Recommendations from the South West Clinical Senate Council meeting on 27th September 2018

To what extent are providers in the South West able to deliver the national commissioning pathways for colorectal cancer patients?

What are the key areas for pathway redesign and provision of service that will improve the quality of experience & timeliness of treatment for patients across the region?

Overview

Colorectal cancer is the fourth most prevalent cancer in the UK and the 2nd largest killer. Achieving world-class cancer outcomes: a strategy for England 2015-20 sets out ambitions for the earlier diagnosis of all cancers.

The South West Clinical Senate Council met on 27th September 2018 to discuss the implementation of the whole pathway guidance for colorectal cancer.

The colorectal pathway includes four entry points:

- Via screening for colorectal cancer which includes the faecal occult blood test and, more recently the recommendations from the National Screening Committee that Faecal Immunochemical Test (FIT) is introduced by April 2019.
- Through the 2-week referral pathway for suspected cancer
- A routine referral from general practice
- Presentation at the emergency department

Bowel cancer, when diagnosed and treated early has a good prognosis. However, mortality from bowel cancer in the UK lags behind many of the OECD countries. The ambition of the national guidance (Clinical Advice for the Commissioning of the Whole Bowel Cancer Pathway) is to reduce the large unwarranted variation in diagnosis and treatment and to increase the uptake of screening so as to enable earlier diagnosis.

The Senate heard evidence about the significant impact of increased referrals and, in particular, the issues about diagnostic capacity and workforce.

Evidence

As per standard Senate practice, the Senate Council had previously been sent papers to support their deliberations on the day. Further in-session support was provided in the form of presentations from senior clinicians and commissioners including workforce and screening.

- Clinical Advice for the Commissioning of the Whole Bowel Cancer Pathway https://www.uclh.nhs.uk/OurServices/ServiceA-Z/Cancer/NCV/Documents/Clinical%20Advice%20for%20the%20Provision%20of%20Bowel%20Cancer%20Services%20Jan%202018.pdf

- Implementing a timed Colorectal Cancer Diagnostic Pathway
  https://www.england.nhs.uk/wp-content/uploads/2018/04/implementing-timed-colorectal-cancer-diagnostic-pathway.pdf

- Quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care
  https://www.england.nhs.uk/wp-content/uploads/2018/04/implementing-timed-colorectal-cancer-diagnostic-pathway.pdf

- National Bowel Cancer Audit: Annual Report 2017
  https://www.hqip.org.uk/resource/national-bowel-cancer-audit-annual-report-2017/#.W9cvpzHNsmM

Presentations

- Colorectal Cancer: New guidelines for a quality service
  Melanie Feldman: Chair Peninsular Colorectal Group: SW Cancer Alliance

- Colorectal Cancer; Cancer Alliance Work
  Jonathan Miller: SW Cancer Programme Lead

- A systemwide approach to reducing long waiters
  Dr Amelia Randle: Clinical Lead SWAG Cancer Alliance

- Faecal Immunochemical Testing (FIT). Update on National Roll Out
  James Bolt, Head of Public Health Commissioning, NHS England SW (South)

- Self-Assessment against guidance in Devon: Implementing A Timed Colorectal Cancer Diagnostics Pathway – Baseline Audit Tool – Summary Analysis
  Beverley Parker, Devon CCG

Recommendations

1. **Speeding up Treatment:**
   Systems should be encouraged to recognise the distinction between the clinical decision making steps and the administrative process steps in the clinical pathway. The decision making steps are generally far more complex than the process steps and rely on access to the appropriate clinical expertise.

   Four key decision points on the clinical pathway for patients at risk of or with colorectal cancer are identified:

i. This person may have colorectal cancer - what investigations are required?
ii. Colorectal cancer has been confirmed – what next?
iii. When cancer is fully staged, what treatment should be given?
iv. Is the proposed treatment appropriate for this particular patient?

2. **Identifying the barriers**
   All STPs should map the pathways for colorectal cancer across the system to understand the barriers to rapid decision making and treatment. Opportunities should be looked for to run elements of the pathway in "parallel" rather than in "series". STPs should also consider Experience Based Co-Design, gathering experiences from patients and staff, and identifying key 'touch points' (emotionally significant points) in order to improve patient experience of care pathway.

3. **Sharing Learning Across the System**
   The Council recommends that the SWAG and Peninsula Cancer Alliances support a peer review of the delivery of colorectal pathways with the aim of disseminating good practice across the region and highlighting issues that require a regional or national steer. It is proposed that the peer review is designed to explore, in particular the approaches to the 4 decision making points in the pathway for patients presenting either via screening, the 2 week wait, routine referral or as an emergency.

4. **Workforce - Recruitment and Retention:**

   The Council recommends that:

   - The HEE programme for increasing training for endoscopy is supported by all providers. Cancer alliances should work with STPs to support increased participation
   - Consideration should be given by HEE to lobby for extending the endoscopy training to other professional groups e.g. paramedics.

   - Consideration should be given to sharing workforce via networked provision to maximise the impact availability of the skilled workforce

   Most of the workforce plans across the region are dependent on international recruitment which is unlikely to fill the gap. STPs are encouraged to refer to the Senate Council recommendations on workforce http://www.swsenate.org.uk/wp/wp-content/uploads/2018/04/2017-12-06-Senate-Recommendations-Workforce-FINAL.pdf including:

   - Rejuvenated redeployment scheme in which alternative roles are offered to skilled staff members across the system.
   - Provision of support for staff members wishing to leave the NHS e.g. exit interviews and offer of alternative opportunities/roles.
   - Extended return to work programmes to gain the full benefit of re-employing experienced staff who have retired.

5. **Collaborative Commissioning**
   Elements of care impacting on the colorectal cancer pathway are commissioned by different bodies. This increases the risks of the impact on scarce resources not being fully understood with success in one element of the pathway adversely impacting on another.
   Commissioners should work together to avoid unintended consequences either on the colorectal cancer or other pathways of care. Good consistent data collection is needed to include all the different ways a patient can end up on the final treatment pathway.