










Primary Care LGI Pathway Education

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Part of the WCA 26/27 Primary Care Local Improvement Scheme

LIS Requirement 3: Improving the quality and appropriateness of LGI Cancer Referrals

Detail of activity required

- Clinical champions will attend a 1-hour WCA webinar and receive a resource pack to support local education delivery.
- Clinical champions will be responsible for sharing these key messages through locally held PCN or practice meetings, with the aim of reaching all referring clinicians.
- Practice meetings to include a review/discussion of LGI referral quality (the last 5 referrals per practice minimum) against high quality examples provided.

How could this education be delivered within your PCN?

- Traditional PLT session
- Bite-sized updates
- Recorded webinar
- Case discussion at MDT/huddle
- Clinical Cancer Champion cascade model

There is no single correct approach — choose the model that works best for your PCN and practice workforce.

Referral Form Review

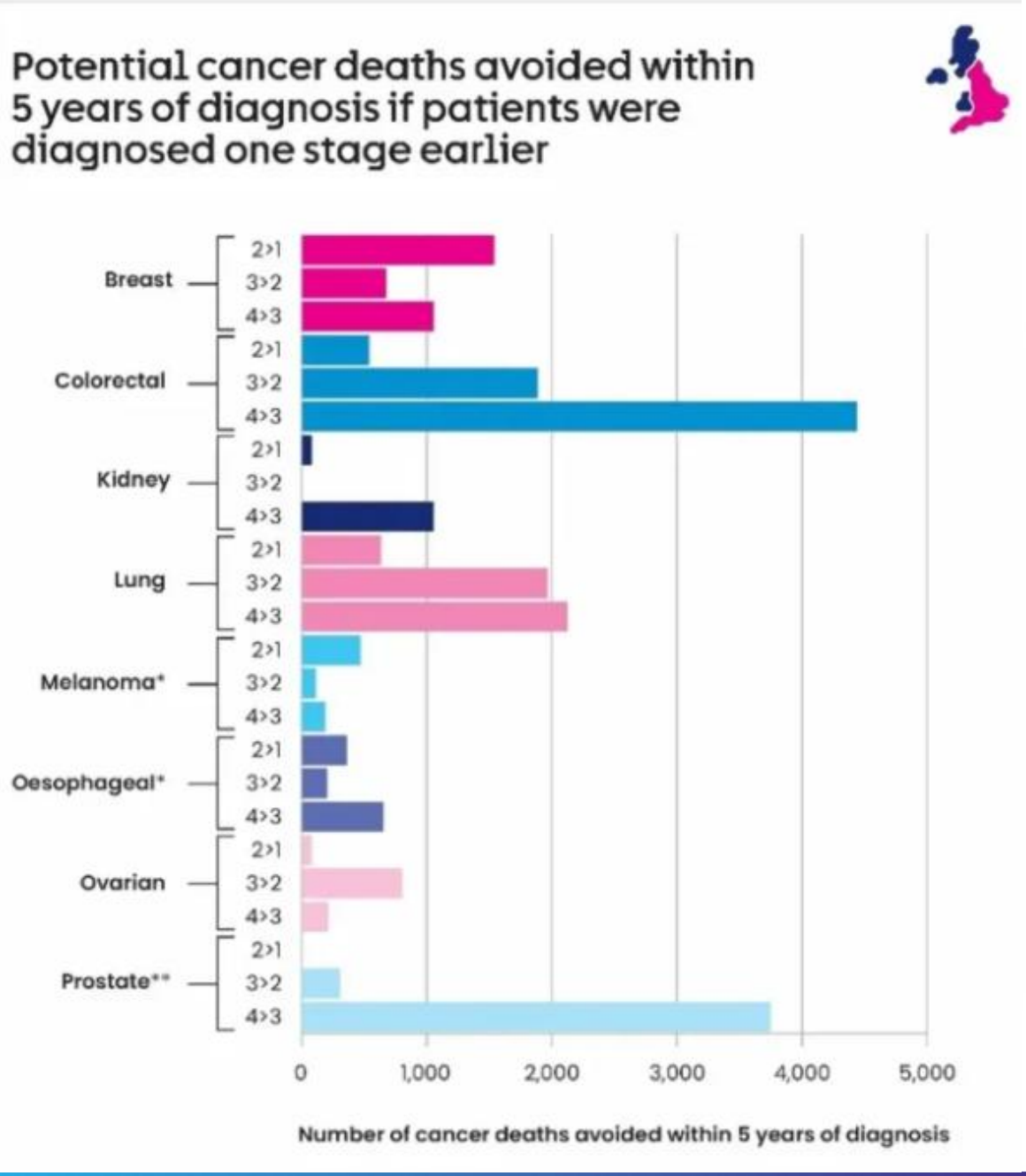
Practice education sessions to include a review/discussion of LGI referral quality (the last 5 referrals per practice minimum) against high quality examples provided.

