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

Meeting of the SWAG Network Colorectal Cancer (CRC) Clinical Advisory Group

Thursday 2nd May 2024, 09:30-16:30

Aztec Hotel, Aztec West, Almondsbury, Bristol, BS32 4TS / MS Teams

Chair: Ms Ann Lyons

REPORT **ACTIONS**

1. Welcome and apologies

Please see the separate list of attendees and apologies uploaded on to the SWAG website here.

2. FIT for purpose: Young Cancer Audit

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Colorectal Surgeon David Messenger

2.1 The faecal immunotherapy (FIT) audit and evaluation in adults under 50 years in SWAG

It is now well recognised that colorectal cancer is becoming more prevalent in the younger population, with the risk for those born in the mid-80's being two times higher than those born in the mid-60's, and the risk of rectal cancer three times higher.

SWAG data shows that 70% of patients <50 are diagnosed at an advanced stage. CRC CAG needs to consider how this can be reduced. Heat maps across the country show that incidences are more prevalent in the South West, with a 10% year on year increase in cases.

There was a peak of incidences in patients >50 when the Bowel Cancer Screening Programme (BCSP) was introduced. This has since levelled out and, in the long term, it is likely that there will be more younger patients with advanced disease than older patients.

Results from the South West audit show that 25-30% of patients >50 with early onset colorectal cancer (EOCRC) wait for over 6 months before seeking help with symptoms that prompt a referral into the service.

Approximately half of these referrals were made via a two week wait suspected colorectal cancer pathway, and 27% presented as an emergency, which is far worse than the 15% average number of emergency presentations reported by the National Bowel Cancer Audit (NBCA).

When EOCRC is identified at Stage 1 or 2, long term survival outcomes are above 80%, in comparison to just over 40% for those diagnosed at Stage 3 or 4, which is lower than for older adults.

It had previously been recommended by SWAG CRC CAG to roll out FIT to adults >18 years with symptoms of concern, as it is known to have a high negative predictive value to allow for risk stratification of referrals, however, much of the evidence of FIT is based on adults >50 and so the rationale for the evaluation is to determine the diagnostic accuracy for adults <50, and to develop a model to identify cancer risk based on the FIT value, by looking at results in different age bands.

To date, FIT data has been gathered on all patients <50 from between 01/01/2021 and 30/06/2023 and cross referenced with new CRC diagnoses from each Trust. This has resulted in approximately 125-130 cases for analysis.

Results will be presented at a future meeting.

Future Agenda Item

Thanks were given to the numerous contributors, as listed in the presentation.

Discussion:

BCSP is aiming to lower the age range from 56 to 50 in the near future.

Network Lead for Endoscopy Mark Feeney updated that the BCSP aspires to reduce the current FIT colonoscopy threshold from 120 to 80 over the next 2-3 years, which will then be in line with practice in Scotland.

An Expression of Interest to pilot the FIT 80 study was circulated to screening centres this week. Centres that apply will find out if they are a pilot site by the end of June, and it is hoped to deliver results in Quarter Three for analysis in the new year.

This is an ambitious ask as it involves delivering 50% more screening within the same cost envelope, and it will be interesting to see how many centres agree to take part. The rationale is that extra capacity will be made by use of colon capsules, CTC, cyto-sponge, and by reducing the number of colonoscopies and gastroscopies.

The central screening laboratories will still be used to process the samples.

Another audit of FIT is also underway, run by Keith Pohl, which will investigate the use of FIT pre, during, and post COVID, and the impact on colonoscopy.

Initial data shows that SWAG performs well with very few patients getting a colonoscopy with a FIT result less than 10.

SWAG CRC CAG had previously agreed that FIT testing would not be arranged for patients with Iron Deficiency Anaemia (IDA) and symptoms of concern, as a negative result may be falsely reassuring. Peninsula do arrange FIT for patients referred with IDA.

Action: To share an estimate of the number of additional cancers that will be picked up at an earlier stage via the FIT 80 pilot following review of the literature from Scotland. **Mark Feeney**

A bid is being submitted for an AI polyp detection kit. **Potential Future Agenda Item**

Performance of endoscopy services has hugely improved in the South West due to the combined efforts of the regional team.

A post-colonoscopy missed cancer audit has been running over the past 2-3 years which should provide data on how to improve endoscopy skills in the future.

The Endoscopy Network arranges outreach visits to provide centres with endoscopy updates. Four have been held to date and a further three centres will be visited in the near future.

Use of diagnostics has halved in UHBW following the wide-spread adoption of FIT.

2.2 Multi-Cancer Blood Test (MCBT)

A pilot MCBT programme is being developed to offer MCBT to one million patients across the UK, as detailed in the presentation.

