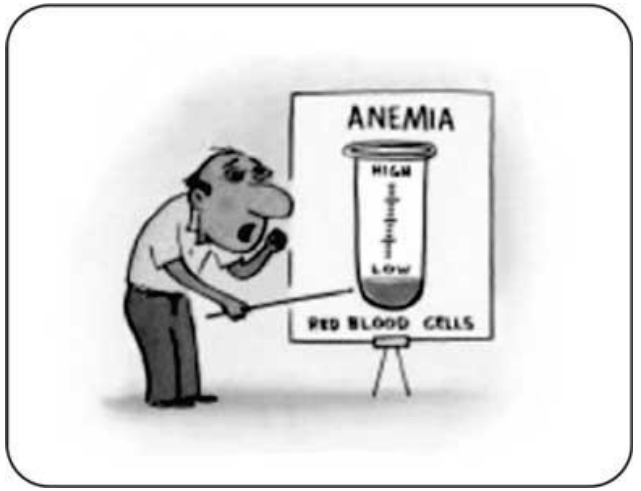
or

<60 yrs

or



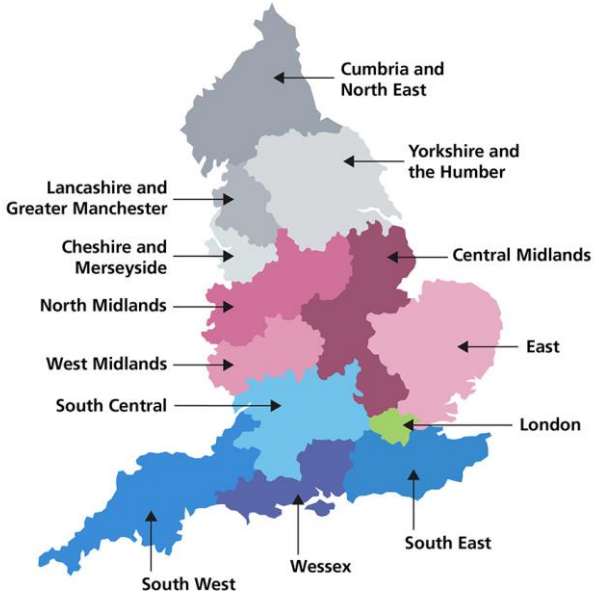
≥60 yrs



2015 - English GPs with access to FOBT

	ENGLAND N=511	English Region %												
	% (95% CI)	1	2	3	4	5	6	7	8	9	10	11	12	***p*-value**
FOBT	**54** (49-59)	62	56	69	50	42	47	49	34	45	80	57	46	<0.01

Nicholson (2016)

