

Colorectal Pathway Meeting minutes
Wednesday 16th July 2014, 2 pm – 4 pm
Nightingale Lecture Theatre, UHSM

Attendance:

Sarah Duff	Clinical Director and Consultant Colorectal Surgeon, UHSM
Edwin Clark	Colorectal Surgeon and Trust Representative, Stockport
Sophie Harrison	Palliative Medicine Consultant Representative, UHSM (deputy)
Caroline Whitaker	Stoma Care Nurse
Sarah Taylor	Primary Care Representative
Debbie West	Clinical Nurse Specialist and Palliative Care Representative, UHSM
Mark Saunders	Clinical Oncologist, Christie
Michael Braun	Medical Oncologist and Research Representative, Christie
Scott Brown	Clinical Nurse Specialist and Deputy Trust Representative, Christie
Rajeev Kushwaha	Colorectal Surgeon and Trust Representative, CMFT
Usman Khan	Colorectal Surgeon and Trust Representative, East Cheshire
Caroline Bruce	Colorectal Surgeon and Trust Representative, Mid Cheshire
Billie Moores	NW QA Screening Director, NHS Screening Programmes
Melissa Wright	Pathway Manager, Manchester Cancer
Malcolm Wilson	Colorectal Surgeon and Trust Representative, Christie

Apologies:

Paul Harris	Colorectal Surgeon and Trust Representative, Bolton
Saad Salman	Colorectal Surgeon and Trust Representative, Pennine
Kamran Siddiqui	Colorectal Surgeon and Trust Representative, Tameside
Marius Paraoan	Colorectal Surgeon and Trust Representative, Wigan
Rahul Deshpande	Hepato Pancreato Biliary Representative
Lucy Davidson	Radiotherapy Pathways, Christie
Alistair Makin	Consultant Gastroenterologist and Screening Representative, CMFT
Vivek Misra	Clinical Oncologist, Christie
Amanda Ogden	Clinical Nurse Specialist and Trust Representative, Salford
Anna Davenport	Consultant Histopathologist and Trust Representative, UHSM

Agenda Item	Action
<p>1. Welcome and Introductions</p> <p>SD welcomed everyone to the meeting and each member introduced themselves.</p>	
<p>2. Apologies</p> <p>Apologies were noted.</p>	
<p>3. Minutes of the last meeting and Matters Arising</p> <p>The minutes of the last meeting were approved. There were 4 matters arising:</p> <ul style="list-style-type: none"> • RAS testing guidelines SD explained that these were brought to the Clinical Subgroup and with the support of MS and MB the guidelines were now finalised and would be circulated. • Short course radiotherapy audit/guidelines SD explained that these were discussed at the Clinical Subgroup meeting in May following an audit presentation by LD which identified the variance in time to surgery following radiotherapy across the region. Guidelines for the implementation of short course radiotherapy had been put together by LD, MB and VM. Following its implementation, there would be a re-audit to review any regional variances. MWn was concerned that the background to the guideline led to a reduction in the use of short course radiotherapy without adequate discussion and that this has been reducing but should probably be used more. SD explained that the aim of the guidance was to determine the interval between short course radiotherapy and surgery rather than to lead to a change in radiotherapy practice and indications in the region. SD agreed to discuss this further with MS/VM and clarify the current oncological indications for short course radiotherapy to be presented at the next Clinical Subgroup Meeting in September • Questionnaires SD explained that questionnaires had gone out to clinical leads on survivorship and early rectal cancer, but there had not been many responses to date. SD asked if all Trusts could return their questionnaires by the end of July so the results could be presented at the September Clinical Subgroup meeting. • Bowel Cancer Screening Project update SD identified that good progress had been made in regards to this project. The aim will be to target the 20% of people who test positive in the Bowel Screening Programme but who do not go on to have a colonoscopy. This equates to around 150 people per screening centre. The plan will be to write to GP's when a patient does not attend a colonoscopy asking them to contact their patients to encourage them to re-engage. There will also be some qualitative work around identifying what method of communication with patients is effective at getting results. This information would be useful to the national team and has not been captured previously. ST suggested that the letter should indicate the methods used by the Screening Programme to attempt to re-engage the patient as this would encourage GP's to try and make 	

