Colorectal Subgroup Minutes
Tuesday 22nd September 2015, 2pm – 4pm
CTCCU Seminar Room, UHSM

ATTENDANCE	
Sarah Duff	Chair & Clinical Director and Consultant Colorectal Surgeon, UHSM
Tom Pharaoh	Associate Director, Manchester Cancer
Mike Braun	Medical Oncology, Christie
Edwin Clark	Colorectal Surgeon, Stockport
Dave Smith	Colorectal Surgeon, Bolton
Vanessa Denvir	Patient Rep (observer)
Hannah Leaton	Macmillan User Involvement
Malcolm Wilson	Colorectal Surgeon, Christie
Julie Williams	Colorectal CNS, Pennine
Nicola Thibbeault	Colorectal CNS, Mid Cheshire
Rubeena Razzaq	Consultant Radiologist, Bolton
Mahmoon Solkar	Colorectal Surgeon, Tameside
Vicky Kenyon	Colorectal Nurse, SRFT
Margaret Parker	Colorectal CNS, CMFT
Sue Poulson	Colorectal Nurse, Bolton
Nicola Fairclough	Colorectal CNS, Bolton
Lindsey Wilby	Macmillan LWBC Project Manager (Manchester Cancer)
Sarah Dunne	Colorectal CNS, Christie
Julie Brewer	Colorectal CNS, Christie
Angela Jeff	Colorectal CNS, East Cheshire
Scott Brown	Colorectal CNS, Christie
Carol Cunningham	Colorectal CNS, Tameside
Paula Harrison	Colorectal CNS, SRFT
APOLOGIES	
Heather Hughes	
Caroline Bruce	
Marius Paraoan	
David Donnelly	
Yvonne Chantler	
Jennifer Moore	

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 SD reminded the board about the Bowel Cancer screening campaign. The campaign dates are 24th August 2015 - 3rd April 2016. The minutes from the last meeting were agreed to be an accurate record.	
4. MC Objective 1 – Improving outcome and survival rates **a) Patient Pathway redesign** SD referred the Board to the letter sent by Monitor to all trusts throughout the country in July. The letter sets out 8 key priorities and asks each trust to assess themselves against the 8 priorities. SD confirmed that the Colorectal pathway is not achieving the 62 day target. The Christie have produced an improvement plan outlining recommendations/improvement actions that can be achieved in any pathway. The introduction and implementation of cancer validation SOP has been drafted but work is ongoing with commissioners. Diagnostics are a problem, SD asked the Board if 'straight to test' was an option? On reviewing the pathway it was felt that nothing should be changed until the waiting and turnaround times for diagnostic tests have been reviewed and a decision is made with regard to diagnostics across the region. TP confirmed that the Cancer Managers are looking at diagnostics and asked the group to forward any data intelligence gathered on any problems. TP asked the Board to make suggestions to commissioners re: pathway re-design. **ACTION: Review all trusts self-assessments against the 8 key priorities for colorectal pathway**	**SD/New Pathway Manager**

5. MC Objective 2 – Improving the patient experience	
a) Macmillan Innovation Fund and CNS Group SD informed the Board that the CNS group meeting took place prior to this meeting. The project manager is due to commence on 2/11/15 to manage the Colorectal LWBC Innovation Fund project. Laura Stephenson will be based at UHSM in cancer services. SD encouraged the group to make use of Laura and make a list of what Laura can do to help. The projects are making really good progress.	
ACTION: Trusts to identify areas for Laura to work to take forward LWBC activity.	**All**
b) Salford LWBC experience (Vicky Kenyon) VK told The Board that they are currently involved in a project developing stratified pathways and self management over at SRFT. All follow-ups are currently nurse led. It is clear that patients needs change as they move along the pathway. At SRFT all patients' details are entered onto a database and this schedules all their routine investigations for 60 months, appointment cards are automatically generated. The project streamlines patients suitable for self management. VK confirmed that self management was optional for patients, as not all patients are happy self managing. Patients involved with remote monitoring are invited to health and wellbeing events, and are able to call the CNS/Consultant with any worries or concerns. The service is working very successfully at SRFT and VK suggested organising a session at SRFT to demonstrate the database etc.	**SD/VK**

6. MC Objective 3 Research and clinical innovation **a) Research update** SD suggested the Board could arrange a meeting next year dedicated purely to research trials that they can recruit patients to. Please let SD know if this is of interest.	**ALL**
b) HiP study Mr Dale Vimalachandran presented to The Board. He and his team are going to conduct a large, multi centre, prospective observational study to assess the difference in surgical complications between Hartmann's procedure and intersphincteric APE (IAPE). The study is to commence in November, using an online database for collecting data. If any of you are interested in taking part please contact Mr Vimalachandran.	**ALL**
7. MC Objective 4 Improving and standardising high quality care across the service **a) Data review** SD informed the Board that all trusts have been achieving 2WW and that they are generally doing OK. The 31 day target is almost there. 62 day data is not well achieved.	
b) Guidelines Update SD produced a table of guidelines that require updating and asked each trust to commit to updating a guideline.	**ALL - please choose and contact SD**
• **Imaging guidelines** SD asked the Board to read the new guidelines and provide feedback. Could each trust please share the new guidelines with their radiologists to and ask for their feedback.	
• **Early Rectal Cancer Management** The draft form of these guidelines was discussed in July. They have changed slightly and set out technique, issues & concerns, post assessment, decision making & follow up protocol. The only early rectal cancer MDT providing a comprehensive service is CMFT. SD would welcome any comments on whether all cases should at be discussed at CMFT. Dave Smith and Edwin Clark raised concerns regarding preoperative MDT assessment of all polyps though to be benign, this was agreed not to be necessary. The early rectal cancer MDT would discuss management for all T1 cases that were identified as such preoperatively and also discuss histology and postoperative decision making for cases that were thought to be benign but where histology showed malignancy after excision. This would allow all T1 cases to be considered for clinical trials.	

There was broad agreement that all early rectal cancers should be discussed through a centralised MDT. Details of pathway needs to be discussed further and defined. • **Colorectal Stenting Guidelines** The most recent NICE guidance has slightly changed for stenting. The guidelines have changed and been updated to reflect this. A regional list of named practitioners is a requirement for peer review. SD asked each trust to send names of who provides out of hours stenting - colorectal surgeons, gastroenterologist & radiologists names and what arrangements are in place for urgent stenting.	**SD/Dave Smith/Edwin Clark/Jim Hill/David Donnelly** **ALL**
8. A.O.B. None	
Date of next meeting: Pathway Board Wednesday 18th November, 2015 2-4pm, Nightingale Lecture Theatre, UHSM	