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

Meeting of the SWAG Network Colorectal SSG
09:30-15:30, Wednesday, 30th November 2016
Penny Brohn Cancer Care, Chapel Pill Lane, Pill, BS20 OHH

THIS MEETING WAS SPONSORED BY NORGINE, MERCK SERONO AND KYOWA KIRIN

Chair: Mr Michael Williamson (MW)

Notes **Actions**
(To be agreed at the next SSG Meeting)

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 previous notes and actions / MDT membership

Notes:

Section 7.1 of the notes on the Genomic Medicine Centre has been amended according to advice from Newton Wong. As there were no further amendments or comments following distribution of the minutes from the 29th June 2016, the notes were accepted.

Actions:

Details of the CANDID trial are to be circulated to the group. **HD**

Rowland Hackett has now retired from the role of user representative. The group was asked to consider recent patients who might be suitable for the role. The user involvement brief will be circulated. **HD**

An attempt had been made to convene a meeting of the colorectal radiologists to agree the structure of standardised reports, and establish how this can be implemented. The meeting was abandoned due to low attendance numbers. Another potential date will be circulated. **HD**

3. Clinical Guidelines

3.1 SABR for oligometastases

Please see the presentation uploaded on to the SWCN website

Presented by Charles Comins

The Stereotactic Ablative Body Radiotherapy (SABR) service has been offered for the last 12 months in Bristol. SABR targets tumours within the body, rather than intracranial tumours, with high dose radiotherapy by use of multiple radiotherapy beams. The UK introduced the service in light of technical advances that compensate

for tumour movement, reducing the dose received to surrounding structures. Bristol is one of 17 centres that was selected to deliver SABR for oligometastatic disease, via the Commissioning through Evaluation scheme. In Bristol there is a Linear Accelerator. SABR can be delivered very accurately with these machines. A very small area of disease is given a very high dose of radiation so the fall off in the dose is very steep. It allows clinicians to treat patients and areas they were not able to treat before as the toxicity of treatment is remarkably low.

Oligometastatic is hypothesised to be the transitional state between localised and widespread metastatic disease. It has yet to be determined whether ablating growing metastatic disease is beneficial for a particular cohort of patients. There are two trials that will aim to answer this: SARON for NSCLC, and CORE for patients with 1-3 metachronous mets from breast, lung and prostate cancer primaries. These prevalent disease types were chosen to capture the maximum evidence of SABR's efficacy. Careful discussion with patients will be required to set realistic expectations. Patients presenting with metastatic disease in any tumour site aside from spine, who have been disease free for six months, with 1-3 lesions in up to 2 different organs, can be referred. Standard treatment can be given in conjunction with SABR.

There is some data that suggests ablating some tumours might stimulate the immune system to attack other metastases. SSG members are to refer any potential patients. If SABR cannot be delivered in UH Bristol, there may be another centre in the country where it can. Inclusion and exclusion criteria will be circulated to the group and further details can be found here.

There is an opportunity within the NHS to research whether these treatments are beneficial to patients. Groups in the Netherlands and Canada have just finished treatments for a small Phase 2 study and are hoping to carry out a bigger Phase 3 trial. The PulMiCC trial for colorectal lung metastases has an option to include SABR; it has been difficult to recruit to the trial and it is unlikely to meet targets.

3.2 Lynch Syndrome testing update

Please see the presentation uploaded on to the SWCN website

Presented by Newton Wong (NW)

The Royal College of Pathologists' standard operation policy for reflex mismatch repair (MMR) immunohistochemistry of colorectal carcinoma (2014), recommends testing all patients diagnosed who are 50 years of age or younger at the time of diagnosis. The National Institute for Health and Care Excellence (NICE) has reviewed this recommendation, and circulated a draft diagnostic consultation document in mid-October for comments by 11th November 2016. This recommends testing all patients with colorectal cancer at the time of diagnosis, and multiple steps for further genetic tests. The Bristol Genetics team response to the consultation is documented within the presentation. The proposed guidelines, which are due to be published in April 2017, would have a significant impact on the current service; increased funding would be required and the extra workload for pathology and other members of the MDT would need to be managed. Identification of relatives with Lynch syndrome would

lead to an increase in colonoscopies. Results could potentially be held on a Lynch syndrome database, and the responsibility for feeding back results could be delegated to a specific member of the MDT. Patient pathways may need to be reconfigured to incorporate the guidance and an appropriate consent process will need to be put in place. This is for further discussion in local MDTs. The finalised guidelines will be reviewed at the next SSG meeting. **NW**

4. Service Development

4.1 The Significant Polyps and Early Colorectal Cancer (SPECC) programme

Please see the presentation uploaded on to the SWCN website

Presented by Sarah Crane (SC)

SPECC, a national development programme focussed on consistent treatment of significant polyps and small T1 tumours, is the most recent workshop provided by the Pelican Cancer Foundation charity. There are 6 free places available for every colorectal MDT; additional colleagues would need to pay a fee of £95.00 to attend. The 6 workshops held to date have received positive feedback. A South West workshop will be held next year. The date will be circulated by SC. **SC**

A case study of a rectal polyp that initially had a negative biopsy but was subsequently upgraded to an SM3 category cancer, prompted discussion of clinical decision making in terms of the tests to offer at each stage; when surgical intervention would be deemed appropriate, and when it was more appropriate to watch and wait.

