Greater Manchester Cancer

Colorectal Pathway Board

Colorectal Pathway Board – Minutes
Wednesday 2nd November 2016, 2.30pm – 4.30pm
Nightingale Lecture Theatre, Nightingale Centre, UHSM

Attendance	**Representation**
Sarah Duff	Chair, Clinical Director and Consultant Colorectal Surgeon, UHSM
Sue Coggins	Patient Representative
Ian Buchanan	Patient Representative
Paula Harrison	Clinical Nurse Specialist, SRFT
Jonathan Epstein	Colorectal Surgeon, SRFT
Jennifer Moore	Stoma Care Specialist Nurse, UHSM
Lisa Wardlow	Colorectal Clinical Nurse Specialist, The Christie
Sarah Wemyss	Colorectal Clinical Nurse Specialist, The Christie
Claire Stelfox	Colorectal Clinical Nurse Specialist, Stockport
Jill Taylor	Colorectal Clinical Nurse Specialist, Stockport
Helen Ashby	Colorectal Clinical Nurse Specialist, UHSM
Nicola Fairclough	Colorectal Clinical Nurse Specialist, Bolton
Sajal Rai	Colorectal Surgeon, Stockport
Kalena Marti	Consultant in Medical Oncology, The Christie
Heather Hughes	Colorectal Clinical Nurse Specialist, Mid Cheshire
Emma Brown	Colorectal Clinical Nurse Specialist, CMFT
Paula Harrison	Colorectal Clinical Nurse Specialist, SRFT
Vicky Kenyon	Colorectal Clinical Nurse Specialist, SRFT
Mamoon Solkar	Consultant Colorectal Surgeon, Tameside
Naomi Mackenzie	Consultant Colorectal Surgeon, WWL
Malcolm Wilson	Consultant Colorectal Surgeon, The Christie
Rubeena Razzaq	Consultant Radiologist, Bolton
Caroline Henson	Consultant Gastroenterologist, UHSM
Tracey Purcell	Stoma Care Specialist Nurse, CMFT
Mohammed Mazen Sadat	Consultant Colorectal Surgeon, East Cheshire
Apologies	
Kathryn Place	Service Improvement Lead, WWL
Salim Kurrimboccus	Colorectal Surgeon, PAHT
Mark Saunders	Consultant Clinical Oncologist, The Christie
Marius Paraoan	Consultant Colorectal Surgeon, WWL
Caroline Bruce	Consultant Colorectal Surgeon, Mid Cheshire
Edwin Clark	Consultant Colorectal Surgeon, Stockport
David Donnelly	Consultant Colorectal Surgeon, CMFT
Lucie Francis	Macmillan User Involvement Manager, Greater Manchester Cancer
In attendance	
Nicola Remmington	Pathway Manager, Greater Manchester Cancer

Welcome, introductions and apologies

1. Minutes of last meeting

The minutes of the last meeting were reviewed and approved.

Items not on the agenda:

a. <u>The creation of Greater Manchester Cancer</u> <u>- Thomas Pharaoh, Associate Director, Greater Manchester Cancer</u>

Discussion summary	The board received a presentation from Thomas Pharaoh regarding the creation of 'Greater Manchester Cancer': TP_Colorectal_ Board 02 11 2016.pd Greater Manchester Cancer_Briefing_10 2
Conclusion	The board welcomed this development.
Actions and responsibility	**TP invited feedback from all:** **Email: Thomas.Pharaoh@nhs.net** **M: 07734 683085**

b. <u>Interim Pathway Director</u>

Discussion summary	SD informed that board that Mr Sajal Rai has agreed to act as Interim Pathway Director for 3-6 months once SD's tenure finishes in December 2016.
Conclusion	The board welcomed the appointment.
Actions and responsibility	**SR to finalise dates for 2017. NR to forward to all.** **Contact details for Mr Sajal Rai:** **Email: Sajal.Rai@stockport.nhs.uk**

c. **Appointment of Pathway Board Representative to the GM Cancer Vanguard Aftercare Pathway Project Group**

Discussion summary	SD highlighted that as yet no-one from the Pathway Board has volunteered to be the Colorectal Lead on this project despite numerous requests.
Conclusion	SD asked all to reconsider.
Actions and responsibility	**Board members to contact SD/NR should they be willing to get involved in the project.**

