Manchester Cancer

Colorectal Pathway Board Meeting Minutes
Wednesday 18th November 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
David Donnelly	Colorectal Surgeon, CMFT
Sajal Rai	Colorectal Surgeon, Stockport
Salim Kurrimboccus	Colorectal Surgeon, PAHT
Julie Williams	Clinical Nurse Specialist, PAHT
Yvonne Chantler	Clinical Nurse Specialist, Wigan
Nicola Fairclough	Clinical Nurse Specialist and Stoma Care, Bolton
Nicola Thibeault	Clinical Nurse Specialist, Mid Cheshire
Heather Hughes	Clinical Nurse Specialist, Mid Cheshire
Caroline Whitaker	Stoma Nurse Specialist, UHSM
Mohammed Sadat	Colorectal Surgeon and Trust Representative, East Cheshire
Kamran Siddiqui	Colorectal Surgeon, Tameside
Mamoon Solkar	Colorectal Surgeon, Tameside
Dave Smith	Colorectal Surgeon, Bolton
Apologies:	
Rahul Deshpande	Hepatobiliary Surgeon, CMFT
Marius Paraoan	Colorectal Surgeon and Trust Representative, Wigan
Caroline Bruce	Colorectal Surgeon and Trust Representative, Mid Cheshire
Scott Brown	Clinical Nurse Specialist and Deputy Trust Representative, Christie
Gillian Bulpin	Macmillan Nurse and Palliative Care Representative, UHSM
Samantha Kay	Macmillan Consultant, UHSM
Rubeena Razzaq	Consultant Radiologist, Bolton
In attendance:	
Laura Stephenson	Living With & Beyond Colorectal Cancer Project Manager
Hannah Heaton	Macmillan User Involvement Lead, Manchester Cancer
Nicola Remmington	Pathway Manager, Manchester Cancer

Agenda Item	Action
Welcome and Introductions The pathway director (SD) welcomed all to the meeting. Laura Stephenson (LS) was introduced as the new Living With & Beyond Colorectal Cancer Project Manager and also Nicola Remmington (NR) as the new Pathway Manager at Manchester Cancer.	
Apologies All apologies received were noted.	
1. Minutes of the last meeting and Matters Arising The minutes of the last meeting were approved. The matters not on the agenda are – **a. 62 Day Target - Trusts self-assessments against the 8 key priorities** (NHS England Publications Gateway Reference: 03614) – responses received from The Christie, UHSM and Stockport. Once all responses have been received findings and identified common themes will be presented to the Pathway Board.	
2. MC Objective 1 – Improving outcome and survival rates **a. ACE2 Project** ST summarised the ACE2 Project details stating that the project is based specifically on vague symptoms and setting up Vague Symptoms Pathways. A GM bid (GM SCN, Manchester Cancer & GM Commissioning Board) was put forward and out of thirty schemes was one of the five successful bids. Details are still to be finalised and therefore funding, Project Management & data analysis etc is still to be established. ST is attending a meeting next week in London with reps from the other four successful bids to confirm as to the exact provision. Focusing on patients whom GPs are concerned about but unsure as to where to refer them. ST based the GM bid largely around a patient ST had seen: 67yr old lady, weight dropped from 52 to 45kg with no other symptoms and ST established that she could have referred this lady on seven different pathways: UGI, LGI, Lung, HPB, Urology, Gynae or Haematology. ST chose to refer the lady to LGI who then had a Colonoscopy which was normal so she was stepped down from a TWW on that basis, then had a CT scan six weeks later which showed renal cancer. ST stated that she had felt in the dark as to which pathway to choose but that Urology would probably have been the last pathway she would have referred the patient to, based on such vague symptoms. The project will be running two pilots within GM: one in Oldham which will be Radiology led and another pilot at UHSM which will be physician led. Long term ambition is to establish One-Stop Clinics for patients referred on Vague Symptoms pathway. Vague symptoms will include: weight loss, fatigue, bloating, non-iron deficient	

