RM Partners
NW & SW London Cancer Alliance

NHS

NEW Gastrointestinal (GI) Urgent Suspected Cancer (USC) Stratified Pathway Implementation

Guidance for Primary Care

October 2025

Hosted by The Royal Marsden NHS Foundation Trust

Case for Change

Demand is increasing….a risk stratified approach is needed

- Common and non-specific GI symptoms have led to **increased urgent suspected cancer (USC) referrals.**
- Trusts face increased diagnostic demand and capacity issues, **causing longer delays** for high-risk GI cancer patients.
- NHSE FIT compliance and delivery metrics show that NWL and SWL have one of the highest rates nationally for patients with FIT<10 being triaged and having **unnecessary colonoscopy procedures**.
- A *'risk stratified'* approach will ensure only **high-risk patients undergo colonoscopy.**

Maximising use of FIT as an important diagnostic tool

- All LGI USC pathway referrals require an accompanying FIT test result.
- Patients with FIT<10 should be monitored in primary care using safety netting with ongoing symptom evaluation.
- The risk of colorectal cancer in those with a negative result (FIT <10), a normal examination and full blood count is <0.1%.[1]

1. A cohort study of duplicate faecal immunochemical testing in patients at risk of colorectal cancer from North-West England | BMJ Open

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NEW GI USC Stratified Pathway - Combined Triage

- Secondary care will have a unified triage process for UGI and LGI (Urgent Suspected Cancer – USC) referrals from primary care. Please continue to refer using either LGI or UGI Pan London 2ww forms. Please **DO NOT DUPLICATE** the referral for both tumour types for the same patient.
- **Initial Triage UGI/LGI USC Referrals:**
  - Conducted within 24 hours by either a GI clinical nurse specialist (CNS) or nurse endoscopist.
  - Utilises the new GI Straight to Test (STT) USC triage algorithm.
  - Low risk patients (based on FIT result) receive clinical review for either discharge or are re-routed to an alternative pathway. **GP/patient informed.**
- **LGI Referrals**
  - FIT result **required for all referrals** (unless exceptional circumstances).
- **Straight to Test**
  - Appropriate patients receive a telephone triage call by a GI CNS by Day 3.
  - Confirms next steps such as colonoscopy, flexi sig, CTCV, or OPA.
- **Diagnostics**
  - Completed between Day 10-14.
  - Aim to rule out cancer by Day 28 (NHSE Faster Diagnosis Standard)

FIT < 10 Pathway Overview

FIT ≥10 → Refer via lower GI Urgent Suspected Cancer (USC) pathway

FIT <10 + persistent symptoms → Consider alternative pathway

FIT <10 + resolved symptoms → Provide advice and safety netting

NICE Guidelines for FIT<10 and Management in Primary Care

- NICE[2] recommend safety netting patients who have **not returned a FIT** and those with a **FIT <10 result**

- **Clinically appropriate action for FIT <10 patient:**
  - Reassess and consider repeating FIT (at 4-6 weeks after initial FIT)
  - Advice and guidance
  - Non-specific symptoms (NSS) Urgent Suspected Cancer referral
  - If concerns for lower GI cancer remain (e.g. new onset iron deficiency anaemia) consider USC referral
  - Routine GI pathways

- Safety netting patient verbally and with written material may be helpful e.g

"Your recent stool test showed a very low-risk result. You do not need a hospital referral at this stage. If your symptoms continue or worsen, please contact us again."

2. https://www.nice.org.uk/guidance/dg56/chapter/1-Recommendations

Documentation of Exceptional Circumstances:

1.Clinical Presentation

- Describe the patient's symptoms and clinical findings in detail.
- Note any deviations from typical presentations or expected outcomes.

2.FIT Test Results

- Clearly state the FIT test result (e.g., FIT<10).

3.Reason for Exception:

- Explain why the patient’s case is exceptional. This could include:
  - Persistent or worsening symptoms despite a FIT<10 result.
  - Presence of additional risk factors
  - Include any additional tests, imaging, or specialist opinions that support the need for further investigation.
  - Any unusual clinical findings that warrant further investigation.

If the above information is not included, secondary care colleagues will not be able to process the referral.