The pilot has been put on hold and will be revisited in a future meeting.

2.3 Cancer Vaccine Launchpad (CVLP) study

The CVLP study will assess the feasibility of establishing the cancer vaccine pathway, which involved numerous complex steps. The vaccine is based on the mRNA technology that is now available following production of the COVID-19 vaccine, and involves development of a vaccine course using an individual's cancerous tissue.

There is a CRC trial arm: BNT-122-01 with stringent inclusion and exclusion criteria, details of which are documented in the presentation; it is for high-risk Stage 2 and 3 cancers with a complete surgical resection. There is some overlap with existing oncology studies such as FOxTROT and TRACC Part C.

Patient identification would ideally occur prior to surgery via the MDT, or after surgery based on MDT pathology discussion.

Patients need to have a ctDNA test before commencing adjuvant treatment and again after treatment has been completed. If the ctDNA test is still positive at that point, then they may be eligible for development of a vaccine. It is estimated that around 10% of the patients consented will go on to have the vaccine.

UHBW and NBT have just opened as a site and are currently recruiting 1-2 patients per month until the pathway becomes embedded. Opening the trial was complicated as it was initially industry driven and only recently NIHR portfolio badged.

The Cancer Vaccine Delivery Site for Colorectal Cancer is Velindre in Cardiff, Wales and may result in patients dropping out due to the burden associated with frequent travel; it involves 15 vaccinations over a 12 month period.

It is hoped that vaccine sites will be made available in a local SWAG centre for future studies. They are currently divided by tumour site in sub-specialist centres across the country.

Efficacy data is not widely available at present, but some positive results have been demonstrated for patients with pancreatic cancer.

The current lack of evidence needs to be carefully communicated when consenting patients to appropriately manage their expectations.

3. Review of Previous Report and Work Programme

As there were no amendments or comments following distribution of the report from the meeting on Thursday 11th May 2023, the report was accepted as finalised.

At the previous meeting, CRC CAG had been asked by the national team to look at variations in the neoadjuvant radiotherapy treatment given to patients with rectal cancer who are due to undergo a major resection, with the suggestion that practice should be standardised and variation reduced. It was fed back that variation was appropriate with this treatment, and the South West regional guidelines will continue to be followed to offer personalised care, which can either be short or long course radiotherapy based on the individual's radiotherapy treatment planning outcomes. The national team have since abandoned investigating this particular treatment variation and have proposed a new one for colorectal cancer, for further discussion on the agenda today.

Treatment of rectal cancers is a rapidly evolving field and there is a move towards watchful waiting, although more evidence is required.

Action: CRC CAG will audit patients managed via watchful waiting; assistance will be sought from the academic trainees. — **David Messenger/ Trainees**

From the Work Programme:

Personalised Care and Support:

A system, ideally an app, is required for patients to access their hospital information as they are not able to see their hospital appointments or information leaflets on the NHS app.

Patient Representative Stephen Rowley reports from the Colorectal Cancer Support Group that it would be the patient's preference to have access to their results due to the significant delays with receiving result letters.

A variety of apps are being developed but they need to be codesigned with patients.

The My Sunrise app is recommended. It is used across the Peninsula and includes an area developed by the GMSA for patients with lynch syndrome.

CRC CAG recommend that the same app is adopted across the SWAG region. — **CAG Recommendation**

FIT requests:

GP Representative Glenda Beard continues to encourage GPs to request FIT tests via the Integrated Care Environment (ICE) to reduce the amount of manual inputting of request forms for the laboratory team.

Clinical Guidelines:

CRC CAG are invited to comment on leaving the guidelines in the generic format or if more prescriptive content is required.

Action: To circulate the SWAG Clinical Guidelines for the biennial update. — **H Dunderdale**

Standardised radiology reporting:

A representative from Radiology is not available to attend the meeting today.

Action: Consultant Radiologists from each Trust will be identified to attend and lead on standardised reporting of CT, MRI and PET scans in accordance with Royal College of Radiology Guidelines. — **H Dunderdale**

Implementation of Multi-Disciplinary Team Meeting (MDTM) Streamlining Reforms:

NBT MDT have implemented a system to safely streamline the MDT by using standardised protocols so that not every pre-operative patient requires discussion. This is supported by a pre-MDT radiology review, where it is confirmed if the case is straightforward and does not require MDT input prior to surgery.

It would be difficult to replicate this pre-screening MDT in other centres, and important particularly to RUH to have radiology review within the MDT due to imaging being outsourced and not necessarily reviewed by specialist Lower GI radiology colleagues.

