NHS South West Clinical Senate

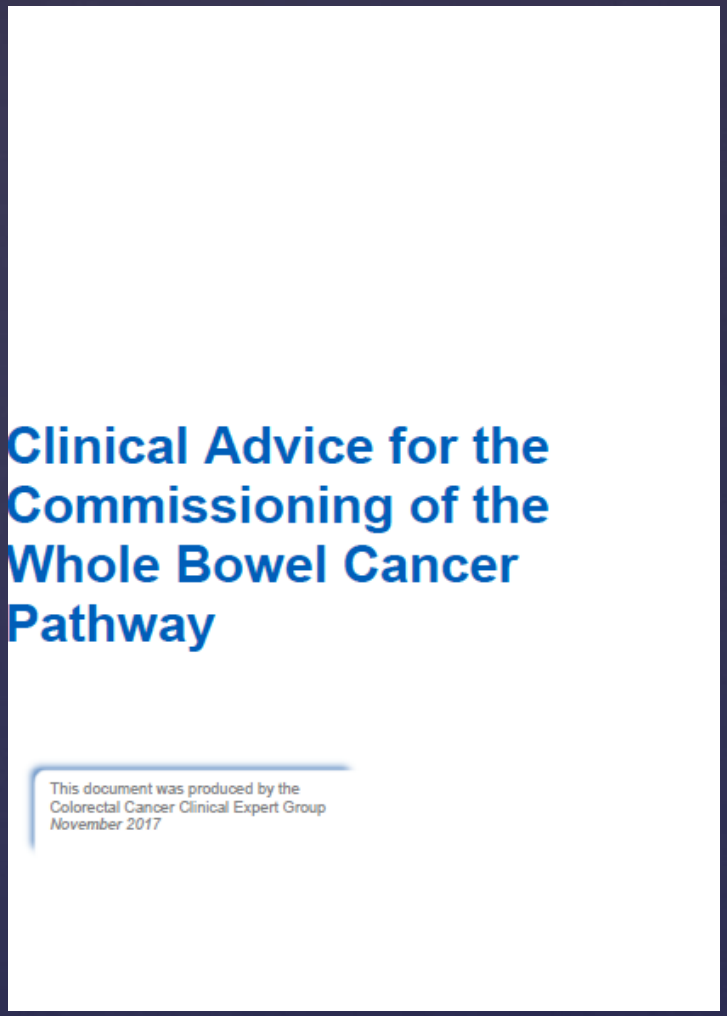
NHS Peninsula Cancer Alliance SWAG Cancer Alliance

SW Colorectal Cancer Peer Review Project.

SW Clinical Senate/Peninsula & SWAG Cancer Alliances

SW Clinical Senate Meeting 11th February 2021

Melanie Feldman RCHT



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?

The task set in May 2019

Context: cancer services and national direction

The principle – NG12 (2015)

Look for cancer at an early stage by lowering the threshold for suspicion and investigation

- Do more tests
- Many of these on the worried well
- Do them repeatedly in patients with benign disease that has similar symptoms

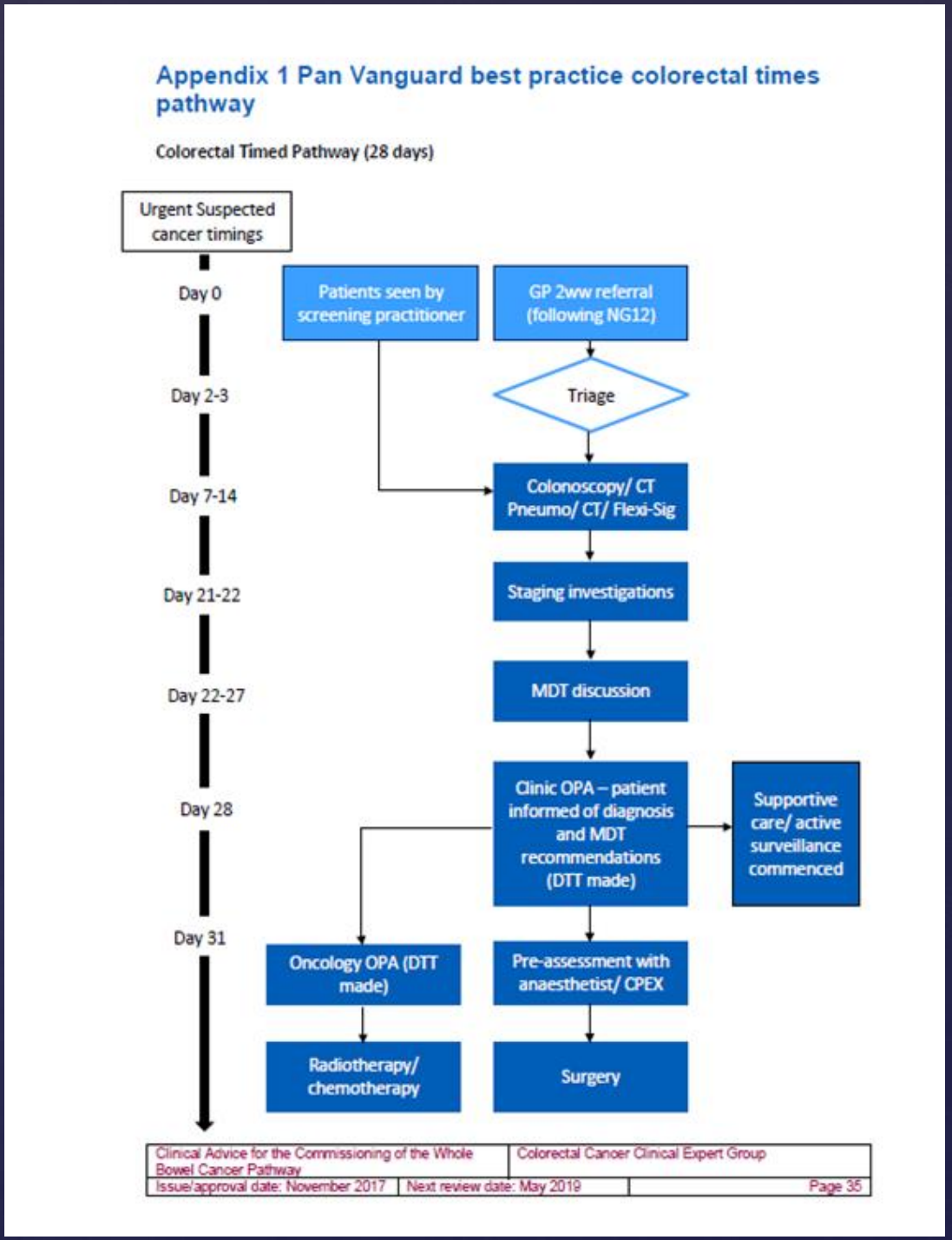
Find cancer at an earlier stage when treatment is more likely to lead to cure