2. Objective no 1 – Improving outcomes / survival rates

a. **Cancer Vanguard Operational Standards work-stream – Dr Roger Prudham**

Discussion summary	Dr Roger Prudham did not attend the meeting – deferred to next PB meeting.
Conclusion	
Actions and responsibility	

b. **ACE2 Project Update (Non-Specific but concerning symptoms clinic) – Dr Sarah Taylor**

Discussion summary	ST provided the following presentation to the board: ST_Presentation_ACE2.pptx Pilot sites at UHSM & PAHT (Oldham Hospital). Concerns were raised regarding the potential for a high increase in referrals.
Conclusion	ST reassured the board that stringent monitoring of referral rates will be in place and also a similar project was conducted in London during ACE1 which found referral rates to be slow. Initial figures from the London ACE 1 project have shown success: 3 cancers from 70 referrals, therefore it is appropriate to continue with the ACE2 project.
Actions and responsibility	**ST to continue to provide updates on the project to the board.**

c. **GP Education Plan –** Dr Sarah Taylor (Cancer Vanguard Primary Care Cancer Education Platform Gateway C Project)

Discussion summary	ST summarised the Cancer Vanguard project stating that the online cancer education platform will provide education aimed at: • Enhancing public health messages • Delivering improvements in cancer recognition and referral • Supporting care during treatment • Ensuring delivery of the recovery package • Best practice for those living with and beyond cancer, including end of life care
Conclusion	Pilot lung and colorectal early diagnosis modules of primary care education platform Gateway-C with 8 practices in January 2017.
Actions and responsibility	**ST to continue to provide updates on the project to the board.**

d. **CRUK Bowel Screening Campaign – Be Clear on Cancer**

Discussion summary	SD provided details of the campaign which will run from 09/01/17 – 02/04/17 aiming to increase awareness and participation in the NHS Bowel Screening Programme (specifically, gFOBT): CRUK_announcement_letter.pdf CRUK_BCOC16_BOWEL_BRIEF_FINALv2
Conclusion	The campaign is aiming to achieve a 10% increase in uptake amongst First Timers and a 3% increase in uptake in Non-Responders. Across all 32 campaign CCGS there could be an estimated : • Additional 520 people adequately screened • Additional 15 colonoscopies following one month of advertising and direct mail activity SD highlighted that there may be a further increase in secondary care demand as awareness will potentially lead to an increase in symptomatic patients going to the GP etc.
Actions and responsibility	**All to ensure that their Trust is informed of this upcoming campaign and of the potential for an increase in referrals.**

3. Objective no2 – Improving the patient experience

a. Macmillan Innovation Fund and CNS Group Update

Discussion summary	SD provided the below summary of achievements of the Macmillan Innovation Fund: Macmillan Innovation Fund.ppt
Conclusion	Going forward we need to ensure: Trust & MDT commitment to support the CNS Group – time/attendance/recovery package promotion and development. Also need to ensure further topics of focus are developed through the CNS group e.g.: • Development of a local Patient Survey • Audit of progress against defined recovery package objectives at end of 2017/18
Actions and responsibility	**All to continue supporting the CNS group by facilitating CNS attendance from each trust.**

b. User Involvement Update

Discussion summary	Evangelie Dunn (Macmillan User Involvement Manager for Colorectal) has now left her role and therefore Lucie Francis will resume her role as the User Involvement Lead for the Colorectal Pathway Board (LF not present). IB highlighted that the UI Team are working to establish a small community of people affected by Colorectal cancer (minimum 6 people) to feed into the Colorectal Pathway Board (via SC & IB) in order to ensure a broad range of representation, including aspects of treatment involving Surgery, Chemotherapy, Radiotherapy etc.
Conclusion	All to remain aware of the available resource the UI Team is able to offer in the development of future projects.
Actions and responsibility	**All to forward details of potential members for this small community group to LF, E: Lucie.Francis@nhs.net**

c. National Cancer Patient Experience Survey (NCPES) Update

Discussion summary	Additional information was presented showing the response denominator per trust (to be included in the survey a minimum response rate of 21 had been set): • CMFT, UHSM WWL – all below 21 & therefore not included • remaining trusts excluding the Christie & PAHT all had low response rates. As Christie patients are a heterogeneous population of mainly chemotherapy/radiotherapy patients the responses may have been significantly different to other sites.
Conclusion	This highlighted that meaningful comparison by trust is not possible with the current NCPES survey results. The board agreed to proceed with the development of a local patient survey to be developed through the CNS Group.
Actions and responsibility	**CNS Group to develop local patient survey. Survey to be approved by the board before dissemination.**

