LCA Colorectal Clinical Forum
16th October 2014
Welcome
Colorectal Pathway Update

Mr Muti Abulafi
LCA Chair, LCA Colorectal Pathway Group
Pathway Group Achievements Since June & Challenges Ahead

Achievements

• Publication of the clinical guidelines
• Pathway Group Response to the MoC completed and presented to the LCA Clinical Board

Challenges

• Delivering the work programme for 2014 /16
  – Leads assigned to implement the work programme – task and finish groups
  – Laparoscopic surgery rates and NBOCAP data completeness
  – Stratified pathways, HNA, treatment summaries
  – Straight to test and improving our performance on 62 day standard
  – Local Recurrence and anal cancer services
• Agreeing KPI and compliance metrics
• Accreditation of units
• Engagement with Stakeholders
Colorectal Compliance Metrics and Accreditation of Colorectal Provider Units

How do I ensure compliance
Colorectal Compliance Metrics

For information on metrics please contact Stephen Scott, LCA Senior Data Analyst at: stephenscott@nhs.net
Accreditation of Colorectal Provider Units

Mr Muti Abulafi
LCA Chair, LCA Colorectal Pathway Group
Providers should become subject to an accreditation scheme

The group will develop a scheme that measures quality, safety and patient experience and draws on existing information routinely collected by NHS and nationally mandated organisations

- JAG accreditation
- Peer review compliance
- NBOCAP participation – CA and DC >80%
- COSD staging and compliance
- Compliance with LCA and NICE clinical guidelines
- NCIN service profiles (includes modules on patient experience, clinical outcomes...etc.)
Questions
Colorectal Commissioning Intentions for London 2015/16

Mr Muti Abulafi
LCA Chair, LCA Colorectal Pathway Group
Purpose

• Cancer will be commissioned in line with
  – NICE IOG
  – NICE QS
  – London MOC
  – NCSI

• Services commissioned against a timed tumour level pathway to support delivery of National CWT standards

• A number of services commissioned
  – to support ED in line with best Practice Early detection pathways
  – Manage the consequences / Late effects of anticancer treatments
Purpose

• In total there are 16 commissioning intentions

• 5 generic and 3 specific to colorectal cancer

• Each intention has a quality and information requirement

• Information collected either as
  – Mandated requirement
  – Peer review requirement
  – Part of NBOCAP

• Aim to introduce into Trust contracts for 2015/16 round
## Colorectal specific

<table>
<thead>
<tr>
<th>Ref</th>
<th>Commissioning intention</th>
<th>Quality requirement</th>
<th>Information requirement</th>
<th>Reference/rationale</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>All GPs to have direct access to colonoscopy for low risk, not no risk of cancer via a diagnostic service</td>
<td>Commissioned services will be required to be JAG accredited. 99% of non-urgent referrals within 6 weeks</td>
<td>- Waiting times and reporting times reported quarterly. - Outcome of any JAG assessment to be shared with commissioners within 5 working days.</td>
<td>In accordance with “Improving Outcomes: A Strategy for Cancer” DH, January 2011 Pan London Early Detection pathway</td>
<td>Combination of 1 and 30 from 2014/15</td>
</tr>
<tr>
<td>2</td>
<td>All GPs to have direct access to diagnostic services - flexible sigmoidoscopy for low risk, not no risk of cancer</td>
<td>Commissioned services will be required to be JAG accredited. 99% of non-urgent referrals within 6 weeks</td>
<td>- Waiting times and reporting times reported quarterly. - Outcome of any JAG assessment to be shared with commissioners within 5 working days.</td>
<td>In accordance with “Improving Outcomes: A Strategy for Cancer” DH, January 2011 Pan London Early Detection pathway</td>
<td></td>
</tr>
</tbody>
</table>
Colorectal specific