Does the referral demonstrate all the components required for optimal triage and straight-to-test booking?

✓ Clear symptom chronology and duration
✓ Why cancer is suspected clearly stated
✓ Examination findings including DRE documented
✓ FIT, FBC and renal function included
✓ Previous investigations documented
✓ Frailty score recorded
✓ Patient informed and willing to undergo investigation

Why are we focusing on bowel cancer?

- Bowel cancer is the fourth most common cancer in the UK, with almost 43,000 people diagnosed every year.
- It is the second leading cause of cancer death in the UK accounting for over 7,500 deaths each year.
- Analysis shows that the greatest number of cancer deaths could be avoided (approx. 4500) with a shift in bowel cancer diagnoses from Stage 4 to Stage 3.



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Why are we focusing on bowel cancer?

HIOW Colorectal Cancer Audit (25/26 LIS) and Bowel Cancer Pilot Projects

Primary care delays
- Repeated consultations
- FIT delayed/not requested
- No DRE/examination
- Anaemia not fully investigated

Knowledge gaps
- Uncertainty around FIT<10
- Alternative pathways underused
- Variation in safety netting
- Inconsistent frailty recording

Secondary care delays
- Capacity constraints
- Delayed investigations
- Fragmented pathways

System opportunities
- Improve referral quality
- Earlier risk stratification
- Consistent coding
- Shared pathway understanding

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Learning objectives

- Optimise pre-referral assessment
- Improve referral quality
- FIT<10 guidance and alternative pathways
- Further learning points – rectal bleeding/haemorrhoids and IDA
- Safety netting

The patient pathway - Dorset

Symptoms → Primary Care Assessment → FIT/Bloods/Examination → Referral → FDS Triage → Investigation → Diagnosis/Treatment

DCH

Referrals triaged daily by CN/NP in the electronic patient record → Outcome – Virtual Clinic, F2F anyone, F2F Cons/Reg, Diagnostic first seen (STT CT) → Anal mass, anal ulceration or requiring consent form 4 – F2F with Cons/Reg → F2F with anyone if frail or likely to need CTC and PR not completed

UHD

Daily triage by ACP team → CFS 1-3, <85 with bowel symps/ WL/IDA and FIT+ve abdo pain to nurse tel assessment clinic → CFS 1-5 any age abdo pain or rectal mass to Nurse F2F, CFS 4-5 >85 nurse F2F, CFS 1-5 any age, translator, sens probs nurse F2F → CFS 1-9 anal mass/ ulceration/ consent form needed consultant F2F → FIT <10 with proven IDA – directed to IDA service

