Colorectal Pathway Board Meeting minutes
Wednesday 15th July 2015, 2 pm – 4 pm
Nightingale Lecture Theatre, UHSM

Attendance:

Sarah Duff	Chair & Clinical Director and Consultant Colorectal Surgeon, UHSM
Sarah Taylor	Primary Care Representative
Debbie Hitchen	Clinical Nurse Specialist, CMFT
Tracey Purcell	Clinical Nurse Specialist, Colorectal and Stoma Care, CMFT
Paul Harris	Colorectal Surgeon and Trust Representative, Bolton
Sue Poulson	Colorectal Nurse Specialist, Bolton
Debbie West	Clinical Nurse Specialist and Palliative Care Representative, UHSM
Scott Brown	Clinical Nurse Specialist and Deputy Trust Representative, Christie
Rubeena Razzaq	Consultant Radiologist, Bolton
Michael Braun	Medical Oncologist and Research Representative, Christie
Rahul Deshpande	Hepatobiliary Surgeon CMFT
David Donnelly	Colorectal Surgeon CMFT
Jennifer Moore	Stoma care Nurse UHSM & Christie
Angela Jeff	Colorectal CNS East Cheshire
Chelliah Selvasekar	Colorectal Surgeon Christie

Apologies:

Sajal Rai	Colorectal Surgeon, Stockport
Samantha Kay	Macmillan Consultant, UHSM
Marius Paraoan	Colorectal Surgeon and Trust Representative, Wigan
Mohammed Sadat	Colorectal Surgeon and Trust Representative, East Cheshire
Carol Cunningham	Clinical Nurse Specialist and Trust Representative, Tameside
Nicola Fairclough	Clinical Nurse Specialist and Stoma Care, Wigan
Michele Dade	Clinical Nurse Specialist, Colorectal and Stoma Care, Bolton
David Bisset	Consultant Histopathologist, Bolton (Now retired)
Gill Bulpin	Macmillan Nurse and Palliative Care Representative, UHSM
Malcolm Wilson	Colorectal Surgeon, Christie
Nicola Thibeacoult	Clinical Nurse Specialist, Mid Cheshire
Heather Hughes	Clinical Nurse Specialist, Mid Cheshire
V. Rudralingam	Consultant Radiologist, UHSM

In attendance:

James Leighton	Pathway Manager, Manchester Cancer
Tanya Humphreys	Macmillan user involvement lead, Manchester Cancer

Agenda Item	Action
1. Welcome and Introductions The pathway director (SD) welcomed all to the meeting. She also informed the board that Melissa Wright is leaving Manchester Cancer and taking up a new post at the Christie. On behalf of the board she thanked her for her support and wished her well in her new role.	
2. Apologies All apologies received were noted.	
3. Minutes of the last meeting and Matters Arising The minutes of the last meeting were approved. The matters not on the agenda are – a. MMR web link SD confirmed that the mismatch & repair guidelines had been finalised and were now available on the Manchester Cancer (MC) website on the link below. She confirmed that all stakeholders were informed of the guidelines and they should now apply to all clinically relevant patients. http://manchestercancer.org/wp-content/uploads/2014/09/MMR-Guidelines.pdf b. Update to short-course radiotherapy guidance SD confirmed to the board that this guidance was also now complete and is available from the MC website. http://manchestercancer.org/wp-content/uploads/2014/09/Short-course-pre-op-pathway.pdf c. Annual report and plan This was now completed and submitted to MC for adoption and is available from the MC website. http://manchestercancer.org/wp-content/uploads/2014/09/Colorectal-Cancer-Pathway-Board-Annual-Report-Annual-Plan-20152.pdf	
a. MC Objective 1 – Improving outcome and survival rates a. Bowel Screening GP re-engagement project Shenna Paynter (SP) from Public Health England attended the meeting and presented on the Bowel Screening GP reengagement project which was currently underway. She outlined the bowel screening programme pathway and the issues that are raised with patients with a positive FOB who choose not to follow up this positive test. She confirmed that approximately 20% of positive FOBs do not make it to colonoscopy and that 1 in 10 of these will have underlying bowel cancer. She then reported on a n audit undertaken in 2013 as to why patients did not progress The re-engagement project was set up to try and engage GPs to encourage these patients to follow through their screening following a positive FOB test. The process was that each GP would receive a letter from the screening programme medical	

directors informing them that their patient had not undergone colonoscopy following a positive test and explaining the potential consequences of this. Of the approximately 100 letters sent out, about 12% of patients had re-engaged. Several patients with pathology had been identified but no malignancy. She confirmed that this was proving to be a low cost means of addressing this issue but that the re-engagement rate of about 12% had been lower than expected. The screening hubs were keen to continue the project. However further work was to be undertaken to assess if it could be improved upon. The results will be fed into the ACE national project to inform further action to improve screening uptake. Following the presentation from SP the board had a wide ranging discussion on the issues raised by the project and if the board needed to do more to support increased uptake in the screening programme. The board acknowledged the importance of this project and affirmed their commitment to its success. There were no actions for the board. SP also informed the board about a Cancer Research UK bowel screening advertising campaign that was about to commence. She confirmed that it would promote the bowel screening programme it would run from August 15 until March 16. She confirmed that her office were awaiting on the output from a pilot campaign that was undertaken in London before she could inform the board of the likely impact of the campaign on diagnostic resources.	
4. MC Objective – Improving the patient experience a. <u>Macmillan innovation fund and CNS Group</u> SD now confirmed that a project manager, Laura Stephenson (LS), had been recruited for this project. It is anticipated that LS would take up this role sometime in October 15. She also confirmed that an objective on living with and beyond cancer was part of the board's annual plan with a number if phased objectives to be delivered over the next three years. One of which was the universal introduction of treatment summary plans for all patients with all trusts having introduced these or to have a plan to do so within the next year. SD went on to provide an update on a small pilot of treatment summaries in UHSM and the largely positive response from local GPS. Following a discussion on impact and implementation of the introduction she asked that all clinical teams should review current processes and develop plans for rolling out their use over the next twelve months. b. <u>User involvement</u> Tanya Humphrey (TH) Macmillan user involvement lead at MC attended the meeting to update the board on how the patient involvement team would support boards in having representation form people affected by cancer. She explained that a user involvement team had been recruited and would all be in post by August, however Michelle Leach who is the manager for user involvement for the CR board was already in post.	**All sites to review current processes and develop a plan for the use of treatment summaries.**