5. Patient experience / living with and beyond cancer update

5.1 Results of the 2015 National Cancer Patient Experience Survey (NCPES)

Please see the presentation uploaded on to the SWCN website

The 2015 NCPES was distributed to patients diagnosed with cancer between April and June 2015; results were published in Summer 2016. It was not possible to make a direct comparison with the previous survey results as many of the questions had been modified. The results from UH Bristol were disappointing, but had improved from the year before. Extensive work to identify the problems associated with the patient experience had been undertaken via focus groups and telephone interviews. This showed that shared care across Trusts had a negative impact on the patient experience. Work is underway to ensure that the patient pathway is streamlined where possible, and patient information on the services across the region, including the specialist support workers available at each stage, is provided. SSGs are developing shared care leaflets for this purpose. Ruth Hendy (RH) will liaise with Carole Chapman to arrange development of such a leaflet for the Colorectal team. **RH/CC**

A selection of the colorectal cancer NCPES results from across the region was compared with the national average results. Data from Weston had not been

published due to the low number of responses received. Performance by all Trusts was above average in relation to the question *Were the results of the test explained to you in a way you could understand?*

The significant discrepancies in pre-operative assessment (POAC) clinic times allocated across the region was identified as the main reason why TST and YDH provide a significantly better patient experience in comparison to the other Trusts. NBT and UH Bristol have a total of 15 minutes to discuss their patient's diagnosis and operation. In TST, the patient attends two clinics prior to surgery; the first appointment is for 45 minutes, and the second for 30 minutes. The YDH team also spend far longer talking with their patients. The patient information booklet used by the Taunton team, plus the CD of information on the patient pathway, were thought to be responsible for Taunton's high results on the provision of understandable information; these will be shared with the regional team. All results from the NCPES will be added to the presentation. This will be distributed to surgical leads to use as evidence for the need to extend POAC time. **HD**

5.2 Living With and Beyond Cancer (LWBC) SSG task

Cancer Network Manager, Jonathan Miller, has asked providers to describe their current approach for the following:

- The groups into which patients are risk stratified (high risk, low risk etc.)
- Criteria for determining risk stratification
- Consultant led face-to-face follow-up agreed for each group (if any)
- Other scheduled appointments (e.g. nurse led, non-face-to-face)
- Scheduled diagnostics for upgraded groups (if any)
- Health & Wellbeing clinics, including timing and whether generic or site specific
- Signs for concern (including side effects and recurrence) and method of re-access to service.

Once this information has been collated, the SSGs will be asked to agree a consistent network approach. It is hoped that guidance on risk stratification can be reviewed at the next meeting.

The CNS team were asked to provide information on implementation of the recovery package in each Trust for discussion in the next meeting. **CNS team**

It was agreed that Health and Wellbeing events should be provided by the patient's diagnostic centre.

6. Network Issues

6.1 Cancer Alliance update

Please see the presentation uploaded on to the SWCN website

In order to implement the National 5 Year Forward Cancer Strategy, providers and

commissioners have been instructed to form Cancer Alliances.

For the South West area, there will be 2 Cancer Alliances (CA).The SWAG Cancer Alliance matches the geography of the SWAG SSG Support Service. It has been agreed that the existing cancer steering groups, BNSSG, BANES, Somerset and Gloucestershire, will continue to convene, working to agreed terms of reference, and will nominate 2 to 3 representatives to form the Cancer Alliance board, representing primary care, secondary care and CCG members. A Clinical Lead will be appointed to Chair the group and interviews are currently underway. Membership will also include patient and charity representatives. If agreed, the SSG Support Service will provide administrative support for the CA to ensure two way communications between the CA and SSGs.

It is hoped that SSGs will be asked to participate in decision making exercises proposed by the alliance. When relevant items are on the CA agenda, SSG Chairs will be invited to contribute to these meetings.

The practicalities of how the CA will function, the availability of money and resources, and the agreed standards to deliver, are currently under discussion.

A draft report detailing the overarching priorities and site specific priorities identified by SSGs will be submitted, in the hope that this will be used to inform the Cancer Alliance Work Programme.

Bath will represent Wiltshire in the SWAG Cancer Alliance, and Wiltshire will represent Bath in the Midlands Alliance.

