



Somerset, Wiltshire, Avon and Gloucestershire (SWAG) Cancer Alliance

Meeting of the SWAG Network Colorectal Clinical Advisory Group (CAG, formerly SSG)

Wednesday, 5th June, 09:30-14:00

Penny Brohn Cancer Care, Chapel Pill Lane, Pill, Bristol, BS20 0HH

THIS MEETING WAS SPONSORED BY AMGEN AND SERVIER

Chairs: Mr Michael Thomas (MT) & Ms Julie Burton (JB)

NOTES

(To be agreed at the next CAG Meeting)

ACTIONS

1. Welcome and apologies

Please see the separate list of attendees and apologies uploaded on to the South West Clinical Network website [here](#).

2. Review of previous notes and actions

Notes:

As there were no amendments or comments following distribution of the minutes of the meeting on Wednesday 16th January 2019, the notes were accepted.

Actions:

Faecal Immunotherapy Test project: The project update will be circulated.

HD

Watch and Wait surveillance schedules: For review at a future meeting.

Patient management post complete clinical response to neo-adjuvant chemo-radiotherapy for rectal cancer: Awaiting results from the Royal Marsden Trial to inform management; currently each centre has their own strategy.

Increasing incidence of colorectal cancer in England: A paper has been submitted for publication and the findings have been presented to the American Cancer Meeting. Further analysis of results will be undertaken.

Meeting of the Cancer Clinical Leads, Monday 3rd June 2019: The purpose of the meeting was to recommend initiatives for improving Multi-Disciplinary Team (MDT) meeting efficiency and share progress of implementing initiatives, with recognition that solutions will vary according to the needs of each particular cancer site and centre. The meeting was well attended with representatives from all relevant cancer sites. Examples of MDTM reforms which are now underway were provided by Pathology, Sarcoma, and Skin cancer teams in addition to the Colorectal reforms due to be discussed in the meeting today. Detailed descriptions of clinical features are required to enable triage to be achieved, as is the need to audit implementation of such processes.

Other points of significance:

There was agreement that patients with complex needs requiring management across several MDTs are to remain the responsibility of the site specific cancer MDT to which the patient is initially referred, until a diagnosis necessitates formal handover to another team.

Cancer Alliances have been instructed to develop Rapid Diagnosis Centres for patients with serious non-specific symptoms. The use of funds allocated specifically to improve cancer services versus management of benign disease requires further consideration.

3. Clinical guidelines

3.1 Pathology update

Presented by Newton Wong (NW)

The TNM Classification of Tumours 8th Edition has now been fully adopted. Flow Cytometry is routinely reported for all patients. Tumours with vascular invasion are now classified as having a worse prognosis in comparison with nodal spread.

Genetic Laboratory hubs have been allocated across England, with one based in North Bristol Trust in collaboration with Royal Devon and Exeter. All testing should cease in other centres starting about July 2019.

A business case, submitted by Consultant Pathologist Newton Wong in response to the NICE recommendation that all patients with colorectal cancer should be tested for Lynch Syndrome, has been turned down by North Bristol Trust. NICE Recommendations do not have the same capacity to influence funding decisions as NICE Technological Appraisals. This may not be recognised by the general public, and Freedom of Information requests about the need to provide the tests had been sent by a charity in 2016 when the guidance was first published. It was felt that the guidance was released prior to any assessment of its effect on capacity.

Lynch Syndrome testing is provided for all patients with colorectal cancer diagnosed in RUH Bath and Somerset; the decision not to test, made by North Bristol Trust, will also affect patients in Weston and UH Bristol. As this constitutes an inequity in access to services for the SWAG population, a letter will be drafted on behalf of CAG to request that the Business Case should be reconsidered.

HD/MT

3.2 Structured radiology reporting

Please see the presentation uploaded on to the SWCN website

Presented by Julie Burton on behalf of Eric Loveday (EL)

A survey had been undertaken to establish the current practice of specialist colorectal cancer radiology reporters, and to assess the level of interest for implementing structured reporting.



