

Meeting of the SWAG Network Colorectal Cancer (CRC) Clinical Advisory Group

**Thursday 11th May 2023, 13:00-17:00, Engineers' House, The Promenade
Clifton Down, Bristol, BS8 3NB**

Chair: Mr Michael Thomas

REPORT

ACTIONS

(To be agreed at the next CAG Meeting)

1. Welcome and apologies

Please see the separate list of attendees and apologies uploaded on to the SWAG website [here](#).

2. Review of last meeting's notes and actions

As there were no amendments or comments following distribution of the reports from the meetings on Thursday 6th October 2022 and Friday 6th January 2023 the reports were accepted as finalised.

3. Coordination of patient care pathways

3.1 Regimens in Rectal Cancer: Is there any evidence for variation in outcomes?

Please see the presentation uploaded on to the SWAG website

Cancer Alliance Project Manager W Lo/ MDT members

W Lo has been asked by the NHS England Treatment Variation Group to highlight that variation has been identified from the National Bowel Cancer Audit (January-December 2019) in the use of neoadjuvant radiotherapy treatment for patients with rectal cancer who are due to undergo a major resection.

Data from the 2019 audit, which includes all centres from England, showed that 36% of patients who had a major resection had neoadjuvant treatment, of which, 76% had long course and 18% had short course radiotherapy; the remainder were recorded as having an alternative pre-operative treatment.

Data from the 2020 audit showed an increase in the percentage of patients having short course therapy.

A list of how standardisation of practice may impact resources is documented in the presentation.

The National team has since tasked Cancer Alliances to plan how to address the variation and a significant amount of funding is being made available for this purpose.

CRC CAG are asked to help NHS E better understand the variation and to provide assurance that evidence-based local radiotherapy policies are in place, with the aim to standardise treatment across the country.

A Treatment Variation Working Group Meeting will be held on Wednesday 5th July 2023.

It is hoped that the metrics chosen to monitor progress of the project can be made available via the 'Model Hospital' digital information system. The Denominator, which is the number of adult patients receiving elective resection for colorectal cancer, is already recorded, but the Numerator, which is the number of adult patients receiving pre-operative radiotherapy within 12 weeks prior to elective resection for colorectal cancer, is not available at present. It is hoped that this will be available by the time of the workshop in July.

Action: Two clinical expert volunteers will be asked to attend the workshop from CRC CAG.

H Dunderdale

Discussion:

As the variation has not been identified as a problem that impacts patient outcomes and, in light of the many changes in practice occurring at the moment, with patients moving from pre-operative radiotherapy to combined neoadjuvant treatment, the group discussion concluded that it would be safer not to aim to reduce the variation, but to continue practice in line with the South West Radiotherapy Operational Delivery Network agreed radiotherapy policy in place [here](#) where the indications for long term or short term radiotherapy are documented.

It is hoped that the clinical experts that attend the workshop can influence how the money allocated to treatment variation can be spent so that it can be used to measure meaningful quality indicators that have an impact on patient outcomes, such as R1 resection, Quality of Life (QoL), Toxicities etc.

**CAG
Recommendation**

Action: CRC CAG Oncologists to share the ideal quality indicators to measure and any concerns about delays in the neoadjuvant treatment pathway / resources required prior to the July 2023 workshop to influence funding allocation.

**Clinical
Oncologist
members**

Radiotherapy for rectal cancer is only delivered in allocated regional centres.

Short course radiotherapy was on the increase now that there were combined Systemic Anti-Cancer Therapy options that can potentially reduce the risks related to long term radiotherapy.

Practice will continue to be based on the most up to date clinical evidence available, with oncological therapy tailored to the individual patient, rather than protocolising to reduce a treatment variation based on no evidence.

AGREED

Patient Representative S Rowley highlighted that it is paramount to link any clinical outcome measures with QoL outcomes.

The circumferential resection margin involvement (R1) is particularly important to measure for this reason as it can result in significant comorbidities.

3.2 Faecal Immunochemistry Test (FIT) uptake update

Please see the presentation uploaded on to the SWAG website

Presented by Lead Healthcare Scientist in Immunology, E Roberts

E Roberts was involved in the initial set up of FIT testing in 2018 and has now returned.

The total number of FIT requests continues to increase and is now nearly 10,000 per month. The vast majority are sent by General Practitioners.

Additional staff have been appointed to manage the increased workload and a second analyser has been purchased to improve turnaround times.

Requests made from other sources include day case, emergency, external, inpatient, outpatient, and private requests. These are currently less than 100 requests per month.