The national team have put MDT streamlining back on the agenda and have tasked the Cancer Alliance with reporting back on the streamlining initiatives that have already been undertaken and the next steps planned.

MDT outcomes and the number of repeat discussions are required to accurately measure streamlining initiatives.

Management of significant polyps:

It is important to track significant polyps on a cancer pathway; a letter will be sent to this effect to operational management teams on behalf of CRC CAG.

Watch and wait surveillance schedules:

NBT and UHBW follow the Royal Marsden protocol; this could be included in local Standard Operational Policies and agreed across each centre.

Patient Experience Surveys:

It is planned to develop local surveys as it is difficult to make plans for improvements based on results from the National Cancer Patient Experience Survey (NCPES). The NBT survey will aim to provide 'live' data on a monthly basis in contract with NCPES which is always a year out of date by the time it is reviewed.

Action: The Work Programme will be updated and recirculated. **H Dunderdale**

4. Genomic Medicine Service Alliance (GMSA) / Lynch Syndrome Update

Please see the presentation uploaded on to the SWAG website

Presented by Clinical Nurse Specialist Siobhan John

The Lynch Syndrome Transformation Project was officially completed in April 2024.

Siobhan John will remain in post until August due to the delayed start to the post and will provide ongoing support.

Ongoing support will also be provided to train the CNS team in genetic counselling.

The aim is to transition to provide the lynch service as business as usual. Short, medium and long term goals are documented in the presentation.

Work with Primary Care has just commenced and will be a focus going forward.

The Clinical Genetics Service in Bristol is going through a period of multiple changes, and many of the Clinical Geneticists are now going to be based in Exeter.

The Peninsula and SWAG Cancer Alliances have approved a further two years of funding to support the transition, which may be used to fund an inherited cancer nursing role for 0.5 WTE per alliance to further develop pathways and cascade testing following diagnosis.

The test MSI Plus is going to be trialled to see if that can be used to speed up turnaround times. The South West Genomic Laboratory Hub (GLH) turnaround time compares favourably with other hubs across England.

GMSA will also continue to support ICBs to develop business cases to support the inherited cancer workload.

The majority of hospitals are now offering mainstreaming of genomic tests. RUH are still undertaking the training with Siobhan and the Clinical Geneticists. MDT outcomes need to direct referrals to the CNSs trained in mainstreaming, rather than to Clinical Genetics.

Training materials have been developed into a Toolkit which has been approved by the GMSA with patient and public involvement.

Once the patients' results have been returned, any confirmed findings of inherited cancers or significant variants will be referred on to the Clinical Genetics Rapid Access Clinic which has a 6-12 week waiting list.

The competency framework developed by Siobhan has been adopted nationally and can be used for any inherited cancers. It is set up to continue to provide the mainstreaming training once the inherited cancer nurse posts cease.

A Regional Expert Network Group has been set up for SWAG and Peninsula which is chaired by Frank McDermott and attended by the Clinical Geneticists to assist local clinical teams with any complex cases. The next meeting is Monday 20th May 2024, 12:30-13:30. CAG members can join the distribution list by sending a request to the generic email: rduh.lynch-polyposis@nhs.net

The network has become well established and is working successfully.

Patients with Polyposis can also be discussed at a monthly Rare Disease National Collaborative Network Meeting.

Work is now underway to provide GPs with guidance on referring patients to Clinical Genetics.

A familial cancer predisposition syndrome survey was sent by a medical student to 6853 patients in a Bristol based GP practice; 1401 patients responded, of which 234 people had a family history of 3 or more relatives with cancer and cancers in a relative <50, plus 16 patients matched the Amsterdam criteria. This may have been successful in identifying the missing percentage of patients with lynch syndrome in this patient cohort.

Draft guidance is awaiting ratification on prescribing aspirin for patients with lynch syndrome and will be finalised once the CAPP3 dose review has been published. Local guidance of 150mg if <70kg or 300mg if >70kg is advised in the interim.

A lynch syndrome companion section has been added to the My Sunrise app, which was originally developed in Cornwall. Once the app is downloaded, the patient can choose their treatment hospital (which only includes details of the Peninsula hospitals at present), and then can select 'I have got bowel cancer' to see details of the colorectal cancer team, contact details, patient information leaflets, details of what happens at appointments. The app is also being used in Cornwall to consent patients for SACT.

App to download for patients with Lynch Syndrome

Patients in SWAG can download the app and select 'I am in Bristol', and then they will have access to the lynch syndrome companion section only. It has been developed with patient and public involvement and gives guidance on surveillance. It will be further developed to add reminders about surveillance schedules and taking aspirin. CRC CAG members are invited to download it and recommend this to all patients with confirmed lynch syndrome.