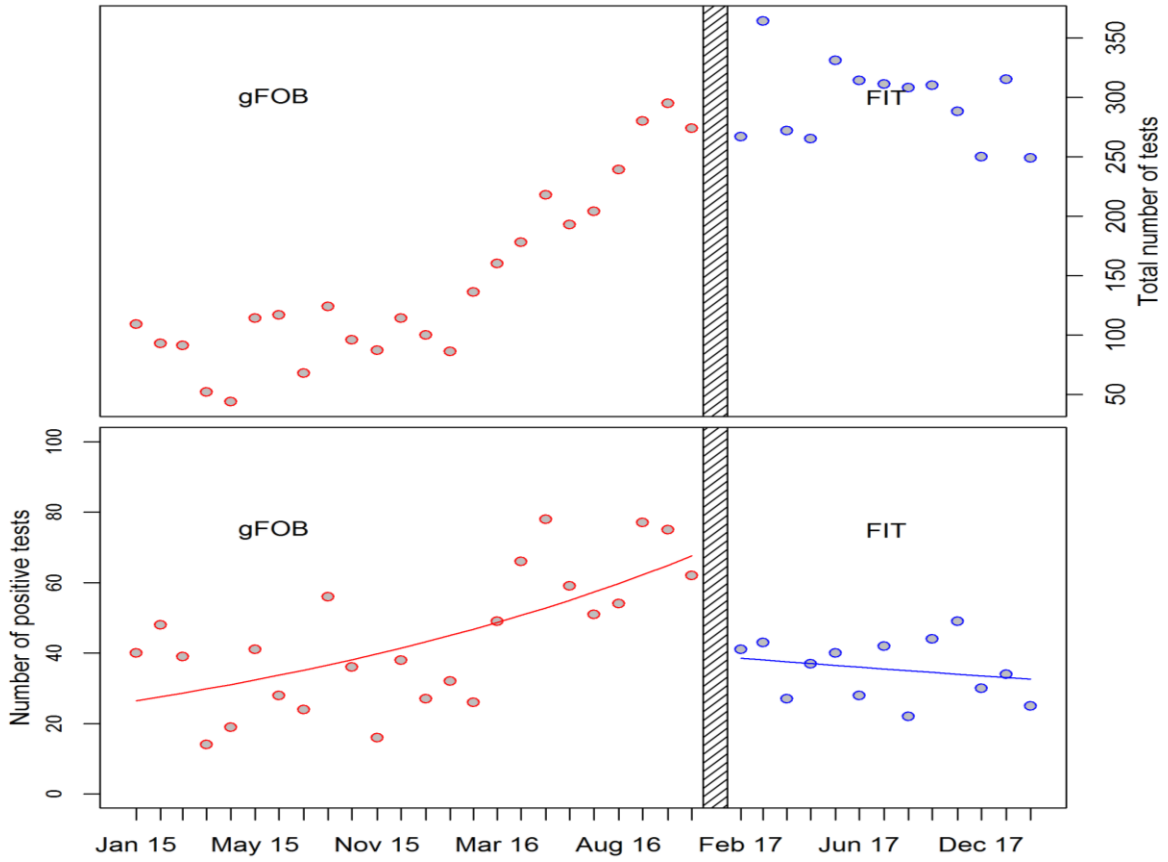


FOBT requests – Jan 15 to Dec 17 - Oxfordshire

Halving of positive tests

Lower false positive rate

11% vs 34% (p<0.01)



Nicholson (2018) flgastro-2018-101052

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NICE National Institute for Health and Care Excellence

DG30: Quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care (2017)

- 10 studies identified
- None reported data that on people with symptoms who are judged to be at low risk of colorectal cancer.
- Only one study was done in primary care (almost).

Recommendation

- FIT recommended to guide referral for suspected colorectal cancer in people without rectal bleeding who have unexplained symptoms but do not meet the criteria for a suspected cancer pathway referral
- ≥10 micrograms hb/g faeces

Analysis of FIT use in primary care

- 14,487 consecutive cohort of FITs
- 12,509 patients from primary care prior to referral
- Oxfordshire CCG / OUH laboratories
- Within the context of NG12/DG30
- HM-JACKarc laboratory method
- Symptom capture from FIT requests
- Follow-up in the linked hospital record

- Focus here on the 9,896 people with ≥6 months follow-up

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	All N (% FIT ≥7 µg/g)
Age-group (years)	
18-39	793 (8.8)
40-49	1400 (7.1)
50-59	2749 (7.9)
60-69	1651 (9.1)
70-79	1868 (14.2)
≥80	1435 (20.6)

	All N (% FIT ≥7 µg/g)
Clinical Features	
Abdominal pain	2,501 (7.9)
Anaemia	2,791 (14.5)
Blood in stools	1,477 (19.7)
Change in bowel habit	5,011 (7.6)
Inflammation	173 (18.5)
Iron deficiency	1,208 (11.7)
Thrombocytosis	134 (8.2)
Tired all the time	66 (7.6)
Weight loss	951 (10.8)

	All N (% FIT ≥7 µg/g)
Outcome	
Colorectal cancer	105 (91.4)
Benign disease (Polyp <10mm/Diverticulosis)	80 (22.5)
Bowel inflammation	204 (36.3)
High risk adenoma (Polyp >10mm or high-grade dysplasia)	373 (41.6)
No significant pathology	418 (16.3)
No further investigation	8,716 (7.9)

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Diagnostic accuracy of FIT in primary care

FIT Threshold (µg/g)	Sensitivity (95% CI)	Specificity (95% CI)	PPV (95% CI)	NPV (95% CI)
≥7	91.4 (86.1-96.8)	89.8 (89.2-90.4)	8.74 (7.07-10.4)	99.9 (99.8-100.0)
≥10	90.5 (84.9-96.1)	91.3 (90.8-91.9)	10.1 (8.15-12.0)	99.9 (99.8-100.0)
≥20	84.8 (77.9-91.6)	93.7 (93.2-94.2)	12.6 (10.2-15.1)	99.8 (99.7-99.9)
≥50	74.3 (65.9-82.6)	96.4 (96.0-96.7)	17.9 (14.3-21.5)	99.7 (99.6-99.8)
≥100	61.0 (51.6-70.3)	97.6 (97.3-97.9)	21.3 (16.7-26.0)	99.6 (99.4-99.7)
≥120	57.1 (47.7-66.6)	97.8 (97.6-98.1)	22.1 (17.2-27.1)	99.5 (99.4-99.7)
≥150	54.3 (44.8-63.8)	98.1 (97.8-98.4)	23.4 (18.1-28.7)	99.5 (99.4-99.6)

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FIT performance per 1,000 patients tested

FIT Threshold (µg/g)	Positive FITs n (%)	Cancers detected n (%)	Positive FITs to detect one cancer "number needed to scope"	Negative FITs n (%)	Patients with cancer and a negative FIT "the cancer miss rate"
≥7	111 (11)	10 (91)	11	889 (89)	1
≥10	96 (10)	10 (91)	10	904 (90)	1
≥20	71 (7)	9 (85)	8	929 (93)	2
≥50	44 (4)	8 (74)	6	956 (96)	3
≥100	30 (3)	7 (61)	5	970 (97)	4
≥120	28 (3)	6 (57)	5	972 (97)	5
≥150	25 (2)	6 (54)	4	975 (98)	5

