

**Colorectal Pathway Board Meeting minutes
Wednesday 26th November 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
Sarah Taylor	Primary Care Representative
Amanda Ogden	Clinical Nurse Specialist and Trust Representative, Salford
Chelliah Selvasekar	Colorectal Surgeon, Christie
Debbie West	Clinical Nurse Specialist and Palliative Care Representative, UHSM
Michael Braun	Medical Oncologist and Research Representative, Christie
Scott Brown	Clinical Nurse Specialist and Deputy Trust Representative, Christie
Jennie Moore	Stoma Care Clinical Nurse Specialist
Samantha Kay	Macmillan Consultant, UHSM
Gill Bulpin	Macmillan Nurse, UHSM
Nicola Thibeacoult	Clinical Nurse Specialist, Mid Cheshire(deputy)
David Bisset	Consultant Histopathologist, Bolton (deputy)
Vicky Kenyon	Clinical Nurse Specialist and Trust Representative, Salford
Heather Hughes	Clinical Nurse Specialist, Mid Cheshire (deputy)
Mark Saunders	Clinical Oncologist, Christie
Melissa Wright	Pathway Manager, Manchester Cancer

Apologies:

Paul Harris	Colorectal Surgeon and Trust Representative, Bolton
Caroline Bruce	Colorectal Surgeon and Trust Representative, Mid Cheshire
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	Hepatopancreatbiliary Representative
Lucy Davidson	Radiotherapy Pathways, Christie
Alistair Makin	Consultant Gastroenterologist and Screening Representative, CMFT
Vivek Misra	Clinical Oncologist, Christie
Anna Davenport	Consultant Histopathologist and Trust Representative, UHSM
Billie Moores	NW QA Screening Director, NHS Screening Programmes
Usman Khan	Colorectal Surgeon and Trust Representative, East Cheshire
Aswatha Ramesh	Colorectal Surgeon and Trust Representative, UHSM

Agenda Item	Action
<p>1. Welcome SD welcomed everyone to the meeting.</p>	
<p>2. Apologies Apologies were noted.</p>	
<p>3. Minutes of the last meeting and Matters Arising</p> <p>The minutes of the last meeting were approved. SD explained that the agenda template had been revised to reflect the objectives of Manchester Cancer Provider Board. These were; improving one year survival; improving and standardising high quality care across the whole service; developing research and clinical innovation and improving the patient experience.</p> <p>There were 4 matters arising:</p> <ul style="list-style-type: none"> • Bowel cancer screening project <p>SD explained that this had commenced 2 weeks ago and the national hub based in Rugby has begun sending letters from the Hub Director to GPs of patients who have tested positive but failed to make SSP appointments. In addition, the 3 Manchester screening centres have begun sending letters out to GP's from the Screening Centre Clinical Director when their patients fail to attend an appointment. A Project Manager has been seconded one day a week from the NHS Screening Programme to run the pilot and evaluation will commence in January. SD indicated that she had met with the Hub Director, Dr Steve Smith, who expressed an interest in undertaking a wider project across the whole of the region, focussing on the earlier part of the patient pathway, but this will be dependent on the outcomes of the pilot and identifying additional resources.</p> <ul style="list-style-type: none"> • Early rectal cancer <p>SD explained that the draft updated NICE guidelines are out for consultation and will be published in December. The guidelines will indicate that for T1 rectal cancers there is little evidence for the different approaches. They will also indicate that patients should be discussed at an MDT with all different options and risks presented to the patient.</p> <ul style="list-style-type: none"> • Lap colorectal cancer survey <p>SD identified that the lap colorectal survey had taken place and there was a 40% response rate from all Trusts. Findings from the survey were reported at the Minimal Access North West surgeons meeting in October. The non-responders will be chased up and the data will be presented to the Clinical Subgroup meeting in January. The basic findings are that the indications for laparoscopic surgery have widened since the guidelines were written by the Network, therefore the guidelines will be rewritten to reflect the change in practice.</p>	