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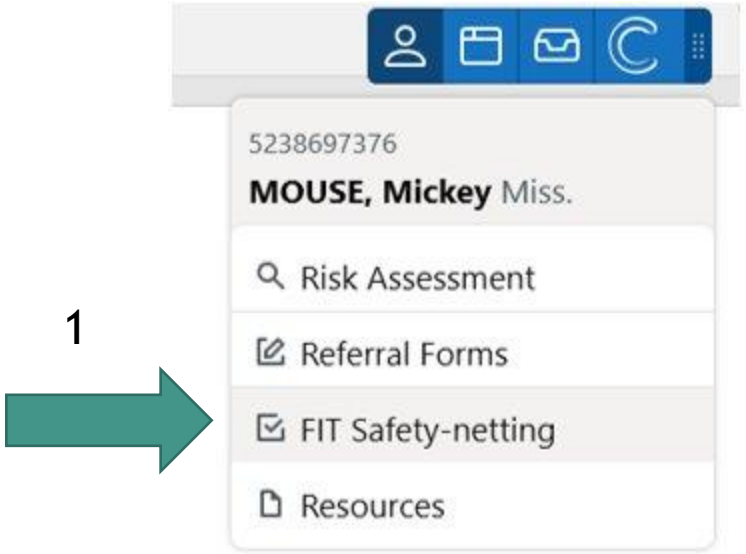
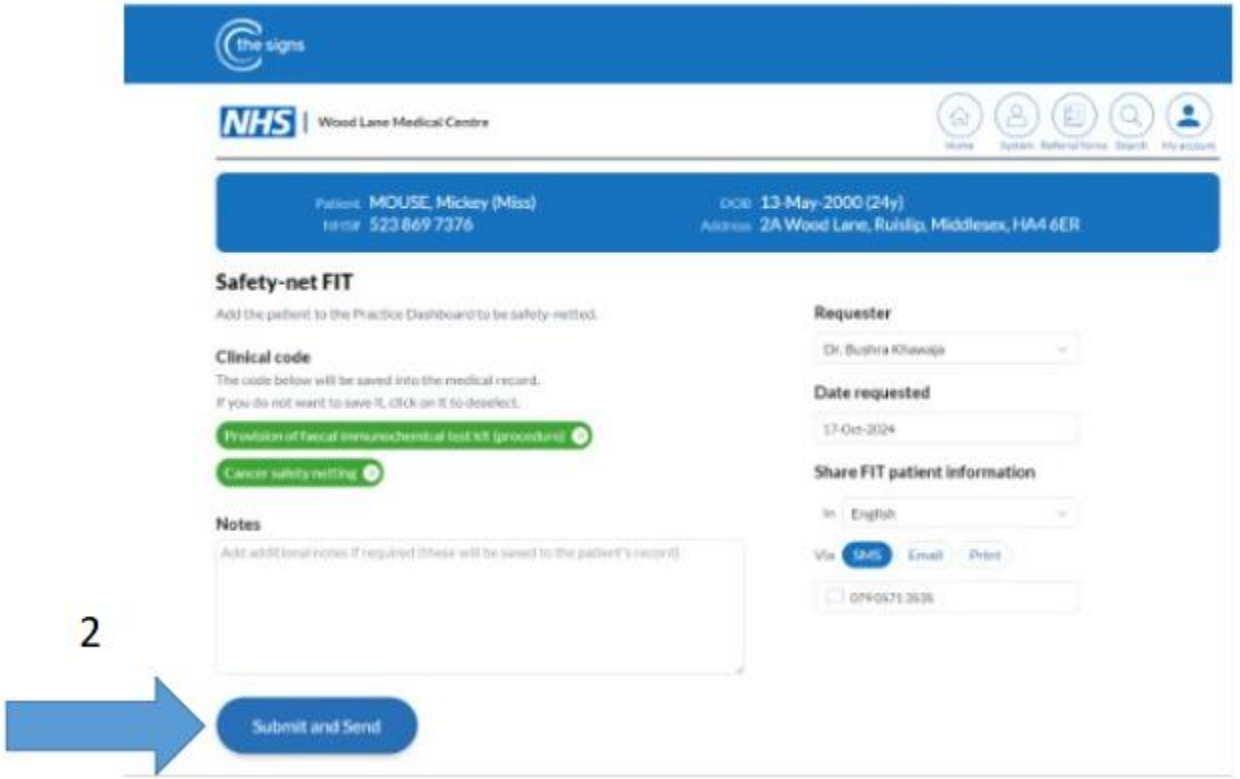
Pre Referral Criteria for Primary Care

