Colorectal Pathway Board – Minutes
Wednesday 23rd March 2016, 2.30 pm – 4.30 pm
Nightingale Lecture Theatre, UHSM

Attendance:

Sarah Duff	Chair & Clinical Director and Consultant Colorectal Surgeon, UHSM
Sue Coggins	Patient Representative
Ian Buchanan	Patient Representative
Yvonne Chantler	Clinical Nurse Specialist, WWL
Nicola Fairclough	Clinical Nurse Specialist, Bolton
Dave Smith	Colorectal Surgeon, Bolton
Scott Brown	Clinical Nurse Specialist and Deputy Trust Representative, The Christie
Deborah Hitchen	Clinical Nurse Specialist, CMFT
Malcolm Wilson	Colorectal Surgeon, The Christie
Zoe Holliday	Clinical Nurse Specialist, UHSM
Debbie West	Clinical Nurse Specialist, UHSM
Nicola Thibeault	Clinical Nurse Specialist, Mid Cheshire
Heather Hughes	Clinical Nurse Specialist, Mid Cheshire
Rubeena Razzaq	Consultant Radiologist , Bolton
Salim Kurrimboccus	Colorectal Surgeon, PAHT
Marius Paraoan	Colorectal Surgeon, WWL
Mike Braun	Consultant in Medical Oncology, The Christie
Laura Stephenson	Living With & Beyond Colorectal Cancer Project Manager
Lucie Francis	Macmillan User Involvement Lead, Manchester Cancer
Nicola Remmington	Pathway Manager, Manchester Cancer
Sajal Rai	Colorectal Surgeon, Stockport
Claire Arthur	Consultant Clinical Oncologist, The Christie
Usman Khan	Colorectal Surgeon, East Cheshire
Mamoon Solkar	Colorectal Surgeon, Tameside

Apologies:

Caroline Bruce	Colorectal Surgeon, Mid Cheshire
Sarah Taylor	Primary Care Representative
David Donnelly	Colorectal Surgeon, CMFT
Gill Bulpin	Palliative Care Specialist Nurse, UHSM
Samantha Kay	Consultant in Palliative Care, UHSM
Emma Brown	Clinical Nurse Specialist, Tameside
Margaret Parker	Clinical Nurse Specialist, CMFT

Agenda Item	Action
Welcome and Introductions The pathway director (SD) welcomed all to the meeting. **a. Patient Representative Introduction** Ian Buchanan (IB) was introduced as a new Patient Representative to the Board. IB is observing today's meeting in order to inform his decision as to whether to become a permanent PB member.	
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. Regional diagnostic waits survey (Trust Cancer Managers)** This regional audit was scheduled to be completed by the end of August 2015 has now been received and shows that the average time to a Colonoscopy is between 10-14 days with no Trust achieving an average of <7 days. Therefore this shows that there isn't currently the capacity within the system to accommodate trying to reduce diagnostic waiting times and has been removed from the Trust Cancer Managers Meeting Agenda. **b. 2WW Proformas** Draft version of a GM wide single referral proforma was presented at the GP Cancer Clinical Leads meeting in January and was approved pending minor amendments (eGFR <3months). Final draft will be shared once available. **c. Mismatch Repair (MMR) audit** (**Available results within presentation slides at end of doc**) As there had been some dispute regarding numbers etc. SD requested for a further audit to be conducted across all trusts in order to ensure that the pathway is effective and being adhered to by all. **Audit question:** How many cases (50yrs or under) had a resection in each Trust for the time period April – Oct 2015 and how many had MMR testing? **To date four Trusts have provided data:** East Cheshire, Mid Cheshire, Pennine and Tameside. Current results indicate that MMR testing is not consistently being requested by Pathology. **ACTION: Remaining trusts to conduct MMR audit and forward data to SD/NR by the end of April 2016.** **d. Annual Report & Plan 2015/16** NR confirmed that the report is due by the end of June 2016 and invited volunteers to contribute to its formation. SD highlighted that the objectives for the Annual Plan would need to be agreed. SD suggested that the following objectives from 14/15	**ALL**

should remain within the 15/16 annual plan:

i. To increase screening uptake to above the national average (by 2019)
ii. To improve patients experience of care in line with the National Cancer Survivorship initiative (by 2019)
iii. Enhance recruitment of colorectal patients to clinical trials (by Aug 2017).