Clinical Genetics will contact the BCSP to organise the colonoscopy screening for all new patients with lynch syndrome.

Historical patients have not been included in this process to date.

Clinical Genetics is based in Bristol but run satellite clinics across the region.

5. Managing Staff Fatigue

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Psychologist Mike Osborn

Colorectal CAG are invited to contact Dr Osborn with any questions that may arise following the presentation.

CAG members are encouraged to think about how to manage the potential risk of psychological fatigue caused by workload pressures, which has always been high risk, but is currently a much higher risk than usual due to the exponential increase in treatment load. Provision of intensive treatment and support to ill and distressed patients has increased 8 fold over the last decade, as demonstrated in a recent presentation by Prof Mark Beresford.

Attention should be drawn to the accumulative every day small behaviours and brief experiences that can have a critical impact on our health and immune system, rather than focusing on more profound critical incidences.

Culturally, complaining about small everyday stresses, such as car parking or problems with IT systems, can be perceived as trivial. However, recognising the impact of these issues can have the biggest return on improving your quality of life, as it is prolonged duress that makes threat defence responses dominate which, in turn, can cause fatigue. Threat defence responses also do not automatically stand down once work has finished, and it can be helpful to arrange a quiet reunion with those that you live with when you return home.

Fatigue and exhaustion differs from tiredness, as it is an indication that the brain has depleted resources to the primitive brain, which interrupts the ability to regulate your mood and find things interesting, pleasurable or amusing, which can undermine your confidence.

Because hospital staff are high functioning and used to high performance work in stressful environments, the response to fatigue is likely to be more fight than flight and result in irritation, annoyance and reduced tolerance for being critiqued.
This cognitive disruption, which is as real as the brain fog caused by chemotherapy, causes moral injury to NHS staff as you are all working very hard but also feel the need to apologise for the things that have not been possible to achieve, leading to misplaced guilt.

The talk is not presuming that everyone is feeling these pressures in the same way or at any given time but is simply to raise consciousness of the risk of cognitive fatigue.

To help mitigate or manage this risk, staff are encouraged to make deliberate and active steps to review what it is that you personally need, and to regularly incorporate these needs into your daily routine with benign self-compassion and complete moral authority.

Composure and civility should be prioritised, and incivility called out. It is advised to 'strike when the iron is cold' to try to maintain your balance of composure below 4 to 5 out of 10 as once the adrenaline becomes higher than this, it can take significantly more time to dissipate. Even if anger and aggression is righteous, it is never helpful.

Fatigue management cannot be reduced to a test of will power, control or strength, but rather it is a test of flexibility and adaptability.

There is a psychological paradox of fatigue management, in that the virtues of a person working in the hospital environment exactly match fatigue risk factors.

Maintaining a healthy team culture is the most protective factor to ensure social safety.

In summary, CAG members are asked to prescribe for themselves the advice that a feisty compassionate colleague would recommend.

6. Symptomatic Immunochemistry Testing (FIT) Update from Severn Laboratory

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Clinical Scientist Adrian Heaps

There has been a huge increase in workload related to FIT over the past 6 years. Initially the service was set up to process 500 tests per month, and now the laboratory process approximately 1200 tests per month.

There are now two HM-JACKarc FIT Analysers in the laboratory which are straightforward and reliable to use. It is the pre and post analytical processes that are the most difficult to manage due to the footprint of the SWAG Cancer Alliance network, which includes 4 ICBs and various non-SWAG work, each of which send FIT requests in different formats, with some sending paper requests which is very unusual now, and others requesting via ICE. Gloucestershire uses a completely different requesting system.

The paper requests required an enormous amount of manpower to input into the laboratory systems.

Positivity rate has been very stable over the past few years and is typically between 17-19%.

There has been a steady increase in the number of referrals for patients <50 which has now plateaued at around 20% over the last year.

A change in the requesting criteria was introduced in July 2022 by the British Society of Gastroenterology (BSG), which now includes indications for a two week wait referral, non-site-specific symptoms, and low risk but not no risk symptoms. It took a year for the old forms to be used up and the system to be updated, but referrals with the new criteria have now been received over the last 11-12 months. The highest number of requests received relate to the low risk criteria.

The second highest number of requests are sent with no information provided. There have been many educational drives to try to improve this.

Looking at the request criteria by age group shows the majority of younger patients are referred using the low risk criteria and majority of older patients in the two week wait criteria. As expected, the percentage of positive FIT results is highest in the 80 plus age group. It is interesting to see that positivity is highest in those under 30 in comparison with the 30-59 age groups. This is the same across all referral criteria reasons.