As responses showed that the majority of radiologists used varied forms of structured reports, and in the absence of guidelines from the Royal College of Radiology, it was recommended that a uniform approach to reporting should be adopted.

CAG members fully support the specialist radiologists in their progress with this helpful service improvement, which will be audited, as a network, once in place.

**EL / Specialist
CRC
Radiologists**

4. Clinical opinion on network issues

4.1 MDT reforms – national and local developments

Please see the presentation uploaded on to the SWCN website

Presented by Ann Lyons (AL)

It is noted that MDT activity is not to be considered as confined to MDT meeting (MDTM) activity. All patients with cancer will ultimately be discussed by relevant MDT members when appropriate, within or outside the meeting environment.

In recognition of the demand on MDT systems, a national MDT Streamlining pilot was recently undertaken by NHS England. Breast and Colorectal Cancer MDTs participated in the SWAG region but, due to the tight timelines, the pilot continued independently in the Bristol Colorectal MDTs, and a triage form for streamlining discussion of resectable colon cancer is now in use in North Bristol Trust. This has optimised the length and quality of MDT discussions for complex cases, but has increased preparation time for the team members partaking in the triage process (CNS input is required to gather information on patient co-morbidities and preferences). All rectal, anal and unknown patients are still listed for discussion.

Positive feedback has been received from the MDT participants. The radiology and pathology forms include an option for patients who meet the straightforward triage criteria to be listed for MDTM discussion at the request of the responsible clinician. The clinical and operational function of the MDT will be audited on a quarterly basis; a database is maintained for this purpose.

Draft results from the national pilot showed that some sites had increased the length of discussion time after a triage system was introduced; it was recognised that solutions to MDT reforms will vary according to the needs of each particular cancer site and centre.

A quick win for the Taunton MDT arose from the Meeting of the Cancer Clinical Leads, where it was agreed that network MDT outcomes do not need to be re-discussed by the local MDT unless the local MDT has been tasked with an action. It is also planned to stratify non-cancer diagnoses from the MDT list. These patients are discussed by the Weston MDTM at present as there is no separate benign MDT and this is the allocated timeslot and safety net to ensure that administrative requirements are completed for the handover of patients.



RUH Bath MDT has not implemented MDTM streamlining reforms to date.

Yeovil MDT is stratified to ensure that patients are listed at decision making points and have introduced an information only section at the bottom of the list for relevant patients, including patients for palliative care. Clinical criteria are used to streamline discussion of benign cases, aside from complex polyps, which are managed according to SPECC guidelines.

UH Bristol MDT had started to implement the change, but this did not seem to have a huge effect due to the low number of straightforward cases; the review of images within the meeting was considered to be of benefit. It is important to define who sees a patient post-operatively after pathology review at the MDTM.

MDTM reforms can be individualised to meet the needs of each site as long as imperative requirements are regionally agreed, for example, double reporting of imaging by a gastrointestinal specialist radiologist.

MDT Leads

5. Service development

5.1 Introduction to the South West Genomic Laboratory Hub (GLH)

Please see the presentation uploaded on to the SWCN website

Presented by Rachel Butler (RB)

CAG is asked to consider the ideal service for the GLH to deliver for patients with colorectal cancer.

In December 2018, the UK reached its goal of sequencing 100,000 genomes. Over 3,550 samples, of which 2,643 were for rare diseases, were collected by the West of England Genomics Centre (which consisted of a virtual body of GMC champions who consented patients and coordinated the necessary pathways in collaboration with the clinical teams) across all the provider Trusts. Results are now being returned for analysis en masse, resulting in the management of a significant initial workload. Transition from a project to a standard NHS service with continued involvement from the GMC team is now underway by reducing the number of laboratories from 25 to a network of 7 Genomic Laboratory Hubs, all processing a core set of samples according to the same standards. North Bristol Trust was successful in the bidding process to become one of the GLHs in partnership with Royal Devon and Exeter Trust. Each hub has been given the responsibility for processing a number of additional specialist tests, which are divided so it is clear who is doing what for each indication / disease.

