Response to NHS Chief Executive’s Open Call for Evidence and Ideas

Respondent ID: 76

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The following answers are relevant to our experience within bowel cancer surgery.

**What can the NHS and NHS Commissioning Board learn from local, national and international best practice to accelerate the pace and scale of adoption of innovations in the NHS? [Please include relevant examples, published papers or other evidence you have found useful.]**

The traditional concept of surgery was a specific intervention, or procedure, by an individual, often a pioneering surgeon with on many occasions’ poor initial results and long periods of time prior to adoption or in some cases complete abandonment. This model has evolved in recent times and surgical interventions are currently classed as either specific procedures involving a surgical team or part of a multi-disciplinary approach that involves other clinicians and commonly other forms of treatment\(^1\). Surgical innovations can involve novel equipment or technique, and often combinations of both. All require adequate training, careful audit, dissemination of results and critical analysis of effectiveness and cost-effectiveness. Additionally it is increasingly recognized that surgery is skill based; skills can be improved and transferred and both mentoring and ongoing continuing evaluation is essential.

A good example of local, national and international adoption of innovation in surgery is the development and adoption of TME \(^2\) - precise surgery for bowel cancer which has been proved to improve patient outcomes. In the late 1980’s Swedish surgeons were exploring radiotherapy as an additional treatment for rectal cancer but noted poor surgical results. Having read the Heald literature\(^4\) and the published evidence they initially visited Basingstoke and then invited Heald, Phil Quirke (Leeds pathologist) and Moran to Stockholm to operate in a structured “workshop” environment in the early 90’s. It was notable that the concept of a multidisciplinary team involving an MR radiologist, a Pathologist and surgeons participated in these workshops which focussed on “specimen orientated surgery”. This novel concept combining “live surgery” with multidisciplinary team discussion workshops was evaluated on the 1.5 million population of Stockholm and shown to reduce local recurrence, improve survival and reduce the proportion of patients who require a permanent stoma\(^5\).

The Swedish concept of “live surgery workshops” was introduced by Moran and Heald in Basingstoke and through the Royal College of Surgeons in London in the mid 1990’s and subsequently developed into multidisciplinary team workshops, expanding the role of optimal imaging, selective pre-operative treatment and careful clinical and pathological audit of outcomes. These MDT –TME Development workshops were adopted and funded by the NHS and the English

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\(^1\) From Theory to Theatre, overcoming barriers to innovation in surgery, Royal College of Surgeons 2011


National MDT programme was delivered to all colorectal cancer MDT’s between 2003 and 2006. This initiative has been subsequently replicated in many other countries, including Sweden, Norway, Denmark, Belgium and more latterly Canada and North America.

The on-going work from Basingstoke, particularly with the MERCURY study and personal experience with low rectal cancer identified the issues, problems and opportunities with the management of low rectal cancer and focussed on these issues over the past 10 years. This work has led to the development of LOREC; the English National Low Rectal Cancer Programme which is supported and funded by the National Cancer Action Team (www.lorec.nhs.uk) LOREC is currently in a pilot phase and incorporates MDT workshops, cadaveric surgical training, surgical mentoring and audit. LOREC is now recognized globally as futuristic, effective and cost-effective and has been the focus of worldwide interest in developing similar initiatives.

A similar unique NHS initiative has been the highly successful programme for the introduction and adoption of laparoscopic colorectal surgery, the LAPCO programme. The details will be provided separately by Mark Coleman and his LAPCO team.

Medical innovation is most frequently incremental – research results demonstrate areas of development, e.g. improved imaging, results of long term follow up of adjuvant therapies, improved understanding of anatomical structures. All these areas need the whole multi-disciplinary team’s understanding and adoption – e.g. in bowel cancer best practice is changing from a high percentage of patients receiving neo-adjuvant therapy reducing to only selected patients with advanced disease who are more likely to benefit.

For complex conditions, such as low rectal cancer, the multi-disciplinary decision making requires in depth understanding and collaboration and a major input from the patient’s perspective to optimize outcomes and improve quality of life. We believe that developing changes in best practice and close team working is best achieved, as previously demonstrated, by face to face team workshops and discussion and cannot be adequately achieved through electronic or self-managed sessions within host hospitals. Bringing teams together engenders discussion, group adoption and change in practice e.g. LOREC – a clinical oncologist agreed that she currently over subscribes neo adjuvant radio therapy, this was warmly greeted by the rest of her MDT who had been arguing this point for a long time.