The hard work of the laboratory team was acknowledged; additional members have been appointed to manage the workload, which is still problematic when receiving thousands of samples after the weekend. It could be necessary to extend the working day and open over the weekend in the future. It is hoped that reducing the threshold for asymptomatic screening will reduce some of the pressures on the service, which was not originally designed to process this volume of work.

BNSSG will now not accept a two week wait referral without a FIT test unless it is for IDA or an anal mass.

Somerset have formed a Colorectal Faster Diagnostic Hub service that will request FIT tests for patients if not already requested by their GP. The hub also improves the quality of two week wait referrals by arranging for missing blood tests and other information to be added to the form, enabling referrals to be appropriately triaged.

The National Cancer Programme expect that 80% of referrals to the suspected colorectal cancer pathway will have a FIT test result arranged by the patients' GP. Data from SWAG is lower than this, but this could be due to the way that the data is exported. SWAG also differs from National guidance by omitting the need for FIT in patients with IDA.

It would be ideal if it could be mandated for FIT requests to be sent with documented referral criteria, which could only happen if all requests were made electronically with a tick box form that could not be bypassed.

The laboratory rejects approximately 2% of FIT samples received where it is not possible to identify the patient from the information provided or if the sample sent is not possible to process, but it is not possible to reject the thousands of samples where the referral criteria has not been documented.

The Director of Pathology Sciences Dave Fisher is looking into an IT solution for referrals that could be used across the board.

Action: To provide an update on FIT request IT platforms at a future meeting. **Adrain Heaps**

The Peninsula model for processing FIT requests is felt to be preferable, where local laboratories process the requests and then feed results to a central service, but the business case to provide this in SWAG was rejected.

SWAG have been asked to revisit the decision to not include IDA in the criteria for FIT testing and to refer these patients straight to test. This was decided in SWAG due to the risk that a negative FIT result could be misleading and, with local knowledge of cancers diagnosed despite having a negative FIT result, CRC CAG still prefer to err on the side of caution with this patient cohort.

Should SWAG change the referral criteria to include IDA, this will be a huge task for the laboratory to redistribute new forms. It would take at least 12 months to embed due to the number of FIT kits stored in GP practices with the existing criteria and to update all of the different ICB request systems.

A Delphi review of the BSG guidance is due to take place in the coming year and if this concludes that patients with IDA should be filtered using FIT, CRC CAG will revisit the decision at this point.

Action: Data will be gathered on the FIT positive results and conversions to cancer and will be analysed with assistance from trainees. **Helen Dunderdale**

7. Single Centre Experience of Total Neoadjuvant Therapy (TNT) compared with Long Course Chemoradiotherapy (LCCRT) Alone for Locally Advanced Rectal Cancer

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Oncologist Tom Strawson-Smith

Outcomes from the RAPIDO, PRODIGE and OPRA trials are documented in the presentation.

An audit was undertaken in Bristol Haematology Oncology Centre (BHOC) to examine the tolerability and efficacy of TNT in comparison with LCCRT, and assess how local outcomes compare with the outcomes from the trial data.

Data was collected on all patients receiving either TNT or LCCRT from 01/01/2021 to 31/12/2022, which included details of the treatment regime, patient characteristics, disease characteristics, safety and tolerability.

This identified 63 patients, two thirds of which were treated with TNT. The medium age of these patients was a decade younger than those treated with LCCRT.

A higher proportion of patients receiving LCCRT alone had a positive circumferential resection margin or threatened margin.

A higher proportion of patients receiving TNT had N2 disease or extramural vascular invasion (EMVI), which made biological sense as they were at higher risk of haematological spread and developing distant metastases.

Three quarters of patients received neoadjuvant therapy consistent with the RAPIDO protocol, and the other quarter received LCCRT with an induction and consolidation approach.

Completion of treatment was achieved in three quarters of patients receiving TNT. All but one patient completed LCCRT. Complete Radiological Response was similar in both treatment arms.

A higher proportion of patients opted for surveillance following LCCRT.

A lower rate of complete pathological response was found in patients treated with LCCRT in comparison to those treated with TNT.

Overall, a third of patients achieved a complete pathological response.

Grade three and above toxicities were reported in a third of patients, with 30% requiring admission to hospital.

The majority of patients progressed to surgery following TNT in comparison to the patients who had LCCRT, who were generally older with more comorbidities, and many of which declined further treatment.

In conclusion, local results are comparable to those reported in the trial, with higher rates of complete response seen with TNT and yet interestingly similar rates of organ preservation with both TNT and LCCRT, and higher rates of Grade 3 toxicities with TNT. Patient selection was particularly important when considering the intensity of TNT.