National genomic test directories for rare diseases and cancer have been published [here](#) that define the genetic and genomic tests that will be made available via NHS England at some point in the near future (potentially April 2020); directories will be reviewed by a panel of experts on an annual basis. A list of tests specific to colorectal cancer is included.

Funding for the service needs to be informed by the number of tests currently undertaken, which have been found to be inconsistent across the region (as

GLH Team



previously noted), and clear pathways for reflex testing need to be developed.

HD

The number of colorectal cancer diagnoses per Trust per year will be exported from the Cancer Stats website to help estimate the quantity of tests required.

6. Coordination of patient care pathways

6.1 Cancer Alliance project update

Please see the presentation uploaded on to the SWCN website

Presented by Mike Thomas (MT)

The SWAG Cancer Alliance is providing some funding to support reduction in Cancer Waiting Times for colorectal cancer. The Cancer Alliance Clinical Leads (Mike Thomas (MT) for SWAG and Melanie Feldman (MF) for Peninsula) will provide communication between the Cancer Alliance and the Clinical Advisory Group to see how each centre can be helped with this process, with assistance from Project Manager Ousaima Alhamouieh. Baseline information from each Trust will be mapped to assess where bottlenecks exist, where additional resources are required, and to identify and share best practice. It is recognised that problems and solutions will vary according to the particular needs of each organisation. MT and MF will arrange a provisional visit to each site in approximately 4 months.

MT/MF

The first meeting of the South West Colorectal Cancer Pathway Delivery Group will be organised on Thursday 25th July 2019.

6.2 Faecal Immunotherapy Testing (FIT) evaluation update

Please see the presentation uploaded on to the SWCN website

Presented by Patricia McLarnon (PM)

Results from the first evaluation of implementing FIT testing, which was rolled out to 600 practices from June 2018 for those patients with low but not no risk of CRC (calculated by NICE as a risk of less than 3%), have shown a predictive value of identifying CRC in 6.2% of patients with a positive FIT result.

Over an 8 month period, 43 cancers have been identified, at least 24 of which were detected at Stage I or II (staging data on some patients is pending).

Uptake of the test varies across the region; GP guidance is continually being disseminated, but this could also be due to different versions of the suspected cancer referral form being used in GP practices, particularly in Somerset.

There was initial concern from some centres that the test might result in an influx of additional two week wait referrals. This has not been demonstrated to date.

An audit on the management and outcomes of those patients with negative FIT test



results will follow.

The Cancer Alliance funding for the test will cease in March 2020; a report to support continued funding will be submitted to commissioners in September 2019 by Project Manager Sarah-Jane Davies (S-JD).

S-JD

6.3 Assessment of Frailty

As discussed in the previous meeting, the importance of recording and acting upon geriatric assessments has been recognised by CAG after assessing evidence on increased length of stay post elective surgery for this patient group. This is now recognised nationally; use of the Rockford scoring tool is recommended.

HD

Initiatives to improve capacity to enable time for the assessments are underway across the region; progress will be fed back at a future meeting.

An audit on the effects of diagnostic investigations on frail patients will be undertaken.

To be allocated

6.4 Two week wait referral pathways and exit strategies

A potential project to triage two week wait referrals according to agreed protocols was proposed as a pilot, to be managed by the UH Bristol CNS team. 97% of referrals result in a benign diagnosis, and standardised letters containing results of straightforward conditions could be developed to discharge patients from the cancer pathway, which would ultimately free up CNS time. The process would need executive approval before it could commence, and would need to be audited.

HD

Bristol and North East Somerset CCG Cancer Lead Alison Wint will be contacted to discuss redirecting outpatient clinic activity to triage activity and the potential impact that this may have on generating appropriate tariffs.

7. Living With and Beyond Cancer (LWBC)

7.1 LWBC update and risk stratification of follow up

Please see the presentation uploaded on to the SWCN website

Presented by Catherine Neck (CN)

The NHS long term plan states that risk stratified follow up should be established for colorectal cancer by 2020. It is planned to purchase an electronic tracking system for remote monitoring, but an appropriate one (potentially My Medical Record) has yet to be agreed. There is no national steer on how LWBC activity should continue to be funded; a sustainable plan is still under discussion.