- Expectations of cure high
- Low acceptance of complications
- Impression that every day counts

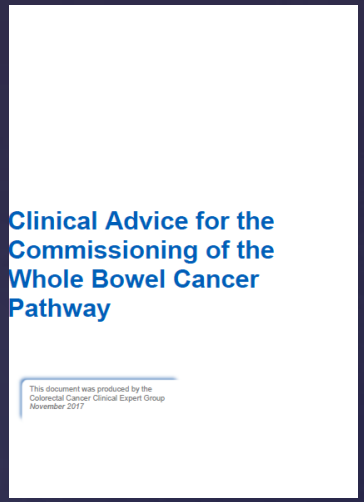
Better survival chances for the person with the cancer

- Expectation of cure which does not include survivorship symptoms
- Prolong life for those without hope of cure
- Multiple rounds of chemo, metastasectomy / ablation

Referral to treatment plan in 28 days (20 working days) in order to start treatment within 62 days

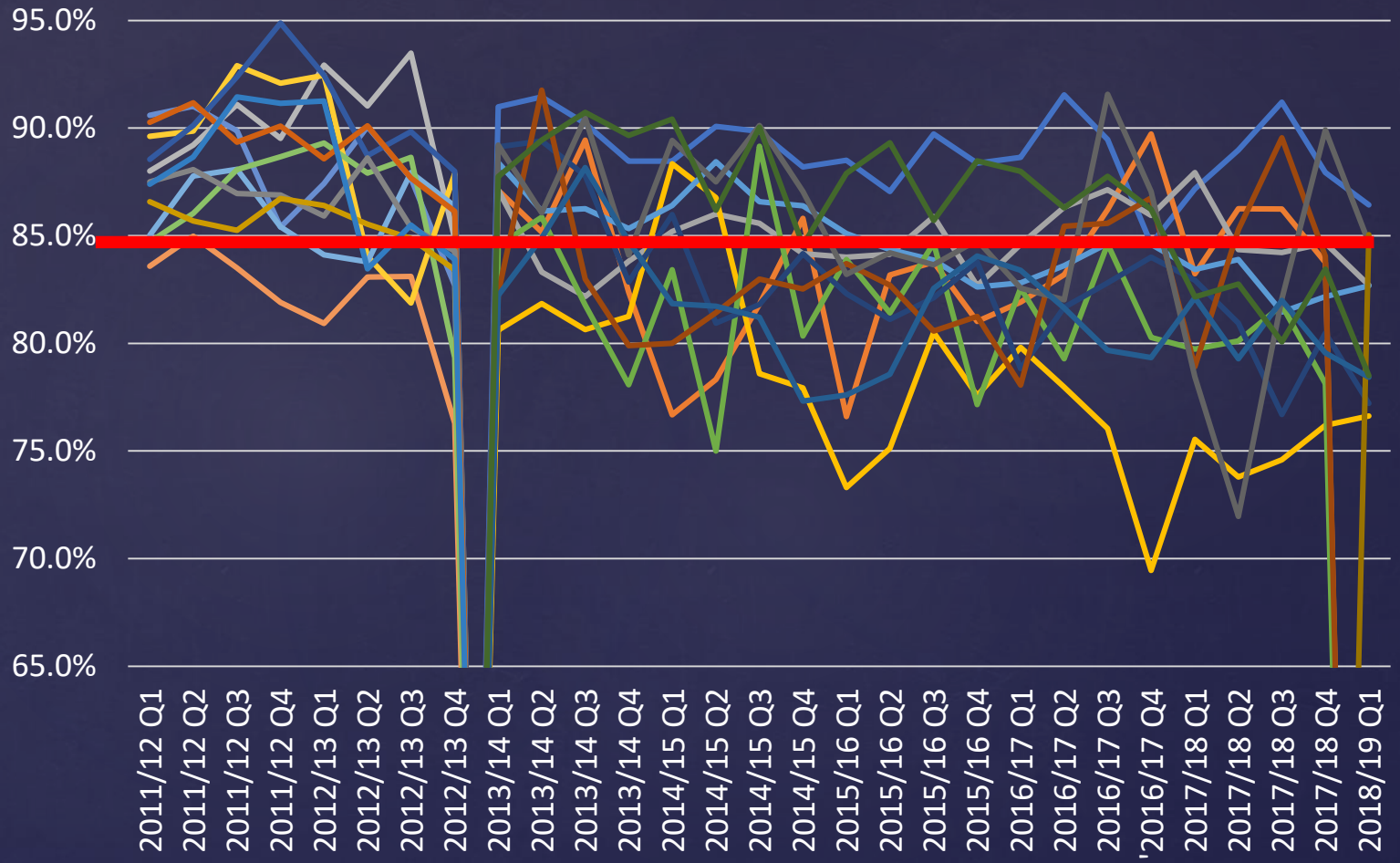


Quality



- CNS to be present when patients receive diagnosis / bad news
- Holistic needs to be taken into account with decision making
- Emergency presentation operations to be carried out by colorectal surgeons
- Operations for complications to be carried out by colorectal surgeons
- Emergency patients (haemorrhage, obstruction, perforation) need HDU
- Anaesthetist as core member of MDT
- After a patient is given a diagnosis of cancer, the patient's GP is informed of the diagnosis by the end of the following working day.