- **Physical examination:** (including DRE where appropriate)
- **Baseline blood tests:** FBC, U&Es, Iron studies should be requested and the results awaited and documented prior to referral. Other tests which secondary care will find helpful are LFTs, bone, CRP, haematinics, coeliac screen and thyroid function in anaemia.
- **FIT test:** For lower GI referrals, FIT test should be requested and the results awaited and documented prior to referral.
- **Other:**
    - **Previously investigated patients -** If the patient has had previous investigation for the same indication within the past 3 years, consider whether re-referral is appropriate; if any concern, please discuss with secondary care using Advice & Guidance, or refer for a clinic consultation.
    - **Patient preference -** if the patient does not wish to go "straight to test", please indicate this clearly on the referral.
    - **Elderly/comorbidity - i**f a patient has moderate or severe frailty, consider if it is appropriate to investigate. This may include dementia. If there is any doubt about appropriateness of investigations, consider speaking with the patient's carer/family members and your wider team.

Ensuring FIT return from patients - Safety Netting system example

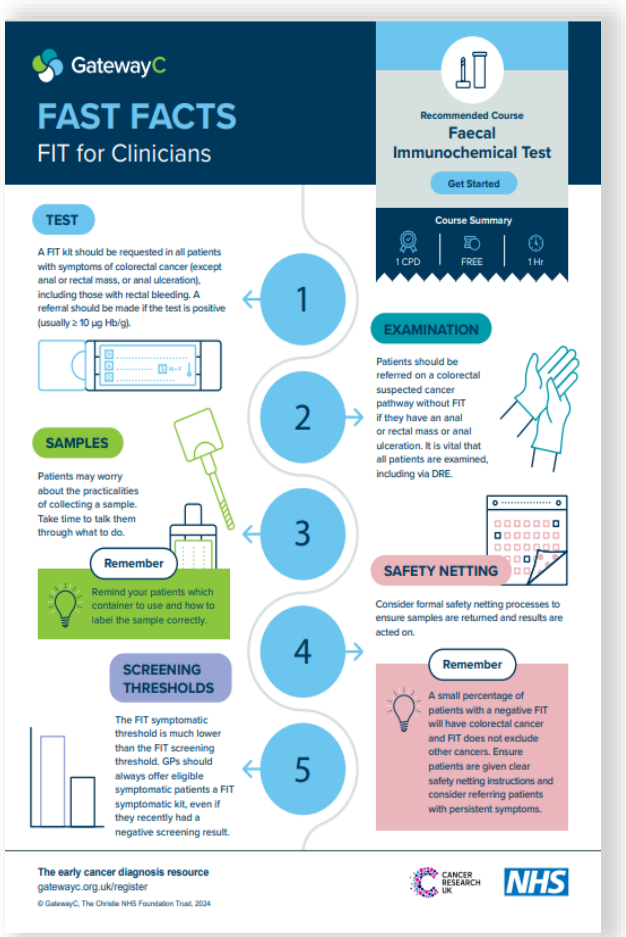
- **C The Signs:** The FIT safety-netting button is on tool bar
- It is a simple process that takes two clicks to complete
- Patient added on dashboard for easy follow up