A discussion ensued regarding the implication of the Cancer Vanguard on the workings of the Pathway Board. NR confirmed that a Cancer Vanguard representative has offered to attend the next Pathway Board meeting if desired – all agreed.

ACTION: NR to invite Cancer Vanguard representative to next PB. **NR**

SD invited suggestions for further objectives for the Annual Plan.

ACTION: All to forward potential objectives for the 2015/16 Annual Plan to SD/NR by end of May 2016. **ALL**

2. MC Objective 1 – Improving outcome and survival rates

a. Greater Manchester Cancer Vanguard

SD stated that she had attended a recent Manchester Cancer Pathway Director Forum at which a further update regarding the Cancer Vanguard was provided including a summary of the Value Proposition (previously issued to the PB).
SD presented a number of slides (**see slides at end of doc**) highlighting the following:

- Cancer Vanguard structure
- Clinical Transformation Work Programme (cross-cutting teams)
- Future work stream priorities pertinent to the Colorectal PB
  - Prevention, Screening & Early Detection
  - Diagnostic Models
  - Clinical and Operational Standards
  - Living With & Beyond Cancer

SD highlighted that regarding the LWABC element the Colorectal PB have obviously already embarked on this through the Innovation Fund Project. The Cancer Vanguard New Models of Aftercare (LWABC) programme is looking at self-management pathways currently focussing on Breast, Colorectal and Urology. SD has attended an initial meeting with Wendy Makin [LWABC Lead] and highlighted that without robust standardised IT support stratification of self-management across the region would be very difficult. SD requested for a volunteer from the PB to attend future meetings as the Colorectal PB representative.

ACTION: A member of the group to volunteer to attend the Cancer Vanguard New Models of Aftercare (LWABC) meetings as the Colorectal PB representative – contact SD/NR. **ALL**

b. ACE2 update (written summary provided by Sarah Taylor)
(**See slides at end of doc**)

ST has sent her apologies but provided a written summary to SD.
ACE2 is looking at Vague Symptom pathways and conducting a 2yr pilot.
Pilot sites:

- **UHSM** – GP referral to initial assessment by gastro-enterologist; same day CT scan if needed; gastroscopy/colonoscopy with 2-3days; results within 7 days.
  Start date: May2016
- **The Royal Oldham Hospital** – GP referral to Radiology opinion regarding initial investigation (CT/Ultrasoud); Same day scan and hot-reporting followed by gastro-enterology appointment with gastroscopy if needed.
  Start date: TBC

Project will be fully up and running by September 2016.
SD stated that financial support for this project has yet to be fully confirmed. Project Manager will be required.
London Cancer had run a similar project during ACE1 and found the referral rate from GPs to be slow. However, the results from the initial 6 months found 3 cancers from 70 referrals.

c. NBOCA 2015 (National Bowel Cancer Audit Report)
(**see slides at end of doc**)
SD highlighted that the report was published in Dec 2015 relating to patients diagnosed from April 2013 – March2014 and is therefore 18 months out of date at time of publication.
Headline results included:

- **Diagnosis (for GM)**:
  - 9.1% of Colorectal Cancer patients in GM had been diagnosed via a Screening referral
  - 20% by Emergency Admission
  - 55% by GP Referral
  - 15.9% Other/Not known

SD highlighted that the increase in **Screening** presentation was encouraging and results in better survival.
SD stated that we are about average when compared to other national networks but the rate of '**Other/Not Known**' presentation at 15.9% is worryingly high and indicates that 1 in 6 patients has missing data.
Emergency Admission rates had stayed constant for the last 5 years with 1 in 5 patients presenting through this route despite an increase in education and screening uptake.