Percentage of patients starting treatment within 62 days

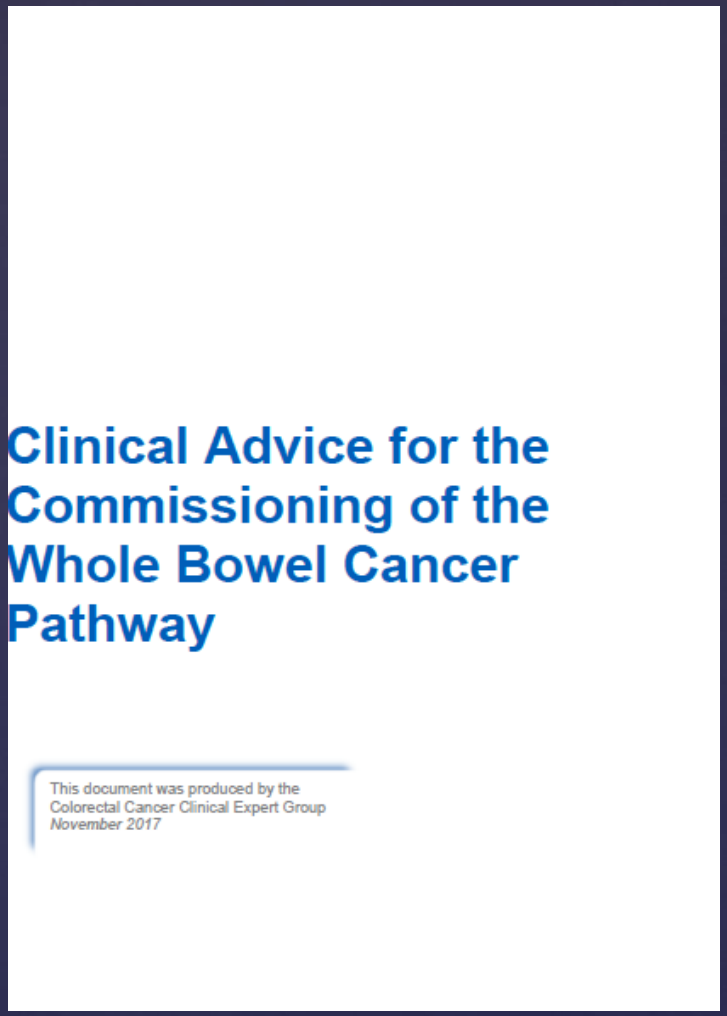


PCTs CCGs

Must not worsen one area of the service in order to improve another.

It’s difficult.

It’s partly about overall resource – money and people. It’s partly about pathways. It’s partly about manpower. It’s partly about choices organisations make.



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The task set in May 2019


sky
sky
sky
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sky
LCL

5 Pathway steps where decisions are made:

How shall we investigate?

Cancer found, what next?

What is the right thing to do?

Is that right for this individual?

Quality parameters?

Protocols for managing the 2WW referrals

Staging

MDT processes

Preop assessment and communication

Emergencies, follow up, Living Well and Beyond, support, patient experience, clinic set ups

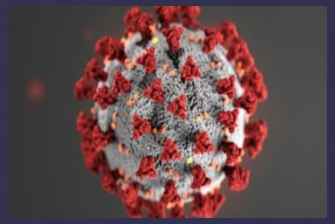
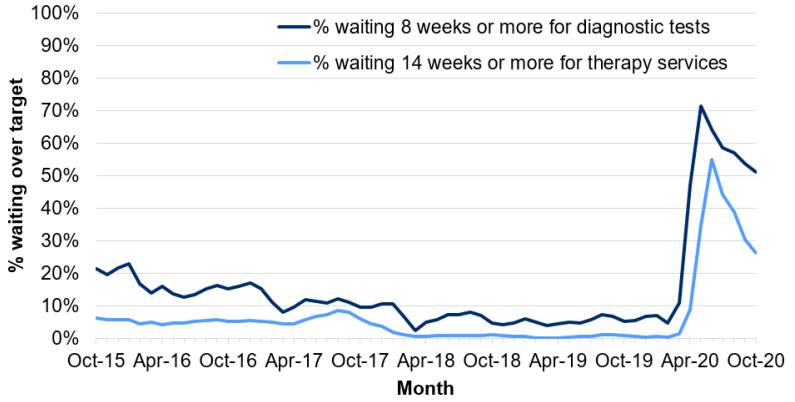


Chart 8: Percentage of patients waiting over the target time for diagnostic and therapy services by service target, October 2015 to October 2020



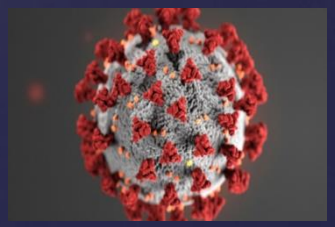
Source: Diagnostic and Therapy Services (DATS), NHS Wales Informatics Services (NWIS)