Action: Future work will involve looking at long term recurrence rates to confirm local TNT outcomes, with a plan to re-audit in 1 to 2 years. Watchful waiting practice and outcomes will also be audited.

T Strawson-Smith/Trainee Colleagues

Complete pathological response rates were higher than the complete radiological response rates as people continued to respond to treatment in the weeks up until surgery was performed.

The local data may be reassuring to patients who decide to take the watchful waiting approach.

8. Interpreting Cancer Waiting Time (CWT) Targets in line with the Best Practice Timed Pathway

Please see the presentation uploaded on to the SWAG website

Presented by Cancer Alliance Programme Manager Nicola Gowen

CRC CAG seek clarity on how the 28 day target sits with the other Cancer Waiting Time Targets. The politically driven targets, which are not based on clinical evidence, are now perceived by patients as essential to meet to have successful treatment outcomes, which is a misconception.

It is not expected that every patient will meet CWT targets dependent on the complexity of their pathway, with the performance target being 85%. The purpose of the targets is to monitor how the majority of patients are managed and reduce variation across the country.

Following review of the CWT targets, it has been decided to stop assessing the service based on the two week wait target, and instead performance will be assessed based on the 28 day faster diagnostic standard (FDS), which has a performance target of 75%. The two week wait 'first seen' date will continue to be recorded, as it is still a useful measure to assess the speed of the pathway.

The 28 day FDS is counted from the day of GP suspected cancer referral to the day that a patient is told that they are diagnosed with cancer or not, and so includes all patients referred via this route.

The 31 day target for decision to treat and 62 day referral to treatment targets are still monitored and also run from the day of GP referral.

There used to be a separate Consultant upgrade from routine referral target. This is now also included in the 62 day target.

The 28 day best practice pathway involves arranging all diagnostics prior to MDT discussion at Day 21, to achieve the outpatient clinic appointment to communicate results at Day 28.

The pathway could be streamlined if all relevant people were engaged with booking the next step required. Reflex testing has made a significant difference to the lung cancer pathway.

The FDS 75% target was achieved across SWAG with some variation between Trusts. National priorities are to continue to improve the diagnostic and treatment pathways by increasing capacity, implementing straight to test pathways, improving productivity by streamlining MDTs for example, and partnering with Primary Care to improve referral quality.

As well as the anxiety associated with waiting for result letters following investigations, patients can get very anxious with the initial speed of the pathway and would benefit from provision of psychological support from the outset, as recommended by Patient Representative Stephen Rowley.

Patients in SWAG are routinely given CNS contact details at the point of colonoscopy.

9. Clinical Research Trials

Please see the presentation uploaded on to the SWAG website

Presented by Research Lead Consultant Oncologist Tom Strawson-Smith

The SWAG region has low research activity in comparison to other research networks and is an area where improvements need to be made.

National clinical trial recruitment from April 2023-March 2024 shows that 14,835 patients have been recruited to Lower GI cancer trials across 18 research networks; in 2022/23 a total of 12,454 patients were recruited. The majority were non-commercial trials and about one third commercial with 54.8% interventional and 38.5% observational.

The full list of trials open and in set-up will be circulated.

Question 58 in the National Cancer Patient Experience Survey 'Cancer research opportunities were discussed with the patient' scored below average across SWAG and lower for urology in comparison with the national average.

Patient Representative feedback is to let the patient know that research trials have been considered, even if the outcome is that there is no eligible trial available.

A website is now available where patients can proactively register their interest in participating in research, and there is also e-learning for staff to help facilitate research conversations: https://learn.nihr.ac.uk/.

Results from the Participant in Research Experience Survey are documented within the presentation.

The NIHR 6-month Associate Principal Investigator (PI) scheme is still open to any interested clinician who doesn't have research in their current role. It allows associates to work alongside current PIs on studies (as documented in the presentation) signed up to the scheme.

Any PI interested in getting help from an associate while helping their personal development is to get in touch.

The second cohort of the Principal Investigator Pipeline Programme (PIPP) to support research nurses, midwives and dentists to become PIs commences today.

The Clinical Research Networks (CRNs) are transitioning into Research Delivery Networks (RDNs) to reflect that there are increasing amounts of research in non-clinical settings. The primary purpose of the RDNs remains the same: to support delivery of high quality research and increase the capacity and capability of future research. The networks are dropping from 15 to 12. The West of England will expand to include Dorset and Salisbury and will be renamed South West Central.

NIHR website links and team contact details are available within the presentation.

10. National Bowel Cancer Audit: SACT Data

A national workshop is due to be held on the 8th May 2024 to discuss reducing variation in the delivery of adjuvant SACT post major resection for Stage 3 colon cancer.