- **Treatment Received/Mortality Rate (National):**
  - 63% Major Resection/Mortality rate of 2.9%
  - 4% Too Little cancer/Mortality rate of 0.9%
  - 11% Too much cancer/Mortality rate of 34.5%
  - 4% Too frail/Mortality rate of 29.7%
  - 17% Not Known or Other/Mortality rate of 14%

SD highlighted that the data further demonstrates the importance of early diagnosis to improve survival rates.

- **Mortality rates following surgery (National)**:
  - Elective 2.2%
  - Scheduled 2.4%
  - Urgent 10.5%

- Emergency 13.3%
- Missing urgency of operation 7.1%

SD highlighted that mortality rates following major resection have improved significantly over the last five years and post operative mortality depends on the urgency of operation. There is a wide range of mortality rates following *emergency* surgery **within GM** ranging from 0% (Christie – as expected due to having no A&E) to 29% (East Cheshire).

- **Mortality Rates following surgery (Regional): (see slides at end of doc)**

Mortality rates range from 0% (Christie) to 7.9% (Bolton) but all Trusts are within the expected range of variance with the National Average being 3.9%, therefore no Trust within GM is currently an outlier.
DS stated that Bolton Trust had conducted an audit following the publication of this data due to their performance rate of 7.9% (which had spiked from their previous performance) being the highest within the region. DS conducted the audit himself and found that within the total there were three deaths recorded post-op that were not directly related to the Colorectal surgery: two of the patients had been discharged from hospital at day 6/7, of these two, one was readmitted at Wigan and had an MI and died on day 85 and the other patient had a cardiac arithmia and died on Coronary Care. The third patient was discharged promptly following resection with a C1 histology and had one round of chemotherapy but presented at A&E, arrested and died. MS therefore highlighted that it is not appropriate to take the data at face value and context is imperative but not provided within the publication. SD agreed that there are problems with the data as readmissions within 90 days are being recorded irrespective of episode i.e. they may be admitted within hospital within the 90 days following surgery but this episode of care may be completely unrelated to the surgical episode of care (eg. A patient admitted for a removal of cataracts operation within the 90 days following colorectal surgery will be recorded as a readmission within 90 days relating to that original surgery episode).
However, SD highlighted that commissioners will be looking at this data and therefore it is imperative that this data is presented to them within context.

- **Laparoscopic Surgery (National)**:
  - Increased rates of Laparoscopic Surgery each yr
  - 48% of cases treated with complete laparoscopic resection
  - 57% are started laparoscopically
- **Laparoscopic Surgery (Regional)**:
  - 50% started laparoscopically in GM compared to 57% nationally
  - GM (grouped with Lancashire and South Cumbria) are the 4th lowest performing Network (GM was a late adopter of laparascopic surgery but has increased performance year on year)

- **Length of Stay (LOS) following Surgery (National):**
  - LOS >5 days has reduced slightly but remains high at 68.6%
- **Length of Stay (LOS) following Surgery (Regional):**
  - LOS >5 days for GM, L&SC is 76% (joint worst performing Network along with London Cancer)

SD stated that most Trusts will have a KPI [Key Performance Indicator] set by their CCG relating to LOS and the requirement for it to be <5 days. SD stated

that this is an arbitrary target and not indicative of quality of care and LOS will be highly dependent on aspects of social care provision and SD has fed this back to the CCGs. SD highlighted that Enhanced Recovery is very important and ensuring patients are fit to be discharged as early as possible is important but the target of <5days is not evidence based and therefore arbitrary.

- **Readmission Rates following surgery (National):**
  - Remains stable but high at 20.1% despite reduction in LOS performance
- **Readmission Rates following surgery (Regional):**
  - Adjusted readmission rates are very variable ranging from 8.7% (WWL) to 25.7% (UHSM)

- **2 Year Survival (National):**
  2015 audit uses patients diagnosed between 2011-12.
  - Overall, 2 year survival has been stable since 09/10 at 67%
  - Major Resection improved to 82% (09/10 - 80%)
  - Local excision – 90%
  - No excision – 36%
- **2 Year Survival (Regional):**
  - Adjusted 2yr mortality region average is 22% (same as National). All Trusts are within the expected range of variance (previously two trusts had been outliers but have improved their position).