The patient pathway - HIOW

HHFT	All referrals triaged daily by FDS nurses in ERS	Outcomes: STT Colonoscopy/CTC F2F OPA with Cons/Reg Telephone OPA with Cons/Reg	Palpable mass or ulceration see in OPA	FIT negative asymptomatic IDA to IDA pathway
PHU	Referrals graded by a band 8a nurse or consultant	Mandatory info checked inc previous refs inc multiple referrals	If all info present: STT / nurse led f2f / consultant f2f	IDA pts sent to GASTRO irrespective of raised FIT
UHS	Triaged by non clinical team against protocol	PS 0-1 Nurse led telephone assessment PS 2 – Nurse Led F2F	Palpable Abdominal mass, rectal or anal mass or very complex PMH or Consent issues to Consultant F2F clinic	IDA service run by Gastro Cons and tests arranged virtually with review if required

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Essential pre-referral assessments

- FIT
- FBC/U&E
- Abdominal examination
- DRE
- Frailty score

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Essential pre-referral assessments

SYMPTOMS AND REASON FOR REFERRAL (ESSENTIAL)

Clinical History: *I am concerned because…*

Physical examination findings, please include a digital rectal examination: *(This will allow patient to follow a straight to test pathway and access treatment more quickly, if needed.)*

I did a FIT test as per NICE guidance because my patient has:

- ☐ Abdominal mass
- ☐ Change in bowel habit
- ☐ Iron Deficiency Anaemia
- ☐ **<** 50 years with rectal bleeding **AND** either abdominal pain **OR** weight loss
- ☐ **≥** 40 years with unexplained weight loss **AND** abdominal pain
- ☐ **≥** 50 years with rectal bleeding **OR** abdominal pain **OR** weight loss
- ☐ **≥** 60 years with anaemia (not just iron deficiency anaemia)
- ☐ None of the above but clinical concern (please specify in clinical history above)

INVESTIGATION RESULTS (ESSENTIAL)

FIT Result:	_____ug/ml		
Bloods - required in determining investigation/treatment options *Please ensure the following recent blood results are available (U&Es must be within 3 months):*			
Hb:	Na:	K:	eGFR:
Bloods have been requested if not done in last 3/12) ☐			

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Examination changes the patient pathway

- PR examination mandatory before CT colonography
- Rectal/anal masses bypass FIT pathways
- Document findings clearly

Key message:
If it isn't documented, it hasn't happened.

Frailty and decision making

Rockwood Clinical Frailty Scale. Please tick most appropriate box:

ROCKWOOD CLINICAL FRAILTY SCALE (CFS)

- ☐ 1 - Very Fit
- ☐ 2 - Well
- ☐ 3 - Managing Well
- ☐ 4 - Vulnerable
- ☐ 5 - Mildly Frail
- ☐ 6 - Moderately Frail
- ☐ 7 - Severely frail
- ☐ 8 - Very Severely frail
- ☐ 9 - Terminally ill



Frailty scoring influences:

- Investigation choice
- Suitability for colonoscopy
- Need for face-to-face review
- Shared decision making

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Previous investigations and coding

Include previous:

- Colonoscopy/endoscopy
- CT imaging
- USC (2WW) referrals
- Relevant specialist reviews

Code investigations accurately
This is likely to be added to the Wessex USC LGI form

Further patient information – why does this matter?

PATIENT INFORMATION

Please tick to confirm:

☐	Patient is aware that this is a Fast Track referral to exclude cancer
☐	Patient has been provided with a fast track cancer pathway information leaflet or sent an electronic link. Leaflet available in different languages at: https://cancermatterswessex.nhs.uk/fast-track-referrals/
☐	Patient is expecting to be contacted by secondary care within 2 weeks and knows who to contact if this doesn't happen.
☐	Patient is willing to undergo investigation

ACCESSIBILITY

Please tick any of the following that apply to your patient:

		Admin use only
☐	Patient has cognitive impairment that may affect their mental capacity for consent. If yes, please confirm date best interests meeting completed: __/__/____	**NP**
☐	Patient has significant mobility impairment – please tick if hoist is required, please specify: …	**TT**
☐	Patient has significant sensory impairment, please specify: …	**NP**
☐	Patient will require an interpreter, please specify language: …	**NP**
☐	Patient requires hospital transport, please specify type: …	

