FIT 62 years, $p = 0.10$) and gender ($p = 0.41$). Although the differences did not reach significance, advanced pathology in the FIT group was much higher, both in polyps $\geq 10$ mm diameter (FIT 86% vs no FIT 14%, $p = 0.30$) and CRC incidence (FIT 4.5% vs no FIT 1.0%, $p = 0.19$).

**Conclusions** Despite the challenges of managing clinical services during a pandemic, our data demonstrates an increased use of FIT in the colorectal pathway in line with updated guidance. This is particularly encouraging as there was insufficient time for an adequate communication strategy. However, a substantial proportion of patients were referred based on FIT results with neither NG12 nor DGS30 compliant symptoms; perhaps showing that FIT can potentially increase referrals if used incorrectly. Some patients were referred with a negative FIT and a preponderance of NG12 symptoms, possibly indicating that clinical concern over traditional cancer risks may prompt referral despite an objectively very low cancer risk.

**Introduction** Studies have evaluated FIT in patients meeting NG12 criteria suggesting greater accuracy for colorectal cancer (CRC) detection. The FAST score (faecal-Hb, age and sex test score) was proposed to improve the utility of fHb in the diagnosis of CRC. In 2019, Herts Valleys CCG instituted the use of FIT for patients in primary care presenting with symptoms meeting DGS30 and some lower risk NG12 criteria (PPV <3%), excluding those with higher risk symptoms of iron deficiency anaemia (IDA), mass or rectal bleeding. We aimed to evaluate the utility of FIT with NG12 referral criteria and FAST score for the detection of CRC in our population.

**Methods** The medical records of all patients undergoing a FIT sample with a minimum of 6 months follow up between June 2019 and July 2020 were reviewed and cross referenced with the trust cancer database. Other outcomes recorded during a pandemic, our data demonstrates an increased use of FIT in the colorectal pathway in line with updated guidance. This is particularly encouraging as there was insufficient time for an adequate communication strategy. However, a substantial proportion of patients were referred based on FIT results with neither NG12 nor DGS30 compliant symptoms; perhaps showing that FIT can potentially increase referrals if used incorrectly. Some patients were referred with a negative FIT and a preponderance of NG12 symptoms, possibly indicating that clinical concern over traditional cancer risks may prompt referral despite an objectively very low cancer risk.

**Results** 3460 patients with bowel symptoms undertook a FIT sample. 132 patients had SBD. 13% of patients were <50 with a FIT result $\geq 10 \mu g/g$ in 12%. 22% were 50-59 with a FIT result $\geq 10 \mu g/g$ in 16%. 65% were $\geq 60$ with a FIT result $\geq 10 \mu g/g$ in 26%. The sensitivity, specificity, PPV, NPV and accuracy of a FIT result $\geq 10 \mu g/g$ for patients 50-59 were 85% (CI 66 to 95.8%), 87% (CI 84 to 89%), 19% (CI 15.8% to 23%), 99.4% (CI 98.5% to 99.8%) and 87% (CI 84% to 89%) and for patients $\geq 60$ years were 86% (CI 77 to 92%), 77% (CI 75 to 87.5%), 14% (CI 13 to 16%), 99.2% (CI 98.7% to 99.5%) and 77% (CI 75% to 79%). The sensitivity, specificity, PPV, NPV and accuracy of a FIT result $\geq 10 \mu g/g$ for patients <50 years were 87.5% (CI 47 to 99.7%) p=1.0, 89% (CI 85.7 to 91.9%) p=0.35 and <0.01, 13% (CI 9 to 17.8%), 99.7% (CI 98.4 to 99.96%) and 89% (CI 86 to 92%) respectively.

**Conclusion** FIT performed well for the detection of SBD in all age groups with equivalent sensitivity between age groups and improved specificity in younger age groups compared with patients $\geq 60$ years.