Colorectal Clinical Sub Group Meeting – Minutes

Thursday 12th January 2017, 10.30am – 12.30pm

Seminar Room G18, Pinewood Education Centre, Stepping Hill Hospital, SK2 7JE

Attendance	**Representation**
Sajal Rai	Chair, Clinical Director and Consultant Colorectal Surgeon, Stockport
Ian Buchanan	Patient Representative
Paula Harrison	Colorectal Clinical Nurse Specialist, SRFT
Debbie Hitchen	Colorectal Clinical Nurse Specialist, CMFT
Rubeena Razzaq	Consultant Radiologist, Bolton
Aswatha Ramesh	Consultant Colorectal Surgeon, UHSM
Emma Brown	Colorectal Clinical Nurse Specialist, CMFT
Malcolm Wilson	Consultant Colorectal Surgeon, The Christie
Jonathan Epstein	Consultant Colorectal Surgeon, SRFT
Dave Smith	Consultant Colorectal Surgeon, Bolton
Kalena Marti	Consultant in Medical Oncology, The Christie
Usman Khan	Consultant Colorectal Surgeon, East Cheshire
Rachel Connolly	Colorectal Clinical Nurse Specialist, The Christie
Sarah Wemyss	Colorectal Clinical Nurse Specialist, The Christie
Claire Stelfox	Colorectal Clinical Nurse Specialist, Stockport
Jill Taylor	Colorectal Clinical Nurse Specialist, Stockport
Apologies	
Kathryn Place	Service Improvement Lead, WWL
Sue Coggins	Patient Representative
Salim Kurrimboccus	Colorectal Surgeon, PAHT
Mark Saunders	Consultant Clinical Oncologist, The Christie
Mike Braun	Consultant in Medical Oncology, The Christie
Doreen Dooley	Colorectal Clinical Nurse Specialist, Stockport
Mamoon Solkar	Consultant Colorectal Surgeon, Tameside
Edwin Clark	Consultant Colorectal Surgeon, Stockport
In attendance	
Lucie Francis	Macmillan User Involvement Manager, Greater Manchester Cancer
Nicola Remmington	Pathway Manager, Greater Manchester Cancer

Welcome, introductions and apologies

1. **Minutes of last meeting**

The minutes of the last meeting were reviewed and approved.

Items not on the agenda:

a. **Pan Vanguard collaboration – UCLH, Royal Marsden & Greater Manchester Cancer**

Discussion summary	SR updated the board on the development of a pan-vanguard initiative to establish agreed clinical pathways to be adopted across all three Vanguard sites. The Colorectal pathway will be the first pathway to be piloted.
Conclusion	Project is in its initial stages as only one teleconference meeting has occurred.
Actions and responsibility	**SR to update the board on any developments.**

2. **Objective no 1 – Improving outcomes / survival rates**

a. **Bowel Cancer Screening – Jane Pilkington, Head of Public Health Commissioning**

Discussion summary	Jane Pilkington unable to attend – deferred to next meeting.
Conclusion	
Actions and responsibility	

b. **National Bowel Cancer Audit Annual Report 2016**

Discussion summary	SR presented highlights from the NBOCA report and discussed the letter of concern issued by NBOCA relating to the 18month stoma rates for GM: nati-clin-audi-bowe-canc-2016-rep.pdf Bowel Stoma outlier letter to Network_Gre
Conclusion	**18 Month Stoma Rate:** As the adjusted 18 month stoma rate for GM, Lancashire & South Cumbria is at 58.5% compared to a national rate of 49.8% ways to improve

