



South West Strategic Clinical Network
Somerset, Wiltshire, Avon and Gloucestershire (SWAG) Cancer Services

Meeting of the SWAG Network Colorectal SSG
09:30-12:45, Wednesday, 29th June 2016
Penny Brohn Cancer Care, Chapel Pill Lane, Pill, BS20 OHH

This meeting was sponsored by MERCK SERONO and AMGEN

Chair: Mr Michael Williamson (MW)

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 Strategic Clinical Network website [here](#).

2. Review of last meeting minutes

As there were no amendments or comments following distribution of the minutes from the 14th October 2015, the notes were accepted.

3. Patient pathways

3.1 Review of the South West Lower GI two week wait proforma, version 9.2

The proposed Cancer Concern 2WW referral form, which was one form for all cancer referrals, was rejected by the group at the previous meeting and now a new site specific form, which mirrors NICE referral guidance, has been produced by Cancer Network Manager Jonathan Miller and circulated for feedback.

The level of concern section of four questions added by members of the Clinical Commissioning Groups was not considered necessary, and it was recommended that this was deleted. There was a high level of concern tick box on the current form for Taunton which was considered to be more useful; however, the form would not usually be viewed by the Colorectal Consultant to see whether this box had been ticked, as most patients are now referred straight to test.

The colorectal cancer symptoms section would be edited so that the age ranges were ordered chronologically. Once amended, the form will be recirculated for further ratification.

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It was recommended that the available results section should be mandatory to complete but the GP representative felt that this could result in delayed referrals due to the turnaround time for receiving some of the results. The North Bristol Trust system for referrals via ICE was difficult to complete, as once completion commenced, it was not possible to access the patient information required to complete the form unless you came out of the system again.

The 2WW referral leaflet, which provides useful information for patients, was often

not given out by the GP representative, as it was considered too cancer heavy to give to patients undergoing exclusion tests. Use of a leaflet that had similar language to a smear test leaflet was recommended as an alternative. A generic information letter was available in North Bristol Trust. This will be sent to HD by Ann Lyons (AL) for circulation.

AL

4. Clinical guidelines

4.1 Tumour testing for people with bowel cancer under 50

The patient information leaflet and the consent form relating to the lynch syndrome test for all patients diagnosed with bowel cancer under the age of 50 have been updated and can be published on the SWSCN website once the letter head has been amended. The process for consent differs across centres, with some centres screening the patients prior to referring to a geneticist, and some referring directly to a geneticist. In view of the difficulties that arise when getting the full information completed on family history, it was suggested that this should be collected at the initial referral and the information sent to MDT coordinators to upload on the cancer register. Processing of samples for patients with life limiting illnesses will be prioritised. Patients under 50 have around a 20% chance of testing positive for Lynch Syndrome.

4.2 The new high sensitivity faecal occult blood test

NICE Guidance (NG12) recommendations state that patients should be tested for occult blood in faeces to assess for colorectal cancer in adults without rectal bleeding who are

- Aged 50 and over with unexplained abdominal pain or weight loss
- Aged under 60 with changes in their bowel habit or iron-deficiency anaemia
- Or aged 60 and over and have anaemia even in the absence of iron deficiency.

Devon CCG carried out a review of the guaiac Faecal Occult Blood test and the new faecal immunochemical tests (FIT), which concluded that FIT was the better test. An audit will be conducted in primary care to determine the number of patients who meet the NICE criteria for the test, and the current management of these patients so that the cost of supplying the test and the subsequent hospital activity can be assessed. Advocates of FIT suggest that haemoglobin levels can be set low enough to give no false negatives, opening the possibility of using FIT before all colonoscopies intended for detection of cancer alone. NICE is reviewing the use of FIT in symptomatic patients. This is due for publication in April 2017 (<https://www.nice.org.uk/guidance/indevelopment/gid-dg10005>) This is a valuable, relatively low cost (between £5-10) test for low, but not no-risk patients, who may otherwise not be tested.

A letter will be written on behalf of the Colorectal SSG for dissemination to local commissioning groups to ask for the FIT test to be made available as soon as possible. In the interim, until the FIT test becomes available, GPs are recommended to refer patients who meet the FOB criteria on an individual case basis after making a shared

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decision with the patient.

5. Network issues

5.1 Cancer Alliances and Peer Review

Please see the presentation uploaded on to the SWSCN website

Presented by Nicola Gowen

In order to implement the National 5 year forward Cancer Strategy, providers and commissioners have been instructed to form Cancer Alliances. These are a similar concept to the old style cancer networks. Details and processes are still under discussion. There is likely to be an alliance for providers and commissioners encompassing Bristol, Bath, Weston, Somerset and Gloucester, similar to the SWAG cancer network area. The next meeting is scheduled for 22nd July to finalise footprints and local structures. These will be agreed in August, set up in September and established by November.

Peer Review has been replaced by the Quality Surveillance Programme (QSP). It now includes many other services as well as cancer, is focused more on outcomes from existing datasets, and should prove to be less intensive. The existing Peer Review documentation will need to be updated and maintained in the event that a QSP visit is announced, but it will no longer need to be uploaded to the CQUINS website.

Self-assessments will now be submitted on the Quality Surveillance Information System (QSIG). The current deadline for submission is end of August 2016. Cancer Managers will send the relevant information to those requiring access to the system.