- **NBOCA CONCERNS:**
  - Incomplete and/or inaccurate data

SD presented data highlighting inaccurate and incomplete recording of data in relation to Rectal Cancer Management (**see slides at end of doc**). SD highlighted that at individual trust level, this can make trusts appear poor achievers or excellent achievers depending on how the data is interpreted, nationally it contributes to the Network appearing to perform poorly or inconsistently compared to other Networks and Regionally it provides (inaccurate) data that will be used to support the direction of the commissioning of services. MW stated that this will also guide focus and direction for the Cancer Vanguard programme.

SD stated that it is imperative that Trusts focus on ensuring both data accuracy and data completeness in order to accurately present performance to the public and also to effectively guide commissioners. Trusts need to acknowledge the importance of National Audits and embed robust recording systems appropriately.

ACTION: All to feedback to their Trusts the importance of effective, accurate and sustainable recording of performance data. **ALL**

MP raised concerns regarding the quality of pathology reports and data included in such reports and SD stated that all should be reporting to the nationally agreed pathology reporting guidelines including the RCP minimum dataset for colorectal cancer.

ACTION: SD to send MP the National Pathology Guidelines. **SD**

d. Individual surgeon specific outcomes **(see slides at end of doc)** All GM surgeons are within the expected range of variance for elective operations.	
3. Objective No 2 – Improving the patient experience **a. Macmillan Innovation Fund and CNS Group** LS fed back from the CNS meeting held directly prior to the Clinical Sub Group meeting regarding implementing the Recovery Package. A second focus topic session was conducted on **Holistic Needs Assessments** (HNAs) and **Care Plans** (previous session had covered **Treatment Summaries)**, summary doc:  Focus_Topic_-_Holistic_Needs_Assessmen LS highlighted that the CNS group are also now able to communicate outside of meetings through a social network forum set up via NHS Networks. SD highlighted that the funding for the project will finish in November 2016 and reporting on achievements will take place within October 2016 (with presentation). Progression is going well to date with a large number of Trusts completing Health & Wellbeing Events and rolling out Treatment Summary implementation. SD highlighted that this progression has been due to a great deal of enthusiasm from the CNSs but in order to embed change the whole MDT need to be on board. **ACTION: All Trusts to continue to support the implementation of the Recovery Package.**	**ALL**
b. Late Effects Pathway SD stated that late effects of Colorectal Cancer treatment are currently under recognised and under treated and many studies have highlighted that there is significant unmet need. SD presented details of the work conducted by Dr Jervoise Andreyev at the Royal Marsden NHS Foundation Trust relating to late effects following radiotherapy treatment and surgical treatment for bowel cancer. SD summarised the set of Algorithms proposed by Dr Jervoise Andreyev for management of investigation and treatment of symptoms designed for the CNS and Gastroenterologist to work together (**see slides at end of doc**). SD stated that there is a booklet available describing these algorithms which are excellent but generic and SD proposed the following: • **Set up a working group** to review the available algorithms, assess viability and then produce an agreed set of algorithms to be used within the Network. Work Group to contain: Gastroenterologists, CNSs, Surgeons, Oncologists and patient reps and representation from the Urology & Gynae pathways. MW agreed with the proposal but highlighted that caution may be required as this could lead to a considerable increase in Follow up referrals for which the resource is currently unavailable. SD stated that this would not necessarily be the case if an effective self–management system was in place whereby patients have documentation available on late effects directing them to CNSs as their first point of	