	the GM position needs to be identified. MW highlighted that many Christie patients are operated on without the intention to reverse the stoma within six months due to the complexity of their conditions and therefore these patients should not be included within the audit. However, it is noted that there is still an issue for routine procedures. **Laparoscopic Surgery:** Nationally approx. 55% of major resections are completed laparoscopically compared to approx. 44% for GM, Lancashire & South Cumbria, therefore need to improve this position. **Length of Stay (LOS)**: Proportion of patients still in hospital five days or longer after resections for GM, Lancashire & South Cumbria is at approx. 77% which is the second to highest strategic clinical network (SCN) position (London Cancer Network is the only SCN with a higher LOS at approx. 82%).
Actions and responsibility	**18 Month Stoma Rate:** Board to conduct an audit to identify appropriateness of cases included in NBOCA findings for GM and present to NBOCA. **MW to forward the letter of response to NBOCA issued by The Christie to the board for review (to be disseminated to the Board by NR).** *[Since the meeting MW has stated that the Christie's response to NBOCA has been published in the Appendices section of the NBOCA report (**pg81**).]* NBOCA 2016-report.pdf **Laparoscopic Surgery:** SR to feedback to the lead (Chelliah Selvasekar) of the Minimal Access Surgical Group of North West (MasNow) to highlight the current position at the group's forthcoming meeting for developing an action plan. **LOS:** SR to liaise with ERAS leads of all Trusts to highlight this issue for local action.

c. CRUK Bowel Screening Campaign – Be Clear on Cancer

Discussion summary	SR provided details of the campaign which is running from 09/01/17 – 02/04/17 aiming to increase awareness and participation in the NHS Bowel Screening Programme (specifically, gFOBT): CRUK_announcement_letter.pdf CRUK_BCOC16_BOWEL_BRIEF_FINALv2
Conclusion	The campaign is aiming to achieve a 10% increase in uptake amongst First Timers and a 3% increase in uptake in Non-Responders. Across all 32 campaign CCGS there could be an estimated : • Additional 520 people adequately screened • Additional 15 colonoscopies following one month of advertising and direct mail activity SR highlighted that there may be a further increase in secondary care demand

	(specifically Endoscopy demand) as awareness will potentially lead to an increase in symptomatic patients going to the GP etc.
Actions and responsibility	**All to ensure that their Trust is informed of the current campaign and of the potential for an increase in referrals.**

3. Objective no2 – Improving the patient experience

a. CNS Group Update

Discussion summary	SR stated that focus topics for the Nurses Group for future areas of work had been agreed as follows: • Development of a GM wide local Colorectal patient experience survey. • Recovery Package – to continue to monitor the development of all areas of the Recovery Package and ensure standardisation of delivery across GM (with specific focus on Health & Wellbeing Events, Treatment Summaries and Health Needs Assessments). Audit to be conducted at end of 17/18. • Psych support – establish current provision and develop work-plan/collaborations in order to ensure an equitable service across GM.
Conclusion	SR reminded all for the need to ensure: Trust & MDT commitment to support the CNS Group – time/attendance/recovery package promotion and development. Also need to ensure further topics of focus are developed through the CNS group e.g.: • Development of a local Patient Survey • Audit of progress against defined recovery package objectives at end of 2017/18
Actions and responsibility	**All to continue supporting the CNS group by facilitating CNS attendance from each trust.**

b. Stratified Self Management Pathways – GM Cancer Vanguard Transforming Aftercare Pathways Project update

Discussion summary	SR provided an update on the project (pilot site at UHSM): GM Cancer Vanguard - Transf Aftercare Pa
Conclusion	The next stage of the project is the introduction of the Infoflex software system which will automatically generate patient follow up appointments etc. via co-ordinating all PAS data. The aim of the project is to reduce CNS administrative workload and also improve patient experience and ensure effective utilisation of available resources.
Actions and	**SR to provide further updates to the board.**

responsibility	

c. User Involvement Update

Discussion summary	IB highlighted that the UI Team are continuing to work to establish a small community of people affected by Colorectal cancer (minimum 6 people) to feed into the Colorectal Pathway Board (via SC & IB) in order to ensure a broad range of representation, including aspects of treatment involving Surgery, Chemotherapy, Radiotherapy etc.
Conclusion	All to remain aware of the available resource the UI Team is able to offer in the development of future projects.
Actions and responsibility	**All to forward details of potential members for this small community group to LF, E: Lucie.Francis@nhs.net**