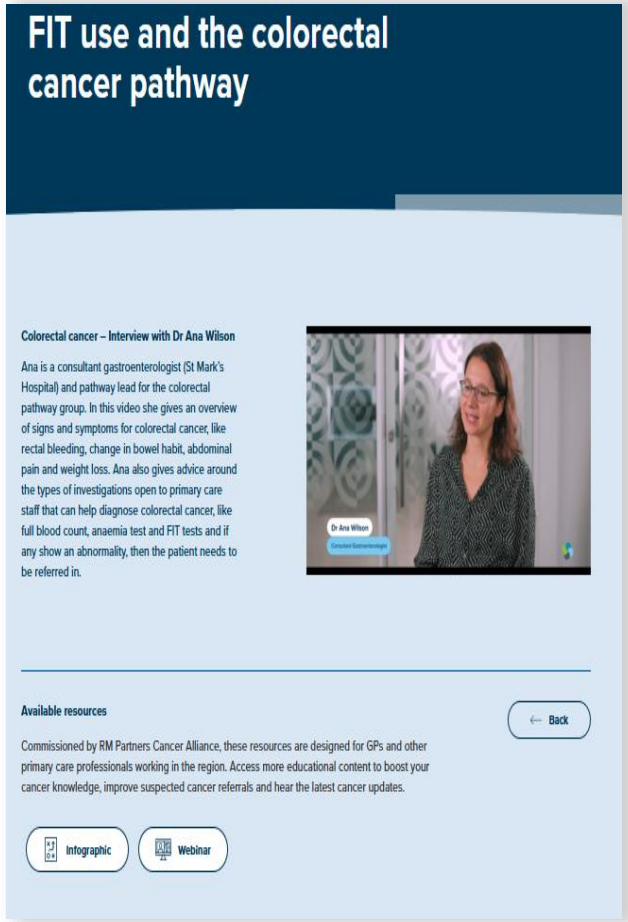


[Get Started - C the Signs Help Center for EMIS and S1]

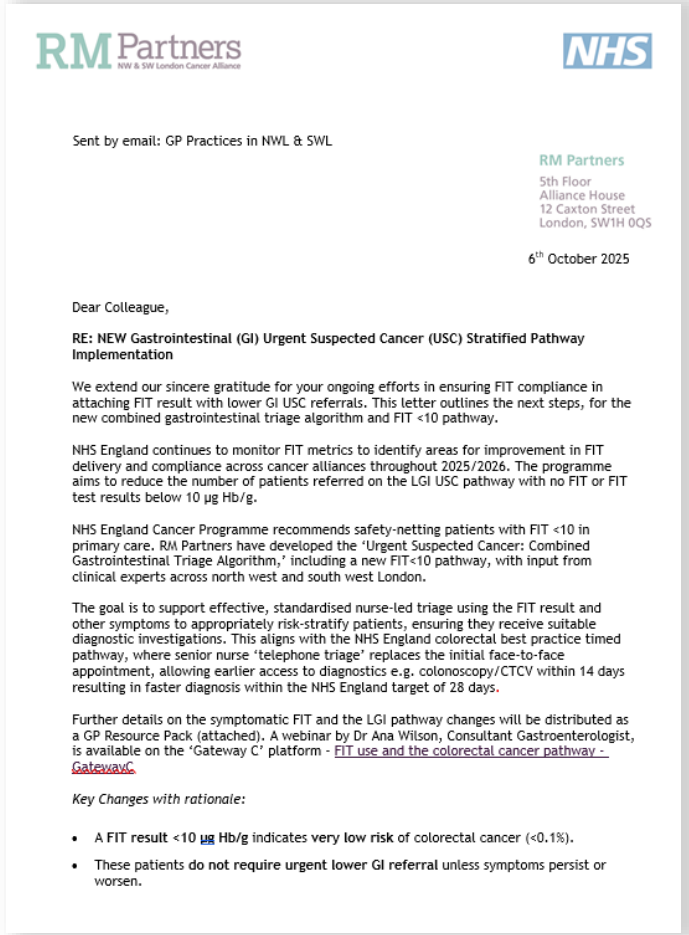
Additional Resources Available



GatewayC_Infographic_FIT-Clinicians-2.pdf



FIT use and the colorectal cancer pathway - GatewayC - Video



RM Partners
NW & SW London Cancer Alliance

NHS

Sent by email: GP Practices in NWL & SWL

RM Partners
5th Floor
Alliance House
12 Caxton Street
London, SW1H 0QS

6th October 2025

Dear Colleague,

RE: NEW Gastrointestinal (GI) Urgent Suspected Cancer (USC) Stratified Pathway Implementation

We extend our sincere gratitude for your ongoing efforts in ensuring FIT compliance in attaching FIT result with lower GI USC referrals. This letter outlines the next steps, for the new combined gastrointestinal triage algorithm and FIT <10 pathway.

NHS England continues to monitor FIT metrics to identify areas for improvement in FIT delivery and compliance across cancer alliances throughout 2025/2026. The programme aims to reduce the number of patients referred on the LGI USC pathway with no FIT or FIT test results below 10 µg Hb/g.

NHS England Cancer Programme recommends safety-netting patients with FIT <10 in primary care. RM Partners have developed the 'Urgent Suspected Cancer: Combined Gastrointestinal Triage Algorithm,' including a new FIT<10 pathway, with input from clinical experts across north west and south west London.