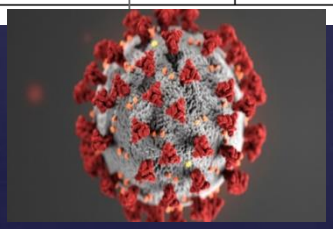
Title: Referral to Treatment (RTT) Waiting Times, England

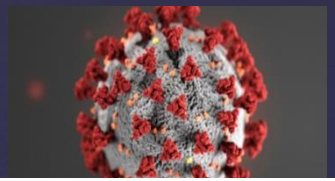
Period: April 2007 to November 2020
Source: NHS England and NHS Improvement: monthly RTT data collection
Basis: Commissioner
Contact: england.rtt@nhs.net

Year	Month	Incomplete RTT pathways							
		Median wait (weeks)	92nd percentile (weeks)	No. within 18 weeks	% within 18 weeks	No. > 18 weeks	No. > 52 weeks	% > 52 weeks	Total waiting (mil)
2020/21	Apr-20	12.2	30.6	2,810,146	71.3%	1,132,602	11,042	0.3%	3.94
	May-20	15.3	34.3	2,386,214	62.2%	1,448,357	26,029	0.7%	3.83
	Jun-20	17.6	37.4	2,005,774	52.0%	1,854,188	50,536	1.3%	3.86
	Jul-20	19.6	40.0	1,895,264	46.8%	2,151,443	83,203	2.1%	4.05
	Aug-20	14.8	42.1	2,260,431	53.6%	1,959,684	111,026	2.6%	4.22
	Sep-20	12.0	43.7	2,638,278	60.6%	1,716,606	139,545	3.2%	4.35
	Oct-20	11.1	44.6	2,909,467	65.5%	1,532,640	162,888	3.7%	4.44
	Nov-20	10.4	45.1	3,040,809	68.2%	1,419,903	192,169	4.3%	4.46
	Dec-20								
	Jan-21								
	Feb-21								
	Mar-21								

Notes:







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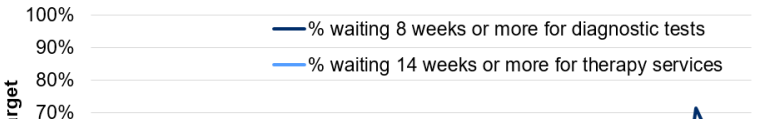

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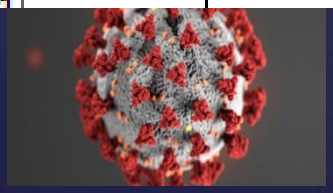

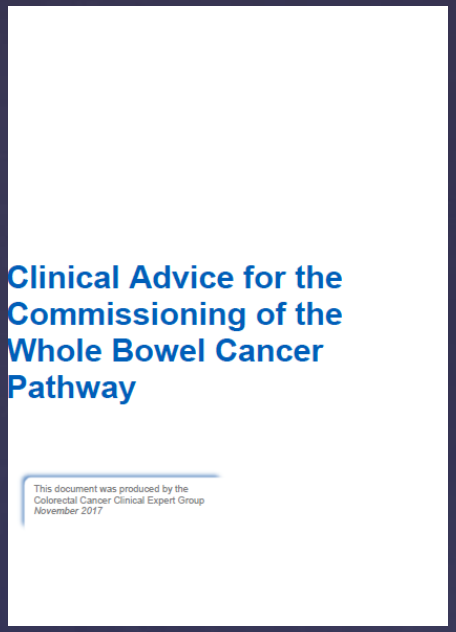

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What are the key areas for pathway redesign and provision of service that will improve the quality of experience & timeliness of treatment for patients across the region?

How can the Peer Review Project help us rebuild services following COVID changes?

What we did…

- Melanie Feldman & Mike Thomas Clinical Leads
- Ousaima Alhamouieh Project Manager
- Jon Miller SW Lead
- John Renninson, Amelia Randle Clinical Leads for CAs

- Stakeholder planning meeting
- Meetings and information to trusts / cancer service managers
- Data requests
- Site visits with MDT peers
- End of day feedback
- 2 safety notices
- Individualised reports
- ‘What works’ report

Data gathering

- Over 200 data items in the 'Commissioning Advice….)
- Areas for MDT lead, cancer services manager
- Volumes, waiting times and facilities/processes

Site visits

- Supportive interactions
- Format adjusted after 3 visits
- Can be both underwhelmed and overwhelmed by engagement
- Well received
- Identified 'twin' units who can share experience of change

Trusts who declined to join the project…

And those who were reluctant at first

Region wide problems

- Diagnostic capacity
- Access to useful data
- Antique IT
- Inadequate infrastructure for genetic support
- Emergency operations: right patient right place right surgeon.. We do not facilitate that
- Inconsistent access to radiotherapy
- Lack of network solutions to 24/7 needs

2 safety notices….

Pathology services

On call arrangements

Stuff that works

That Trusts could implement, fits most cancer services

Point 1 – How do we investigate this patient?

- Develop protocols for management for each referral category (fit and frail)
- Electronic requesting
- Request at start of pathway
- Non consultant initial step
- Outsourced diagnostics

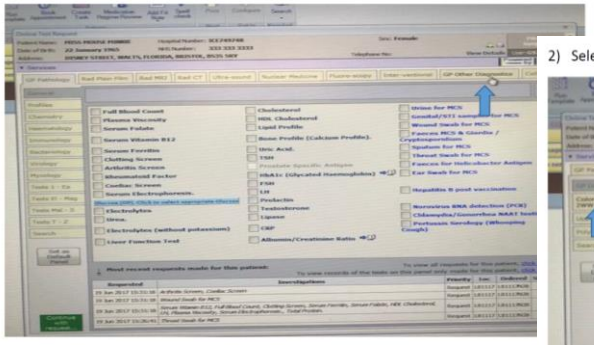
Tool for admin staff to plan first step (pre pandemic)