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FIT performance per 1,000 patients tested

CA125 (≥35 U/ml)

23% ovarian cancers missed

PSA

25% prostate cancers missed

CXR

20% lung cancers missed

FIT (≥10 ug/g)

10% colorectal cancers missed

SAFETY NET PATIENTS WITH NEGATIVE TESTS AND PERSISTENT SYMPTOMS

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Risks of colorectal cancer

Risk of colorectal cancer in a 60 year old **with abdominal pain and change in bowel habit** is

1.0% to 2.6%

Risk of colorectal cancer in a person with a **positive FIT** is

≥10.0%

Risk of colorectal cancer in a 60 year old **without symptoms** is

0.1% to 0.2%

Risk of colorectal cancer in a person with a **negative FIT** is

0.1% to 0.2%

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NHS

Pathway Impact – the Frimley experience

Ian Laidlaw
Chief of Service Surgery, Urology & Cancer Services
Frimley Health NHS Foundation Trust

Committed to excellence | Working together | Facing the future

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NHS Foundation Trust

Patients

- 2917 patients referred 19/6/20 to 30/4/21
- 257 patients excluded as still on investigation pathway
- 2660 patients included
- 110 (4.1%) patients diagnosed with colorectal or anal cancer

FIT Test Referral Pattern

- 2096 (79%) Patients referred with FIT
  - 617 negative FIT (<10)
    - Colorectal/anal cancer incidence 0.2% (1 patient)
  - 1479 positive FIT
    - Colorectal/anal cancer incidence 5.4% (80 patients)
  - 447 patients with FIT >120
    - Colorectal/anal cancer incidence 12.1% (54 patients)
- 564 (21%) Patients didn't have FIT
  - Colorectal/anal cancer incidence 5.1% (29 patients)

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Investigations

Group	Positive FIT	Negative FIT	No FIT	Overall
Colonoscopy	901 (61%)	190 (31%)	198 (35%)	1289 (48%)
Flexible Sigmoidoscopy	194 (13%)	109 (18%)	122 (22%)	425 (16%)
OGD	167 (11%)	127 (21%)	63 (11%)	357 (13%)
CT colonoscopy	243 (16%)	44 (7%)	59 (10%)	346 (13%)
CT scan	408 (28%)	250 (41%)	166 (29%)	824 (31%)
MRI	62 (4%)	10 (2%)	22 (4%)	94 (4%)
Ultrasound	12 (<1%)	7 (1%)	1 (<1%)	19 (<1%)
No investigation (or investigated off 2WW pathway)	189 (13%)	123 (20%)	125 (22%)	437 (16%)

CR Cancer in FIT negative Patients

- Single Patient
  - 1/617 FIT negative 0.16%
  - 1/2917 total referrals 0.034%
- 76 year old male
  - Presented with change in bowel habit
  - Not anaemic (Hb 157)
  - Palpable Polypoidal lesion overlying hemorrhoid
  - Biopsy confirmed T2 adenocarcinoma of rectum
- Examine the Patient !

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Benefits

- Quality and Timeliness
  - Appropriate prompt reassurance of Community based –FIT patients
  - Quality of patient experience
- Timeliness
  - Expedites FIT + patient
  - Reassures FIT - patient
- Quantity
  - Increased Colonoscopy capacity
  - Half of FIT negative avoided colonoscopy
  - Approx 300 colonoscopies – 50 lists in 10 months
  - Brings forward 300 into these slots
  - NB Virtual financial saving as no closed lists
- Safety
  - Secure data on value of test
  - No complications possible in pts who don't proceed to colonoscopy
  - In Covid times has prevented risk to patient and staff of exposure,
- Appropriately diverts patients to investigation on non cancer pathway

Implementation

- Preparation
  - Agree the Direction and team approach
  - Evidence base
  - Documentation, Referral forms Guidance in DXS
  - Q and A
  - Flow diagrams
- Education
  - Joint venture
  - Champions from primary and secondary care
  - Webinar and Place based Education – repetition
- Feedback to practices / practitioners
  - Weekly contact cancer office to practice managers with support from primary care lead clinicians
- Reassurance

Area for further work

- Include Polyp detection
- Identify community-based patients FIT-ve and their outcomes needs long run in
  - as yet unaware of Primary care FIT negative patient subsequently identified with delayed diagnosis

Potential Impact on CRC FIT Screening

- Symptomatic positive 10 +
- Screening positive 120+
- ? As community testing become more prevalent should we review recruitment to screening within a defined period after negative FIT
- If So, How? Automated through Lab?

Summary Observations

- Key elements that supported adoption of the pathway:
  - Published data and evidence to support the pathway
  - Leaders across the system engaged
  - Everyone committed to the same goal
  - Education, education and more education
  - Share the successes

- Key Learnings:
  - Data monitoring – to drive further adoption
  - Map your geography – look at who hasn't attended education sessions not who has
  - Recognize local variation and tailor approaches accordingly
  - Formal capture of patient experience needs to be a more central focus in all we do

- Applying the learning

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Q & A