The MDT-TME programme, LAPCO and LOREC have led the world in complex colorectal cancer care, have improved outcomes for patients and have helped to define effectiveness and cost-effectiveness in innovative treatments.

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6 Postgraduate Multidisciplinary Development Program: Impact on the Interpretation of Pelvic MRI in Patients With Rectal Cancer: A Clinical Audit in West Denmark
Pedersen, B. Ginnerup M.D., Ph.D.1; Blomqvist, L. Ph.D.2; Brown, G. F.R.C.R.3; Fenger-Grøn, M. M.Sc.4; Moran, B. F.R.C.S.5; Laurberg, S. D.M.Sci.6
What specific actions do you think national NHS bodies, such as the NHS National Commissioning Board, need to take to encourage and stimulate the successful and rapid adoption and spread of innovations throughout the NHS?

The NHS is, and has been a leader in innovation and part of this undoubtedly involves co-operation and communication with front line medical staff through subspecialty organizations (such as the Association of Coloproctology of Great Britain and Ireland, ACPGBI for colorectal cancer) and Royal Colleges. In our sphere of the National MDT Development programme and currently LOREC, the agreement from at least one relevant Royal College and key stakeholders such as the ACPGBI has led to initial enthusiasm and demand within the colorectal community. We feel this model has promoted peer influences, cooperation, competition and support.

LOREC has been piloted with a small cohort (28 MDTs, one from each of the Cancer Networks) to trial its viability, enthusiasm by clinicians and assess any improved outcomes for cancer patients. In the past month we have been given the opportunity to deliver these workshops to a further MDT from each cancer network. The overall aim is to deliver this programme to all colorectal cancer MDT’s.

LOREC stimulates successful and rapid adoption and spread of innovations throughout the NHS by working with the whole MDT to identify more precise patient pathways. This adds value both for patient’s outcomes and the NHS in terms of precision treatment and precision resources. The discursive nature of the programme stimulates continuing innovation of the LOREC algorithm of care. By including all multi-disciplinary professionals involved in low rectal cancer care the programme has been rapidly adopted into practice e.g.

1. Empowering MDT’s to request more precise MRI imaging = more precise individualised treatment.
2. Surgeons discussing and enhancing the precision of surgery and treatment relevant to each patient.

Our observation is that medical specialists, involved charities and many patients and relatives of patients with cancer will refer to web based resources but many of these contain inaccuracies and out of date data, which do not help in the understanding and adoption of innovation in surgery.

What specific actions do you think local NHS bodies, such as providers and Clinical Commissioning Groups, need to take to encourage and stimulate the successful and rapid adoption and spread of innovations throughout the NHS?

The information superhighway provides opportunities but also challenges in adoption and spread of innovation. A key future role is the need for medical personnel to be “knowledge brokers” interpreting the vast amount of information currently available, clarifying the details and guiding decision making. There is undoubtedly a current focus on electronic and remote learning but the TME and LOREC experience demonstrate the advantage of face to face group self-learning away from the place of work. A key issue is undoubtedly the “up-front” cost although the success of the MDT, LAPCO and LOREC programmes has undoubtedly out-weighed the initial investment in theses programmes with overall gain for many years after the initial activity. The NHS has led the world in this field and should strive to continue to do so. The positive feedback from these face to face
workshops has included adoption of innovation, improved team working and in depth consideration of working practices.

**What specific actions do you believe others, such as industry, academia, patient groups or local authorities; could take to accelerate adoption and spread, and what might encourage them to do so?**

Patient focus groups, charity organizations and current NHS initiatives such as PROMS (Patient Reported Outcome Measures) have a key role and should be encouraged and included. The third sector voice is very strong to a wide range of stakeholders (e.g. patients, media and politicians). Their enthusiasm and validation of innovation can spread awareness, patient participation and wider acceptance; they can also explain challenging decisions e.g. non-prescription of Avastin (this is an extremely expensive chemotherapy treatment). However the need for rationalization of effectiveness and cost-effectiveness has never been greater. In this the NHS through NICE has led the way in this emotive and difficult area and should continue the essential but often unpopular role. The quality of the evidence review by NICE is a credit to its members and to the NHS in general.

**Do you have any further comments about accelerating the adoption and spread of innovation in healthcare?**

The explosion in readily available information, particularly in the internet, can only accelerate and has to be embraced and utilized. Organizations such as NICE are crucial as part of knowledge interpretation and the role of health care workers as “knowledge brokers” are key in adoption and spread of appropriate innovation in healthcare.