contact, treated as per the algorithm and then discharged back to self-management. SC highlighted that generally when a patient presents with symptoms they would be treated but this cohort of patients presenting with late effects post cancer treatment are currently being overlooked and this needs to be rectified. MW agreed with the requirement but further highlighted that to effectively manage these patients significantly more resource would be required. SC concurred and stated that this also heavily relies upon having accurate and robust data relating to the numbers in order to demonstrate to commissioners of the requirement. SK queried as to whether Surgeons are the best placed to treat these patients to which MW replied that Surgeons would be the best gatekeepers as it would be imperative to ascertain as to whether it is late effects or secondary tumour/recurrence but once that has been established they should then be directed appropriately, e.g. to a Gastroenterologist.	
ACTION: Anyone interested in becoming a member of the Late Effects Algorithm Workgroup to contact Laura Stephenson: **email: laura.stephenson@uhsm.nhs.uk**	**ALL**
Claire Arthur recommended Lucy Davidson to be contacted [Colorectal Specialist Radiographer at The Christie] – NR to contact.	**NR**
c. User Involvement update: LF summarised the Manchester Cancer User Involvement Q2 Report (circulated with agenda). Further developments have included reaching their objective to recruit 100 people affected by Cancer by March 2016 which has now been achieved. A further objective was to have a person affected by cancer on each Pathway Board which has also now been achieved. LF stated that they 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 should he choose to be a standing member) in order to ensure a broad range of representation, including aspects of treatment involving Surgery, Chemotherapy, Radiotherapy etc. LF requested all to forward details of potential members for this group to her [email: Lucie.Francis@nhs.net] LF asked the Board to be aware of the resource now available and that their input into future projects can be very meaningful due to their wealth of knowledge. LF also highlighted that it was imperative to keep those recruited engaged by allocating them to such projects. LF stated the aim was to have this established prior to the next Pathway Board in June 2016.	
ACTION: All to forward details of any potential User Involvement representatives to feed into the small community of people affected by cancer supporting the Colorectal Pathway Board.	**ALL**
4. Objective No 3 - Research and clinical innovation	
a. <u>Research update</u> Michael Braun (MB) discussed the Colorectal Cancer Pathway main CSG trials report Q3 – FY2015-16 (circulated with agenda):	

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MB summarised the report stating that GM are currently ranked in 8th place for recruitment to trials (15 Networks). MB highlighted the performance by Trust stating that there is a wide variation in performance ranging from 97 patients recruited by The Christie through to 1 patient recruited by both East Cheshire & Bolton, however all sites are contributing. MB also highlighted that CMFT always perform well due to partaking in an Observational genetics study (CORGI – which constitutes their full trials recruitment). Pennine have also been successful in recruiting high numbers (53 patients) and these three high performing Trusts have enabled the GM position to remain approximately within mid range performance of all Networks. MB stated that other Networks are effectively recruiting to the **100k Genomes Study** and GM needs to replicate this in order to maintain and hopefully improve our ranking nationally for recruitment to trials. MB is meeting with a representative from the 100k Genomes study [Jane.Rogan, Business Manager - Manchester Cancer Research Centre Biobank, http://www.mcrc.manchester.ac.uk/biobank Jane has offered to present at the next pathway Board meeting in June 2016].
MB referred to the last two pages issued with the Trials report which are a new addition to the report, referring specifically to the following excerpt:

Recruitment by LCRN (normalised per 100,000 population)

LCRN	Sub-Specialty Recruitment - Colorectal	Ranking
East Midlands	57.93	10
Eastern	80.78	7
Greater Manchester	113.74	1
Kent, Surrey & Susse	45.48	15
North East & North C	70.67	9
North Thames	55.71	13
North West Coast	49.48	14
North West London	81.1	6
South London	56.84	11
South West Pennins	85.66	4
Thames Valley & SM	94.26	3
Wessex	111.91	2
West Midlands	77.4	8
West of England	84.55	5
Yorkshire & Humber	56.84	12