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FIT <10 guidance and alternative pathways

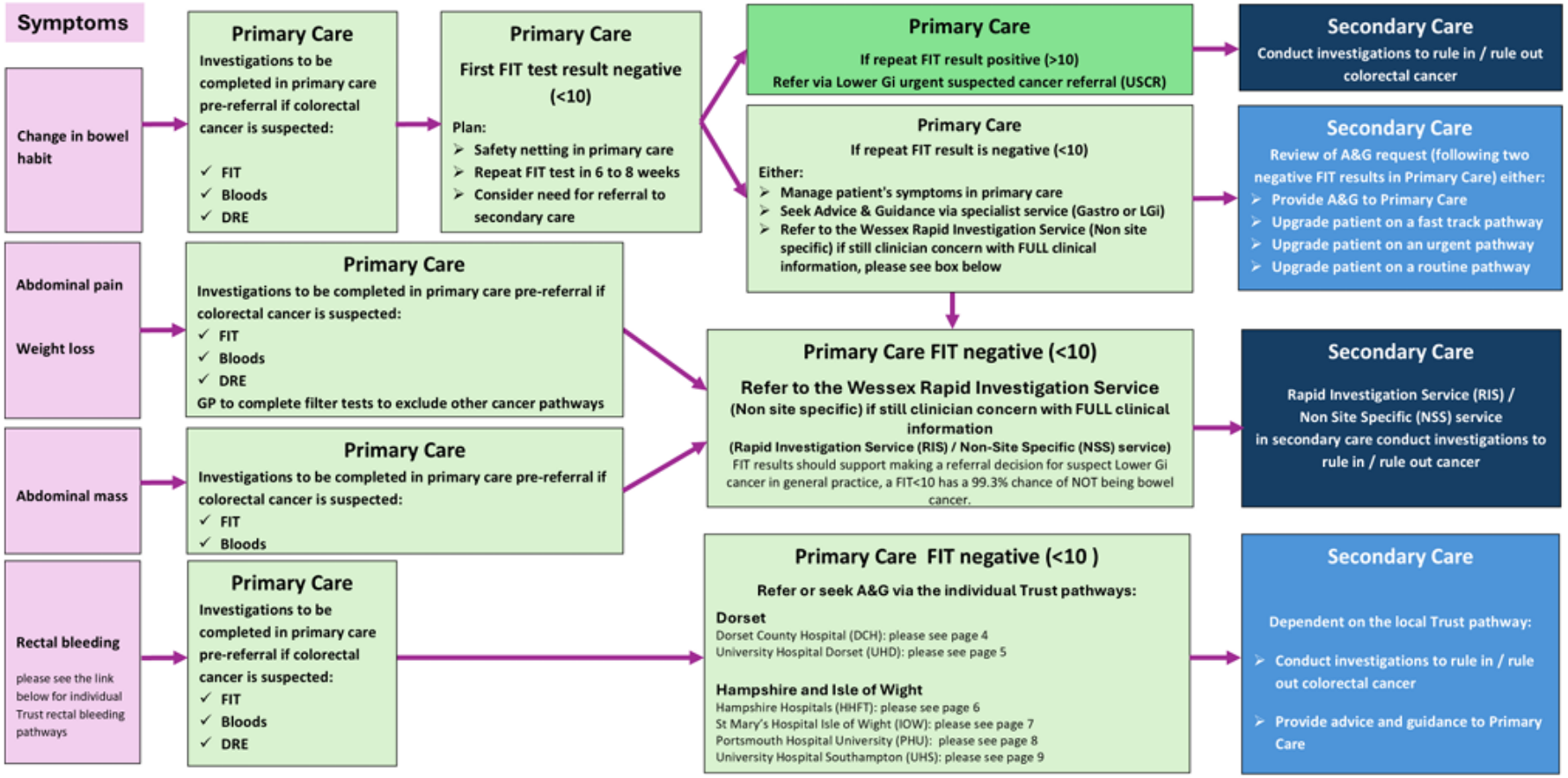
[FIT negative (<10) patient pathways with ongoing symptoms suggestive of colorectal cancer]