The goal is to support effective, standardised nurse-led triage using the FIT result and other symptoms to appropriately risk-stratify patients, ensuring they receive suitable diagnostic investigations. This aligns with the NHS England colorectal best practice timed pathway, where senior nurse 'telephone triage' replaces the initial face-to-face appointment, allowing earlier access to diagnostics e.g. colonoscopy/CTCV within 14 days resulting in faster diagnosis within the NHS England target of 28 days.

Further details on the symptomatic FIT and the LGI pathway changes will be distributed as a GP Resource Pack (attached). A webinar by Dr Ana Wilson, Consultant Gastroenterologist, is available on the 'Gateway C' platform - FIT use and the colorectal cancer pathway - GatewayC

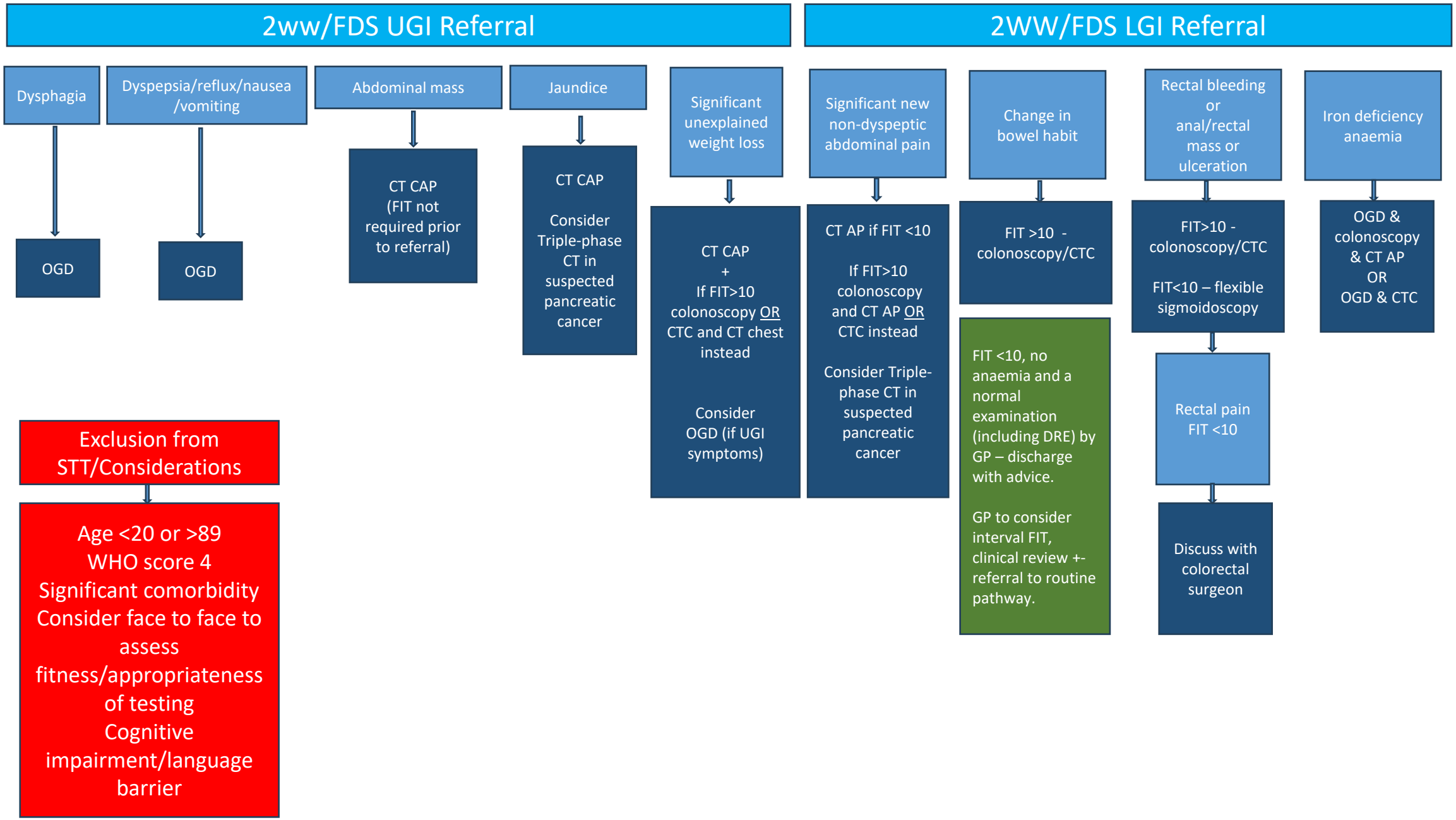
Key Changes with rationale:

