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

Meeting of the SWAG Network Colorectal Site Specific Group (SSG)

Wednesday, 16th January 2019, 10:00-14:30

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

THIS MEETING WAS SPONSORED BY AMGEN, MERCK SERONO and STRYKER

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

NOTES (To be agreed at the next SSG 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. Fluorescent imaging and its use in colorectal surgery

Presented by Trevor Baker, Stryker UK

Fluorescent imaging may be useful in the context of Getting It Right First Time (GIRFT) when conducting precision surgery. Anastomotic leaks dramatically impact the patient experience, increase length of stay, and can cost approximately £3,500 to £11,000. The key to anastomotic integrity is tension, perfusion and technique. The PINPOINT technology, used with indocyanine green perfusion, which is a safe dye that binds to albumin, allows visualisation of the perfusion of anatomy and identification of nodes. Results from several research trials have shown that use of the technology, which attaches to standard laparoscopic stacks, can reduce leak rates. Thoracic, head and neck, gynaecology, plastics, breast, and hepatobiliary surgeons can also utilise the kit.

The methodology in the clinical trials was considered to have some faults, and caution on overstating the capabilities of the kit is recommended. A randomised controlled trial (RCT) is required to provide further evidence for its use, for example, when considering the effect on perfusion in relation to epidurals that can cause mucosal ischemia in the elderly; such a trial is now underway.

The surgeons in RUH Bath and Taunton have access to the technology. It was agreed that it was important to use as part of a trial, but this was complicated by the preference to use it in complex cases rather than randomise to an alternative option. Results from the RCT will be reviewed at a future meeting. **HD**

3. Review of previous notes

As there were no amendments or comments following distribution of the minutes of the meeting on Wednesday 27th June 2018, the notes were accepted.

4. Clinical guidelines

4.1 Frailty in elective cancer care

Please see the presentation uploaded on to the SWCN website

Presented by Jonathan Randall (JR)

Results from an audit of frailty score completion in UH Bristol showed a need to improve the process; 66% of patients in the cohort analysed had a frailty score documented. Information about the assessment tool used, timing of assessment, and interventions once frailty is recognised need to be clarified. The audit also showed a significant increase in hospital length of stay for those patients identified as frail.

Assessment could take place in the fast track clinic, at a results appointment, or in a specific pre-operative assessment clinic. Frail patients should then be directed to a specialist for a comprehensive geriatric assessment of all the contributory factors, as detailed in the presentation.

UH Bristol are providing a pilot prehabilitation and rehabilitation support programme to give patients individualised goals to help optimise stamina. It is hoped that a prehabilitation tariff can be negotiated to make this an established part of the patient pathway. Results will be fed back to the SSG and Clinical Commissioning Groups.

North Bristol Trust has a Consultant Geriatrician who provides a pre-operative geriatric assessment, and RUH Bath has been awarded a grant to run a combined surgical and anaesthetic frailty project, in which frailty assessments are carried out prior to MDT to see if it is possible to optimise health prior to surgery and to inform clinical decision making. Progress of these service developments will be fed back at the next meeting. **JR**

A similar service successfully provided for emergency patients at Taunton, has been halted due to workload pressures. A Geriatrician used to attend ward rounds to make assessments. It had been hoped that this would be rolled out to elective patients.

Frail and symptomatically inappropriate patients are often referred straight to colonoscopy from primary care. It would be useful if a frailty score could be done by the General Practitioner (GP) at the point of referral. This might not be achievable in the 10 minute slot allocated to GPs, who often do not complete the WHO status on two week wait referral forms.

In Taunton, all referrals over the age of 85 are triaged to clinic rather than straight to test. Referrals to NBT and UH Bristol are triaged via the Integrated Clinical Environment (ICE) system.