4. MC Objective – Improving the patient experience

a. National Cancer Patient Experience Survey

SD identified that this was difficult to interpret due to the varying response rates from individual Trusts. The results from East Cheshire were not included due to a response rate of less than 20 colorectal patients. Similarly the number of responses from the Christie (125) would relate to patients having colorectal related treatment, which may not include surgery. SD explained that there were nine questions identified by the Manchester Patient User Partnership (PUP) group that would be used by the Manchester Cancer Provider Board to monitor performance in this area. SD reflected that the questions were identified from a relatively small group of patients whose cancer diagnosis was unknown. SD thought it would be important for the Pathway Board to think about additional questions that may be more useful in supporting people being treated for colorectal cancer. The questions identified from the PUP group were:

- Q.12 Patient felt they were told sensitively that they had cancer
- Q.20 Patient definitely involved in decisions about care and treatment
- Q.22 Patient finds it easy to contact their CNS
- Q.25 Hospital staff gave information about support groups
- Q.27 Hospital staff gave information on getting financial help
- Q.65 Hospital and community staff always worked well together
- Q.67 Given the right amount of information about condition and treatment
- Q.69 Patient did not feel that they were treated as a `set of cancer symptoms
- Q.70 Patient`s rating of care `excellent`/ `very good

SD felt that questions that may be important to their patients were:

- Q15. Patient given a choice of different types of treatment
- Q16. Patient`s views definitely taken into account by doctors and nurses discussing treatment
- Q17. Possible side effects explained in an understandable way
- Q19. Patient definitely told about treatment side effects that could affect them in the future
- Q30. Taking part in cancer research discussed with patient
- Q53. Given clear written information about what should / should not do post discharge
- Q68. Patient offered written assessment and care plan

It was reflected that work to improve the responses to these questions could focus on standardising information to patients and could be supported through the Living with and Beyond Cancer agenda. EC reflected on questions 48 and 49 regarding privacy and the patients` diagnosis and identified that this may be difficult to improve due to how and where a person is diagnosed and the level of privacy available. AO identified that her Trust will review the questions that received poor responses and a Trust based survey of similar questions would be sent out to another group of patients to investigate performance. It was identified that this produced more positive responses as patients were clear what they were being asked. SD thought it would be important for nurses to identify particular questions from the NCPES to use in a separate patient survey, which is required by individual Trusts.

