Somerset, Wiltshire, Avon and Gloucestershire (SWAG) Alliance

Meeting of the SWAG Network Colorectal Site Specific Group (SSG)
09:30-15:00, Wednesday, 7th June 2017
Taunton Hyde Park Conference Centre, Hyde Lane, Taunton, Somerset, TA2 8BU

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 Clinical Network website here.

Mike Williamson stepped down as Chair; an email asking for expressions of interest in the role will be sent out in the near future.

2. Review of previous notes and actions

As there were no amendments or comments following distribution of the minutes of the meeting on 30th November 2016, the notes were accepted.

Recruitment of user representatives: Jackie Mifflin (JM) has agreed to undertake the role of patient representative.

Lynch testing guidelines update: An update on the potential provision of lynch testing for all CRC patients, as per NICE guidelines, will be given by Newton Wong (NW) after discussion at the Annual General Meeting in North Bristol Trust on 20th June 2017. Should this be agreed, the impact on clinic time and the need for extra associated resources would be significant. RUH Bath is due to start providing the test, Taunton has recently started to provide it, and Yeovil send samples for processing to Bristol. Follow up guidance for patients with lynch syndrome will also be discussed at the next meeting. **NW**

Standardised radiology reporting: Consultant Radiologist Andrew Lowe (TST) has expressed an interest in standardising all radiology reporting, as is the process with reporting mammograms. He will be put in touch with Consultant Radiologist Eric Loveday (NBT), whose previous presentation on the subject led to the agreement that reporting should be standardised for Colorectal Cancer. **HD**

Significant Polyp and Early Colorectal Cancer (SPECC) workshop: The Pelican Foundation will hold a SPECC workshop on Friday 8th December 2017, Engineers' House, Bristol. There are 6 free places available for each multi-disciplinary team; additional places cost £90. Implementation of recommendations from the workshop will be discussed at the following SSG meeting.

Great Western Hospital service: It was considered to be of clinical benefit to invite the team at Swindon to future SSG meetings. **Agreed**

Retrospective audit of stoma care: Data for the stoma care audit will need to be

sourced from local patient administration systems (PAS) rather than from the Somerset Cancer Register. PAS data analysts will be contacted to establish the stoma rates across the region. **HD**

3. Living With and Beyond Cancer

3.1 Risk stratification of patient follow up pathways

Please see the presentation uploaded on to the SWCN website

Presented by Catherine Neck (CN)

The national cancer taskforce aims to encourage adoption of risk stratified follow up pathways for cancer patients, to ensure that a consistent service is provided across the UK. The pathways will be agreed by the Cancer Alliance after consultation with the SSGs. The aim will be to discharge patients to self-management wherever safe and appropriate to do so, to increase capacity in outpatient facilities, increase the number of nurse led follow up and telephone follow up appointments. A draft pathway had been compiled based on contribution from teams across the South West and the London Cancer Alliance guidelines. Practice varied across the region, with risk stratified follow up being further reduced in some areas than in the proposed draft pathway, including a reduction in the CT surveillance schedule. The peak recurrence time was noted to be between 9 and 18 months; surveillance should be scheduled accordingly. Follow up was often informed by the performance status of the patient.

The local pathways will be sent to CN and the regional plan updated accordingly and circulated for agreement. **Yeovil CNS team / CN**

There was a digital application follow up system originally developed for patients with hepatitis that allows patients to fill in symptoms online. Patients who do not fill it in are flagged up and contacted. If relevant symptoms are entered, an alert is sent to the team, who can then arrange an out-patient appointment.

Clinical Nurse Specialists from each Trust are invited to present their follow up pathways at the next SSG meeting. **CNS team**

The Cancer Alliance is in the process of submitting a bid for transformation funding to assist with implementation of the recovery package. If successful, this will be used to employ Band 4 support workers to assist the CNS teams.

4. Patient experience

4.1 CNS update / shared care leaflet

Presented by Carol Chapman (CC)

A patient information leaflet to explain why patients may need to travel between centres has been drafted in response to finding out that shared care has a negative impact on the patient experience. This will be discussed further at a CRC nurse forum in the near future. It could be added to the other general patient information. **CNS team**

Surgical and oncological treatment summaries for patients receiving treatment by the anal cancer service need to be routinely sent to the Colorectal CNS teams in local centres. Consultant Surgeon Michael Thomas (MT) and CNS Mia Card (MC) will ensure that this is arranged.

MT/MC

Positive feedback has been received from patients about the DVD produced by Clinton Rogers (with assistance from the local Beacon Centre) and presented by the team at TST. It provides a tour of every step in the colorectal cancer pathway, including the endoscopy department, ward area, theatres and generic MDT discussions. Louise Hunt will provide a copy for the group. **LH**

UH Bristol has appointed a new colleague to the stoma care team.