<table>
<thead>
<tr>
<th>Ref</th>
<th>Commissioning intention</th>
<th>Quality requirement</th>
<th>Information requirement</th>
<th>Reference/rationale</th>
<th>Comments</th>
</tr>
</thead>
</table>
| 10  | All services for colorectal cancer (CRC) will be commissioned in line with NICE guidance through a timed pathway with follow up in line with the NCSI | • All surgeons are completing the required minimum numbers of 20 cases with curative intent per annum.  
• Each MDT completes a minimum of 60 cases with curative intent per annum.  
• Enhanced recovery programme embedded  
• All suitable patients to be offered laparoscopic surgery and resection rates to match the England average  
• Age of referral for low risk, but not no risk of cancer lowered to 45  
• 40% of new patients are followed up through supported self-management  
• Barium enema is not to be used as a first diagnostic test for suspected colorectal cancer  
• People who need emergency treatment should be treated by a colorectal cancer team | • Annual numbers per team and per surgeon annually.  
• % of colorectal cancer patients admitted on the day of surgery.  
• % of patients having laparoscopic surgery. | NICE Guidance Colorectal Cancer 2011.  
http://www.nice.org.uk/guidance/CG131  
NICE IOG CRC 2002.  
http://www.nice.org.uk/guidance/csgcc | Assurance given annually at CQRM in line with the publication of the national colorectal cancer audit.  
New NICE guidance on CRC expected in December 2014. |
## Cancer Generic

<table>
<thead>
<tr>
<th>Ref</th>
<th>Commissioning intention</th>
<th>Quality requirement</th>
<th>Information requirement</th>
<th>Reference/rationale</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>All cancer services commissioned will be required to demonstrate robust treatment decision making through MDTs</td>
<td>All cancer MDTs to be quorate with core membership present at 95% of meetings and that individual core members attend 66% of meetings</td>
<td>Attendance records to be provided six monthly. Action plan for improving attendance provided where not met.</td>
<td>To support a reduction in unwarranted variation in treatment.</td>
<td></td>
</tr>
</tbody>
</table>
| 5   | All commissioned cancer services will participate in the National Cancer Peer Review Programme (NCPR) or other quality assurance programme as defined by commissioners | Compliance threshold of 75%  
No immediate risks or serious concerns | Action plans to address failure to meet the quality requirements provided to commissioners in line with timescales set out in the NCPR handbook | To provide assurance to commissioners in relation to the quality of local cancer services |          |
## Cancer Generic

<table>
<thead>
<tr>
<th>Ref</th>
<th>Commissioning intention</th>
<th>Quality requirement</th>
<th>Information requirement</th>
<th>Reference/rationale</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Agree and implement service consolidation plans – providers will work with their ICS and commissioners to implement the cancer Model of Care</td>
<td>Compliance with implementation gateways (NE&amp;NC only in 2015/16) Provider attendance at ICS pathway groups</td>
<td>Attendance records from pathway boards</td>
<td>Providers will be required to pass through implementation gateways as part of specialist services reconfiguration</td>
<td>Implementation gateways managed through NHSE programme board.</td>
</tr>
<tr>
<td>12</td>
<td>All cancer services will be commissioned to deliver the recovery package as described in the NCSI</td>
<td>% of all new patients will have a completed recovery package by March 2016 consisting of:- • A Holistic Needs Assessment and care plan • Attendance at a health and well-being event • A treatment summary</td>
<td>Completion of the TCST/LCA/LC NCSI template.</td>
<td>NCSI</td>
<td>HNA recording as part of COSD from April 2015. Annual assurance of pathways through CQRM/G. % TBC by the Pan London LW&amp;BC group</td>
</tr>
</tbody>
</table>
# Cancer Generic

<table>
<thead>
<tr>
<th>Ref</th>
<th>Commissioning intention</th>
<th>Quality requirement</th>
<th>Information requirement</th>
<th>Reference/rationale</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Services will be commissioned to manage some of the consequences of anti-cancer treatment specifically:</td>
<td>Services for the management of GI late effects. Services for lymphoedema Services for psychological and physical sexual related problems.</td>
<td>All MDTs that use pelvic RT will have agreed pathways in place for the management of GI late effects. All MDTs where treatments may result in lymphoedema have agreed pathways in place to access services including exercise as per NICE guidance. All MDTs where treatments may result in sexual function problems both male and female have clear referral pathways in place for management</td>
<td>Details of pathways to be provided, including operational policies.</td>
<td>To provide support for those living with cancer as a long term condition.</td>
</tr>
</tbody>
</table>