<p>further contact. SD also explained that there was a meeting early next month with the Screening Programme Managers and the Lead Clinicians. If the project is successful, NHS England may want to fund additional programmes that may involve incentivising GP's to improve uptake numbers earlier on in the Pathway.</p> <p>ACTION: SD to raise the short course radiotherapy inclusion criteria for patient selection with MS/VM</p>	<p>SD</p>
<p>4. Data Review</p> <p>SD provided information on each Trust performance with regard to two week waits and explained that Q4 data for 2013-14 was now available. SD explained that all Trusts apart from Bolton were performing well in this area and that she would be contacting Bolton to understand the issues that were impacting on their performance.</p> <p>The 31 day diagnosis to first treatment data was then reviewed and this indicated that all Trusts were performing well although Wigan had a slight dip in performance in Q4. With regard to 62 day urgent GP referral to first treatment data, performance across the region was difficult to interpret. SD believed that the breaches may relate to delays in diagnosis, either due to more than one test being required or delay to MDT. MWn questioned the data as he didn't feel that the Christie had a 40% breach rate. SD explained that that could relate to a patient who started their treatment at an acute Trust and was then referred to the Christie, however MWn thought that this would have been taken into account as breaches become the responsibility of the originating Trust if the referral is made after 42 days. RK also felt that the data for his Trust didn't reflect the data he had prepared as part of the Peer Review process. SD explained that the data was from the same source as the 2WW and 31 day data, which both looked correct. UK identified that his Trust was also preparing data for the Peer Review process and the data for his Trust looked correct. SD felt that a further explanation of how this data was calculated would be required. MW explained that Manchester Cancer would be meeting with Trust Cancer Leads and could query any questions regarding data collection and data ascertainment. BM asked whether the patients who screened positive were included in the 62 day pathway. SD felt that the data related only to patients who were referred via a GP referral.</p> <p>SD then presented the screening uptake and positivity rates by Clinical Commissioning Group. SD identified that all 3 Manchester CCG's had the lowest uptake rates in the region and the highest positivity rates. Uptake rates for both England and the North West had reduced across the year. ST explained that a local enhanced service will be starting in the Autumn for the Manchester CCG's one component of which would require GP's to contact patients that do not attend their screening appointments.</p> <p>SD asked members if they had suggestions for improving screening rates. ST thought that letters sent on NHS headed papers may encourage patients to re-engage and BM felt that this would be feasible. BM explained that FIT tests will be replacing FOB tests in the North West in April which may improve uptake as it is only one test. It is currently being piloted with 1 in every 28 kits being a FIT kit.</p> <p>ACTION: MW to contact cancer leads regarding Q4 2013-14 62 day data</p>	<p>MW</p>
<p>5. Research Update</p>	

