Peninsula Cancer Alliance

Meeting of the PCA Colorectal Site Specific Group

Wednesday 13th March 2019: 14:00-17:00

The Arundell Arms Hotel, Fore Street, Lifton, Devon

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This group will observe the requirements of the Freedom of Information Act (2000) which allows a general right of access to recorded information including minutes of meetings, subject to specific exemptions. No one present today had any objections to their names being distributed in the minutes.

Chair: Melanie Feldman
Consultant Colorectal Surgeon (Royal Cornwall Hospitals NHS Trust)

Reference	**DRAFT NOTES**
1.0	**Welcome and Introductions.**
1.1	Please refer to the separate record of attendance here.
2.0	**Matters Arising**
2.1	The group considered the minutes from the previous meeting.
2.2	MF and NK confirmed to the group that the agreed Constitution and proposed Clinical Guidelines has been uploaded onto the SWCN website *(Ref: 1.3)*.
2.3	To view the agreed Constitution, follow this link.
2.4	BP explained that capacity issues remain a challenge, and will be discussed later in the meeting *(Ref: 3.0)*
2.5	MF and NK had taken the decision to cancel the Colorectal Educational Event (scheduled for the 12th February 2019). This was due to an increase in work pressures across the trusts and the absence of key members volunteering to present at the event *(Ref: 5.1).*
2.6	The Chemotherapy Algorithms have been circulated and are in effect in Barnstaple and Exeter. Feedback was not received from the group on these; therefore, it is presumed that these are acceptable to the Peninsula Trust. *(Ref: 5.3)* To view please follow this link
3.0	**Proposed Clinical Guidelines**
3.1	MF went over the proposed clinical guidelines statement and prompted discussion and feedback from the group.

3.1.1 To view the Proposed Clinical Guidelines please follow this link

3.2 Some of the group believe that there is available a more up to date neuroendocrine tumour (NETs) guideline. A recent study day In Barcelona also provided useful updates on NETs.

3.2.1 To view the proposed Peninsula Guidelines for the Management of Gastroenteropancreatic NET's please click here.

3.2.2 **ACTION**: Mark Cartmell to provide information to MF in order for the draft to be updated (after further discussion with Richard Ellis).

3.3 Feedback received from the group suggests that the protocol for Extended Lymphadenectomy for Low Rectal Cancer appear quite prescriptive, and would benefit from the inclusion of references to support the data. The group agreed that a more robust pathway will need to be drafted and reviewed before it can be adopted.

3.3.1 Please click here to view the protocols.

3.3.2 **ACTION**: Sebastian and Mark to take this work forward and report back to the group.

3.4 Finally, feedback was given on guidelines for Pelvic Exenteration for Primary and Recurrent Colorectal Cancer. It was suggested that these also need to be slightly edited and references inserted.

3.4.1 View these protocols here.

3.5 The group were in agreement with the national protocols listed.

4.0 Clinical Opinion on Network Issues and Service Development

4.1 ***North Devon***

The trust is currently waiting for funding to adopt a nurse led service following Cornwall's example.

The imaging provision has doubled, and "straight to test clinics" are running following an increase in referrals since the NICE Guidelines were published.

4.2 ***Plymouth***

The trust has expanded its endoscopy capacity and has outsourced to help offload work in areas with particular demand/capacity issues..

4.3 ***Exeter***

The service currently has a back-log of endoscopies, and also faces imaging constraints.

4.4 ***Torbay***

The trust are currently triaging all referrals and outsourcing some endoscopies. Waiting times for scopes are around 6-weeks-the team are looking at ways to bring this down. A new surgeon has been appointed, but there is no additional theatre time.

4.5 ***Cornwall***

The trust has been evaluating its ability to deliver the new 28-day pathway (20 working days). MF has looked at the electronic booking systems at RCHT and found that there are delays contributable to the computer system. MF requested data on these delays and found that on average it was taking 5.3 days to get a pre-op appointment for a patient. MF presented her findings to the group. To view the slides, please click here

4.6 Delays were also identified in the lack of ability to obtain timely advice for patients with cardiac history.

4.6.1 MF emphasised the importance of looking at the finer details of the pathway and what avoidable delays are happening.

4.6.2 MF discussed the duplication of specialist reporting within MDT's as an additional cause of delays.

4.6.3 MF discussed discrepancies with the data collected from the cancer dashboard, which can produce unreliable information for decision-making. Members of the group suggested that urgent or routine referrals have been affecting the data. MF believes that this needs addressing urgently in order for the data to be more reliable and reflective of the experiences on the ground.

4.6.4 Nikki Gowen informed the group that some trusts have missing data due to a submission error within their teams.

5.0 CADEAS pathway report

5.1 The group discussed the report, to view click here.

6.0 **Service Developments**

6.1 ***North Devon***

The team anticipate that the new CT scanner [located in the car park] will assist with clinic waits, but there is concern that further stratifying of 2ww patients would be casting the net too wide.

6.2 The commissioners discussed the usefulness of regional audit reports in identifying problems within the system.

6.3 Joe Mays discussed endoscopy demands within the service and emphasised the likeliness of this demand increasing and the importance of identify unachievable targets and glitches within the service, to have a higher chance of meeting the waiting times. In practice, this involves getting people through

routine clinics and increasing the levels of surveillance on those patients where cancer is more likely.