Colorectal Specific

1. Non-complex colorectal cancer surgery should be available locally to patients in dedicated elective surgery settings.

2. Patients should be offered surgery using laparoscopic techniques, where appropriate. All colorectal multidisciplinary teams should include at least one fully trained laparoscopic surgeon.

3. Providers should become subject to an accreditation scheme. The need to gain accreditation would encourage low volume providers to grow or exit the market. (Not included in the Baseline Questionnaire)

4. All patients with local rectal cancer should have access to MRI directed surgery and preoperative downstaging therapy. The appropriate surgery should be undertaken for all Londoners.

5. Each provider network should contain one specialist colorectal cancer centre for recurrent local surgery.

6. Transanal endoscopic micro-surgery (TEMS) services should initially be concentrated in the specialist colorectal cancer centres.
## Model of Care Recommendations

<table>
<thead>
<tr>
<th>Common cancers - generic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.</strong> London GPs should have rapid access to diagnostics for initial assessment to exclude or confirm a diagnosis of cancer. Investigations and the return of results should be within one week.</td>
</tr>
<tr>
<td><strong>B.</strong> The accuracy of referrals to secondary care should be improved and clear protocols for acting on the receipt of abnormal results in secondary care should be established to reduce delays.</td>
</tr>
<tr>
<td><strong>C.</strong> Enhanced recovery after surgery programmes should be adopted by all surgical and anaesthetic teams treating patients with colorectal cancer.</td>
</tr>
<tr>
<td><strong>D.</strong> Provider networks should ensure that patient access to a keyworker is available consistently throughout the network.</td>
</tr>
<tr>
<td><strong>E.</strong> Multidisciplinary teams should be standardised across provider networks - Multidisciplinary team recommendations should be electronically recorded in real time to ensure that minimum datasets are captured</td>
</tr>
<tr>
<td><strong>F.</strong> Follow-up services should be reviewed to ensure that they are evidence based and, where necessary or desirable, they should be replaced with bespoke aftercare services based on the emerging survivorship model.</td>
</tr>
<tr>
<td><strong>G.</strong> A patient’s level of risk should be assessed following initial treatment. An individual care plan should then be drawn up addressing the whole range of needs.</td>
</tr>
<tr>
<td><strong>H.</strong> Patients reported outcome measures (PROMs) should be routinely used to measure the experience and outcomes of aftercare services by cancer survivors</td>
</tr>
</tbody>
</table>
Summary of Pathway Group work plan for 2014/15/16

- MoC audit 2013 has highlighted areas of improvement and enabled the PG to develop a work programme for 2014/15/16
- Priorities
  - NBOCAP CA and data completeness > 80%
  - Increase laparoscopic surgery rates and reduce variation – to surpass national rates
  - Ensure TEMS providers comply with NHSE specifications
  - MRI rates >90% and all providers to use standardised MRI reporting
  - Local recurrence: business case to inform the optimal configuration of service in LCA
  - Enhanced Recovery: embed in services.
  - Implement Best Practice Pathway for Early diagnosis working with TCS
    - Direct to test
    - Improving performance against 62 day standard
    - Increase uptake of bowel cancer screening
  - Implementation of stratified pathways, HNA, associated care plan, treatment summary / self management care plan
  - Produce a standardised patient information for use across the LCA
  - Anal Cancer - analyse activity and advise on optimal configuration of services
Summary and Conclusions

1. There are 8 commissioning intentions which involve colorectal services

2. Introduced to provide consistent service and reduce variation between providers.

3. Each intention has quality and information requirements

4. Information requirements / KPI are aligned with MoC and work programme of the ICS

5. Information is already collected as mandated requirement, Peer review or NBOCAP.
Stratification: Colorectal cancer follow-up