Symptoms	Patient age				
	Under 50	Over 40	50 to 60	60 to 80	Over 80
Looser and more frequent motions for >3 weeks				PHONE	CLINIC
Unexplained Rectal bleeding			PHONE	PHONE	CLINIC
Unexplained Iron deficiency anaemia			PHONE	PHONE	CLINIC
Rectal or abdominal mass			CLINIC	CLINIC	CLINIC
Positive faecal occult blood (FOB) test				CLINIC	CLINIC
Rectal bleeding and anaemia	PHONE				
Rectal bleeding and change in bowels	PHONE				
Rectal bleeding and abdominal pain	CLINIC				
Rectal bleeding and weight loss	CLINIC				
Unexplained anal mass or anal ulceration	CLINIC	CLINIC	CLINIC	CLINIC	CLINIC
Unexplained weight loss and abdominal pain		CLINIC	CLINIC	CLINIC	CLINIC

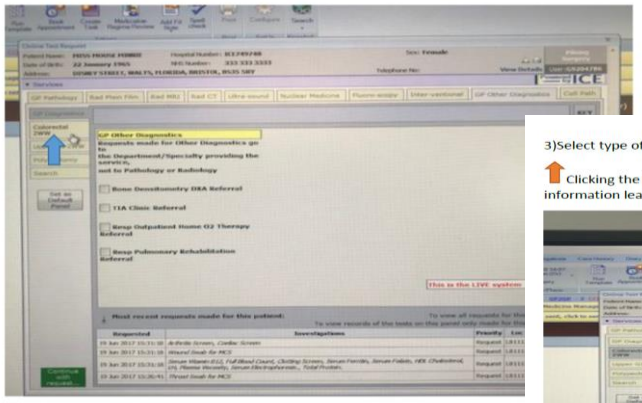
A DTT – A Direct to Test system for Primary Care

NBT Screen Shots for Navigating on ICE

1) Select GP Diagnostics from Right side of the top ribbon

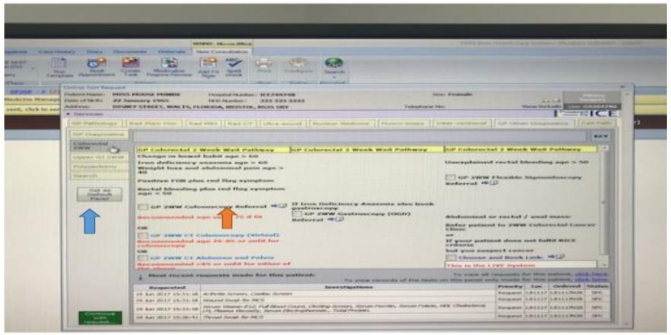


2) Select Colorectal TWW Referral from picking list on the left of screen



3)Select type of investigation required: TWW Colonoscopy, Virtual CT or CT Abdo/pelvis.

Clicking the book icon takes you directly to Remedy website where the patient information leaflet can be printed off



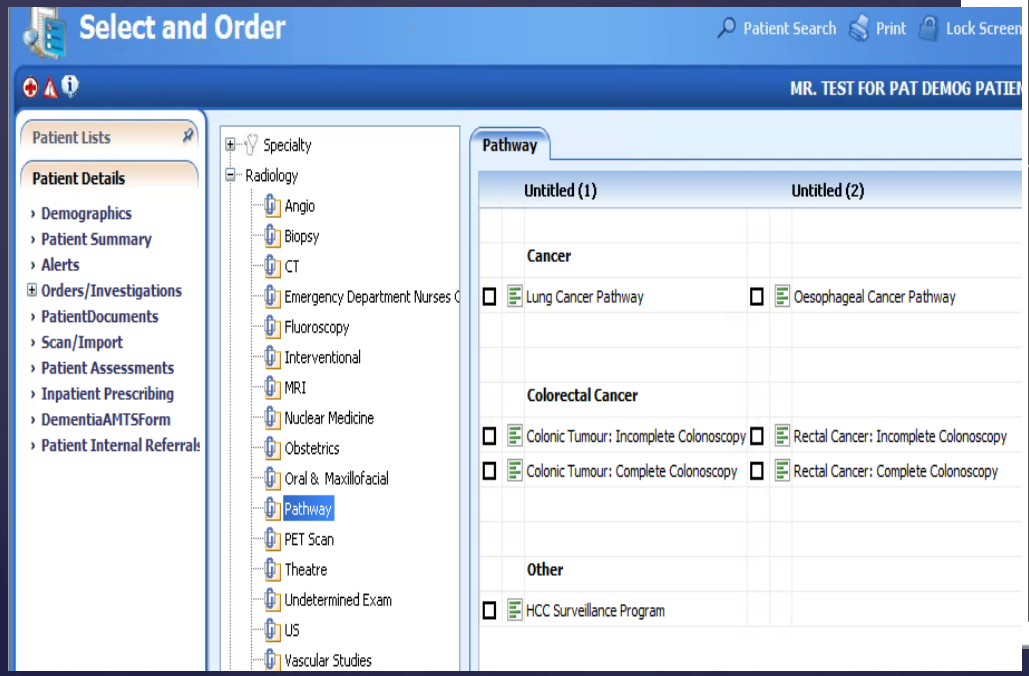
Three models that work:

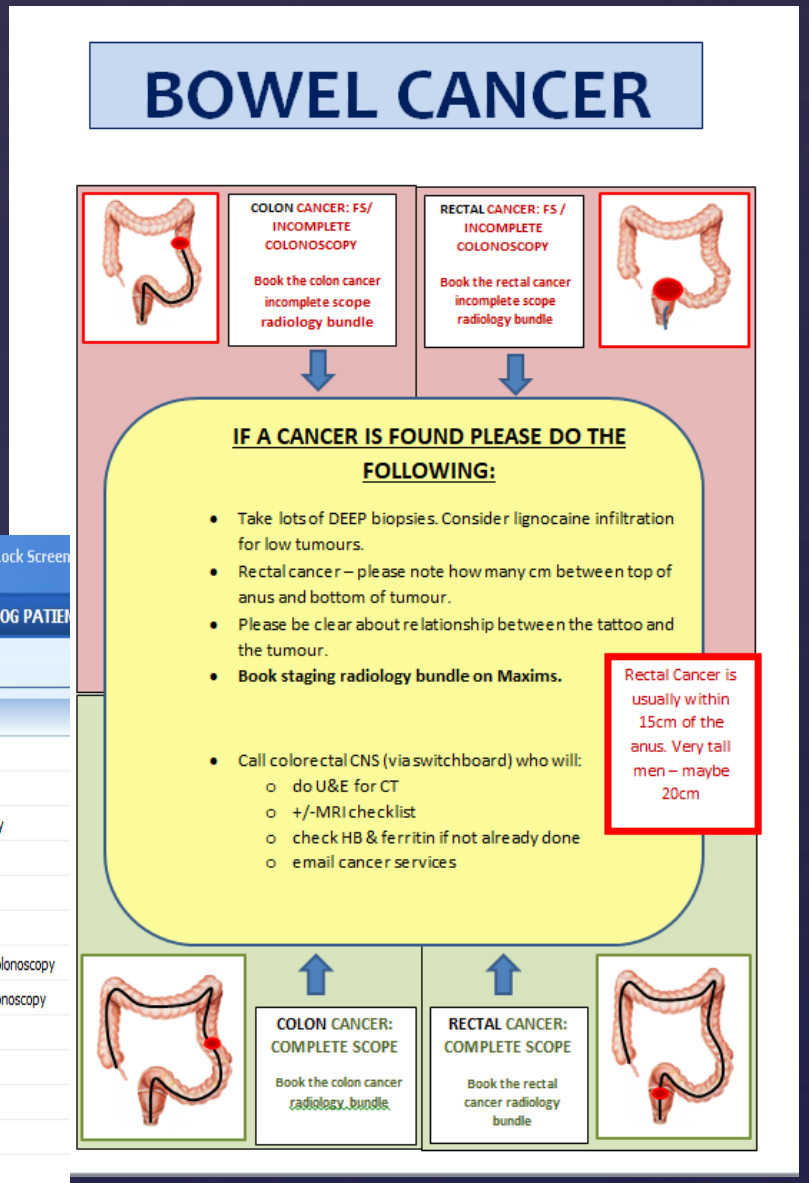
- DTT in Bristol
- Nurse run service in Truro
- Composite model in Salisbury

Point 2 – Cancer found, what next?

- Adapt reports to make the ‘no cancer’ declaration easier
- Bundles of radiology tests for staging
- Staging initiated by radiology
- Electronic reports and cancer navigators to eliminate the admin wait
- Nurses managing the investigation results and requests

Booking bundles of staging tests





Point 3 – what treatment do we recommend? – the MDT

- MDT needs review and policing the day before
- Only one model of 'standard of care' – NBT – pathologist and radiologist takes responsibility for the decision
- MDTs with sections and appropriate people
- Someone who knows and has met the patient
- Work backwards from RTT date to have MDT discussion with the information needed
- Palliative care consultant presence
- R&D nurse presence
- Psychologist present

Point 4 – is this treatment right for this patient?

- MDT clinics immediately after MDT
- Data based crib sheets for complex decisions around rectal cancer
- Some fabulous POA in the region including:
  - Frailty scores throughout the pathway
  - ‘Prepare for surgery’ school
  - CPET for all majors
  - Fitbit and step targets, physio led prehab
  - Integrated elderly care / complex medical physicians

Section 1

Introduction

This leaflet should increase your understanding of your hospital stay and how you can play an active part in your recovery. If there is anything you are not sure about, please ask us. It is important that you understand so that you, and possibly your family or friends, can take an active role in your recovery.

Eating and drinking

At the pre-assessment clinic the week before your operation, you will be offered some nourishing drinks. They are called Fortisip Compact, Fortijuice, Fortisip Yoghurt style, or Build-up. You will be given four drinks of your choice to take home.

Two days before your operation, you need to have three of these nourishing drinks.

On the day of operation, you should have two of these nourishing drinks. You will also be given 2 glasses of a clear carbohydrate drink (called Pre-Load) about 8-12 hours before your operation.

About 3 hours before your operation, you should take another 2 glasses of the clear carbohydrate drink.

A few hours after your operation, you will start having drinks and, if you wish, food. You should have 2 nourishing drinks on this day and 3 per day thereafter. These drinks are important after your operation as your body needs more nourishment to help heal your wounds, reduce the risk of infection and help your recovery generally. You will also need to have ordinary drinks. It is important that you eat and drink early after your operation and we will encourage you to have normal food as well as the nourishing drinks.

Preparing for theatre

On the day before your operation, you may be asked to have some medicine to help clear the contents of your bowel. This gives you loose stools and it is important that you drink plenty of fluid to replace what is lost. Otherwise, you may feel dizzy, sick or have a headache.

Some patients have an enema two hours before their operation to clear the lower end of the bowel.

You will be given an injection of enoxaparin at 6pm. This helps reduce the risk of a blood clot (thrombosis) occurring in the legs, by thinning the blood. This will be given to you each day while you are in hospital.