The percentage of positive tests per year by age is as follows:

2021			
Age	Total	+ve	% +ve
10-19	48	3	6%
20-29	598	62	10%
30-39	1933	241	12%
40-49	4500	471	10%
50-59	9561	1062	11%
60-69	9183	1349	15%
70-79	11950	2226	19%
80-89	7547	1809	24%
90-99	1204	367	30%
100-109	12	2	17%
Grand Total	46540	7592	16%

% Tests performed under 50 years
15%

2022			
Age	Total	+ve	% +ve
10-19	115	6	5%
20-29	1613	222	14%
30-39	4352	457	11%
40-49	7991	817	10%
50-59	13625	1646	12%
60-69	13334	1890	14%
70-79	16705	3064	18%
80-89	11011	2595	24%
90-99	1807	542	30%
100-109	26	9	35%
Grand Total	70584	11248	16%

% Tests performed under 50 years
20%

2023			
Age	Total	+ve	% +ve
10-19	50	4	8%
20-29	882	131	15%
30-39	2174	270	12%
40-49	3759	503	13%
50-59	5799	806	14%
60-69	6099	1016	17%
70-79	7233	1549	21%
80-89	4820	1233	26%
90-99	812	288	35%
100-109	10	3	30%
Grand Total	31646	5804	18%

% Tests performed under 50 years
22%

In July 2022, criteria for requests were adjusted in line with the newly published BSG guidelines.

The FIT tests that include the old criteria are still in circulation and include paper request forms; it will take some time before they are completely replaced by the new tests, which are due to be disseminated soon.

In the interim, GPs are to be encouraged to request the test via the Integrated Care Environment (ICE) system as it is very time consuming for the laboratory to manually enter them all.

GP representative G Beard has been disseminating the message to request FIT via ICE to local GPs and will continue to do so.

Action: GPs need to be encouraged to make requests using the Integrated Care Environment (ICE) as it takes a significant amount of time to input all of the paper request forms.

G Beard / PCNs

Discussion:

The data was important for CRC CAG who, in light of the increased incidence of CRC in the younger patient population, had successfully petitioned to remove the age restriction for the test.

It was confirmed that the thresholds for referring to the test are the same, regardless of age.

Data on conversion rates to cancer diagnoses is required as is how the referral criteria is split across the different age groups.

Trainees in individual centres need to be identified to support finding the outcomes from the data.

CRC CAG will further encourage use of FIT so that the national target increase rate can be met.

Action: To send FIT data to H Dunderdale for distribution to different centres plus information on the national targets.

**E Roberts/N
Gowen**

4. Clinical Guidelines

4.1 Mainstreaming Testing for Lynch Syndrome

Please see the presentation uploaded on to the SWAG website

Presented by Lynch Syndrome Clinical Nurse Specialist S Brook

Funding has been made available to Trusts to support activity for mainstreaming lynch syndrome testing.

Mainstreaming aims to shift genomic testing away from Clinical Genetics to other clinics and specialties. This will involve healthcare professionals in cancer MDTs consenting patients for the tests and communicating results to reduce waiting times and give equity of access to early diagnosis.

Online training is provided in a 2 hour fortnightly MS Teams format, to give the CNS teams the opportunity to practice consultations.

There will also be the opportunity to observe the Lynch Syndrome CNS Team consultations until individuals feel confident to provide this service themselves.

A South West Lynch Syndrome Workshop is planned in the Summer as an introduction.

The service is not expected to create workload issues as patient numbers will most likely be approximately two a month, and the

funding can be used to provide backfill while undertaking the training.

S Brook is leaving the post of Lynch Specialist CNS at the end of the month; teams can contact CNS S John with any queries:

siobhan.john@nhs.net

Discussion:

Patient Representative S Rowley has personal experience of the importance of improving earlier diagnosis, with a family member finding it difficult to get an appropriate referral for several years and subsequently diagnosed late with Stage 4 disease, and the timelines associated with getting genetic results for other family members, many of which have now had polyps removed.

It would be ideal if initial biopsies could be tested, or samples extracted and stored during surgery in anticipation of consenting a patient once ready to approach post operatively.

The need to manage the growing field of genetics with no increase in workforce and the increased complexity and length of genetic counselling appointments was raised by GP Representative G Beard.

However, an online consenting process has been developed for the Jewish BRCA testing programme: [Jewish BRCA - Jewish BRCA](#)

It is no longer thought possible for GPs to refer patients to the UHBW Clinical Genetics Service due to the strict criteria in place due to the volume of patients coming through, and there are many people waiting for counselling and tests.

Clinical Geneticist A Donaldson in UHBW confirmed that the service is not completely closed, with referrals for Lynch Syndrome being accepted via a rapid access clinic, as are other patients with cancer or another life limiting diagnosis.

The progress made by the Lynch Syndrome CNS team to improve the testing pathway was acknowledged.

There is a mixture of testing methods deployed as, often, pathologists are increasingly undertaking Mismatch Repair (MMR) tests using Immunohistochemistry (IHC) on pre-operative biopsies due to the turnaround time for microsatellite instability (MSI) from the laboratory and the need for a result to inform neoadjuvant treatment. This does have a cost implication as IHC needs to be

funded in-house, whereas MSI is centrally funded. MSI is undertaken on post operative samples where turnaround time is less urgent.

Severn laboratories were noted to have a staffing crisis at present which is holding back a lot of the service.