Claire Taylor
Macmillan Lead Nurse Colorectal Cancer
St Mark’s Hospital
Content

• What is stratified follow-up?
• What is the evidence re benefits
• Pilot study
• What might be drawbacks
• Commissioning intentions
• LCA CRC work plan
A stratification process will help to identify which care pathway is most suitable for each patient, based on the level of care needed for the disease, the treatment and the patient’s ability to manage, and therefore what level of professional involvement will be required.
3 forms of aftercare are:

• **Supported Self Management** – information given about self management support programmes or other types of available support, the signs and symptoms to look out for, and who to contact if they notice any, scheduled tests, and how they get in touch with professionals if any concerns.

• **Shared Care** – where patients continue to have face to face, phone or email contact with professionals as part of continuing follow up.

• **Complex Case Management** – where patients are given intensive support to manage their cancer and/or other conditions.
Rationale for stratified pathways

• Responsive to individual needs e.g. can facilitate access to specialist care when needed.

• Risk stratification dependent on need: self management, shared care or complex

• Based on an ethos of partnership and peer support

• Aiming to embrace 5 shifts i.e. consideration to consequences of cancer treatment, using PROMs
5 key shifts

1. a greater focus on recovery, health and well-being after cancer treatment.
2. holistic assessment, information provision and personalised care planning.
3. Supported self-management
4. away from clinical follow up to tailored support that enables early recognition of the consequences of treatment and the signs and symptoms of further disease.
5. measuring experience and outcomes
Shift 4: from follow-up to after-care

To ensure those living with and beyond cancer get the care and support they need to lead as healthy and active a life as possible, for as long as possible NCSI, 2010
NCSI defined four priorities

1. Recovery package
2. Redesigning follow-up
3. Physical activity
4. PROMs and consequences of treatment
As part of a recovery package
Aims of colorectal cancer follow-up care

• To improve survival – detection of recurrent disease

• To improve quality of life - management of any treatment complications

• Support and reassurance

• Audit

‘Among patients who had undergone curative surgery for primary colorectal cancer, the screening methods of CT and CEA each provided an improved rate of surgical treatment of cancer recurrence compared with minimal follow-up, although there was no advantage in combining these tests’, FACS trial, JAMA 2014
Benefits of risk stratification for clinicians

• Re-designing will enable clinicians to spend more time with complex patients
• Changes emphasis of follow-up care
• Supports patients in self-management
Benefits for the healthcare system

**Capacity issues**
Cancer prevalence increasing by a million a decade

**Financial benefit**
Release savings – estimated at £98 per follow-up

This approach might reduce unplanned admissions by 10% (NHS, Improvement, 2011)
and for patients

Patients cite the two main advantages

a) as convenience

b) low-cost when compared to a hospital attendance.

It may lead to an improvement in patient reported outcomes of care.
St Mark’s pilot – stratified follow-up pilot for low risk colorectal cancer patients
Establishing the clinic

Examine current follow-up care pathways for patients with colorectal cancer
Review evidence and seek patient feedback
Estimate patient numbers
Determine key quality indicators
Meet with stakeholders
Project plan
Criteria for supported self-management

completed curative treatment
a T₁, T₂, T₃ N₀ cancer
no significant surgical complication
willingness will be put on pathway
Patient numbers

- 300+ new patients a year
- 30% may be eligible: excludes private patients, those with severe learning disabilities or mental health issues and patients on clinical trials
- Across 4 Consultants = 100 patients a year plus any who can step down
Patient feedback

8 Trust Cancer user group members

- In the community
- What if no services available locally to meet need.