Completion of treatment summaries and provision of Living Well events varied across the region. Weston has recently stopped treatment summaries as it is believed that someone should be appointed to undertake this work; this is the process in YDH. RUH also cannot complete them due to a lack of administrative support. Funding from Macmillan for refreshments at the RUH events has now ceased; stoma companies may be approached to assist with this. There was a project underway to move away from holding site specific events and change to generic events. The reasons for and against this are to be explored. Patient education days are organised by the stoma care team in Taunton; these are not cancer specific. UH Bristol holds regular generic Living Well days with site specific break-out groups which receive positive feedback. YDH are planning to implement a similar model.

It was noted that YDH Cancer Waiting Times (CWT) are frequently breached due to colonoscopy capacity.

4.2 Consenting complex patients

Please see the presentation uploaded on to the SWCN website

Presented by Angus McNair (AM)

As part of a PhD study, conducted on behalf of The Bristol Centre for Surgical Research, information has been gathered from existing patient information sheets, from interviews with pre-operative and post-operative patients at different stages, and from surgeons, to determine the most reasonable 'core' amount of information required to ensure patients can give informed consent prior to colorectal surgery.

Patients did not find that the current legal consent process provided them with adequate preparation for the consequences of surgery as it concentrates on medical issues. It was also important to manage the amount of information disclosed, as too much information has been found to be counterproductive, leading to heightened levels of anxiety.

The Montgomery v Lanarkshire Health Board case had redefined the law on informed consent, which previously tested a doctor's conduct by asking whether the consent process was considered by a responsible body of medical opinion. Now the law states

that the doctor's conduct is to be considered by a *reasonable person* in the patient's position. The Royal College of Surgeons and General Medical Council have since published guidance on informed consent to eliminate variation in practice, but there was a need to further refine the information given out prior to complex cancer surgery. Results are documented within the presentation.

There was currently a variety of consent forms of different lengths being used across the UK. The technique for obtaining informed consent requires adaptation to meet the needs of the individual; it was paramount to document the discussion thoroughly to reflect the mutual decision. It would be ideal for consent to be obtained over the course of 2-3 outpatient appointments to give sufficient time for the patient to be prepared; this would conflict with government CWT targets, which were noted to have no relation to the biology of the disease. The input from CNS contact and completion of Holistic Needs Assessments was vital to consolidate the information given, in addition to the surgical consent process.

5. Quality indications, audits and data collection

5.1 National Bowel Cancer Audit (NBCA) 2016 report for 18 month stoma waits (2011-2014)

Please see presentation uploaded on to the SWCN website

Presented by Louise Hunt (LH)

An internal audit of stoma waits, conducted in comparison with data from NBCA, had revealed a number of potential causes for the differences between Taunton and national figures. This was not felt to be of concern as there was a problem with the denominator for the data collection, which included all stomas rather than specifically rectal cancers. There had also been issues with the data submission due to staff changes and data not being completed correctly on the Somerset Cancer Register (SCR); it was not currently possible to amend the historical data. There is a small window during which data can be amended in the submission that is due in the next few weeks. Another issue had been found when recording TNM staging. If MX is entered into the SCR, the patient record will not be uploaded; the field should be left blank.

6. Clinical Guidelines

6.1 SWAG Clinical Guidelines Biennial Review

The consensus of the SWAG Colorectal SSG is to offer Transanal Total Mesorectal Excision (TATME) for low rectal cancer in the following circumstances:

- The procedure is undertaken by two surgeons who have undergone formal training
- An appropriate AirSeal device is utilised
- Mentorship is to continue for as long as the surgeon/s deem it to be necessary
- Details of each procedure will be uploaded on to the LOREC registry here, to

facilitate audit.

It had been difficult for some centres to access funds to purchase the equipment; UH Bristol has denied the request. The AirSeal device in RUH Bath was purchased for their team by a local charity. Data on the first 40 cases will be analysed at a future SSG meeting.

Serology screening for the human papillomavirus (HPV) is recommended for all patients diagnosed with anal cancer; data from the Head and Neck 5000 study implies that HPV SCC is responsive to chemotherapy.

All patients with colorectal cancer are recommended to take long term low dose aspirin (75mg) if tolerated.