<p>b. Living with and Beyond Cancer champions and innovation fund applications.</p> <p>SD explained that LWBC was a cross cutting Pathway Board within Manchester Cancer and Wendy Makin was its Clinical Director. An educational event was held yesterday which highlighted the work taking place and its focus on survivorship and what happens to patients post discharge. The group would ideally like to have LWBC champions from each Pathway Board to ensure it is part of their working agenda. SD feels that this is already high on the agenda of this Board and has identified ST to be the lead for the group in relation to primary care related issues and ideally would like a representative from secondary care. SD didn't feel the role would require a lot of extra work, but rather would be a liaison point with the LWBC Board to highlight any issues back to this Board. MB asked whether the representative should be medical or a specialist nurse and SD felt that a CNS would be able to be more proactive in this role.</p> <p>SD explained the Innovation Fund was being financially supported by Macmillan. The fund is currently 90k but there may be potential to increase this depending on the level of applications received. Applications should focus on the implementation of the recovery package and the closing date in 31st December 2014. SD highlighted the ideas she had come up with to date which included; re-establishing the CNS group to support the sharing of good practice across areas of the recovery package and improve liaison with primary care; Developing a treatment summaries pilot and a survivorship scheme, which would support the recruitment of a project worker who would support Trusts to implement parts of the recovery package.</p> <p>From these ideas, SD felt the CNS group would be the most suitable to make an application for as the nurses were better at driving change in departments and could ultimately support each other by hosting shared events such as Health and Wellbeing days and patient events. SD suggested inviting all CNS to a meeting either before or after a Pathway Board meeting. The meetings could take place around 3 times a year and the funding could support expenses and the development of Health and Wellbeing events. ST identified that East Midlands have a pilot for a community based CNS and this might be something that the Innovation fund could support. AO thought it would be useful to understand what they did to ensure there wasn't duplication. VK explained that nurses from the hospital were being used to support satellite clinics in the community and this could be further explored. SD thought the aims of this bid would be to establish the group and to have regular meetings, for two new hospital sites to set up and run health and wellbeing clinics and for one new site to be using treatment summaries within a year.</p> <p>ACTION: Nominations for LWBC secondary care representative to be forwarded to SD SD to consult with members of the Pathway Board on Innovation Fund application prior to submission</p> <p>c. Delivery of chemotherapy locally</p> <p>SD indicated that Prof. Gordon Jayson, Chair of the Systemic Therapy Pathway Board had contacted all Pathway CDs regarding their aim of delivering 80% of suitable regimens in the community within local hospital Trusts. He is consulting with</p>	<p>Pathway Board SD</p>
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<p>individual pathways to determine whether they agreed with this aim in principle and to identify which regimens would be deemed suitable. SD highlighted that one concern would be regarding patients on trials who would need to access certain drugs that were only available via the Christie. MB indicated that certain units are currently not set up to give certain therapies, but this could be developed. He also highlighted that the more patients are able to receive therapies locally, the more challenging it will become to persuade patients back to the Christie to engage in certain clinical trials.</p> <p>MS felt that the capacity of units to deliver more chemotherapy would need to be evaluated and SD indicated that this would be part of the strategy and funding and resource would be focused locally.</p> <p>ACTION: SD to draft a reply to Prof. Jayson identifying that the Board agreed in principle but additional resource would be required to deliver safely</p>	<p>SD</p>
<p>5. Research and clinical innovation</p> <p>a. Research update</p> <p>MB identified that the figures highlighted on the front page of the previous report were wrong. The current performance for colorectal trials across the Network is good, however if things were to continue on a similar trajectory then the overall target would not be met. MB identified that Focus4 was now open to recruitment and it is anticipated that this will support the region meeting its RCT target this year, however the overall target of 20% of patients recruited will be more challenging but feels that the performance next year and in 2016 will be better.</p> <p>MS highlighted that the Aristotle trial has recently commenced and should be opening into more sites. MB highlighted that Mid Cheshire and East Cheshire were not set up to deliver the trial due to issues with pathology. SD felt that more sites should be encouraged to join the trial. MS identified that the CREATE survey had been sent out and was part of setting up the CREATE trial, this would be unlikely to be ready for at least another year.</p> <p>With regards to the Add-Aspirin trial, MB explained that there had been a meeting to discuss the development of this at the NCRI conference. The rationale for the trial relates to the data gathered from cardiac prevention studies where aspirin was given and identified this cohort also had less bowel cancer. There are also studies of bowel cancer patients who, when taking aspirin, had fewer recurrences. The colorectal study aims to recruit 2600 patients within the UK. The entry criteria will see patients initially receiving a low dose of aspirin then subsequently randomised into the 2 different doses or the placebo. The outcomes will look at the disease free survival following diagnosis. The trial will be eligible to Stage II and III colon or rectum adenocarcinoma patients as well as patients who have undergone resection of liver metastases with clear margins. Patients who have had surgery with standard neo-adjuvant/adjuvant therapy will also be eligible. Those already on aspirin would not be suitable, which may be the case for many elderly patients. MB indicated that there were concerns regarding patients' haemorrhaging but explained that the cardiovascular studies show this is a small risk and there was a similar risk for those patients within the control group. MB encouraged all sites to open this trial as it was accessible to many patients and fairly straightforward to deliver. ST asked whether</p>	