4. Objective No3 – Research and clinical innovation

a. Research Update

Discussion summary	KM presented the following update focussing upon the NIHR Colorectal Trials Report 2016/17 Q1-Q3 Report and the ADD-ASPIRIN trial: Research Update Jan 17.pptx GM is ranked the 10th largest network of 15 yet is the 7th biggest recruiting network with The Christie being the main recruiting centre within GM. However, KM highlighted that with FOXTROT now closed recruitment to broader trials must be focussed upon. **ADD-ASPIRIN:** Recruitment to the ADD-ASPIRIN trial across GM is still very poor (only 55 patients to date which is ranked 14th of the 15 networks). GM should be a large recruiter as the trial is aiming for 11,000 participants nationally and is simple to recruit to. The board further discussed lack of awareness regarding the campaign.
Conclusion	There is a need for a publicity drive across the region. Also need Principal Investigators at each trust to drive forward.
Actions and responsibility	• **All to continue to highlight ADD-ASPIRIN trial at MDT meetings and also to ensure a Research Nurse is attending MDTs to help drive recruitment.** • **KM to contact West Midlands Network (Worcester Hospital) to request suggestions as to how to increase recruitment (currently the highest recruiter).** • **KM invited all to contact her if experiencing difficulties in recruitment, E: kalena.marti@christie.nhs.uk**

b. 100k Genomes Project – Karen Tricker

Discussion summary	Karen Tricker (KT) provided an update to the board:  Genome Summary Report - November 2  100,000 Genomes Project - Manchester. KT highlighted that GM are currently ranked the lowest recruiter nationally. The Christie have led on the project for GM with UHSM starting to recruit as of Jan 2017. SRFT, Stockport and Pennine are to start recruitment in the near future.
Conclusion	**Obstacles to recruitment**: • Extensive consent form (45 minutes to complete). KT stated that Local Clinical Research Network (LCRN) staff can be used to facilitate this. • Not all trusts are currently able to access Biobank.
Actions and responsibility	**KT offered assistance to any trust experiencing difficulties in recruitment (staff are available to visit sites and offer assistance/instruction). Contact: Karen.Tricker@cmft.nhs.uk**

5. Objective No4 –Improving and standardising high quality care across the whole service

a. Cancer Waiting Times Performance Data review

Discussion summary	SR presented **Cancer Waiting Times** (CWT) performance data for Q1, Q2 and Q3 (October only) 2016/17:  Colorectal CWT Performance Presenta
Conclusion	**CWT**: **TWW target**: GM has improved its position after falling in Q2 from 96.4% (Q1) to 93.6% (Q2) to now showing at 94.4% for Oct17 with a total of 2 trusts failing this target (CMFT and Tameside). Both PAHT and SRFT have recovered their position for Oct17 and are currently compliant. GM continues to perform above the national average. **31D target:** GM continues to achieve this standard performing at 99.34% for Q1 and 99.1% for Q2. However, for Oct17 there has been a dip in performance currently showing at 97.2% for GM with both Bolton and CMFT failing the target (overall GM is still showing as compliant). **62D target:** GM performance continues to fall for GM from 79.1% (Q1) to 77.6% (Q2) to 75.5% (Oct17) and therefore continues to be below the national target of 85%. SR highlighted that falling TWW performance will inevitably lead to difficulties along the pathway potentially resulting in falling performance for the

	62D target. **Straight-to-Test:** Possibly may help improve performance but may also simply shift the problem to another area within the pathway if resource is not increased yet referrals continue to rise. Also, capital investment required to implement straight-to-test practices.
Actions and responsibility	**Request for STT feedback:** Each trust to invite clinicians/ specialist nurses to share experience of STT pilots that have either been completed, currently running or about to start and feedback to the board. Particular interest: Wigan, Tameside and Wythenshawe. **Tameside STT pilot:** Kamran Siddiqui to present update at the next meeting. **GM wide common STT protocol:** Aim is for the board to develop this protocol for all Trusts to adopt (or adopt with local modifications).