FIT negative (<10) patient pathways with ongoing symptoms suggestive of colorectal cancer

NHS Wessex Cancer Alliance

Breakdown of Trust's individual FIT<10 negative pathways; for patients where there is a strong clinical concern of colorectal cancer

Dorset County Hospital : page 4 | University Hospital Dorset: page 5 | Hampshire Hospitals: page 6 | St Mary's Isle of Wight: page 7 | Portsmouth University Hospital: page 8 | University Hospital Southampton: page 9



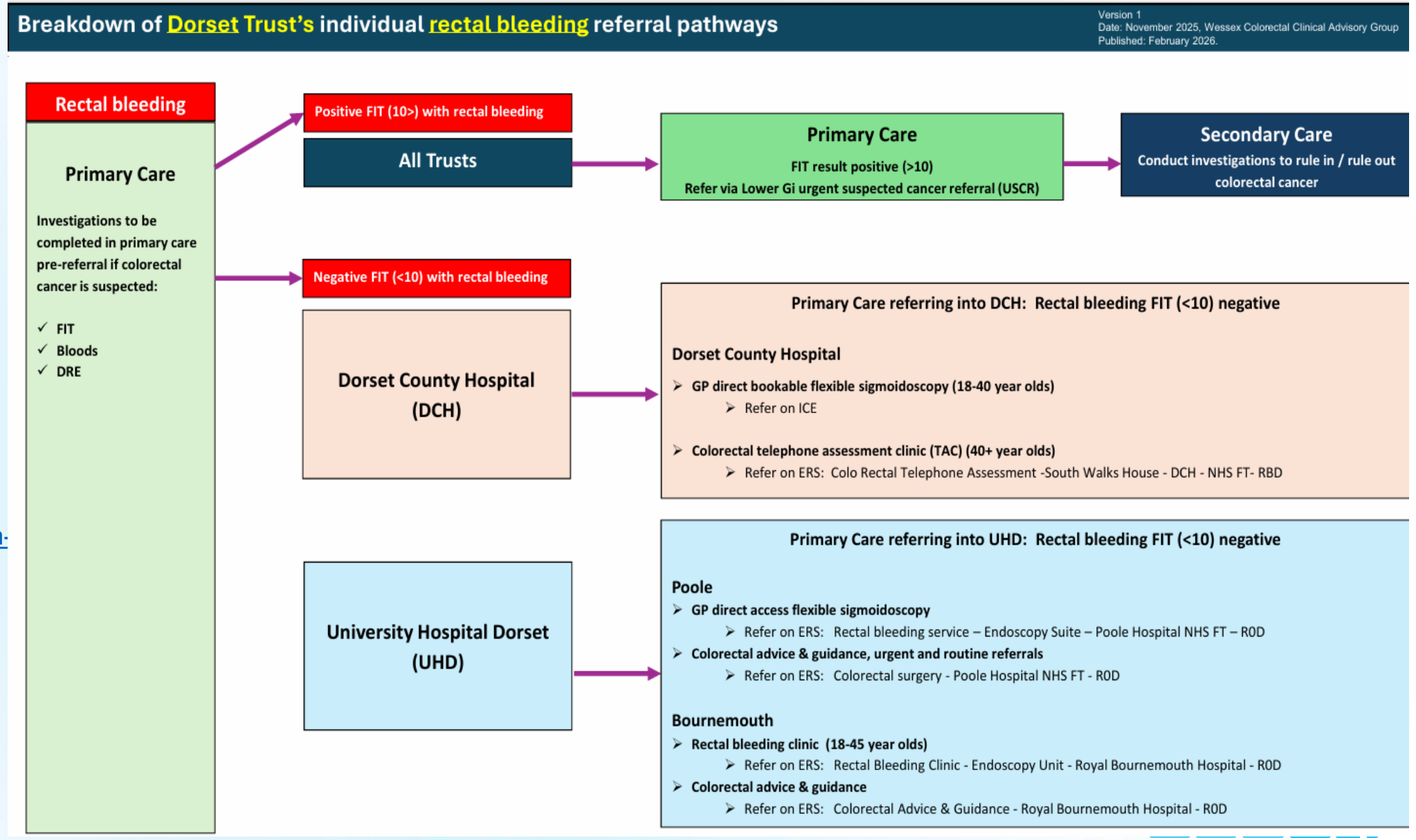
Link to the rectal bleeding pathway document (pathway flowchart for each individual Trust across Wessex):
Wessex-rectal-bleeding-with-FIT-result.-V1.-February-2026.pdf

