

**Colorectal Pathway Meeting
minutes****Wednesday 26rd February, 3pm – 5pm
Seminar Room 7, ERC, UHSM**

Attendance:

Sarah Duff	Consultant Colorectal Surgeon, UHSM
Michael Braun	Consultant Medical Oncologist, Christie
Malcolm Wilson	Colorectal Lead Clinician, Christie
Saad Salman	Colorectal MDT Lead, Pennine Acute
Ramesh Aswatha	Consultant Surgeon and MDT Lead, UHSM
Laura Morrison	Colorectal Audit Manager, Christie
Lee Malcomson	Audit Manager, Christie
Zoe Coombe	Cancer Research Network Manager, Christie
Melissa Wright	Pathway Manager, Greater Manchester Cancer Services
Anne Usansky	Nurse Practitioner, Christie
Scott Brown	Colorectal Clinical Nurse Specialist, Christie
Karen Telford	Colorectal Consultant Surgeon, UHSM
Chelliah Selvasekar	Colorectal Consultant Surgeon, UHSM
Angela Jeff	Colorectal Clinical Nurse Specialist, East Cheshire
Usman Khan	Colorectal Lead Clinician, East Cheshire
Kamran Siddiqu	Colorectal Lead Clinician, Tameside

Apologies:

Paul Harris, Bolto
Caroline Bruce, Mid Cheshire
Dominic Slade, Salford
Nick Lees, Salford

Felix Mazarelo, CMFT
Edwin Clark, Stockport
Andrew Renehan, Christie

Agenda Item	Action
<p>1. Update – Manchester Cancer, Cancer Pathways, Colorectal Pathway Board</p> <p>SD welcomed everyone to the meeting. SD provided some background to the cancer pathway structure and why she wanted the lead clinicians to meet. It was explained that regionally, cancer mortality has reduced but the gap between the rest of England has not reduced. Bowel screening uptake is also lower than England average and there is later presentation.</p> <p>SD then explained the Greater Manchester and Cheshire Cancer Services structure and its relationship with the Provider Board who would act as an Executive Committee. The aim is to achieve world-class outcomes and experience for patients in Greater Manchester. It was explained that the Colorectal Pathway Board should represent the whole pathway, from primary care through to survivorship and end of life care and include a patient representative.</p> <p>SD clarified that the Pathway Board would allow clinicians and other interested parties to work together to develop and improve pathways and services, ensure all patients have access to a similar level of service, which would be detailed in a project plan.</p> <p>To ensure the work of the GMCCN Colorectal Site Specific Group was not lost and continued to allow comprehensive secondary care clinician engagement across the region, it was proposed that the Colorectal Pathway Board consist of 2 groups – a pathway board and a clinical subgroup. The 2 groups would alternate meetings, have a joint work programme and report to the Provider Board as a single entity. There would be overlap between the groups, a single trust representative from each trust would sit on the Pathway Board and up to 3 representatives for the Clinical Subgroup. A question was asked regarding commissioning. It was felt that this group will be critical to informing commissioning decisions. SD thought that data collection to map the pathway would be important to identify any gaps in provision.</p> <p>It was noted that the previous GMCCN Colorectal SSG had been more functional than other clinical specific groups which will support the development of project plans. SD requested that Lead Clinicians at the meeting nominate members for the Pathway Board in their own Trusts for SD to choose from to allow the Pathway Board to be truly multidisciplinary in its composition. The first meeting will be taking place on 19th March.</p> <p>ACTION: All Lead Clinicians to nominate a member and deputy member for the Pathway Board</p>	<p>SD/Lead Clinicians</p>
<p>2. Research Update</p> <p>ZC explained that Cancer Research Networks will no longer exist in their current form but will be merging with the Clinical Research Networks. There will be six divisions to these networks and cancer will be in the first</p>	

