NHS
Barnsley Clinical Commissioning Group

Primary Care Changes to Colorectal 2 Week Wait Pathway

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Colorectal cancer is the fourth most common diagnosed cancer in England, and is the third most common cancer in both men and women.

- In 2016, only **40.3% of all colorectal cancers were diagnosed at an early stage**. This varies by cancer alliance with a range of 36.1 - 45.6%.
- There is **considerable** variation in Routes to Diagnosis. Patients from the **least deprived quintile are less likely to be diagnosed through an emergency presentation** (by nine percentage points).
- More deprived patients also have lower survival at given Routes to Diagnosis.

Better Patient information	Provided at point of referral, information resources can empower patients and help to manage anxiety by setting out what can be expected from the diagnostic process (e.g. tests, timings and communications). This information can benefit patient experience and also encourage compliance, which will reduce delays along the pathway (i.e. reduced DNAs and re-booking of appointments).
Service model	• Clinical triage to optimise direct access diagnostics, ensure patients in the 'right place, first time' – change NO first OPD face to face appointment • Standardised diagnostic bundles with simultaneous booking of all likely investigations

Day 0	Day 0-3	Day 3-14	Day 14	Day 21	Day 28
Urgent GP referral Including locally agreed information	**Clinical triage** with telephone consultation	**Straight to test (STT)** Colonoscopy or CT Colon / CT / Flexi Sig +/- OGD	**Staging Investigations** Contrast CT Chest / Abdo / Pelvis MRI +/- TRUS (rectal cancer) Bloods (incl. CEA)	**MDT**	**Communication to patient on outcome** (cancer confirmed or all-clear provided)
		Cancer unlikely Patient informed; discharged back to GP			
Patient information Provided in primary care		**Outpatient clinic** Only if not clinically appropriate for straight to test			

0	GP referral – local agreements made ensure minimum dataset can facilitate straight to test provision. Primary care provision of FIT testing prior to referral for appropriate patients. Patient information resources developed for primary care – ensure patient engagement and empowerment
1-3	Clinically led triage – Consultant supervised and delivered by appropriately trained clinician – ensure bowel prep arrangements agreed.
3-14	Straight to test provision for all eligible patients. Parallel booking of other relevant tests
	Ensure provision for early outpatient consultation for patients unsuitable for straight to test for appropriate investigation planning
14	Staging Investigations – Standardised diagnostic bundle, booked at time of initial test.
21	MDT and discussion of treatment options. Some patients on clear and agreed cancer pathways may be discussed more briefly either at the beginning, or end, of the MDT.
21-28	Clinic Review – Consultant supported by CNS. Consider fitness for treatment and discussion regarding diagnosis & treatment options. Appropriate communication and contact with CNS should be considered throughout the pathway (e.g. at endoscopy, telephone consultation)

Fast Track 2ww Lower GI Referral Form

1. Includes question about GP has discussed the possibility of cancer with this patient.
2. Includes that the patient confirmed that they can be available to attend an appointment within the next two weeks
3. Includes - do you think the patient would be appropriate for a straight to test (STT) colonoscopy?
4. Includes - Is the patient fit for a day-case colonoscopy with home bowel prep?
5. Includes - Has the patient been given the information leaflet? Are they aware that will get a phone call from Nurse about bowel prep?
6. If blood test indicates new anaemia – not to start medication as will impact on timescale to have colonoscopy
7. Referral form will be used to triage patients next step – straight to test or requires OPD appointment