A robust triage system that sends patients to the correct tests is required, including clearly defining who takes ownership of results at each stage, and the exit strategy for referring on to alternative diagnostic tests once cancer has been excluded. This is relevant to approximately 94% of patients referred to the service. An Iron Deficiency Anaemia Clinic is available in NBT for all relevant patients. A strategy to manage

straight to test referrals and exit pathways for benign patients will be planned for discussion at the next meeting. **MT/JB/HD**

5. Living With and Beyond Cancer (LWBC)

5.1 Progress on implementation of the Recovery Package

Presented by Catherine Neck (CN)

Macmillan and Consultant Anaesthetists are developing prehabilitation guidance for Commissioners. Results will be presented at the next meeting. **CN**

The SWAG Cancer Alliance made a successful bid for Transformation Funding from the National Cancer Board to improve roll out of Living With and Beyond Cancer activity. The funds have been used to appoint Band 4 Cancer Support Workers to support the Clinical Nurse Specialists who deliver the Recovery Package, including Holistic Needs Assessments (HNAs), Living Well Days and End of Treatment Summaries. It is also being used to fund additional Allied Health Professionals, Project Managers, provide relevant MDT members with Level II Psychological Skills training, and Cancer Care Reviews in Primary Care.

Data on the activity is now being reported, although the systems for capturing it make it difficult to know if it is accurate. Since an early HNA at 31 days post diagnosis has been introduced, the provision of post treatment HNAs has decreased. Living Well event activity is on the increase. Differences in the way these are provided are being assessed, for example, patients in NBT are invited at the beginning of the pathway. Provision of End of Treatment Summaries is currently low across all services due to workload pressures. Compliance with the SWAG agreed Risk Stratified Follow Up Pathway will be assessed from next year. **CN**

6. Quality indicators, audits and data collection

6.1 Is there an increasing incidence of colorectal cancer in England?

Please see the presentation uploaded on to the SWCN website

Presented by Adam Chambers (AC)

World-wide, the rate of colorectal cancer has been shown to be gradually increasing over the past 20 years in countries with a higher Human Development Index. In the UK, mortality rates have reduced as a result of the Bowel Cancer Screening Programme.

Data on adults in England with colorectal cancer aged over 20 from 1974-2015, was sourced from the National Cancer Registration & Analysis Service (NCRAS). This is a highly accurate and complete dataset, and to date is the largest study of its kind.

The increasing rate of diagnoses has been shown to be statistically significant in each age-period cohort, with a 20% increase in patients aged 20-29 and 30-39. The effect is mirrored when looking at the South West data in comparison to England and data

from the USA and Canada.

A birth cohort effect was observed in those patients born after 1965. A surge in diagnoses in the 40-49 age range may be likely. Results could have implications for the provision of screening and diagnostic tests.

Further analysis will be undertaken to identify if there are any differences in phenotype/biology in this age group, and will look further into other features such as stage at presentation, and demographic information. Identification of environmental or genetic causes should be a focus for future research. **AC**

Increased understanding of managing long term sequelae for young people diagnosed with colorectal cancer is required, as is promotion of awareness campaigns directed to at risk groups.

Evidence from a large study in Australia had found minimal evidence of colorectal cancer being related to diet, and there has been a vast amount of environmental changes in Western culture over the time period that may have contributed to the increasing incidence. It is important to distinguish between causation and correlation when looking for evidence

A paper on the findings will be submitted to the American Cancer Meeting and Lancet Oncology in the near future. **AC/MT**

It was the recommendation of Patient Representative Jackie Mifflin that awareness campaigns become part of the secondary school biology curriculum if this was currently not included.

7. Clinical opinion on network issues

7.1 MDT reforms – national and local developments

Please see the presentation uploaded on to the SWCN website

Presented by Ann Lyons (AL)

Following review of the Cancer Research UK MDT Effectiveness Report by each SSG, and Professor Martin Gore's appointment by the National Cancer Transformation Board to reform MDTM working arrangements across the UK, an inaugural meeting of the SWAG Cancer Clinical Leads was held on Monday 16th July 2018 to define a loco-regional approach to MDT meeting reforms.

