**Important update about the Direct to Scope Upper GI pathway – March 2017**

**This includes suspected upper GI cancer referrals**

**Key Updates**

* The form has been updated – please ensure you use the new version (Version 3)
* The service is recommended for ongoing use by the Clinical Senate (with representation from commissioners and primary and secondary care)
* CT scans should be booked in primary care for patients with significant weight loss (see page 4 of the referral form).
* For patients where a CT has been booked in primary care the hospital will ensure they also receive a clinic appointment (in addition to their direct to scope endoscopy)
* There is an opt out system for hospital follow up of benign conditions (see below and page 5 of the referral form)
* The conditions we will follow up has been clarified (see page 5 of the referral form)
* Referrals for iron deficiency anaemia should be sent to the iron deficiency anaemia clinic. Where they meet suspected cancer guidelines they should be referral via the colorectal pathway.
* Histology will continue to be sent to the referring GP in line with BMA guidance and after taking advice from medical protection societies (see below for a detailed description). A guide to histology results has been developed and is available online.

**Key advice**

* Use version 3 of the referral form
* Book a CT at the time of referral for patients with significant weight loss
* Please use one referral criterion only
* Ensure the form is complete
* Refer iron deficiency to the iron deficiency service or to the colorectal service

**Prospective audit data shows (324 patients included)**

* No missed upper GI cancers
* Age range of referrals 21-96years
* 3% have upper GI cancer (in line with national rates and previous audits)
* Non-upper GI cancers diagnosed include rectal, lung, breast, renal, lymphoma, and myeloma. Most are identified via CT.
* 64% of people have blood tests (despite being part of referral criteria)
* 73% forms complete
* 57% forms have a the follow up box completed

**Why am I being asked to act upon histology results and why was this agreed?**

The decision to ask GPs to act upon histology results was ratified at the Clinical Senate meeting following representation from the hospital, primary care and the CCG. Additionally advice has also been sought from medical defence unions and the decision was made in line with their advice.

There is no specific advice with GMC good medical practice regarding responsibility for acting upon test results but the BMA guidance is that “The receiving clinician has access to the relevant clinical information to place the test results in context” and that “clinicians should assume that the ordering clinician is responsible for receiving and acting upon results and should not assume that others who can view the result will take action”.

As endoscopy routinely incorporates taking samples for histological analysis, histology reports may form part of the overall test result. Whoever refers a patient for endoscopy has the best access to the relevant clinical information within which to place the result in context. This is the reason histology results are sent to the person referring a patient for endoscopy and is well established as standard practice for both open access endoscopy and intra-hospital referrals.

**What conditions will be followed up by the hospital and how?**

There is an opt out system for hospital follow up.

If you have opted out you must take full responsibility for the ongoing management of your patient.

For those that have not opted out, the following conditions will be offered follow up;

* Gastric ulcers
* Severe oesophagitis – grades 3, 4 or 5. Grades 1, 2 or 2a do not need follow up.
* Barrett’s oesophagus – these will be followed up via the Barrett’s clinic
* Benign oesophageal strictures – these are likely to be offered dilatation
* Oesophageal strictures of uncertain nature – will be offered CT scanning and clinic review
* Duodenal strictures – will be offered CT scanning and clinic review
* Non-inflating stomachs – will be offered CT scanning and clinic review
* CT booked with in primary care or at the time of endoscopy - will be offered clinic review

**What are the benefits of the new service?**

* NICE requires a direct to scope service
* There have been no missed upper GI cancers
* It has shorted the time from referral to diagnosis by around 2 weeks
* It has improved compliance with the 62 day treatment target for patients diagnosed with cancer
* It has improved the journey for patients diagnosed with upper GI cancer

Going straight to test allows us to ensure that when patients attends for results it is done so in the presence of a specialist nurse, with a full MDT outcome and in receipt of all relevant results

* It has shortened the waiting time for routine clinic referrals from around 22-24 weeks to around 6-8 weeks.
* Under the previous system some patients referred routinely were then diagnosed with cancer (i.e. outside of cancer pathways). For those patients, because of long waiting times, there could be long delays in diagnosis. Having shorter waiting times across the board improves care for those with unsuspected cancer.
* The previous system had been overwhelmed with referrals which did not meet cancer referral guidelines and had led directly to the long waiting times. A change was required to meet the needs of patients across the Wirral.
* The direct to scope system has been designed to follow up patients with positive findings

We understand primary care colleagues may prefer a system where all patient with symptoms are automatically reviewed in clinic but for a large number of patients this is not needed.

The volume of referrals is such that if we were to offer routine follow up to all patients we would have very long waiting times and compromise the care of patients referral via other pathways.

**An advice sheet is provided to all patients and GPs along with the endoscopy report.**

**This pathway, referral form and guidance has been developed with close collaboration with the CCG and colleagues from primary care. We welcome any further feedback you have about the process.**