She confirmed that all boards would have a user representative by March 16 and that these representatives would be supported by a network of other users that are yet to be identified. She also outlined a current proposal to undertake a conurbation wide patient experience survey. Following a discussion there were no actions for the board.	
5. Research and clinical innovation a. <u>Research update</u> Michael Braun (MB) provided the board with an update on recruitment to clinical trials extracted from the NIHR platform. He reported on recruitment in GM when compared with other areas of the country. He advised the board that comparison with previous years was difficult due to changes in geographical boundaries. Part of the variation seen in comparison to other areas was caused by other areas having specific trials in specific locations and so being able to recruit large number of patients into single trials and so inflate recruitment numbers. Looking to the future he reviewed the current portfolio of clinical trials available in Greater Manchester and their potential for recruitment. SD proposed to the board that as an alternative to just having an update at a board meeting that one of the CSG meetings is devoted to research instead. She felt that this would allow for greater discussion and examination of the issues surrounding research recruitment and allow trial leads to join the meeting and help inform the group. The January CSG may be used for this purpose.	**SD to confirm if January CSG to become a research meeting**
6. MC Objective Improving and standardising high quality care across the service a. <u>Data review</u> SD presented data on screening uptake and that the uptake in GM was 53.2% (nationally 57%) and just above the 52% required to make it cost effective. She outlined that the three Manchester CCGs had a much lower uptake compared with the remaining GM CCGs. The response to this is linked to the earlier discussions of the board on screening uptake. SD presented a report on the 2 week wait time compliance over the last quarter and that all had achieved it apart from Bolton and Mid-Cheshire. However Bolton had achieved it across the whole year, like all other Trusts with the exception of Mid-Cheshire. In delivery of the 31 day target all Trusts had complied with this standard. However with regard to the 62 day target this remained an issue in the conurbation. In the quarter under report it was only achieved by Bolton and Tameside and over the year only Bolton, Tameside and Wigan achieved compliance. She noted that delivery of this standard had deteriorated from the same time period last year.	

b. New NICE referral criteria and 2 week wait audit Jane Hughes (JH), a SpR at UHSM, presented to the board an audit undertaken following the recent publication of the NICE guidance for suspected cancer referrals. The audit was to assess the potential impact for services in Greater Manchester. JH outlined that the audit reviewed the 2 week wait colorectal referrals made to UHSM in November 2014. She reviewed the patient notes and assessed compliance with the guidance at that time and then how many of the referrals would be managed differently under the wider criteria of the new guidance. The results of the audit can be seen in the embedded document below. JH confirmed that the audit, and recognising its limitations, had shown that the new recommendations would result in an ~94% increase in patients being eligible for 2 week wait referral and a significant impact on capacity for both clinic and endoscopy. SD in reviewing the recommendations noted their limitations in not helping GPs by defining the symptoms better. Sarah Taylor (ST) explained to the board the work being undertaken in developing a risk assessment tool to support GPs in conjunction with the SCN. This was progressing and it is anticipated that colorectal referrals would be first to be assessed using this tool. The board acknowledged the potential for the guidelines to increase the clinical workload and agreed to keep it under review. c. ERC guidelines SD outlined to the board the reported incidence of early rectal cancer (ERC) across the conurbation. She asserted that based on NBOCA submitted data last year there were 1827 colo-rectal cancers in GM of which one third were rectal cancer. Of these approximate 600 patients, only 5.3% of these rectal cancers would have local excision. If the staging data is over laid on this then the maximum number of T1 staged cases expected in GM per year would be somewhere between 23 -32 per year. This equates to 2-3 per Trust per year. Given such low numbers, and following the audit reported to the board last year, she proposed to the board that in future this work should be centralised and managed by a the established ERC MDT at CMFT. This would bring GM more into line with existing NICE guidance. She then outlined to the board the current service being provided at CMFT for these patients and the proposed ERC pathway. There followed an in depth discussion within the board of this proposal that examined both the rationale for and delivery of the proposal. There was also recognition of the potential impact on patients of locating the service at CMFT. SD agreed to circulate the guidelines and the proposed pathway to the board for their consideration and to share with colleagues.	**SD to circulate draft guidance and proposed pathway**
7. A.O.B.	

There was no other business.	
8. Date of next meetings Tuesday 22nd September, CSG, 2-4pm, CTCCU Wednesday 18th November, PB, 2-4pm, Nightingale Lecture Theatre, UHSM	