Version 1
Date: November 2025, Wessex Colorectal Clinical Advisory Group
Published: February 2026.

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Rectal bleeding pathways - Trust specific information

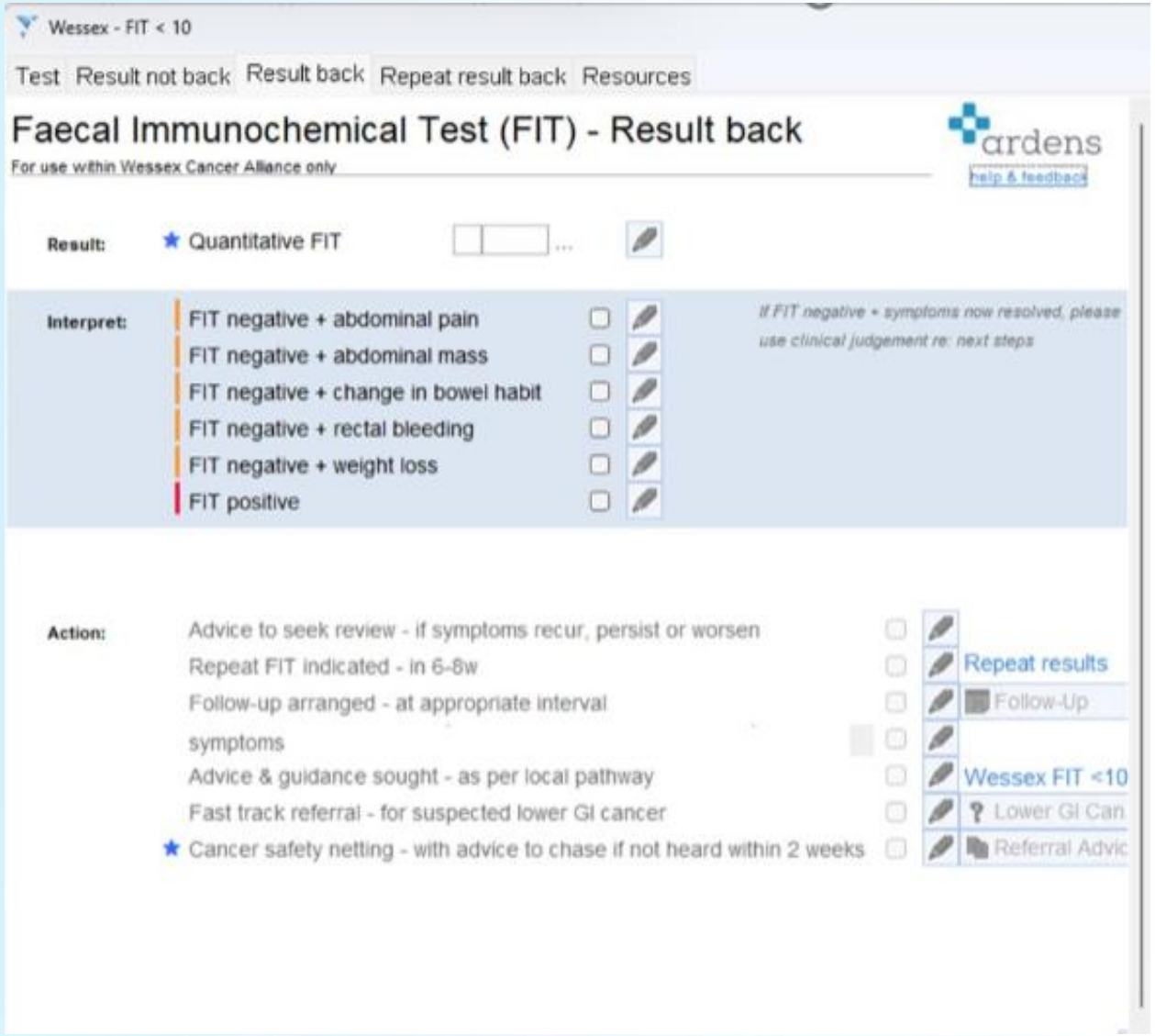
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FIT <10 Pathway Support