MB had sought clarification from NCRN as this positions GM as the highest recruiter when normalised per 100,000 population. MB's contact at NCRN stated that this addition to the report had been sourced outside the usual channels and therefore

himself queried the recruitment rate reading of 113.74 per 100,000 population which would put GM top 1st place stating that this could be due to: a). different National population stats or b). the time when the data was cut that the creator of this table report used, but is ultimately unsure as to how they arrived at their outputs. MB's contact stated that according to their National population stats based on FY 2015/16 Greater Manchester Network (Source: ONS) = 2.943,521 population then output for GM is 250 recruitment for Q1-3 and is 8.5 recruitment per 100,000 normalised and puts GM in a very respectable ranking of 5th National (England). MB's contact provided the following doc:

ODP_Recruitment_per_100000_L...Popul

MB summarised that we are unsure of our exact ranking position for this but ultimately GM is performing well.
MB highlighted the importance to continue to endeavour to recruit to trials.

b. Date of Research meeting:

Wednesday 20th April 2016 1.30 – 5pm
Lecture Theatre 2
Education & Research Centre
UHSM

SD discussed those secured to present (stated within flyer):

Research Flyer_CPD.pdf

SD confirmed that **3 CPD points** have been assigned to the event and strongly encouraged all to attend.

ACTION: All to attend Research meeting if possible and to invite appropriate colleagues. — **ALL**

5. Objective No 4 - Improving and standardising high quality care across the whole service

a. <u>Data review</u>

2WW: SD presented a report on the 2 Week Wait (2WW) target compliance for Quarter 3. SD stated that all Trusts had achieved or exceeded the national target of 93% with the exception of Pennine and UHSM who both were just slightly below target. Greater Manchester as a whole had attained the target comfortably at 95.2% (England: 93.5%). Also, Salford has recovered their position after a fall in performance during Q2 and were now back within target. SD noted that the number of 2WW referrals continues to rise quarter on quarter (Q3: 4428 for GM).

31 Day Target: In delivery of the 31 day target all Trusts had achieved or exceeded the national target of 96% with the exception of CMFT and WWL. Greater Manchester as a whole have attained the target comfortably at 98.4% (England:

97.9%), however, performance has dipped slightly from the previous quarter as all Trusts had previously attained this target in Q2 (GM performance for Q2: 99.53%).

62 Day Target: SD highlighted that GM had attained this target (national target: 85%) for the first time during 15/16 as both previous quarters GM had failed to attain this target. GM performed at 86.9% whereas nationally this target was not achieved with performance at 75.2% for England. Only three trusts remain below target (CMFT, The Christie and WWL) whereas during Q2 only three Trusts had managed to attain this target so there has been a significant improvement in performance within GM in order to be able to achieve this target and hopefully performance will be sustainable going forward.

b. Guidelines update:

i. Peritoneal Tumour Service guidelines/Omer Aziz:
SD stated that OA had provided a summarised version of the guidelines, including the referral form:

PTS_CPOC_Guidelines_for_referral_Incl_R

SD stated that this should help improve the quality of referral information being sent to the Christie.

ACTION: NR to upload onto MC website. **NR**

c. Resources for Coloproctology 2015
(Document issued with agenda) SD stated that this is a useful document particularly with regards to highlighting what will be needed for a good quality service in light of future service reconfiguration.
(**For highlighted interesting points please see slides at end of doc**)

6. Any other business

Late Effects Survey: NR stated that there had been a good response from the CNSs completing the Late Effects Survey issued by the LWABC Pathway Board. The LWABC PB have since requested for an amalgamated single response and also requested that this is approved by the Colorectal PB prior to sending. NR has the final document and will forward to all to approve.

ACTION: NR to forward final LWABC Late Effects survey response for all to approve. **NR/ALL**

7. Date of next meetings:

Clinical Research Update in Colorectal Disease: Wednesday 20th April 2016, 1.30pm-5pm, Lecture Theatre 2, Education & Research Centre, UHSM (in place of CSG Meeting).

Pathway Board: Wednesday 29th June 2016, 2.30-4.30pm, Nightingale Centre Lecture

Theatre, UHSM.	

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