The results are used to inform which patients are less likely to respond to neoadjuvant treatment therefore the absence of results would not result in restriction of treatment.

5. Patient Experience

5.1 Patient and Public Voice forum

Presented by S Rowley

An inaugural SWAG Patient and Public Voice forum was held on Tuesday 10th May 2023, which gave the Patient Representatives from across the region the opportunity to meet and learn from each other.

Initial induction into the role and training was discussed with the view to having patient experts that are able to provide feedback to CAG colleagues on any relevant projects (NIHR grants for example) that need early patient engagement.

S Rowley is involved in helping produce information for the Colorectal Cancer National Screening Programme.

6. Review of MDT membership changes / meetings / service

6.1 Updates from each Centre

Salisbury:

The colonoscopy backlog has improved but workload continues to rise.

Previously, as seen during the Peer Review assessment, the service had a straight to test (STT) pathway which helped to streamline the two week wait referrals.

As of today, the well-established rapid referral triage team, which act on behalf of the CRC Consultants, have had their requesting rights withdrawn for CT colonography. This may have an impact on the speed of the pathway, as the consultants will need to pick up this workload and make the requests unless agreement can be made with radiology to overturn this decision.

The CRC CAG had previously highlighted the Salisbury pathway as excellent clinical practice to share with other units and recommend that the STT pathway remains in place.

RUH Bath:

The unit has been incredibly busy this year with significantly more cancer resections than previous years and around 400 two week wait referrals each month. It has not been possible to implement the STT pathway for GP referrals to order colonoscopy, with the tests still being arranged by Secondary Care triage of the 2WW referrals.

Action: Evidence will be gathered on the different regional approaches to STT to define the ideal model and ensure that there is parity across the region.

**H Dunderdale /
Future agenda
item**

NBT:

The STT pathway is working very well, with appropriate patients being seen in the clinics and the benefits of FIT being realised. There have been numerous video conferences with GPs in collaboration with G Beard, D Messenger and R West to facilitate engagement which will continue.

Potential future agenda items:

- It has been noted that there is a time lag to first endoscopy for those patients identified via the Bowel Cancer Screening Programme due to patient preference; there is a need to emphasise to patients the importance of timely attendance to these services
- Surgical services are becoming increasingly more specialised. Future discussion of the position statement published by the ACP would be of benefit at a future meeting
- Expansion / development of the CNS team; there has been support from the SWAG Cancer Alliance to facilitate this
- Adoption of Artificial Intelligence platforms for patients to self monitor (My Medical Record / DrDoctor).

**Future agenda
items**

7. Any other business

Watch and Wait schedules will be revisited at a future meeting.

**Future agenda
items**

An update on the AIN service and virology will be presented at the next meeting.

Consultant Surgeon M Thomas stood down from the role of CRC CAG Chair. Consultant Surgeon A Lyons expressed an interest in the role.

S Rowley has been recruited to a Research Team in University College London with aiming to recruit people from different ethnic minorities to test different techniques to improve uptake of FIT testing. Any CAG members interested in helping with the recruitment process can make contact via H Dunderdale.

One such approach is to make better use of community pharmacists.

Action: Requests for funding Continued Professional Development courses are to be sent to H Dunderdale.

CAG Members

8. Colon Capsule Endoscopy (CCE) update

Update provided by Consultant Gastroenterologist D Pearl directly after the meeting.

Action: The national data on the CCE pilot will be forwarded to CRC CAG

D Pearl/H
Dunderdale

Local recruitment has been low at approximately 60 patients out of the 200 recruitment target. However, approximately 4,900 patients have been recruited out of the total national target of 11,000.

The local experience does not match the national experience as many patients do not fit the recruitment criteria due to the elderly population.

There are now three patient cohorts eligible for the pilot:

- FIT positive but low risk ($\geq 10\mu\text{g/g}$ - $100\mu\text{g/g}$)
- FIT negative ($>10\mu\text{g/g}$) with symptoms of concern
- Polyp surveillance.

The addition of polyp surveillance has helped to boost recruitment numbers.

It has not been possible to access the group of patients who are FIT negative as these are now routinely discharged.

The pilot team had been redeployed to help manage the colonoscopy backlog but now the full complement of staff has returned. This includes 1 Lead Nurse and 2 nurses to provide cross cover. It is



Somerset, Wiltshire, Avon and Gloucestershire (SWAG) Cancer Services

anticipated that this will improve recruitment as it will be possible to run 2-3 clinics per week.

From the national data, it has been shown that at least 30% (local data suggests more than this) of patients will need a colonoscopy or scope of some sort following CCE. Now that there is no colonoscopy backlog, from which you get an instant result, it makes CCE a difficult sell.

A longer term CCE project linked to AI with no clinician reporting would be ideal, but AI has yet to be validated for assessment of the colon. It has been validated for small bowel which is in use in other UK centres.

The nursing staff complete the related Electronic Case Report Forms required for each case with support from the R&D team.

It has not been possible to source patients from YDH to date due to previous staff shortages.

-END-