6.4 ***Cornwall***

The team discussed their ambition to achieve a 4ww, as this would ensure that routine referrals are appropriately stratified for endoscopies. It would also provide relief to service pressures, by drawing out those patients that are within the 2 WW whom require referrals to other services. Essentially creating a Cancer exclusion service.

6.5 ***Torbay***

The team discussed the implementation of a more personalised approach when preparing a patient for a 2ww, by ensuring that they prioritise their time to be available to receive telephone calls. It was agreed that orange cards are frequently misused.

7.0 RCP qFIT meeting update

7.1 MF discussed the implementation of qFit. To view the presentation, please click here.

7.2 JM explained that the data; of the 15% of patients that had a positive qFIT result; only 6% had cancer confirmed on further investigation. Focus needs to be on entering these patients onto the Cancer registry within 12 months in order for them to be audited.

7.3 The criteria for the test is the old NG12 criteria but with a lower age limit of 50. Please click here for further information.

7.4 The uptake of qFIT tests from GPs has been variable' the test cannot be used as a rule in or out for 2ww criteria. Often this test is viewed as a possible solution for the endoscopy crisis, but it is not.

7.4.1 Bev Parker provided a commissioning update;

7.4.2 BP explained that the CCG are looking at changing the pathways for colorectal, as it has become clear that clinicians within the trust are too busy to spend time undertaking developmental work. Money has been allocated to facilitate this with the Devon Delivery Group looking at pathway development at a regional level.

7.4.3 A new performance standard report is being finalised which looks at new standards that could potentially take away the 2 week wait.

7.4.4 ACTION: Bev to send to NK to circulate once finalised.

8.0 AIN pathway requirements

8.1 The group discussed if there had been any developments to the AIN pathway.

8.1.2 **ACTION**: The Torbay surgeons have agreed to liaise with Ian Daniels (RD&E) in order to tackle the following issues identified in the previous meeting *(Ref: 2.1)*

1. Good registry to follow
2. Joining up the pathway with gynae

9.0 **SPECC** *(Click to View)*

9.1 NK recently circulated the above documents to the group

10.0 **CCG Updates**

10.1 BP provided a follow up to the minutes from the previous meeting *(Ref: 3.0)*

10.1.1 Phil Hughes is looking at demand/capacity/ investment planning at each trust and the creation of a standardised pathway. .

10.1.2 Peer review report soon to be published will reflect the capacity, workforce, and standardisation of points per procedure.

10.1.3 The report will contain internal suggestions for each trust and system challenges and recommendations to overcome.

10.1.4 **ACTION**: BP to email to NK to circulate when report is finalised.

10.2 Lorraine Long provided an update from NHS Kernow CCG.

10.2.1 62d performance has greatly improved; the intention is that urgent patients will be seen within 4 weeks. In order to move forward with this Cornwall is awaiting sign up from “STP- Shaping Our Future”

11.0 **100,000 genomes**

11.1 Ana Juet provided an update on the project to the group. Please click to view slides

11.2 **ACTION**: MF has asked Ana to write a brief summary on genomes that can be circulated to the rest of the group for a brief overview.

12.0 **LWBC Update**

12.1 ***Exeter***

The team have begun their site-specific Health and Wellbeing clinics in response to feedback from patients, who felt that they were receiving little benefit from generic health and wellbeing events.
They are beginning to create virtual health and wellbeing videos with the aim that this will reach more people and save people from travelling long distances.

12.1.1 **ACTION**: MF has asked Exeter to share their virtual videos with the rest of the

trusts.

12.2 ***Plymouth***

The team held one large Health and wellbeing event, but attendance was poor.

12.3 The group discussed whether holding generic health and wellbeing events is an effective use of clinicians' time. NK explained that there are excellent examples of very successful HWB events in Exeter events; for prostate cancer patients, uptake of the site specific clinic is around 97%-It is felt that the success of this is directly linked to consultants driving this forward with patients. There have also been some very positive, unintended consequences of the educational content delivered at the HWB clinic, including the radiotherapy team recognising that patients are treatment continent, when previously they might not have been.

12.4 ***Cornwall***

The team have set up a site-specific health and wellbeing clinic and are in the process of collecting patient feedback.

12.5 The group discussed the importance of promoting the events to increase attendance.

12.6 BP discussed that there will be a new Patient/Public Engagement Lead, to be hosted by the CCG-this will help to be obtain patient feedback/evaluation.

12.7 Patient representative:

12.7.1 KJ commented that at the beginning the HWBC were a big success in Cornwall. On a personal level, KJ explained that leading up to his operation he was given very little information about what to expect, and that ideally information should have been given to him at the beginning of the process to be of real benefit.

12.8 Cornwall's first Colorectal site-specific health and wellbeing clinic will be held on 22nd May.

13.0 Risk Stratified Pathway

13.1 The group discussed the pathway currently in place at RCH, which includes a low risk pathway and a more intensive follow up for high-risk patients. Most of these follow ups will be via telephone.

ACTION: Cornwall to send details of the pathway to NK to circulate around the group

14.0 AOB

14.1 Some members of the group asked for Bowel Prep antibiotics to be discussed.

14.1.2 The group discussed the evidence available for the use of antibiotics although discussions with Micro and infection control colleagues suggests they are hot

on not prescribing.

14.1.3 Torbay recently had a visit from the GIRFT team who recommended that they should be using antibiotics for bowel prep patients.

14.2 Due to time constraints MF has asked this topic to be added to the next meeting's agenda for further discussion.

15.0 Date of next Meeting

15.1 A Wednesday in September is preferred. NK to confirm.

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