anaemia (possibly all anaemia) and also GP gut feeling. The expectation is for this to not increase TWW referral rates as these patients are already being referred as TWW but essentially on incorrect pathways which ultimately increases likelihood of delayed diagnosis and 62D breaches. This will be Referral Proforma based in order to ensure analysis of referral route is possible. ST will provide updates of progression at the next meeting. **b. New 2WW guidance and referrals – what to do about FOBT?** New NICE Colorectal Cancer guidelines were published in June 2015 and at the last PB meeting it had been discussed that referral rates could increase by 100% as a result. SD highlighted the guidelines shortcomings, specifically the lack of any timeframes around change in bowel habit, the lack of definition around the change of habit, the lack of definition around haemaglobin and what constitutes anaemia and what constitutes significant weight loss (refer to presentation slides for direct comparison of old and new guidelines). This change in guidance will result with a gap for patients between 50-60 yrs of age who have a change in bowel habit or have iron deficient anaemia only being referred through on FOBT testing. Because of this Prof R Steele, President of the Association of Coloproctology, and others issued a letter which was published in BMJ in Aug 2015 (refer to slide). SD has discussed this with the CCGs and is strongly advocating to not use FOBT and for there to be a single GM wide approach to this. However, some CCGs want to adhere to the NICE guidelines while other CCGs want to investigate this matter further and have a consensus across all CCGs. The evidence regarding FIT and its place as a diagnostic is not available but may be within the next year and SD queried as to whether it would be possible to have FIT in the ACE2 project which ST agreed would be potentially possible. SD has been looking at how other areas across UK have been responding to the change in guidance and found that London Cancer and London Cancer Alliance also disagree with the change and have made their own amendments (see slide). Tayside are currently investigating FIT testing and the finding that undetectable FHb (40% symptomatic population) had 100% NPV for CRC. However, not all FIT tests are the same so work is ongoing but it is highly likely that in the future a FIT test will be able to establish non-urgent referral. **GM Pathway Board position:** Group agreed to not recommend guaiac based FOBT, await NICE HTA on FIT test and those patients whom NICE recommend FOBT should be referred for investigation. Also, want to have a single TWW proforma for the whole of GM and for the tests requested to be the same. **ACTION:** SD will draft GM TWW proforma and share with group in the near future (by email). SK highlighted importance of GP education regarding appropriate TWW referrals and	**SD**

ensuring GPs complete the referral forms correctly. ST agreed and stated this information needs to be fed back to GPs – SD stated audits need to be completed after the new referral form has been issued in order to establish rate of inappropriate referrals from GPs. SM stated that at Tameside, after discussions with GPs, had completed a pilot for straight-to-test Colonoscopy during 14/15 involving 120 patients. SM offered to present findings at next Pathway Board meeting. **ACTION:** SM to present straight-to-test Colonoscopy pilot findings at next Pathway Board meeting.	**SM**
3. MC Objective – Improving the patient experience **a. <u>Macmillan innovation fund and CNS Group</u>** SD feedback from the CNS meeting held directly prior to the Pathway Board regarding implementing the Recovery Package and that all Trusts were progressing well. Macmillan Innovation Fund reports for quarter 1 and quarter 2 had been shared with the group which are required by Macmillan in order to monitor progress – currently only spent £11 of £40k budget yet progress has gone well due to a large number of meetings being held and effective communication between the team. PAHT have recently held their first Health & Wellbeing Clinic (HWC), Mid-Cheshire & UHSM regularly host HWCs, Central and Bolton are soon to host a HWC. Work on Treatment Summaries has also been going well. SD stated that now there was an even greater opportunity to develop further with the appointment of LS as the Living With & Beyond Colorectal Cancer Project Manager. LS is based at UHSM and is part-time (3 days per week). SD explained that because the CNS group is working so well they would like to extend the meeting by 30 minutes and therefore move the the Pathway Board/Clinical Subgroup meeting start time back by 30 minutes and start at 2.30pm instead of 2pm – agreed by group. **Treatment Summaries** – SD stated that in last year's Annual Report all Trusts agreed to have a plan for the introduction of Treatment Summaries by the end of 15/16 (Treatment Summaries to be issued to both the patient and the GP and a further copy saved in the patient's notes). This will be focussed on at the next CNS group meeting. SD highlighted that Treatment Summaries are well liked by both patients and GPs and there is also pressure from commissioners that all patients should be provided with a Treatment Summary and the LWABC Board are also requiring confirmation that plans are in place to implement. SD asked for the Clinicians to support their CNSs in progressing with this. ST also re-affirmed that GPs find Treatment Summaries very useful.	**All sites to review current processes and develop a plan for the use of treatment summaries.**