A presentation from Cognitive Scientist Tayana Soukup Acencao gave details of 3 tools that can be used to improve MDT streamlining. SSG members will be contacted to see who may be interested in attending a training day on use of the tools. People receiving the training would have to review at least 1 alternative MDT.

It was recommended that a 10 minute break is introduced in meetings after a period of 1 hour of discussion, or after 20 patient discussions, to prevent cognitive

fatigue and the negative effect that this can have on the quality of decision making. It was also recommended that MDT Chairs visit alternative MDT meetings to compare styles. In addition, it is planned to address the varied quality of triage systems by the development of online referral proformas with mandatory fields. Additional recommendations are detailed within the presentation. The group will meet again in approximately 6 months to discuss progress.

SWAG Breast and Colorectal MDTs are participating in an MDT streamlining pilot. Information is being collected on the length of time taken for patient discussions prior to implementing pre-determined standards of care for patients who meet certain criteria.

A potential method to triage patients to protocolised care outside the MDT has been drafted by Consultant Oncologist Stephen Falk. Any diagnoses staged as T3 or inoperable would go through the MDT. Data collection on all cases would be maintained through the MDT in the background, and management would be audited on a 4 monthly basis.

This process may not be suitable for the Taunton MDT as it had not been possible to find time to review cases outside the MDT. It was noted that for some case discussions, radiologists might re-review and make additional findings within the MDT that can change decision making. The most important factor in MDTs was considered to be maintaining discipline. The MDT streamlining initiatives were felt to be less relevant for the smaller MDTs in Bath and Yeovil.

MDT reforms will be revisited when the related dataset is available to be reviewed by Stephen Falk (SF). **SF**

7.2 Recommendations from the Clinical Senate

Presented by Julie Burton (JB)

The following recommendations were made by the Clinical Senate at its meeting in September 2018.

Speeding up treatment: Systems should be designed to recognise the distinction between the clinical decision making steps and the administrative process steps in the clinical pathway.

Identifying barriers: All Sustainability and Transformation Partnerships (STPs) should map the pathways for colorectal cancer across the system to understand the barriers to rapid decision making and treatment. Opportunities should be sought to run elements of the pathway in ‘parallel’ rather than in ‘series’. STPs should also consider Experience Based Co-Design, gathering experiences from patients and staff, and identifying key ‘touch points’ (emotionally significant points) in order to improve patient experience of care pathways.

Sharing learning across the system: It is proposed that the peer review should be designed to examine, in particular, the approaches to the 4 decision making points in the pathway for patients presenting either via screening, the 2 week wait, routine

referral or as an emergency.

Workforce – recruitment and retention: The Health Education England (HEE) programme for increasing training for endoscopy is supported by all providers. Cancer alliances should work with STPs to support increased participation. Consideration should be given by HEE to lobby for extending the endoscopy training to other professional groups e.g. paramedics, and to sharing the workforce via networked provision to maximise the impact availability of the skilled workforce.

Collaborative commissioning: Elements of care impacting on the colorectal cancer pathway are commissioned by different bodies. This increases the risks of the impact on scarce resources not being fully understood as success in one element of the pathway can adversely impact on another. Commissioners should work together to avoid unintended consequences either on the colorectal cancer or other pathways of care. Good consistent data collection is needed to include all the different ways a patient can end up on the final treatment pathway.

8. Coordination of patient care pathways

8.1 Cancer Alliance / Faecal Immunotherapy Test (FIT) project update

Please see the presentation uploaded on to the SWCN website

Presented by Nicola Gowen (NG)

The National Cancer Transformation Board has awarded transformation funding (2017/18) to the South West Cancer Alliances (CA) for the purpose of improving earlier diagnosis of colorectal and lung cancer. To achieve this for colorectal cancer, the CA has made a commitment to introduce straight to test (STT) pathways for all GI endoscopy procedures in all the provider Trusts. Funding for nurse endoscopy training was included to help achieve the aims of the project.