<p>MB identified that going forward there would be a focus on oncology studies. He highlighted that Focus 4 was now open registrations for this were being made via the Christie and the Adjuvant Aspirin trial was still being developed and not open for recruitment. Recruitment for Foxtrot is on track and recruitment was taking place internationally. This trial requires specific training of radiologists and this has impacted on some trusts such as Leighton, where the radiologist who had received this training has left the organisation.</p>	
<p>6. Interim 2014 NBOCAP report</p> <p>SD explained that the report will be delayed this year due to its authors not being able to access HES records. The result of this is that data in the interim report is not risk adjusted. SD identified that linked data will be published later in the year and referenced some headline data from the report:</p> <ul style="list-style-type: none"> • 90-day mortality remained stable at 4.6% • A third of patients do not have a resection and these patients have poorer outcomes • Of those who are resected, 66% of colon patients and 80% of rectal patients are still in hospital at 5 days post-operatively. Five days is the figure identified in the report as the 'ideal' number of post-operative days. • Increased laparoscopic resection rates for elective surgery • 5% of rectal cancers have a local excision – this is the same % as last year's report • 93% rectal cancers resected have CRM - ve <p>SD identified that rates of emergency admissions had not changed and the chances of a patient dying were much higher for those with an emergency presentation and highlighted that further education for both patients and primary care professionals may be required.</p> <p>Greater Manchester and Cheshire had a high proportion of patients with a length of stay longer than 5 days. SD thought that 5 day post-operative stay as an indicator of best practice may need to be challenged as it may not reflect on the quality of care received for patients who require a longer hospital stay.</p> <p>With regard to surgical access, the numbers of patients undergoing laparoscopic surgery had not increased significantly in emergency cases since 2009 however it had gone up to 61% in elective cases.</p> <p>SD felt that the final NBOCAP report, once available would need to be reviewed and presented to the Pathway Board and Clinical Subgroup with a specific focus on 90-day mortality, 2-year mortality and stoma rates.</p> <p>ST asked whether there was information on emergency admission patients who may have originally seen their GP. EC felt that few patients that presented as an emergency would have been to see their GP. SD recognised that there are decision support tools to support primary care professionals in making referrals. This was felt to be an area where further work could be undertaken regionally to investigate the patients who presented as an emergency to identify whether they had contacted their GPs or had un-investigated symptoms prior to emergency presentation.</p>	

<p>ACTION: To review findings of final report once published</p>	<p>PB/CSG</p>
<p>7. Colorectal Pathway Board annual report and annual plan</p> <p>SD explained that as part of her role as Clinical Director for the Colorectal cancer pathway, she will be required to complete an annual report, identifying the work that has taken place to date, the outcomes and progress achieved as well as meet some of the Peer Review requirements. The annual report will develop the work programme for the coming year by developing 3 – 5 objectives which would need to be aligned to the broader objectives of Manchester Cancer. SD explained that both she and MW had been working on developing these documents which would be finalised by the end of the month. Once developed they would be shared with the Pathway Board and Clinical Subgroup. The objectives planned were presented and discussed with the Pathway Board.</p> <p>ACTION: Finalised report to be sent to members of the Pathway Board and Clinical Subgroup.</p>	<p>MW</p>
<p>8. National Cancer Patient Experience Survey (NCPES) 2013</p> <p>SD highlighted some key questions from this survey which included the NCPES questions included in the cancer service profile data (questions 35-37). This data reflects on three questions including the percentage of questions scoring either red or green to indicate that they were either in the top or bottom 20% nationally. It was noted that both East Cheshire and Salford Royal had the least number of items below the national average as well as a significant number of questions scoring above the national average.</p> <p>RK felt that patients who have a lot to communicate will be more likely to respond to the survey and CMFT are proactively chasing patients to return their questionnaire. MWn identified that there may be collaborative lessons for the region i.e. the formatting of patient leaflets. It was recognised that patients were given a lot of information pre-operatively and may not remember the content of it all. SH identified that there were also questionnaires sent out to families and carers following bereavement (although this was not specific to cancer deaths) which may also offer insights to family’s experience of care.</p> <p>ACTION: To review NCPES data released in August to identify patterns and share good practice SH to send SD a copy of the bereavement survey q</p>	<p>CSG/PB SH</p>
<p>9. A.O.B.</p> <p>SD explained that she wanted to support the primary and secondary care interface in colorectal cancer and as part of this, a GP training event would be developed in conjunction with the HPB and upper GI Pathway Boards to give a comprehensive perspective to primary care professionals regarding cancer and the entire gastrointestinal tract.</p> <p>Work with primary care to improve primary/ secondary care communication was suggested as an area that could be usefully explored.</p>	

<p>10. Date of next meetings 4th September, Clinical Subgroup CTCCU Seminar Room 26th November, Pathway Board, Nightingale Lecture Theatre</p>	
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