4. Objective No3 – Research and clinical innovation

a. Research Update

Discussion summary	KM highlighted that the Q2 NIHR Research Trial report was no yet available due to staffing issues at the NIHR. KM presented the following update focussing upon the ADD ASPIRIN trial: PDF Research Update 02.11.16.pdf Recruitment to the ADD ASPIRIN trial across GM is very poor (only 28 patients to date yet GM should be a large recruiter as trial is aiming for 11,000 participants nationally). The board discussed lack of awareness regarding the campaign.
Conclusion	There is a need for a publicity drive across the region. Also need Principal Investigators at each trust to drive forward.
Actions and responsibility	**All to highlight trial at MDT meetings.** **KM invited all to contact her if experiencing difficulties in recruitment,** **E: kalena.marti@christie.nhs.uk**

5. Objective No4 –Improving and standardising high quality care across the whole service

a. Data review

Discussion summary	SD provided **Cancer Waiting Time** (CWT) performance data for Q2 2016/17 (at time of report Jul & Aug data only available) and a summary of the **CCG Improvement & Assessment Framework** (new framework providing initial baseline ratings for 6 clinical priority areas: https://www.nhs.uk/service-search/scorecard/results/1173): Performance & CCG I&A Framework Prese
Conclusion	**CWT**: For **TWW** performance GM has significantly fallen from 96.4% (Q1) to 93.1% (Jul & Aug16) with a total of 4 trusts failing this target (CMFT, PAHT, SRFT and Tameside). For the **31D target** GM continues to achieve this standard performing at 100% (Jul & Aug16). For the **62D target** GM performance has increased from 79.1% (Q1) to 82.1% (Jul & Aug16) however this is still below the national target of 85%. SD highlighted that falling TWW performance will inevitably lead to difficulties along the pathway potentially resulting in falling performance for the 62D target. **CCG Improvement & Assessment Framework**: SD noted that this is the first time such information has been made publically available but as the data is not tumour specific effective analysis is problematic. **Commentaries and criticism in BMJ - BMJ 2016;353:i5554**
Actions and responsibility	**None stated**

b. RAS Next Generation Sequencing (NGS) migration update

Discussion summary	SD highlighted that the new test methodology from pyrosequencing to next generation sequencing (NGS) will provide the following benefits: • Increase the number of oncogene mutations that can be detected (in KRAS & NRAS, adds BRAF and PIK3CA) • Reports may have additional information if clinically relevant • Cost remains the same • Lab turn-around time remains the same
Conclusion	The cost remains the same yet significant benefits will be encountered by moving to this methodology.
Actions and responsibility	**None stated**

c. Straight to test (STT) colonoscopy – Naomi Mackenzie, Consultant Colorectal & General Surgeon at WWL

Discussion summary	Naomi Mackenzie (NM) provided the following presentation: NM presentation.pdf
Conclusion	Very successful pilot resulting in 54% of suspected colorectal cancer referrals received during period of pilot (FY 2015/16) being triaged straight to test. Commissioners are pleased as this is saving money and improving both patient experience and CWT performance through decreased pathway times. Informal patient feedback has also been very positive.
Actions and responsibility	**Trusts to consider within their MDTs whether STT colonoscopy is possible in order to speed up their diagnostic pathways.**

6. Any other business

Discussion summary	• **NICE draft guidance on colorectal cancer testing for MMR mutations** NICE has recommended that **everyone** who is diagnosed with **colorectal cancer** should be tested for an **inherited genetic condition** called **Lynch syndrome** (LS). SD highlighted that this would result in a huge increase in testing. End of consultation 11/11/16. • **Pelvic Cancer Side Effects Event** Friday 31st March 2017, Leeds. Flyer: Pelvic Consequences Flyer.pdf • **Work Plan**: SD highlighted that maintaining progress on the agreed 5 objectives will require focus and commitment going forward: Colorectal_Pathway_Board_annual_workpl • **Thanks to Sarah Duff:** As this is the last meeting to be chaired by SD due to SD finishing her tenure as Pathway Director at the end of Dec16, MW and the board gave sincere thanks to SD for her effective leadership during her time as Pathway Director and her ever apparent dedication and hard work.
Conclusion	
Actions and responsibility	**None stated**

7. **Date of next meeting**

Thursday 12th January 2017 10.30am – 12.30pm
Seminar Room G18
Pinewood Education Centre
Stepping Hill Hospital
SK2 7JE
Site map: here