LWBC activity is progressing well across the region in comparison with other Cancer Alliances. The appointment of Cancer Support Workers to support Clinical Nurse Specialists with administrative processes has improved the level and type of support available to patients. Completion of treatment summaries is variable, and the



collection of data on the activity present challenges.

Details of the SWAG Colorectal Stratified Pathway are within the presentation; the current capacity and requirements for each team to deliver the pathway need to be defined.

North Bristol has a remote monitoring process, but this is not working at present as many GP practices decline to perform the required tests. This is a region wide problem that the Cancer Alliance is trying to address.

RUH Bath has a remote monitoring process in place.

Yeovil District service risk stratified follow up, and has a drop-in phlebotomy service, or patients can go to their GP.

Taunton & Somerset have a drop-in service for secondary care related tests only.

Weston Area risk stratified follow up: patients are given a list of alert symptoms and the contact details of the CNS team should they need to attend a drop in clinic.

UH Bristol currently provides follow up to all patients via clinic appointments.

8. Research

8.1 Clinical trials update

Please see the presentation uploaded on to the SWCN website

Presented by David Rea (DR)

The National Institute for Health Research (NIHR) has revised the high level objectives from 2019/20 to allow increased focus on smaller recruiting trials. The 30 day and 40 day set up targets have been replaced with a new median study set-up time. The former 30 objectives have now been replaced with 5 harmonised objectives.

New Chief and Principal Investigators will be sought for areas of research that are currently under-represented.

Two West of England Clinical Research Specialty Leads have been appointed: Consultant Oncologist Helen Winters and Consultant Gynae-Oncologist Claire Newton.

Recruitment figures (sourced from EDGE), open trials and trials in set up are documented within the presentation. The recruitment target per 100,000 population for Colorectal Cancer is 3; this had been comfortably exceeded in 2018/19. The recruitment of expected numbers within the estimated time frame will need to be improved in the coming year.

Inclusion of data from Yeovil and Taunton has not been possible on this occasion as the Peninsula Research Delivery Manager responsible for supplying the information was no longer in post. This will be addressed prior to the next meeting.

DR



9. Patient experience

9.1 Clinical Nurse Specialist (CNS) update

Presented by the CNS team

RUH Bath: Nurse led clinics have recently been implemented; the main challenge to organising these has been finding an appropriate space in the new oncology centre. The Living Well events are consistently receiving positive patient feedback. Some patients have requested more information on non-research based complementary therapies, which are not considered appropriate to include. Requests to hold the events earlier on in the patient pathway are under consideration; the events are currently held 3 times a year. Support from Macmillan had been reviewed to manage the provision of conflicting advice. The new Cancer Support Workers (CSWs) are working well with the CNS team and are assisting with Holistic Needs Assessments (HNAs). It is planned to develop an existing post to address the current shortfall in support for metastatic patients.

Weston: Living Well events are now being held earlier in the patient pathway, and CWS are helping to track surveillance investigations. The designated oncologist has recently left, and the locum oncologist will be leaving in July, at which point, patients will need to travel to Bristol for treatment.

UH Bristol: A system to track follow up is currently awaiting approval which will help the team to commence the risk stratified follow up pathway. Patient support groups are in the process of being set up. A patient representative treated for squamous cell carcinoma will be identified and invited to join CAG.

HD/CNS Team

North Bristol: CSWs have integrated well with the team and are providing patients with pre-operative HNA and joint HNAs with the patients' CNS as appropriate. A fantastic Prehabilitation service called 'Energise' is available to patients with a funded physiotherapist. Many local gymnasiums support the programme, which is available to any patient in the BNSSG region.

Yeovil District: Positive patient feedback has been received on the support provided for patients by the CSWs and the provision of Living Well events.

Date of next meeting: To be confirmed via Doodle Poll (January 2020)

-END-