- A **FIT result <10 µg Hb/g** indicates **very low risk** of colorectal cancer (<0.1%).
- These patients **do not require urgent lower GI referral** unless symptoms persist or worsen.

Letter to GP colleagues dated 6th October 2026

NEW GI Combined Triage Urgent Suspected Cancer Straight to Test Algorithm

Including FIT < 10 pathway


2ww/FDS UGI Referral
Dysphagia
OGD
Dyspepsia/reflux/nausea /vomiting
OGD
Abdominal mass
CT CAP (FIT not required prior to referral)
Jaundice
CT CAP
Consider Triple-phase CT in suspected pancreatic cancer
Significant unexplained weight loss
CT CAP + If FIT>10 colonoscopy OR CTC and CT chest instead
Consider OGD (if UGI symptoms)
2WW/FDS LGI Referral
Significant new non-dyspeptic abdominal pain
CT AP if FIT <10
If FIT>10 colonoscopy and CT AP OR CTC instead
Consider Triple-phase CT in suspected pancreatic cancer
Change in bowel habit
FIT >10 - colonoscopy/CTC
FIT <10, no anaemia and a normal examination (including DRE) by GP – discharge with advice.
GP to consider interval FIT, clinical review +- referral to routine pathway.
Rectal bleeding or anal/rectal mass or ulceration
FIT>10 - colonoscopy/CTC
FIT<10 – flexible sigmoidoscopy
Rectal pain FIT <10
Discuss with colorectal surgeon
Iron deficiency anaemia
OGD & colonoscopy & CT AP OR OGD & CTC
Exclusion from STT/Considerations
Age <20 or >89
WHO score 4
Significant comorbidity
Consider face to face to assess fitness/appropriateness of testing
Cognitive impairment/language barrier

Minimum age	Symptom	Secondary care action
Any	Dysphagia	Organise OGD If OGD negative but significant symptoms consider barium swallow; consider ENT referral if high dysphagia
30	Dyspepsia/reflux/nausea/vomiting	Organise OGD unless patient previously investigated in last 3 years for same symptoms
Any	Abdominal mass	Organise CT CAP (FIT test not needed on referral to secondary care) • If previous imaging – discuss with consultant
Any	Jaundice	Organise CT CAP • Consider in addition CT triple phase in suspected pancreatic cancer (please confirm exact protocol with local radiologist)
30	Significant unexplained weight loss	Organise CT CAP • + if FIT>10 – colonoscopy OR CTC and CT chest as an alternative to CT CAP • Consider OGD If UGI symptoms
30	Significant new non-dyspeptic abdominal pain	Organise CT AP • if FIT>10 – colonoscopy and CT AP OR CTC • Consider in addition CT triple phase in suspected pancreatic cancer (please confirm exact protocol with local radiologist)
30	Change in bowel habit	FIT >10 organise colonoscopy/CTC FIT <10 with no anaemia and a normal examination (including DRE) in primary care – discharge with advice. GP to consider interval FIT, clinical review +- referral to routine pathway.
30	Rectal bleeding Anal/ rectal mass or ulceration	FIT should be carried out on non-bloody stool FIT>10 - colonoscopy/CTC FIT<10 - flexible sigmoidoscopy If rectal pain and FIT<10 – discuss with colorectal surgeon If age <30, consider downgrade to routine; refer back to GP if patient has had investigation within last 3 years
30	Iron deficiency anaemia (men and non-menstruating women only; proven by low Hb & one of: low ferritin, low MCV or low MCH)	Organise OGD and colonoscopy and CT AP OR OGD and CTC • In chronic anaemia, if previously investigated, re-investigation is not required • Referral can be downgraded if not confirmed IDA (i.e.. Low Hb and one of low ferritin, low MCV or MCH) • if low ferritin but normal Hb only consider investigation if FIT positive