4. Research and clinical innovation **a. <u>Research update</u>** Michael Braun (MB) had sent his apologies but had forwarded an update (Colorectal Cancer Pathway main CSG trials report Q2 – FY2015-16) which SD will circulate to the group. SD highlighted that GM is a relatively small region (serving population of 2.9million) and our recruitment figures are only okay and potentially this is due to variation in what trials are available locally as opposed to nationally. SD stated that GM needs to improve research trial recruitment. To assist with this there will be a CSG meeting session dedicated to research in order to promote greater discussion and examination of the issues surrounding research recruitment. Chief Investigators of major national trials have been invited and attendance confirmed to help inform the group of active trials. SD invited the group to suggest items for the day. ST suggested inviting Academic Health Science Network to discuss ideas around early diagnosis (Contact: Emma Thorpe). SD confirmed she will invite to the session. **Date of Research meeting: Wednesday 20th April 2016 1.30 – 5pm**	**All to attend Research Meeting if possible** **SD invite AHSN to session**
5. MC Objective Improving and standardising high quality care across the service **a. <u>Data review</u>** SD presented a report on the 2 week wait time compliance over the last quarter and stated that all had achieved it apart from Salford but nationally England had failed to reach the target. Also, Salford has been achieving the target for the previous three quarters. 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 - for the quarter it was only achieved by Mid-Cheshire, Tameside and Wigan. Nationally only achieved 72% (target 85%). SD congratulated Tameside on being compliant for the last four quarters and invited discussion on how this was achieved. MS stated that although they only have three Consultants they ensure extra theatre lists are secured when demand requires it. SD referred back to the NHS England letter regarding the 8 Key Priorities and the Improvement Plan that Trust Cancer Managers were asked to formulate and implement in response. Specifically, regarding the work in relation to diagnostic waiting times. Once this information has been made available by the Trusts to Manchester Cancer the information will be analysed and shared. **b. <u>ERC guidelines</u>** SD stated that last month the group had discussed Imaging guidelines, Stenting guidelines and Early Rectal Cancer guidelines and the documents had been shared with the group. **Imaging guidelines**: only received feedback from Christie stating they approve the Imaging guidelines – if no further feedback received by next meeting the Imaging	

Guidelines will be adopted. **Stenting guidelines**: received information from five trusts. SD highlighted that there is an appendix to the guidelines showing what the stenting arrangements are for each Trust and showing named stenting personnel and requested for remaining Trusts to forward these details to be included. **Early Rectal Cancer guidelines**– SD stated work is ongoing and will report back after further meetings. **Non-surgical oncology guidelines**: MB to include in larger document for Oncology Treatment that is to be agreed nationally. **Guidelines for surgical emergencies and guidelines for enhanced recovery after surgery**: Being worked on by Stockport Team **Primary care referral guidelines and Colorectal Cancer Investigations protocol:** both out of date and SD stated that once the TWW work has been completed the group will be able to rewrite these guidelines. **Referral criteria for peritoneal tumours to the Peritoneal Tumour Service and Referral and management guidelines for patients with anal cancer:** The Christie team will be rewriting once the new referral guidance has been agreed and SD will invite The Christie to present at January's meeting. SD informed the group that UHSM are currently auditing the use of the **mismatch (MMR) repair guidance** and will present at January's meeting.	**Outstanding Trusts to forward stenting arrangements and named personnel to NR** **SD**
6. A.O.B. None stated.	
7. Date of next meetings **Clinical Subgroup**: Wednesday 27th January 2016, 2.30-4.30pm, Nightingale Centre Lecture Theatre, UHSM. **Pathway Board**: Wednesday 23rd March 2016, 2.30-4.30pm, Nightingale Centre Lecture Theatre, UHSM.	

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