<p>division.</p> <p>MB discussed the Greater Manchester and Cheshire colorectal cancer research report and explained that Mid Cheshire would not be in the figures due to overlap into adjacent regions. He explained that the targets are being met and have already been exceeded for the year and the RCT component has increased through the efforts of surgeons and oncologists. MB also reported that Aristotle is up and running however Focus 4, which is a complex chemotherapy study, was yet to begin.</p>	
<p>3. Regional Audit Update</p> <p>LM went through the results of the audit into Utilisation of Adjuvant Chemotherapy in Colon Cancer. LM explained the aims and objectives of the audit which collected data from 10 MDT's from April 2013 to current date. In regards to identifying which patients to include within the audit, LM looked at the indicators and case mix to identify those considered for adjuvant chemotherapy and those who had already started. 481 patients with colon cancer have been included in the audit to date.</p> <p>A question was asked regarding outcome measures and whether these were included in the audit. LM identified that this will be looked at and data will be collected regarding this.</p> <p>A question was asked regarding surgical access techniques. LM stated that she is asking for this data but the information is not always available. SD asked if there was an easier way for trusts to contribute the data to LM for the audit. LM explained that having MDT minutes was very useful and she has links with all the MDT coordinators.</p> <p>LM then went on to talk about the outcomes of the Complete Response register which focuses on rectal cancer patients who have had long course chemotherapy. LM clarified that there were 186 patients on this register, 98 of whom were from Greater Manchester and Cheshire, the remainder from the other 3 participating regions. 127 of the 186 have had observation only, the recurrence rate appears to be 4% currently. LM indicated that there was a need to look at disease-free survival at 3 years which Lee Malcomson will be working on and will continue to follow them up. LM asked if members did have any appropriate patients, to send their details to the patient referral team</p> <p>ACTION: Lead Clinicians to forward all appropriate patients for Complete Response</p>	<p>Lead Clinicians</p>
<p>4. Regional Stoma rates</p> <p>SD explained that in March 2013, NBOCAP notified the region that 18 month stoma rates for Greater Manchester and Cheshire were 62% compared to the England average of 51%. A decision was taken to ask the individual Trusts to analyse the data sent back from NBOCAP internally. Subsequently, GMCCN contacted NBOCAP to explain the internal audit that was to take place and NBOCAP decided that this was fine as a response and the 2013</p>	

<p>NBOCAP report was published. However, the regional data required assessment and that which had been returned was presented by SD. Issues surrounding methodology were discussed. In GMCCN, there are more patients than average with high ASA, advanced tumours and comorbidity, all of which are associated with higher rates of non-closure. There were significant problems with the data with many trusts reporting inaccurate data and incomplete denominators. SD re-enforced that going forward, NBOCAP submissions need careful checking (probably already happening because of surgeon-specific outcome reporting), need to think about whether early ileostomy closure could become a regional target. (3.3.14: Subsequent return of data from one of the largest trusts shows that the number of stomas at this trust in the NBOCAP data was so incorrect that the overall effect on the regional data will have altered it significantly. Correcting for this alone moves the regional rate to 52% ie. back to the average)</p>	
<p>5. Proposed Colorectal Pathway Board work programme SD discussed some of the challenges for the pathway board which included data and how this would be provided, screening issues, two week wait data, and Trust level data to understand the picture across the region. SD was unclear of how to access data on metastasis/recurrence as this is not collected nationally, however it was recognised that HPB surgeons on MDT's could support referral routes. SD identified that the patients in the current regional audits could be monitored prospectively for development of recurrence. SD also discussed the prospect of PROMS/LARS scores which could be developed. Involvement of patients in the Pathway Board would help guide the choice of patient outcome measures</p> <p>Regional surveys of patterns of care were discussed including follow-up and survivorship services, this would give a picture of how different patient experience is in different areas. Patient directed follow-up is topical but the patient has to remain the focus of care and it was discussed that changes in follow-up should not be simply due to financial pressures.</p>	
<p>6. A.O.B There was no other business</p>	
<p>7. Dates for next meetings</p> <ul style="list-style-type: none"> • Colorectal Pathway Board – 19th March • Clinical Sub-group – 20th May 	