Staying out of bed and walking

After you wake up from your operation, it is important that you start deep breathing exercises. Support your abdomen with a towel and your arms, bring your knees up slightly and lower your shoulders. Breathe in through your nose and out through your mouth slowly. Do this three times and then 'huff' with your mouth as if trying to clean spectacles. Repeat the exercise twice. The whole process should be repeated each hour. This should reduce the risk of a chest infection. You should also point your feet up and down and circle your ankles to reduce the risk of clots in your legs.

The staff will help you out of bed about six hours after your operation. You will need to spend two hours out of bed on the day of surgery and then at least six hours out of bed each subsequent day. You will be encouraged to walk about 60 metres 4-6 times a day, after surgery. By being out of bed in a more upright position and by walking regularly, lung function is improved and there is less chance of a chest infection, as more oxygen is carried around the body to the tissues.

Try and wear your day clothes after your operation because this can help you feel positive about your recovery.

Pain control

It is important that your pain is controlled so that you can walk about, breathe deeply, eat and drink, feel relaxed and sleep well. You may have an injection in your back (epidural) which allows a continuous supply of pain relieving medicine to be given. This is generally removed 2 days after your operation. The doctors will also prescribe other types of pain relieving medicines which work in different ways and you will have these regularly (three or four times a day).

Sickness

Sometimes after an operation, a person may feel sick or be sick. This is usually caused by the anaesthetic agents or drugs we use. You will be given medication during surgery to reduce this, but if you feel sick following surgery, tell the staff who then can provide other medications. It is important to relieve sickness in order to allow you to feel better so that you can eat and drink normally, which will aid your recovery.

Tubes and drips

During your operation, a tube will be put in your bladder so that we can check that your kidneys are working well and producing urine. This will be removed as soon as possible, usually on the morning after your operation. You will have a fluid drip put in your arm during your operation to make sure that you get enough fluid. This should be removed the day after your operation. You may be given extra oxygen to breathe after the operation until you are up and about.

Monitoring

Many different things will be monitored during your treatment including:

- Fluid in and out
- Food eaten
- Daily weight
- When you bowel first starts working
- Pain assessment
- Number of walks
- Time out of bed

Please remember to tell us everything that you eat and drink and what you

Point 5 – other quality markers : follow up

Non consultant delivered

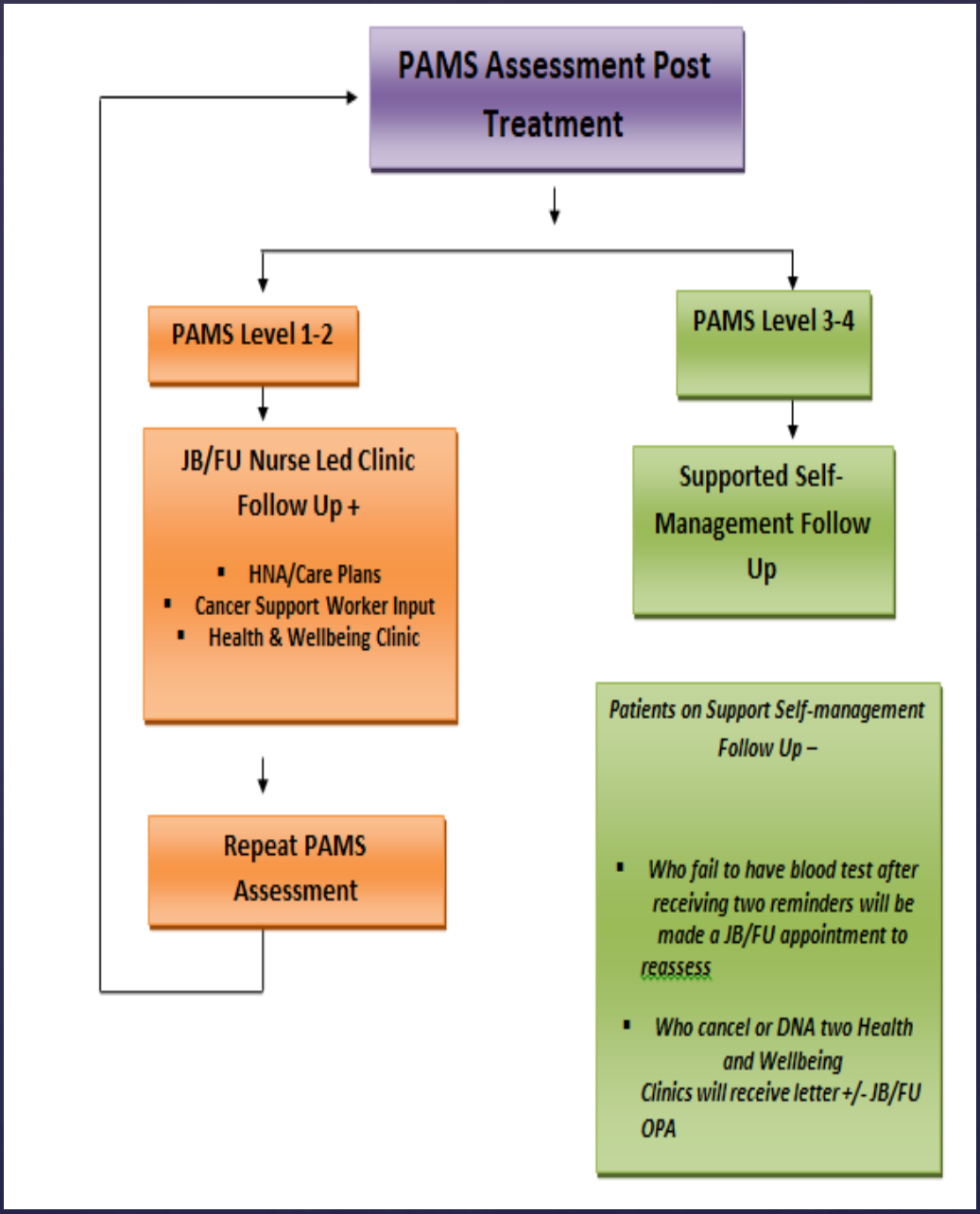
IT tracking or a reliable filing cabinet

Stratify according to risk of recurrence or symptoms/HNA

- Patient activation score – can they do this?

