Colorectal Pathway Meeting minutes
Wednesday 11th March 2015, 2 pm – 4 pm
Nightingale Lecture Theatre, UHSM

Attendance:

Sarah Duff	Clinical Director and Consultant Colorectal Surgeon, UHSM
Mohammed Sadat	Colorectal Surgeon and Trust Representative, East Cheshire
Sarah Taylor	Primary Care Representative
Carol Cunningham	Clinical Nurse Specialist and Trust Representative, Tameside
Debbie Hitchen	Clinical Nurse Specialist, CMFT
Tracey Purcell	Clinical Nurse Specialist, Colorectal and Stoma Care, CMFT
Nicola Fairclough	Clinical Nurse Specialist and Stoma Care, Wigan
Michele Dade	Clinical Nurse Specialist, Colorectal and Stoma Care, Bolton
David Bisset	Consultant Histopathologist, Bolton
Paul Harris	Colorectal Surgeon and Trust Representative, Bolton
Sue Poulson	Colorectal Nurse Specialist, Bolton
Gill Bulpin	Macmillan Nurse and Palliative Care Representative, UHSM
Debbie West	Clinical Nurse Specialist and Palliative Care Representative, UHSM
Malcolm Wilson	Colorectal Surgeon, the Christie
Scott Brown	Clinical Nurse Specialist and Deputy Trust Representative, Christie
Nicola Thibeacoult	Clinical Nurse Specialist, Mid Cheshire
Heather Hughes	Clinical Nurse Specialist, Mid Cheshire
V. Rudralingam	Consultant Radiologist, UHSM
Rubeena Razzaq	Consultant Radiologist, Bolton
Melissa Wright	Pathway Manager, Manchester Cancer

Apologies:

Michael Braun	Medical Oncologist and Research Representative, Christie
Sajal Rai	Colorectal Surgeon, Stockport
Samantha Kay	Macmillan Consultant, UHSM
Marius Paraoan	Colorectal Surgeon and Trust Representative, Wigan

Agenda Item	Action
1. Welcome and Introductions SD welcomed everyone to the meeting.	
2. Apologies Apologies were noted.	
3. Minutes of the last meeting and Matters Arising The minutes of the last meeting were approved. The matters arising would be discussed within the agenda.	
4. MC Objective 1 – Improving outcome and survival rates (a) NBOCA Report 2014 SD explained that the report published in December 2014 related to patients diagnosed within April 2012 – March 2013 which amounted to around 32,000 cases. The headline results included: • 90 day postop mortality is stable at 4.6% • 1/3 patients do not have major resection and have much poorer outcomes - these patients included those that were too frail for an operation or those with metastatic disease • 65% colon and 79% rectal cancer patients are inpatients at 5/7 postop • Increased laparoscopic resection rates for elective surgery • 5% rectal cancers have local excision • 93% rectal cancers resected have CRM -ve SD noted that there was regional variation in laparoscopic surgery, length of stay, 18 month stoma rates and 2-year survival. With regards to 90-day post-operative mortality, this was much better for patients who have a planned operation. Emergency operations have a mortality rate of 15.8% nationally, and all units within Greater Manchester were within the funnel plot for their emergency procedures but the rate of emergency admissions has remained the same for 5 years at 21%, despite greater awareness and screening. The rate of laparoscopic surgery is increasing nationally and this has increased by 5% within the region, however Greater Manchester sits as the fourth lowest performing Strategic Clinical Network (SCN) in laparoscopic uptake. SD noted that the colorectal cancer service specifications are being reviewed and these will indicate a target for this procedure of around 50%. Greater Manchester, Lancashire and South Cumbria SCN has the 2nd highest length of stay (LOS) >5 days and although the reasons for this are unclear the NBOCA report states that these are be multi-factorial and relate to comorbidities and social implications. The report indicated that the SCN performance wtih regard to LOS is unlikely to be due to variation in surgical approach. There is outlying performance for 18 month stoma rates and 2 year survival within the	

region and this has been communicated to the relevant Trusts as well as the Manchester Cancer Provider Board. For 18 month stoma rate, both the region and an individual Trust is an outlier. The Trust reviewed their data resulting in their rate falling by 11% but was still 10% higher than the national average. SD felt that the recording of correct data had to be a priority to prevent future occurrences of incorrect data being published and reflecting poorly on the region. This will require engagement of clinicians in the verification of the data.

For 2-year survival (2008 -11), the national average is 24% and the local SCN is 25.8% but there is a wide variation across Trusts within Greater Manchester with two outlying Trusts. SD contacted the Trust cancer leads regarding their data. Both Trusts are undertaking analysis of their results with actions including greater clinician involvement in the verification of their data as part of a whole scale change of management and a quality improvement programme and a re-analysis of the data with external review from the national audit team.

(b) GP education morning

SD explained that a GP education event was held on 31st January in conjunction with the hepato-pancreatic-billary and upper GI pathways. There were two sessions on screening and early diagnosis and over 80 GP's attended. There was positive feedback from the GP's as well information on what they would like for future education events which has been forwarded to Manchester Cancer. ST explained that Tom Pharoah is developing a strategy to create a standardised module approach to delivering GP education and thought it important that the education focused on the new NICE guidelines. SD asked for individuals and teams to volunteer to arrange and host the next educational event and wondered whether the Christie team would like to take the lead for this.