<p>GP's were being made aware of their patients taking aspirin. MB highlighted that GPs are informed by letter whenever their patients are recruited into a trial. ST felt that many GPs would not read the detail of the letter but it would be important to alert GPs in regards to patients receiving aspirin. SD felt that this could be included in their treatment summaries when these are routinely implemented as part of the recovery package</p> <p>MB also introduced the Marvel study, which was being led by the Royal Marsden Hospital, for patients receiving long course chemotherapy and radiotherapy. The study would like to receive samples from biopsies of subsequent resections and would like to look at MR scans to assess the vascular invasion. MB indicated that the study is open to additional sites.</p> <p>b. Mismatch repair testing</p> <p>MB identified the pathology guidelines had changed in regards to the minimum dataset and now includes guidelines on immunohistochemical testing for mismatch repair (MMR) mutations. It indicates that all diagnosed with colorectal cancer <50 years should be given an MMR test. It also indicates that MMR test should also be given to older patients with poorly differentiated tumours and histological features that suggest that they may have a MMR deficiency. In addition it should be given where prognosis is relevant and on request by an oncologist or a geneticist. MB explained that a working group had been set up to look at this issue and it had been agreed that CMFT would become the regional centre to undertake MMR testing to ensure quality assurance of the relatively small number of procedures. The working group also looked how the pathway would be developed. It was decided that immunohistochemistry test would be initial screening test and clinicians working within genetics would also like additional tests undertaken to identify the patients who do not have hereditary cancers. SD indicated that in 2012 there were 110 patients <50 who would have been eligible for screening and it was felt that there would be around 150 – 180 cases each year that would require testing based on the new guidelines. The group suggested that the histological factors for Lynch syndrome patients >50 years would include lymphocytic infiltrate; mucinous tumours; signet ring cancer; synchronous colorectal cancers and metachronous colorectal cancers. DB indicated that poorly differentiated cancers could also be included in the criteria.</p> <p>MB explained that the oncology cases where Lynch syndrome isn't being considered, would include patients aged 50 -70. It would relate to cases with Stage II tumours only with high risk pathological factors that would include; presence of extramural vascular invasion; T4 and poor differentiation. MB highlighted that there was a clear need to develop clinically applicable guidelines and the criteria for testing was still open for discussion. SD explained it is not clear how the testing will be funded and she would be meeting with commissioners next week to discuss further but thought that CMFT pathology department may have to recharge Trusts for the service and estimated that it would cost around £200 per Trust. SD also explained that there was a Freedom of Information request from Beating Bowel Cancer sent to all Trusts regarding the use of MMR test in certain patient groups. SD had spoken to the requestor to explain the work of the working group that would relate to all Trusts within the Manchester Cancer catchment area. SD indicated that CMFT are working on a business case at present which will include more laboratory support and training as it was acknowledged that the increased testing would double the CMFT workload.</p>	
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<p>ACTION: SD to send letter of support to CMFT to lead on testing on behalf of the Pathway Board Criteria for testing to be sent to Prof Gareth Evans for consultation</p>	<p>SD MB</p>
<p>6. Improving and standardising high quality care across the service</p> <p>a. Data review</p> <p>SD explained that bowel cancer screening uptake in the 3 City of Manchester CCG's was the worst across all the CCG's. Across the North West screening uptake is better than the minimum standard of 52% both in the Q1 2014 and cumulatively from July 2013 – June 2014 but it was less than the national average. The highest positivity rates are in the CCG's with the poorest uptake. SD explained that the across the City of Manchester CCG's, GP's have been asked to sign up to deliver a locally commissioned service. Around 95% of GP's have signed up to deliver this and it will involve GP's delivering an enhanced package of cancer related activities. This will include involvement in educational events, cancer care reviews and the promotion of bowel cancer screening. SD also reflected that there are multi-factorial reasons why patients choose to take part in bowel cancer screening and identified that the Manchester pilot of FIT kits which only require one sample, is being evaluated. The test is more sensitive than the FOB test. The pick-up rate was 8% in the pilot as opposed to 2% in the FOB test. Additionally the compliance rate was 10% higher than the FOB test. SD explained that the test may be rolled out nationally but this would probably not be until 2016. With regards to promoting awareness to the wider population, SD indicated that there are many initiatives including a further Beating Bowel Cancer campaign next year, Health Improvement Facilitators employed by Public Health departments working with practice nurses to try and promote screening and Cancer Champions who are volunteers who have had a personal experience of cancer being educated to promote cancer awareness within community settings.</p> <p>MB highlighted that there is no automatic indicator on GP systems for patients who have not taken up screening (as there is for cervical cancer). SD explained that this was due to GP's not wanting to be involved in the national screening programme when originally established and no financial incentives associated with the project. However, most GP's receive information from the Screening Programme electronically and can add alerts to their systems by appropriate coding.</p> <p>Cancer Wait performance data across all Trusts were reviewed and performance was generally good for all Trusts in regards to 2WW referrals and 31 day diagnosis to treatment.</p> <p>b. 62 day targets</p> <p>SD explained that performance across this target continues to be poor. Although some Trusts did not feel the data represented the activity that took place within their Trusts, it was noted that this data was published and agreed by Trust Cancer Managers. SD reflected that only 3 Trusts achieved the national target and at a national level this target is not being met by Trusts – only 74.1% achieved the target in Q1 (target 85%).</p>	