Instant access to return

Good patient info leaflets / bundles of blood tests


PAMS Assessment Post Treatment
PAMS Level 1-2
PAMS Level 3-4
JB/FU Nurse Led Clinic Follow Up +
HNA/Care Plans
Cancer Support Worker Input
Health & Wellbeing Clinic
Supported Self-Management Follow Up
Repeat PAMS Assessment
Patients on Support Self-management Follow Up –
Who fail to have blood test after receiving two reminders will be made a JB/FU appointment to reassess
Who cancel or DNA two Health and Wellbeing
Clinics will receive letter +/- JB/FU OPA

Point 5 – other quality markers : Operations

Sophisticated use of evidence based practice
Adequate bed base and theatre capacity
Interrogate quality parameters in NBOCA
On call arrangements
Risk scoring
Physical environment and staffing
ERAS nurses for pre/peri/post op continuity
Use of community hospitals
Innovative new roles
Consultant telephone advice

Point 5 – other quality markers : Living Well and Beyond

Whole team involved in running LWB days

Virtual HWB service

Drop in feedback coffee mornings

Cancer support workers as primary contact point for HNA

Royal Devon and Exeter
NHS Foundation Trust

Health and Wellbeing Clinic

Treatments, support services and aftercare for Colorectal Cancers

33:58

Reflections

What we noticed

What we noticed:

It is rarely a team game – ownership almost entirely in surgery

Nobody has info available to really judge how their service is doing

Exec level commitment can turn services around

Accept that old models do not work

Electronic order comms

What are the core activities for each member of the team?

Diagnostic outsourcing is essential

Specific Successes

Pathology investment UHP

Service redesign RDE

Linking Salisbury & Torbay

BMJ Nov 2020

1 Queen Alexandra Hospital, Portsmouth, UK
2 London, UK
3 University of Exeter Medical School, Exeter, UK
4 Imperial College, London, UK
5 John Radcliffe Hospital, Oxford, UK
6 St James's University Hospital, Leeds, UK
7 University of Dundee, Dundee, UK
8 Manchester University, Manchester, UK
9 North Hampshire Hospital, Basingstoke, UK

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Have large increases in fast track referrals improved bowel cancer outcomes in UK?

More precise risk stratification is required to enable timely diagnosis of bowel cancer while avoiding unnecessary investigation, argue **Michael Thompson and colleagues**

Michael Thompson, [1] Daniel O'Leary, [1] Iona Heath, [2] Lynn Faulds Wood, [2] Brian Ellis, [1] Karen Flashman, [1] , Neil Smart, [3] John Nicholls, [4] Neil Mortensen, [5] Paul Finan, [6] Asha Senapati, [1] Robert Steele, [7] Peter Dawson, [4] James Hill, [8] Brendan Moran[9]

UK Department of Health policies to improve survival from bowel cancer through GP referral guidelines and public awareness campaigns have increased urgent referrals to hospitals. This has led to an unsustainable demand for colonoscopy and CT colonography without evidence of significant clinical benefit. These policies could be improved by more precise stratification of the risk of having bowel cancer to achieve prompt, rather than earlier, diagnosis while avoiding over-referral and investigation of patients with transient symptoms

another, by 2009, before the introduction of the public awareness campaign, reporting a predictive value of 7.9%.

Box 1: Seven typical characteristics of bowel cancer[2]

These characteristics identified over 92% of bowel cancers referred to outpatient departments.

Adding two age thresholds: >40 years for the first symptom combination and >60 years for the second and third combinations still identified over 90% of cancers.

- >50% of all patients with bowel cancer present with

Key messages

- The continuing increase in referrals to fast track, bowel cancer clinics and the consequent requests for whole colonic imaging are becoming unsustainable
- Evidence that fast track clinics lead to diagnosis of earlier stage bowel cancer and improve survival is weak
- Many people without bowel cancer worry unnecessarily and have potentially harmful investigations
- Improved stratification of the risk of having bowel cancer could help to solve these problems and enable resources to be redirected to higher value clinical activity such as screening

qFIT as a permanent entrance requirement to 2WW?


Instructions continued

4 COLLECTING THE SAMPLE
Unscrew the top of the sample tube anti-clockwise and scrape the end of the stick along the stool sample.

5 Ensure that the end of the stick is covered in sample but do not coat the rest of the stick. Replace the stick into the device and twist clockwise to close securely. Only do this ONCE.

6 PACKAGING THE SAMPLE
Place your sample tube into the green plastic bag and press along the seal.

7 Place the green sample bag AND the GP request form provided, inside the prepaid padded envelope. Remove the covering strip and fold the top over to seal securely.

Please check you have completed all the steps and post immediately.

Your test result will be returned directly to your GP within 10 days.
If you have not heard from them within 2 weeks please contact them.

Your views are important to us. We use feedback from patients and carers to help us develop our services to ensure we provide the best possible patient care.
Please tell us your experience of this service by visiting our website
www.tinyurl.com/qFIT-Feedback

- Pandemic triage tool
- Some science still to be done
- Trusts bound by national protocols

Next steps: the project

Last meeting was March 11th 2020 RDE follow up

Follow up across the project?

The trusts that opted out?

Regional work: consider networking, genetics resource, diagnostic centres

Use this model for other cancer sites?

Promote team in the MDT. How?

Next steps: rebuilding cancer services in the SW

National influences v local influences

Regional problems: genetics / networking solutions

Data systems

Other cancer sites – sharing the learning