The possibility of inviting the Swindon team to the meeting will be raised at the next Cancer Operational Group meeting. **HD**

7. Quality indicators, audits and data collection

7.1 National Bowel Cancer Audit Platform (NBOCA): latest developments

Service Delivery Manager Alex Newsome (AN) and Operational Manager Alison Roe (AR), from the Clinical Audits and Registries Management Service, provided a demonstration of the NBOCA online platform via Webex. The dataset is one of the largest and most complex in comparison to other national audits. For the SWAG region, data is uploaded automatically via the Somerset Cancer Register (SCR). The platform has drop down mandatory data fields to ensure data quality. Reports can be extracted for local analysis and to improve data quality and completeness. The audit team would like to work with users of the platform to identify potential beneficial areas for future development. The first user group, held in September, identified several areas for improvement that had subsequently been incorporated. Members of the group are to contact AN should they be interested in joining the user group.

7.2 Network audit of two week wait (2WW) referrals

A network audit to review the impact of alternative referral processes had been

undertaken. The dataset, provided by the Cancer Managers from the SCR, included all patients referred via the 2WW system from 1st January 2016 to the 30th June 2016, the number of cancers diagnosed, and the 31 and 62 day cancer waiting time performance. TST and NBT both triaged patients straight to test prior to a clinic appointment, as per NICE guidance. A questionnaire about the direct access pathway had been given to 30 patients in NBT, and had received positive feedback. There had been mixed opinions about the pathway from patients in TST.

The direct access system in NBT had dramatically increased referrals, totalling 1444 in the 6 month period. The data from WGH, TST and YDH showed a high conversion rate of referrals to cancer diagnoses (approximately 1 in 10). NICE ideally want the conversion rate to fall to around 2-3% to support the mathematical model for improving early diagnosis. In contrast to this was the need to monitor the number of patients subjected to unnecessary invasive investigations, and whether there was an associated colonic perforation rate; this could be a subject for a future network audit.

The data from NBT and UH Bristol cannot be clearly differentiated due to the shared use of the SCR, but it appeared that the 62 day target was marginally better in WGH and NBT. The majority of patients were offered a primary definitive treatment within 31 days of diagnosis.

Another potential audit would be to look at emergency admission rates.

To support the direct access to test process NBT employ a taxi service to deliver bowel preparation. If the colonoscopy is negative, a standard outcome letter is sent to the patient's General Practitioner by the Endoscopist. If suspicious of cancer, the Endoscopist will triage the patient to the next step in the cancer pathway. The endoscopy team in UH Bristol have not agreed to this process.

The Department of Health has indicated that failure to offer a straight to test service for every referral will, in the near future, result in financial penalties. There may be financial rewards should this service be developed.

A retrospective network audit of stoma care from 2016 was agreed. The dataset will be agreed by Ann Lyons (AL) and information will be collated by Helen Dunderdale (HD). **AL/HD**

8. Research

8.1 Clinical Trials Update

Please see the presentation uploaded on to the SWCN website

Presented by Stephen Falk (SF)

National recruitment to colorectal clinical trials has fallen. This is related to the stratification and personalisation of cancer treatments, which are progressively more targeted towards examining the subsets of cancer. Local recruitment numbers are low and the colorectal cancer portfolio is sparse. It was increasingly important to

demonstrate that the NHS can conduct effective research by recruiting within estimated times and to target, to be eligible to open trials run by the pharmaceutical industry. The list of open trials and trials in set up are documented in the presentation. A traffic light system, as seen in the presentation, indicates whether a trial is recruiting as predicted.

The Research and Development Department in NBT has asked Principal Investigator Ann Lyons to close the NSCCG trial due to underperformance. However, the data in the presentation shows that the trial is recruiting to time and target. The presentation will be circulated.

Funding for research is allocated to Trusts based on recruitment activity, and varies according to the complexity of the trial and the availability of funding per annum. The following approximate fees would be generated per recruit.

- Band 1: £100 (simple)
- Band 2: £300
- Band 3: £1300 (randomised).

9. Review of patient pathways

9.1 Two week wait referral proforma (version 9.6) and Faecal Occult Blood testing

The form will be amended to include the following wording:

It is also recommended to refer patients when tests show occult blood in their faeces in conjunction with:

- *Aged 50 and over with either abdominal pain or weight loss*
- *Aged under 60 with changes in bowel habit or iron-deficiency anaemia*
- *Aged over 60 with anaemia even in the absence of iron deficiency.*

However, there is no commissioned service for faecal occult blood testing. Patients in this category should make a shared decision with their GP about whether they want to go down the route of investigation, and if they do, enter the 2WW system as they would have if the FOB had been positive.

Iron-deficiency values will be added, and the tests required will be reduced to Ferritin, Hb and eGFR. The changes will be ratified by the MDT leads and then sent to the Clinical Commissioning Groups for their approval prior to publication. **HD**

10. Any other business

Possible adoption of the risk stratified pathways documented in the London Cancer Alliance Colorectal Cancer Clinical Guidelines will be discussed at the next meeting.

Date of next meeting: Wednesday 7th June 2017

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