There have been some changes that could be useful to assess, such as local practice in response to the NICE recommendation that CAPOX should now be given over three instead of six months.

Approximately 60% of patients are receiving adjuvant SACT across SWAG, with very slight variation across centres, but no outliers.

Data has been exported from Cancer Stats on all of the regimens given for colorectal cancer, but it has not been possible to filter this by Stage at present; this may be provided in the workshop.

Action: Conclusions from the workshop will be fed back to CRC CAG. **T Strawson-Smith/K Wallace**

The SACT regimen prescribed is often not documented in the MDT outcome, which is likely due to the algorithm for the decision making being reliant on the patient review in the oncology clinic. This differs from the recording of surgical procedures, where the MDT is used as the treatment planning meeting.

Variation exists in the provision of MSI testing which can inform the benefit of treatment. It is not possible to offer biopsy testing in NBT at present due to resource shortages in pathology, specifically the shortage of Consultant Pathologists. This is offered in all other SWAG centres which informs decisions on the choice of neoadjuvant treatments.

There is the possibility that a biopsy may result in false negatives.

Funding is associated with the treatment variation workstream that could be used to support pathology services.

Action: To write to Laboratory Managers to raise that NBT are an outlier, as MSI biopsy testing is available in all other centres in the SWAG region. **A Lyon/H Dunderdale**

11. Allied Health Professional update: Provision of Prehab and Rehab across the region

Please see the presentations uploaded on to the SWAG website

Presented by Allied Health Professional Cancer Lead and Physiotherapist Jayne Masters from BNSSG

A clear pathway for prehabilitation to rehabilitation has been developed across BNSSG to ensure that assistance is stratified according to the individual patient's needs. Some patients will need targeted advice to meet complex needs, whereas others may already be meeting their own needs, and only need universal wellbeing recommendations that are given to all patients.

Other pathways are in place across SWAG, as documented in the presentations on the website.

Funding has been provided by SWAG to help roll out an exercise programme.

Education and training are also being provided to the clinical team to ensure that everyone can signpost patients to the correct AHP specialist. Several tools are available to assist with the assessments, such as the Rockwood Frailty Score.

Stratified pathways are also required to carefully allocate the limited AHP resources.

In NBT substantive funding is allocated to 4 AHPs to cover the 11 tumour sites. An extra 3.3 AHPs are appointed with temporary funding which is due to cease next year.

Information on the local surgical pathways to refer patients to prehab in both NBT and UHBW, are also documented in the presentation.

SWAG has also funded development of a prehab evaluation dashboard and scoping report, with assistance from South Central and West Commissioning Support Unit, which has highlighted some key recommendations. It shows that a higher percentage of colorectal cancer patients are receiving prehab in comparison with other cancer sites. It also showed that further work needs to be undertaken to define and embed prehab across BNSSG. A clear workforce plan is also required.

Although it is recognised that some patient information may not have been captured on the dashboard, it is apparent that length of stay is lower for patients who have received prehab, which fits with the national picture. The dashboard will be improved to reflect the level of complexities in the prehab provision. It will also be possible to look at the data according to the surgical procedure undertaken.

Currently about 70% of patients are being referred for prehab in NBT.

Discussion:

Seamless provision of prehab has been found to be invaluable in boosting patients' confidence in managing their condition.

It has been harder to engage patients in prehab when they are receiving neoadjuvant therapy, probably due to the multiple appointments involved and the message around protecting yourself during SACT treatment.

12. CNS update

CNS team in UHBW have been adopted by Macmillan. A Lower Anterior Resection Syndrome (LARS) clinic is going to commence in the near future, and prehab has just started at Weston site.

It was not possible to hear the Somerset update due to technical difficulties.

13. Patient Portals and Patient Information

Please see the presentation uploaded on to the SWAG website

Personalised Care and Support Lead Emma Bedggood and Remote Monitoring Project Manager Chelsey Gilmour

There are different patient portals being considered across the SWAG region, and the presentation today is to share how remote monitoring and supported self-management is being delivered in NBT using the system My Medical Record (MMR).

A risk stratified follow up pathway has been embedded into the MMR website to ensure patient follow the appropriate individualised pathway and can also get rapid access to clinical support when required. The website has two interfaces: one that patients can access their personal information, and another for the clinical team to remotely monitor surveillance results.

A recent appraisal of different systems was undertaken in NBT and MMR was found to be preferable.

It is hoped that a notification function will be available in an updated future version.

The main aims are to empower people by making it clear what to expect next in their pathway and how to access support and results in real time.

The system is already live for patients with prostate cancer, and the plan is to go live for patients with colorectal and breast cancer over the summer. UHBW and GRH have already gone live for CRC.