To date, North Bristol Trust and Salisbury Trust are compliant, UH Bristol, Weston, Gloucestershire and Yeovil have implemented a process via CNS triage, Taunton has a direct to test process via GP referrals, and RUH Bath plan to implement STT by March 2019 via Nurse Endoscopy Practitioner triage.

A further allocation of National Support Funding (2018/19) has been granted for the purpose of meeting and sustaining the 62 day Cancer Waiting Times Target and to implement the National timed rapid colorectal pathway.

2017/18 regional performance was between 62-80%, with the target being 85%.

The provider Trusts have made proposals for how to implement the pathway, as detailed in the presentation.

Implementation of the Faecal Immunotherapy Test (FIT)

In line with NICE Guidance on Suspected Cancer: Recognition and Referral, FIT testing has been made available to GP practices in the South West for the low risk but not no

risk cohort of patients. To date, 4278 samples have been received, 14.6% of which were positive, 2.8% of which resulted in a cancer diagnosis.

Initially, there was concern that access to the test would increase endoscopy demand; this has not been found to be the case. Results from a preliminary evaluation of the test, led by Professor Willie Hamilton, will be available in February 2019.

Prevention & Early Diagnosis

The CA ambition is to improve bowel screening uptake to 75% by 2020. The initiative will be directed at poor performing practices with less than 52% uptake, and areas of deprivation and minority ethnic groups. Processes for flagging and reminding non-responders will be put in place, as will specific practices to target the cohort of patients that are considered hard to reach; staff training will be provided.

9. Research

9.1 Clinical trials update

Please see the presentation uploaded on to the SWCN website

Presented by David Rea (DR)

Recruitment figures (sourced from EDGE), open trials and trials in set up are documented within the presentation. The West of England Clinical Research Network (CRN) is currently struggling to meet cancer recruitment targets due to its size in comparison with other networks. The standard for recruitment to time and target was met for 2017/18, which meant that funding for the network remained stable.

The metrics for measuring performance are being revised and may provide ways to recompense research activity according to incidence and prevalence. Heat maps and different models to accurately calculate this are being developed. The recruitment target per 100,000 population for Colorectal is 3, and is currently on target and performing well in comparison with the percentage of cancer incidence in the region.

A spreadsheet of open trials, trials in set up, and trials that are open to new sites is available on the SWCN website here. It is hoped that Principal Investigators (PIs) will use the research slot on the SSG agenda to boost recruitment by promoting new and existing trials.

Can we Save the rectum by watchful waiting or TransAnal surgery following (chemo)Radiotherapy versus Total mesorectal excision for early REctal Cancer (STAR-TREC) trial is now open to recruitment. The trial design, inclusion and exclusion criteria are detailed in the presentation.

9.2 The Detection of Symptomatic Colorectal cancer using Volatile biomarkers (DISCOVER) trial

Please see the presentation uploaded on to the SWCN website

Presented by Andrew Allison (AA)

DISCOVER is open to recruitment in Yeovil District Hospital (Chief Investigator Nader Francis), North Bristol Trust (Principal Investigator Anne Pullyblank), and St James's Hospital Leeds (Prof David Jayne).

The aim is to see if volatile compound analysis of the urine can reliably identify colorectal cancer as a potential alternative to colonoscopy, reducing the risks and unpleasant experience for patients and the cost for the NHS.

Patients referred via the two week wait pathway who are fit for diagnostic tests and able to give informed consent can be approached at their endoscopy or CT appointment, and recruited to give an 11 ml urine sample.

The outcomes measured will be histology at biopsy and resection, VC profiles, and patient acceptability data regarding the urine sampling.

Recruitment is going well in Yeovil, with the majority of patients keen to be involved; overall, recruitment is currently below target.