b. <u>Development of Sector Colorectal MDTs</u>

Discussion summary	SR presented the following summary regarding the proposed development of Colorectal Sector MDTs:  Sector MDTs.ppt
Conclusion	**Concerns:** • **Two–tier system** - Combined MDTs will inevitably result in a high number of patients being discussed at each MDT meeting. In order to tackle this more effective triage will be required along with ensuring all referrals are appropriate (currently MDT meetings have patients discussed that do not have cancer etc.). However, as a consequence of this it may result in a two-tier system as Trusts may choose to conduct a local MDT meeting for those patients not referred to the Sector MDT meeting. • **2 Trusts running Colorectal Services in GM** – Converting to Sector MDTs may result in Colorectal Services in GM effectively being run by just two trusts. While this may be a concern for some clinicians, currently there are no official published plans to this effect • **Reduced quality of MDT meetings** – with the inevitability of Sector MDT meetings being hosted for long periods of time due to high number of referrals it may result in compartmentalisation of the meeting as not all clinicians will be available to stay for the duration of the meeting (e.g. have pts for Radiology review at the start of meeting etc.). However, an effective MDT has ***all*** specialties available in order to ensure a robust and appropriate review. SR acknowledged all of the above concerns but highlighted that as part of the **Healthier Together initiative and formation of 4 sectors and the 4 main hub sites**, merging of MDTs and formation of the 4 sector MDTs is inevitable. This is

	also being driven by the CCGs, e.g. in the South sector (Stockport and Tameside) the CCG have decided to cease funding Colorectal cancer work at Tameside in the near future. SR stated that at the **Healthier Together Clinical Alliance meeting** arranged by Dr Jane Eddleston on the 8th December 2016, the formation of the 4 sector MDTs was discussed for the first time in a workshop format and opinions and suggestions from all 4 sector representatives (clinicians and nurses) were collated in the form of a white paper (to be published). Many board members present today had been in attendance at the Clinical Alliance meeting. It was generally agreed by all at the Clinical Alliance meeting that triaging of referrals with the help of a mandatory MDT referral proforma will be the key to keeping numbers under control and relevant to discussion. Compartmentalising an MDT (into rectal cancers, colon cancers, significant polyps etc.) may be necessary to make best use of available oncologist time. SR highlighted that each sector MDT discussions are led by a **transformation manager and a clinical lead**. It will be important for clinicians in each sector to highlight their concerns as above in a robust manner and identify additional resources that will inevitably be needed (including recruiting more personnel) before a sector MDT can be successfully established.
Actions and responsibility	• **SR to request Christie is represented at future Sector MDT Development meetings.** • **All to feedback to own trust (and their clinical lead and transformation manager for the sector) and forward any concerns to SR to be shared at the next Sector MDT Development meeting.** • **SR to continue to provide updates to the board regarding Sector MDT Development meetings.** • **Next Pathway Board meeting to focus on the development of a Sector MDT and its associated issues.**

c. **TWW Referral Form** – Naomi Mackenzie, Consultant Colorectal & General Surgeon at WWL

Discussion summary	It is a year since TWW referral forms were updated to comply with 2015 NICE guidelines. The forms have been in use for approx. 6 months. Currently reviewing the forms in order to launch revised forms in April'17. **Main concern:** Many GPs are only completing the tick boxes and not supplying other relevant information (there is a box to enable this but it is not very prominent).
Conclusion	**Suggestion:** adopt for all forms the following line asking **"the reason I am concerned this patient has cancer is....."** Board agreed for addition to be adopted on all TWW referral forms.

Actions and responsibility	**ST to feedback to the TWW Referral Group of the board's approval.**

6. **Any other business**

Discussion summary	**None stated**
Conclusion	
Actions and responsibility	

7. **Date of next meetings**

Thursday 16th March 2017
Lecture Theatre A, Pinewood Education Centre, Stepping Hill Hospital
CNS Group Meeting, 1pm – 2pm
Colorectal Pathway Board Meeting, 2pm – 4pm

Thursday 18th May 2017
Seminar Room G19, Pinewood Education Centre, Stepping Hill Hospital
CNS Group Meeting, 9.30am – 10.30am
Colorectal Clinical Sub Group Meeting, 10.30am – 12.30pm

Site map: here