Stoma support group:

12 Inside Out members

‘support should be gradually decreased and withdrawn only when the patient felt ready’

Individual discussions with 8 patients who indicated overall satisfaction with current service but for some:

- a preference for greater continuity
- A need for peer support
- Some dependence upon the Consultant
- Delays in getting appointments and results
Setting of standards

• All patients are offered a full holistic needs assessment & survivorship care plan
• All patients receive agreed surveillance protocol
• All patients are offered core written information
• All patients receive offer of further support
• All patients seen in surgical clinic in 2 weeks if symptoms develop
How to make it happen

• Training: MI, IRMER, ICS, Dragon
• Team work
• Management support
• Securing and developing resources
IT software development

• Results look-up
• Alerts for limits
• Consultant notified if anything acute
• CNS checks results
• GP and patient notified by letter
• Next test booked
The London Cancer Alliance West and South

**CRC MDT** identify patients who meet criteria to enter list to identify possible e-HNA assessment 10 mins

---

**CNS** undertakes virtual clinics every week and reviews all patients on programme to see when planned surveillance due and if results are available they are viewed and actioned. Only once letters sent out to pt and GP can next surveillance test be booked. Over 5 years

---

Decision recorded on patient’s MDT Proforma. Patient informed of this decision at first post-operative OPD and verbal consent gained

---

Patient sent letter by CNS inviting them to join the self-management programme

---

CNS: invites patient to attend the HNA clinic and undertake e-HNA

---

Patient completes e-HNA assessment. CNS: Discussion of patient’s needs and care planning care

---

Patient put on to telephone follow-up and invited to attend Reach for Recovery

---

Self-management box is ticked on GCIS for each patient to activate remote surveillance - can be taken off if they decline

---

Send to patient: Introduction letter, HNA booklet and flier about Reach for Recovery. Send letter to GP about pathway

---

Clinic Clerk makes 6/52 OPA for HNA clinic

---

In St Marks out-patient clinic. Patient offered information on Living with cancer, Health promotion, Top Tips, further sources of support etc

---

CNS plans formal telephone clinic dates with patients and documents updates in GCIS
Colorectal Cancer Supported self-management surveillance schedule: Your checklist

**Your Hospital Number:**

<table>
<thead>
<tr>
<th>Surveillance</th>
<th>Frequency</th>
<th>2-6 months</th>
<th>12 months</th>
<th>18 months</th>
<th>2 years</th>
<th>2.5 years</th>
<th>3 years</th>
<th>4 years</th>
<th>5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical review</td>
<td>As needed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse-led clinic: face-to-face</td>
<td>Once</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone clinics</td>
<td>2-3 initially and then as is needed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health and well-being event</td>
<td>Offered within 1\textsuperscript{st} year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood tests</td>
<td>Every 6 months for first 3 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Questionnaire</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CT-scan</td>
<td>2 within first 3 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>As indicated by endoscopy instruction</td>
<td>Only if not had a full</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Supporting self-management

Explaining how to take Loperamide (Imodium)
Analysis - 28 patients

• There were no unplanned admissions

• Positive lifestyle changes recorded

• Range of referrals made

No abnormalities detected as yet.

All patients attended planned investigations.
Patient satisfaction

The first 20 patients to enter on to remote monitoring were sent a questionnaire; 11 were returned (55% response rate).

100% patients reported that they understood the purpose of the pathway.

100% were satisfied with the nurse-led consultations and all had found them helpful.

80% indicated that their surveillance schedule had been clearly explained and they felt that could access the service easily.

90% of patients were satisfied with an alternative to face-to-face follow-up: 20% opting for e-mail follow-up and 70% preferring phone follow-up.
Difficulties

• Clinic coding – telephone clinic
• Timing of clinic
• Time spent on administration

Advantages

• 1hr consultation
• Therapeutic role
• Timely review of patient concerns
• Flexibility for pts
Commissioning Intentions

40% of new patients are followed up through supported self-management
The Initiative Cycle

How long will change take?
Round Table Discussion & Feedback

Group 1
• Colorectal Stratified Pathways and Treatment Summaries
  – Led by Claire Taylor

Group 2
• Straight to Test
  – Led by John O’ Donohue

Group 3
• Compliance Metrics and units accreditation
  – Led by Muti Abulafi
Summary and Close
Thank you for coming today

Presentations will be available on the website after a week.

www.londoncanceralliance.nhs.uk