6. Research

6.1 The PulMiCC trial

Please see the presentation uploaded on to the SWSCN website

Presented by Tom Treasure and Tim Batchelor

PulMiCC, a randomised controlled trial for colorectal cancer patients with lung metastases, began 5 years ago, aiming to address the current absence of good quality evidence to support the role of pulmonary metastasectomy for such patients. The trial is funded by Cancer Research UK. Eligible patients will have had lung metastases identified after having been successfully treated for colorectal cancer, at which point they would be invited to consent to have investigations to assess suitability for surgery. If suitable, they would then be invited to consent to randomisation between active monitoring of their disease, or active monitoring with pulmonary metastasectomy. Follow up of their disease status would occur at regular intervals for five years to measure their quality of life and lung function. Further details can be

found in the SWAG Colorectal Cancer Clinical Guidelines [here](#).

The trial is open in multiple thoracic centres across the country; Bristol Royal Infirmary is one of the most successful recruiting centres. The trial does not dictate which patients to randomise, due to the lack of evidence to support which metastases to remove versus alternative treatment option, and the BRI team have decided to exclude those patients who have solitary metastases from the randomisation.

The trial details and the uncertainty about best practice is to be introduced to patients as soon as possible. To be statistically relevant, 300 patients need to be randomised; 88 patients have been randomised to date.

An information sheet on the trial will be sent to HD for circulation to all MDT members. Radiology members are to be encouraged to 'Think PulMiCC' as they are often the first person to know that a patient has lung metastases.

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6.2 Clinical trials update

Please see the presentation uploaded on to the SWSCN website

Recruitment to colorectal studies in the region is going well. TRACC and SAILOR are currently in set-up and are due to open soon. There is a need to increase surgical and radiological trials. The website with the NCRI portfolio maps has been developed, making it easier to search for new studies: <http://csg.ncri.org.uk/portfolio/portfolio-maps/>. Stephen Falk is the research lead for the group.

Financial support to retain research staff in North Bristol Trust is needed. The West of England CRN allocates funding to each Trust to conduct research activity. How the funding is spent is determined by the Trust. There is very little additional funding available, although there may be opportunities to support new avenues of research.

7. Service development

7.1 The West of England Genomic Medicine Centre

Please see the presentation uploaded on to the SWSCN website

Presented by Axel Walther (AW)

The West of England Genomic Medicine Centre, hosted by UH Bristol with support from Gloucestershire, North Bristol, Weston and RUH Bath, came into fruition in February 2016. The service is being rolled out in stages, and has started with breast cancer patients in North Bristol Trust. A breast cancer pathway has been created and the first patient has recently been recruited. Another patient has been recruited to the rare disease arm of the project. It is next planned to roll the service out for ovarian, colorectal, sarcoma and lung cancer patients. Funding for the consent process will be allocated to each Trust.

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A cold tissue sample of a certain size, that has to be treatment naïve, is to be sent to the laboratory at North Bristol Trust, or can be sent to the local cell pathology laboratory, provided that it is set up to harvest tissue for the project. The sample can last for two hours at room temperature or forty eight hours if cold. This may have to be arranged via a porter and courier from UH Bristol. In the event that a small sample is taken that is difficult to analyse, the diagnostic biopsy will always be prioritised over the GMC sample. Anyone who would like to be involved in instigating the project is to contact Axel Walther or Programme Manager, Catherine Carpenter Clawson.

Genomic educational opportunities are available as detailed on the website:
www.WEGMC.org.

The service has yet to become available to patients living in Wales who are treated in England. Patients from Yeovil and Taunton, who have their surgery in Bristol, will have their samples processed by WE GMC rather than the SW GMC (South West Genomics Medicine Centre).

At the moment the whole gene sequencing process takes approximately 6-8 months. When available, findings will be reported back to the MDT for verification and subsequent patient contact. By the end of the project, it is hoped that the sequencing will be completed in as few as 10 days.

A colorectal cancer pathway is currently being developed. This will be rolled out firstly in NBT. It is uncertain whether the infrastructure will be in place to then roll out at UH Bristol.

8. Patient experience/Survivorship update

The latest Living Well event in North Bristol Trust, held on the 8th July, was well attended, with 66% of patients present. Consultants, Dieticians, Clinical Psychologist and Clinical Nurse Specialists contribute to the half day programme. In RUH Bath, patients are invited to attend a Living Well day approximately 6-12 months after surgery. Dieticians and Occupational Therapists are invited to contribute. Nurse led clinics, for completion of Holistic Needs Assessments, are due to commence in the near future. The Living Well events in Yeovil District Hospital are consistently well attended and have received excellent feedback. There are negotiations underway with Macmillan about the potential provision of a support worker. The local support group in Taunton is currently oversubscribed but attendance at the Living Well events led by Macmillan was reported to have dropped. Implementation of holistic needs assessments has been delayed in Gloucestershire Hospitals due to time constraints.

The potential for Holistic Needs Assessments to be conducted in primary care was raised. The quarterly Living Well events in Weston were also working well, with senior clinicians attending. The Wellbeing days at UH Bristol were well attended and are introduced as part of a patient's treatment plan. It was noted that the purpose of Holistic Needs Assessments was to signpost patients to services rather than solve the problems identified.



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Completion of End of Treatment summaries varied across the region, and would be difficult to achieve consistently unless Clinical Nurse Specialists were released from other work or given administrative support.

9. Any Other Business

It is hoped that a network audit of the patient pathway can be presented at the next meeting. Administrative support to complete this will be provided by HD to Ann Lyons.

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The importance and value of continuing to meet as a network group was emphasised by the members in attendance.

Date of next meeting: Wednesday 30th November 2016

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