The Clinical Guidelines will be updated accordingly. **HD/MDT Leads**

7. Coordination of patient care pathways

7.1 Implementation of the FIT protocol

Please see the presentation uploaded on to the SWCN website

Presented by Jonathan Miller

A bid for transformation funding for the faecal occult immunotherapy (FIT) test to become available in the South West, which it is hoped will reduce referrals for colonoscopy, is currently underway and, if successful, should commence in October 2017. Results of an audit conducted in Devon showed that a FIT test would be applicable to 12 patients in every 1,000 of the population. Further details are within the presentation. This may result in a shift of work for those patients who have a negative FIT test and ongoing symptoms, which will need to be appropriately managed; this will be modelled in theory before FIT is implemented. There are some technical issues that need to be addressed; the actual process for collecting a sample using the FIT testing kit is not as straight forward as the previous gFOB test. Devon and Bristol, North Somerset, South Gloucestershire CCGs have indicated that they will proceed to supply the test in the absence of national funding. The FIT protocol will be circulated. **HD**

8. Network Issues

8.1 Cancer Research UK MDT Recommendations

Please see the presentation uploaded on to the SWCN website

Presented by Mike Williamson (MW)

Cancer Research UK (CRUK) conducted a research study to see how multi-disciplinary team (MDT) meetings can become more efficient. Since their formation in 1995, demands on cancer services have increased exponentially. The findings and recommendations from the study are documented within the presentation.

The feasibility of implementing Recommendation 1, to identify cases where a protocolised treatment pathway could be applied, will be discussed with the MDT in RUH. **MW**

Recommendation 2, to review and optimise MDT attendance, could be useful to consider. A core group of representatives from each speciality should be present, with sufficient numbers to allow for effective case reviews.

Recommendation 3, to have a completed proforma with all information required, could prevent cases being rolled on to the next meeting; this was the process in Taunton. It was often challenging to ring-fence the time that was supposed to be assigned to job plans for MDT preparation.

As many surgeons as possible attend the BRI MDT to ensure that an MDT member, who knows the patients being discussed, is present whenever possible.

Recommendation 4.1, to ensure MDT decisions were recorded both in real time and projected, was vital to ensure that the person responsible for acting on the next step in the patient's pathway was accurately documented.

Recommendation 4.2, to review mortality and morbidity (M&M) cases in the MDT, in addition to the M&M meetings already arranged, would be considered.

Arranging the MDT into specialist sections was recommended (for example, polyps), to allow members not directly involved in these cases to leave.

9. Research

9.1 Clinical Trials Update

Please see the presentation uploaded on to the SWCN website

Presented by David Rea (DR)

Recruitment figures, open trial and trials in set up are documented within the presentation. Recruitment was exceeding the expected target. A spreadsheet of all the trials available across the region, including Taunton and Yeovil, will be distributed. It was increasingly important to demonstrate that the NHS can conduct effective research to be eligible to open trials run by the pharmaceutical industry, by reducing study set up time and recruiting within estimated times and to target. It would be ideal if expressions of interest for rare cancers could be formulated as a network group. Recruitment could then be sourced from across the region and the centres in which they open could be rationalised. **DR**

SSG members are to contact DR if they would like to undertake training on use of the online resources for research. Centres where recruitment is successful will be identified in order to share best practice, and the CRN will liaise with Research and Development departments regarding required resources.

10. Colorectal Peritoneal Metastases: Referral and Management

Please see presentation uploaded on to the SWCN website

Presented by Akash Mehta (AM), Senior Clinical Fellow, Basingstoke Peritoneal Malignancy Institute

Peritoneal metastases often spread in a predictable pattern. Treatment involves removal of macroscopic disease with cyto-reductive surgery and eradication of microscopic disease with hyperthermic intraperitoneal chemotherapy; further details are documented in the presentation. Basingstoke, which is one of five centres commissioned to provide the service in the UK, has completed 1,200 cases to date; morbidity is under 10% and mortality 1%.

When peritoneal metastases are identified perioperatively, the recommendation is to stop, close and refer. Referrals should be made at the earliest opportunity with the following information:

- CT-CAP with oral + iv contrast
- Colonoscopy
- Histology reports + slides
- Operation notes (small bowel involved?)
- Timeline + systemic chemotherapy.

There is a 2-3 week waiting list for the procedure, after which, Quality of Life scores return to baseline within 3 months.

To conclude:

- Colorectal peritoneal metastasis is not a terminal condition
- CRS + HIPEC can offer survival benefit in selected patients
- Ensure early discussion with/referral to peritoneal malignancy centre
- CPM during planned resection → STOP + refer
- In the future, this may shift from treatment of CPM to prevention in high-risk patients.

11. Any Other Business

Versions of suspected cancer referral forms dated earlier than the form ratified by the group have been published by some CCGs. It will be established if this is the case for the Lower GI form.

Date and location of next meeting to be confirmed

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