This new template in Ardens has been designed to support the Wessex LGI pathway.



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Iron Deficiency Anaemia

IDA was found to be significant delay factor in primary and secondary care in the HIOW 24/25 CRC audit.

- All patients who presented as an emergency had IDA at the time of admission
- 8–10% CRC yield in new IDA *(Pengelly et al., 2013; Snook et al., 2021)*
- Longstanding or recurrent IDA following prior negative gastrointestinal investigations is associated with a lower, but clinically significant, CRC yield of 2-5% *(Ayres et al., 2019; Pengelly et al., 2013)*
- IDA should override negative FIT

FIT in Iron Deficiency Anaemia (IDA): What Should We Do?

BSG Recommendations

https://fg.bmj.com/content/early/2025/10/14/flgastro-2025-103329

- **FIT should be performed in primary care** for patients with IDA
- A negative FIT does NOT exclude significant pathology
- FIT should not replace investigation of IDA (most patients generally still require both upper and lower GI investigation)
- Coeliac serology should be requested before referral

Key message : Investigate the anaemia, not just the FIT result

Patients with IDA still require appropriate investigation.

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Haemorrhoids & Diagnostic Overshadowing

Haemorrhoids were found to be a significant delay factor in the HIOW CRC audit 24/26

- DRE absent/misleading in 75%
- All patients who were incorrectly diagnosed with haemorrhoids in this cohort reported rectal bleeding
- In 75% of cases there were additional red flags present
- Unsurprisingly anal cancer was over-represented

Key messages :

- Don’t let haemorrhoids close the diagnostic process
- Look for additional red flags
- Examination
- Use FIT appropriately
- Safety net effectively

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FIT & Inequalities

Evidence highlights gaps in the uptake and completion of FIT tests, with people in the most deprived areas, most ethnically diverse areas, males, and younger patients less likely to return tests (BJGP 2026).

It is important to try and minimise any potential exacerbation of cancer inequalities through:

- Providing clear instructions on how to complete the kit, including translated materials for non-English speakers
- Encouraging patients to return a sample or offer them a further test if the kit has been lost
- Implementing robust tracking systems for unreturned tests



How does your practice support patients who might have difficulty completing their FIT tests?