<p>SD met with the Cancer Manager at UHSM to review the breaches that took place within the last 6 months at the Trust. The main reasons identified for breaches were patients with a complicated pathway, as well as appointment times falling at 14 day intervals for outpatients and diagnostic tests which accumulated a significant amount of days. Patients who indicate that they are not available for appointments also reduce the amount of time to undertake diagnostic testing and pathways that differ from the norm were also included in the numbers of breaches. It was identified that each breach costs a Trust a significant amount of money. MS thought that there should be greater promotion of the amount lost to Trusts through the breaching of patients. MW explained that the breaching of the 62 day target was also on the agenda of all the Trust Directors of Operation. They have identified 5 pathways they felt were of particular concern and have agreed that a Director of Operations and a Trust Cancer Manager will take responsibility for looking in-depth across Manchester Cancer at the breaches to highlight where the issues were taking place to identify any common themes. MW also explained that a report had been commissioned to review across all Trusts and pathways the time from request to test and the time from test to diagnosis.</p> <p>ACTION: Director of Operation and Cancer Manager Lead to be identified for colorectal pathway, contact to be made from Pathway Board and our concerns shared Outcomes from the diagnosis review to be shared with Pathway Board</p> <p>c. Trust and Surgeon specific outcome data</p> <p>SD explained that surgeon outcome data was available on the Association of Coloproctology Website and NHS Choices. SD has reviewed the performance of all Trusts and feels the Trust data was more important in regards to assessing the overall performance within a team. SD highlighted there was only one Trust nationally indicated as an outlier for colorectal surgery. The data demonstrated that all Trusts within Manchester Cancer had a mortality rate of ≤5%. Data was also available at an individual surgeon level for 90 day mortality. Nationally, there were three surgeons across all surgical specialities that were not rated as within these values. SD reflected that because of the small denominators and large confidence intervals for the data a true picture of individual surgeon performance would not be useful until a surgeon is nearing the end of their career. SD thought it important that this Board looks at the data annually and reviews any concerns across the region.</p> <p>ACTION: Add Surgeon and Trust Specific Outcome Data to the dashboard of measures to be reviewed by the Colorectal Pathway annually.</p>	<p>MW</p> <p>MW</p> <p>MW</p>
<p>7. Date of next meetings Tuesday 20th January 2015, Clinical Subgroup Seminar Room 7, Education and Research Centre (note room change), UHSM, 2 pm – 4 pm Wednesday 11th March 2015, Pathway Board, Nightingale Lecture Theatre, 2 pm – 4 pm</p>	