Joint SWAG & PCA Colorectal Cancer Peer Review Report

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**Background-Case for Change**

Colorectal cancer is the 4th most common cancer in the UK, and 42,000 are diagnosed each year. With a more than doubling of referrals into cancer diagnostic pathways since 2015, there are significant gaps in capacity for endoscopy and radiology provision, surgical and oncology services, set within a financially limited environment. Early diagnosis, fast diagnosis, and equity of access to treatment and care are central to the National Cancer Programme and in the face of doubling demand this has been difficult to deliver nationwide.Cancer Alliances are the vehicle to drive the transformation of services we want to achieve.

*“In spite of improvements in the results of treatment for patients with colorectal cancer, fewer people diagnosed in England survive the disease than patients in comparable countries such as Norway and Switzerland. International benchmarking shows that we are 7% behind these countries in (estimated) five-year survival for colorectal cancers. There are also significant differences between the regions in England.”*

*“Early diagnosis confers the best chance of cure. Lowering the threshold of referral for patients with colorectal symptoms to scaled up and streamlined diagnostic services should impact the unwarranted national and international variation in outcome.”*

**Mr Michael Machesney**

**NHS England Colorectal Cancer Clinical Expert Group**

Rapid diagnostic and assessment pathways have proven to be an effective approach to deliver timely and effective care to patients presenting with cancer symptoms. Delivering the recommended Colorectal cancer National Rapid diagnostic and assessment pathway at Trusts level across the South West is an urgent priority and will reduce variation in access to diagnostic and treatment options.

The South West (SW) Clinical Senate recommended a review of colorectal cancer pathwaysacross the SW in September 2018. The SW Alliances were tasked with answering:

1. To what extent are providers in the South West able to deliver the national commissioning pathways for colorectal cancer patients?
2. What are the key areas for pathway redesign and provision of service that will improve the quality of experience & timeliness of treatment for patients across the region?

To answer those questions the South West Cancer Alliances approach was to harness the creative talents of the teams providing care for patients in colorectal pathways by conducting a peer review. This had two broad aims:

1. To provide CCGs and providers with a holistic assessment of strengths, weaknesses, challenges and to highlight areas of great practice in their area to help them make change happen
2. To enable peer learning, sharing of practical solutions and offer a toolkit of ideas to those tasked with making change happen.

The colorectal surgeons chairing the Peninsular and SWAG colorectal network groups, Melanie Feldman and Michael Thomas have been appointed as the South West Cancer Alliances clinical leads to support the delivery of this quality improvement initiative.

**Project Methodology**

Pathway Peer Reviews have proven to be a successful approach to assess NHS Trusts systems ability to deliver standardized components of quality but also assess quality across the patient pathway, integration of care and patient experience. To ensure a meaningful outcome of the visits, we have liaised with MDT teams and cancer services to gather a data portfolio enabling the Peer Review team to brainstorm before the visits about how Colorectal services are delivered at Trust level and were bottlenecks in the process may be.

The peer review team primary objectives on the visit were:

1. To conduct a multidisciplinary overview of the colorectal pathway and understand operational systems and processes in place to deliver CRC care by assessing the Trust’s data about the pathway, talking to the MDT team and visiting inpatient setting.
2. Get a deeper understanding of how the Trust’s pathway is delivered by talking to a patient group who share their care experience.
3. Give a preliminary report to the team and Medical Director highlighting:
4. Areas where the team has developed excellence or found innovative solutions to deliver their pathways which could be shared with other providers;
5. Areas for development opportunities within the team, including processes, resources & infrastructure to be addressed through the work programme;
6. Immediate risks or serious concerns.

The outcome of the visits will support:

1. Improved engagement of all stakeholders in the SW Colorectal Cancer Services and highlight successful system transformation at local and Alliance level.
2. Identify gaps which can be overcome by adopting solutions that have already been tested and successfully implemented elsewhere in the region.
3. Identify gaps which can be overcome by increasing resource to clinical services.
4. Identify gaps which be overcome by increasing Trust’s ability to access solutions at other providers by building a teamwork and networking culture.
5. Identify priorities for Cancer Alliance to support the provision of ‘faster diagnosis’ agenda and equity of access to treatment across the region.

 **Trust Peer Review Report**

1. **General comments about the cancer pathway and the report**
2. **Summary Feedback Given at the end of the visit**

**Immediate Risks or Serious Concerns**

* None.

**Significant Barriers to Better Performance**

**Delivery of 28-day pathway and 62- day treatment pathway**

**Good practice**

**Development Opportunities– Resource and infrastructure**

**Opportunities to share excellence with regional colleagues**

1. **Detailed Peer Review Report around cancer pathway 5 key decision making.**

**Key Decision 1: How shall we investigate this patient? (Means of processing referral and initial investigation.)**

**The Decision**-

**Key Decision 2: Cancer found – what other information is needed? (Staging, tumour assessment & path to the MDT).**

**The Decision**-

**Key Decision 3: What do we think is the right treatment/options? (MDT Processes).**

**The Decision-**

**Key decision 4- Is that right for this patient? (Communication, support, preoperative planning, oncological/surgical/supportive).**

**The Decision-**

**Key decision 5: How does this team manage the quality aspects? (Delivery of treatments).**

**The Decision-**

**Resources-**

1. **Summary Findings**
2. **General Summary**
3. **Priority suggested areas of improvement:**
4. Streamlining front end of the pathway
5. Implementing a nurse led initial assessment with telephone triage and clinic appointments when necessary.
6. GP DTTFlexi Sigmoidoscopy should be used again.
7. Eliminating paper-based appointments diagnostic requests.
8. Seek leadership support to resolve resistance to change in radiology department.
9. MDT Streamlining
10. Establish a colorectal MDT rather than a mixed GI MDT.
11. Development of clear protocols and automated decision making.
12. Follow up appointments- Current practice requires a lot of CNSs capacity. Implementing an automated stratified follow up is advised (UHP has already implemented a good system that could be adopted). This would increase CNSs time to spend with patients who are still waiting for treatment.
13. **Opportunities to share excellence with regional colleagues**
14. Pathology department with excellent collaborative working practices delivered by a small team under pressure. Turnaround time 3 days!
15. Well-developed leaflets supporting inpatient experience and a well written operational policy.
16. Tracking & cancer services manager practice is unique. We would like to praise Andy for his exceptional management.

Sunita Berry Tariq White

**PCA Managing Director SWAG Managing Director**