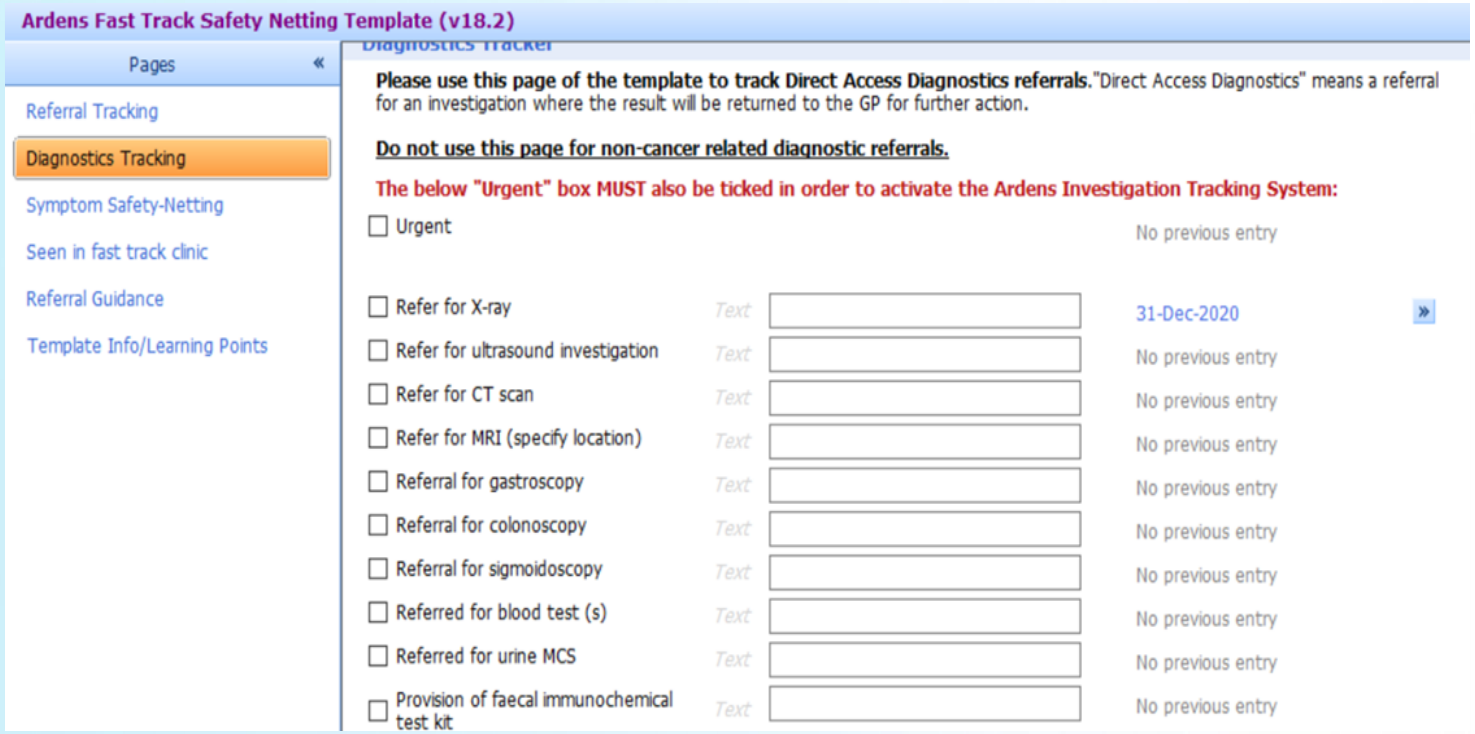
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FIT Safety Netting

Primary care systems now offer electronic methods for tracking and safety netting patients who have received a FIT.

Electronic templates can provide a centralised, efficient approach and can be used by the whole practice team.

FIT Safety Netting is available in both Ardens and CTheSigns.





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Key messages

- Examination and DRE matter
- Frailty influences pathways
- FIT<10 pathway and referral support – low risk of CRC but requires safety netting
- High-quality referrals improve patient care

Useful Information

Referral guidance

- NICE NG12 Guidelines: Suspected Cancer Recognition and Referral
- NICE HTG690 (formerly DG56) FIT testing to guide colorectal cancer pathway referral in primary care
- Wessex FIT & LGI Pathway Information
- Wessex FIT<10 pathway and Rectal bleeding pathway

Further education resources

- WCA Cancer Academy – LGI Education

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Next Steps

We will share the following resources to support delivery of this content:

- Copy of LGI pathway education session slides
- Education session recording
- LGI referral form examples
- Links to online surveys to support evaluation

- Practice session attendees
- Clinical Champion - reflections

Questions