ACTION:

Trust leads to discuss the arrangement of next educational event and confirm with MW

5. MC Objective – Improving the patient experience

(a) Macmillan Innovation Fund and CNS Group

SD explained that the Innovation Fund bid went in late last year and would be aimed at supporting a CNS group to develop and standardise elements of the recovery package across the region. The main bulk of the funding would go towards the recruitment of a Project Worker. It had been announced this morning that the bid had been successful and the first meeting of the CNS group was held prior to the Pathway Board. Along with the recruitment of the Project Worker, the first action will be for members of the CNS group to go back to their Trusts to map their current needs and develop a one-year and three-year plan.

6. Research and clinical innovation

a. Research update

SD explained that MB has sent his apologies to today's meeting and that a trial update will be presented at the Clinical Subgroup meeting. He indicated that there were two

new trials – Hughes Abdominal Repair Trial (HART) and CRIB, which uses cardiac rehab exercise in patients post operatively.	
7. MC Objective Improving and standardising high quality care across the service (a) Laparoscopic surgery guidelines Following a review of current practice which was presented by Rebecca Fish at the last Clinical Subgroup, proposed changes in practice were recommended and these have been included in the new guidelines. Peer Review requirements require that a list of laparoscopic practitioners be included as an appendix to the guidelines. The new guidelines include: 1. Indications for laparoscopic resection 1.1 Patients offered surgical resection as treatment for colorectal cancer should be offered the option of laparoscopic resection where the following criteria apply: • BMI less than 35 • No previous multiple abdominal surgeries • Avoiding T4 cancers on pre-op staging • No signs of obstruction 1.2 Patients in whom the above criteria are not met may also be considered for laparoscopic resection but the choice of surgical approach should be considered carefully and agreed in the MDT. 1.3 All patients in whom the criteria apply should be discussed at the MDT and patients reviewed by laparoscopic surgeons to discuss the benefits of laparoscopic resection. Supporting services and governance 2.1 Units undertaking laparoscopic colorectal cancer surgery should have the facility for preoperative endoscopic tattooing to facilitate intraoperative tumour localisation 2.2 MDTs will submit the total numbers of colorectal cancer surgical resections within the unit and the number performed laparoscopically by the unit to the Pathway Board annually. 2.3 Upon request by the pathway board, MDTs will provide further details on application of the criteria where uptake of laparoscopic surgery appears low. 2.4 MDTs will submit a list of the surgeons offering laparoscopic resections for colorectal cancer in their Trusts to the pathway board (via MW) **ACTIONS:** **List of laparoscopic surgeons indicating their category to be provided to MW** **Any feedback of guidelines to be sent to SD** (b) MMR test guidelines SD explained that a further meeting with the CMFT Histopathologists, Geneticists, Radiologists and Oncologists took place on 3rd February 2015 to develop a guideline that is straightforward for histopathology. It indicates that patients <50 years MMR status will be assessed routinely. For patients >50 years, their case will be discussed at an MDT and any pathological features that suggest Lynch Syndrome with relevant family history will be referred. Other patients may be referred as well at the	**Trust Reps** **Trust Reps**

Oncologists request. The referral proforma is currently in development and diagnostics will be funded via a charge to the Trusts' pathology department from CMFT. ST thought it would be useful if the 2WW referral guidelines included questions to the GP regarding family history that would support the decision on whether to refer for an MMR test. **ACTIONS:** **Any feedback on MMR guidelines to SD**	 **Trust reps**
(c) Data review and scorecard SD explained that there has not been a significant change in the National Bowel Screening Programme uptake and positivity rates SD indicated that the latest 2WW data across the region highlighted that 2WW referrals are increasing despite cancer diagnosis rates remaining the same, this is also reflected in the national data. SD has looked at the2WW data from UHSM between April 2013 – December 2014 and there had been a 68.2% rise in referrals. SD will be auditing the 2WW referrals received by her Trust to understand whether they fall within the current NICE guidelines as well as the draft revised guidelines that are set to be published in May to anticipate demand. ST explained that she had undertaken a similar piece of work for both lung and lower GI within primary care. With regards to the 31 day target, all Trusts are performing well however the performance is still poor in meeting the 62 day target. An audit of this pathway has taken place across the region led by the Cancer Manager for Pennine and Sarah Morton will be presenting the findings at the Clinical Subgroup in May. **ACTIONS:** **SD to audit 2WW referrals from UHSM** **ST to provide outcomes of audit undertaken in primary care**	 **SD** **ST**
(d) Members responsibilities, MC briefing SD explained that Manchester Cancer had produced a briefing on the responsibilities for Pathway Board members. It identified that members of meetings should play a key role in disseminating information to their clinical teams and Trust and action should be taken when members are persistent non-attenders. SD highlighted that the colorectal Board had not nominated lead members for early diagnosis, education, endoscopy, surgery and a patient advocate. **ACTION:** **Board members to contact SD to become named lead for early diagnosis, education, endoscopy, surgery, patient advocate**	 **Board members**
8. A.O.B. RR explained that the radiology guidelines were in the process of being updated and indicated that the diagnostic pathway would now include CT colonoscopy. RR highlighted there was an issue with follow-up protocols which were varied across the region which meant that there was a tendency to over- image. A final draft will be provided at the next meeting.	

ACTION: Draft guidelines to be completed by the next Board meeting.	**VR/RR**
(e) **Date of next meetings** Thursday May 14th, Clinical Subgroup, 2-4pm, CTCCU Seminar Room Wednesday 15th July , Pathway Board, 2-4pm, Nightingale Lecture Theatre	