10. Patient experience

10.1 User representative input

Patient Representative Jackie Mifflin (JM) has been invited to a parliamentary reception at the House of Commons, held to celebrate and discuss how to implement the announcement from the Government that the Bowel Cancer Screening age range has been reduced from 60 to 50 years. Professor Nick Bacon is sponsoring the event. SSG members are to send any information to JM via email that they might want to share at this reception.

10.2 National Cancer Patient Experience Survey Results

Please see the presentation uploaded on to the SWCN website

Presented by Julie Burton (JB)

The cohort of patients who responded to the survey includes all who had attended hospital as an inpatient or outpatient with a cancer related condition between April and June 2017. SWAG results compared with the national average are documented within the presentation. It was only possible for results to be published in Trusts where responses are greater than 20.

A quality dashboard developed by PH England and NHS England is available to view in the presentation; results that are less than the national average are highlighted in red.

The last question included on the dashboard, *'overall, how would you rate your care out of 10*', provided positive feedback as rated between 8.7-9 across the region, in comparison to the National average of 8.8.

It is difficult to know how to interpret the detailed results due to the 18 month delayed return of results. By this time the next survey has been sent out so it is not possible to see the result of any service improvements until 2 years later.

Taunton has consistently positive results and their practice should be shared. Questions about information were often affected by how difficult it is to absorb information at the point of diagnosis.

The results from Question 8. *'When you were first told that you had cancer, had you been told you could bring a family member or friend with you?'* does not reflect the colorectal cancer pathway, where some units actively discourage patients from bringing along family members to endoscopy.

The resulting activity from the LWBC initiative should have a positive impact on several questions, as highlighted in the presentation.

Some of the results appeared contradictory, for example, the question *'were you given the name of a CNS'* was scored below the national average for Gloucestershire, but above the national average for the question '*how easy was it to contact you CNS'*. This was in contrast to YDH which scored the opposite way round, and may be related to not having secretarial cover for a period of time.

The wording of some questions needs to be reviewed; Question 48 '*were you given enough information about whether your chemotherapy was working in a way you could understand?*' was considered confusing as it is not relevant to colorectal chemotherapy given in an adjuvant setting, thus biasing results .

It was often a matter of interpretation, for example a patient representative had stated that they were in a clinical trial, but had never been asked if they would like to take part in research.

Paperwork in Yeovil is being rebranded so that patients are aware that their patient diary contains their care plan. Nurse-led Clinic Letters are also being rebranded to include this as a paragraph heading.

Quality Surveillance and other external parties review the NCPES results to measure provision of quality cancer services, and the results will be used to inform future service provision.

It was noted that the scoring was calculated only if patients selected the highest or lowest scale in the questions, and the majority of people in the UK did not tend to select the most definitive options in surveys.

11. Anal cancer service update

Presented by Michael Thomas (MT)

Dr Stephen Falk and MT have been the Leads for the Squamous Cell Carcinoma service for the past 22 years. Over the last few years, a database consisting of 15 years of diagnoses has been gathered, which is more extensive than any published figures to date. This has been assessed for trends and the effects of various treatment options, and was recently presented at the European Oncology Meeting; a publication of the results is imminent. The data shows a significant increased incident in SCC, in particular in women from a higher deprivation index. Excision of lesions in the anal canal was not recommended; this was of a different biology than anal skin cancer. Prognostic indicators will be examined to determine who responds to treatment and why 20% of patients don't respond. It was clear that malignancies caused by the Human Papillomavirus responded to chemotherapy.

The plan now is to make a database of anal intraepithelial neoplasms (AIN); an update will be given at the next meeting. The current AIN guidelines need to be updated.

12. Any Other Business

Next meeting agenda:

- Frailty update for RUH Bath project
- Straight to test processes and exit pathways for patients for whom cancer is excluded
- Prehabilitation
- Streamlining MDTs
- Analysis of 31 day and 62 day breaches across the region
- Genomic medicine update.

Date of next meeting: To be confirmed by Doodle Poll (June 2019)

-**END-**