Non-IT communications remain available for those patients who do not wish to use the website.

A demonstration video is available to introduce patients to the system.

It is possible to securely message the team, for example, to email the Cancer Support Worker for help using the system or to contact the CNS with symptoms of concern.

A plethora of resources are available on the system.

The clinical view tracking list is colour coded so that you can see if a result is pending (amber) or overdue (red).

Patient feedback to date is very positive plus included some suggestions for improvements that are now being incorporated. Feedback will continue to be collected on a 'You Said, We Did' approach.

Discussion:

It would be ideal if the same system was adopted across the SWAG region.

The surveillance tracking function would be a helpful alternative to tracking using an excel spreadsheet.

The clinical team get an email alert when a patient uses the system to send a message.

At present, it is only for the post-treatment pathway.

14. Peritoneal Treatments: Expanding indications

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Colorectal Surgeon Gui Lee

Basingstoke is one of 5 national referral centres for peritoneal disease and SWAG regularly refer patients on a weekly basis.

The presentation contains all of the latest indications for colorectal peritoneal metastases and eligibility criteria.

In addition to CT and PET, MRI is also useful to assess the extent of peritoneal disease.

The rate of diagnostic laparoscopies has reduced due to improvements in radiological diagnosis.

Rates of complete cytoreduction have improved to 85% and 5 year overall survival data has increased from 30 to 44%, which is most likely due to improved patient selection.

Age had not been found to be a risk factor in overall survival.

A peritoneal metastases registry for the 5 units was launched in 2017 to share outcome data.

It would be ideal if referrals are sent with the entire timeline of previous scans.

The weekly radiological MDT meeting (CRAM) is held every Tuesday, and the main MDT is every Wednesday, where cases from CRAM that do not have a straightforward outcome will be discussed. Decisions on second line SACT are left to the discretion of the local oncologist.

15. Colon Capsule Endoscopy Experience (CCE) at NBT

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Gastroenterologist Ana Terlevich

Colon capsule was first introduced in 2007. It consists of a second generation swallowable video system for allowing nearly 360 degrees coverage, with a battery life of 10 hours.

The procedure involves standard bowel prep, with split dose PEG prep at 7pm the evening prior and at 6am on the morning of the procedure, with clear fluid only from 10am day prior to procedure.

The patient goes to the endoscopy unit at 10am where they are consented, the belt and monitor is attached, and they swallow the capsule. They leave with 50mls of gastrografin and 30ml of Fleet in 1 litre of cold water to take 2 hours after swallowing and a further 50ml gastrografin and 15ml Fleet in 500ml cold water to take 3 hours after the first if capsule not passed, and a bisacodyl suppository 2 hours after this second booster. The patient is advised not to eat until the capsule is passed or the third booster is used.

The monitor and belt are returned to the endoscopy unit the following day to download video.

Contraindications include strictures or a history of obstruction, patients at risk of electrolyte disturbance with bowel prep, and those with swallowing difficulties, constipation or disease associated with slow transit (diabetes or Parkinson's for example).

Three readers have been trained and initially referrals included low risk two week wait; this has been expanded to include polyp surveillance.

When this results in clear, normal views, the patient can be discharged. If the views are incomplete or poor quality, the patient remains on the 2WW pathway and goes for a colonoscopy. If abnormal pathology is found the patients goes on to have a colonoscopy or flexi-sig.

104 procedures have been performed since May 2021, 81 of which were referred according to the 2WW criteria, 9 for polyp surveillance, and 14 for other reasons such as declining a colonoscopy or patient choice.

Results are documented in the presentation.

CCE is as time consuming as colonoscopy and, as many patients need to go on to have a colonoscopy, it generates more work.

Future developments with AI assisted reading or vetting and reading teams based in the community have the potential to speed up turnaround times.

16. Robotic Surgery Update

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Colorectal Surgeon Ann Lyons

Since October 2023, NBT have performed over 170 procedures on colorectal cancer patients using a robot on loan from UHBW. This is due to be returned to UHBW in October 2024, and there is currently no plan in place for it to be replaced. Although NBT already has two robots, these are in full time use by urology.

RUH now has a robot available for colorectal cancer, and robotic surgery is due to commence in GRH and YDH.

It is important to inform patients that these are novel procedures, and strict governance needs to be followed, as documented in the presentation.

Robotic colorectal surgery needs to be provided with equipoise across the region. **CAG Recommendation**

Action: To raise the need for a replacement robot in NBT with Medical Director Dr Michael Marsh **H Dunderdale**

Date of next meeting: To be confirmed by Doodle Poll.

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