Colorectal Subgroup minutes
Thursday 14th May 2015, 2 pm – 4 pm
CTCCU Seminar Room, UHSM

Attendance:

Sarah Duff	Clinical Director and Consultant Colorectal Surgeon, UHSM
Angela Jeff	Colorectal CNS East Cheshire
David Donnelly	Colorectal Surgeon CMFT
Debbie Hitchen	Clinical Nurse Specialist, CMFT
Nicola Fairclough	Clinical Nurse Specialist and Stoma Care, Bolton
David Bisset	Consultant Histopathologist, Bolton
Paul Harris	Colorectal Surgeon, Bolton
Sajal Rai	Colorectal Surgeon, Stockport
Edwin Clark	Colorectal Surgeon, Stockport
Debbie West	Clinical Nurse Specialist and Palliative Care Representative, UHSM
Aswatha Ramesh	Colorectal Surgeon, UHSM
V. Rudralingam	Consultant Radiologist, UHSM
Caroline Bruce	Consultant Surgeon, Mid Cheshire
Rubeena Razzaq	Consultant Radiologist, Bolton
Lucy Davidson	Specialist Radiographer, Christie
Christine Bellis	Cancer Services Manager, Pennine
Melissa Wright	Pathway Manager, Manchester Cancer

Apologies:

Malcolm Wilson	Colorectal Surgeon, the Christie
Scott Brown	Clinical Nurse Specialist and Deputy Trust Representative, Christie
Michael Braun	Medical Oncologist and Research Representative, Christie
Simon Ward	Colorectal Surgeon, East Cheshire

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 The minutes of the last meeting were approved. SD explained that the laparoscopic guidelines had been circulated and no comments had been received. SD also highlighted that UHSM are conducting an audit of their 2WW for colorectal cancer and indicated that referrals may potentially increase by 70% once the new NICE guidance for suspected cancer are introduced. SD explained that radiology guidelines are in the progress of being updated and that there had been no response to the request for named leads required to fulfil the terms of reference for the Pathway Board.	
4. MC Objective 1 – Improving outcome and survival rates (a) Updated colorectal liver metastases guidelines SD discussed the above guidelines and explained the principles of the guidelines which would include referral via an electronic proforma. CMFT will be the site of the specialised HBP MDT and each colorectal MDT will have a named member of the HPB MDT as part of the extended MDT. SD indicated that the follow-up procedures are detailed in the HPB guidelines and these will be circulated to the Board for feedback. A**CTION: Circulate liver metastases guidelines for comments**	**SD/MW**
5. MC Objective 2 – Improving the patient experience (a) Macmillan Innovation Fund and CNS Group SD reported that work is progressing with the CNS group which is supported by the Innovation Fund to develop activities related to the recovery package within their Trusts. There will be a focus on developing 1 and 3 year objectives for living with and beyond cancer (LWBC) and SD strongly encouraged Trusts to support their CNS' in doing this as it is anticipated that this will become a commissioning requirement for cancer services. SD explained that there is also funding for a Project Manager to support this work and a job advert will be going out in the next few weeks. SD indicated that the LWBC Pathway Board had identified proposed objectives that each Pathway Board should aim to sign up to. These included planning for end of treatment summaries following the end of primary treatment and evidence of recovery package provision. SD explained that the LWBC Board will be conducting an audit of patient experience after cancer and will be identifying the main consequences of treatment issues related to tumour pathways. EC thought that treatment summaries might be useful for difficult cases that are referred to many Trusts. SD asked whether interim summaries should be offered for patients going through extensive treatment to fit in with GP's 6-monthly cancer care reviews. It was felt that an initial ambition setting a target for treatment summaries for certain	

patient groups with the development of interim treatment summaries once this has been established. **ACTION: LWBC targets to be included in Colorectal Cancer Annual Plan.**	**MW/SD**
6. MC Objective 3 Research and clinical innovation a. Research update SD updated the Board regarding trials that are currently up and running. ADD ASPIRIN is about to start. This trial is for patients who have had curative resections who will be treated with aspirin for 5 years to see if this has an impact on recurrence of polyps and cancers. FOCUS 4 is recruiting at the Christie for metastatic colorectal patients and FOXTROT has already recruited 800 patients and is looking to recruit a further 300 to the total of 1100. MARVEL is a study involving MRI for patients undertaking long course radiotherapy. SD also noted that there is a study in development by D Vimalachandran, which is not yet adopted. This is a Hartmann's versus intersphincteric APE (HIP) and will be a multicentre observational study to determine rates and use of complications.	
7. MC Objective 4 Improving and standardising high quality care across the service (a) Data review SD explained that the most recent screening uptake data continued to highlight the City of Manchester CCG's performing significantly below the national and North West average. SD also reviewed the most recent staging data (2012) by CCG which identified that in general all CCG's are diagnosing patients at the same stage point with a large number of patients being diagnosed at stage four. (b) Time to short course radiotherapy audit LD presented a follow-up to the short course radiotherapy (SCPRT) audit conducted last year. LD explained that the aim of SCPRT is to reduce the risk of local recurrence. It is recommended that surgery is performed on the following week before the onset of acute side effects of radiotherapy. Following the audit last year, the clinical guidelines were amended to indicate that surgery should take place within 12 days from the start of SCPRT ie. the week following radiotherapy. LD had conducted an audit post the revised guidelines within the same time period as the initial audit. In indicated that 25 patients had undertaken SCPRT which was a 58% decrease from the initial audit and there had been an increase in patients referred for long course radiotherapy. There was no difference in age groups apart from an increase in patients within the 66-70 age range. At an individual hospital level, Pennine had the widest range of days from SCPRT to surgery. Following the change in the guidelines, there had been an improvement in patients having SCPRT within 12 days but only to 60% and LD asked whether this should be an agreed standard rather than a guideline for patients receiving this treatment. SD thought that the SCPRT treatment days should be agreed once a surgery date has been established. LD explained that this had been attempted by the radiotherapy team previously, but a lot of time was spent chasing Trusts for this information. It was suggested that the proposed date of surgery should be included in the referral to the radiotherapy team giving 4-5 weeks' notice, so all of the patients treatments could be organised appropriately.	

(c) Regional 62 day audit

CB explained that an audit across five cancer pathways had taken place. Pennine led the audit for colorectal cancer and 15 breached pathways across the region were picked at random and benchmarked against agreed pathway timelines. The analysis identified that all patients suspected of having cancers had their history and clinical examination and assessment within 14 days and a colonoscopy or OGD between the 14th and 21st day of the pathway. The OPD and decision to treat took place within the 48th to 70th day of the pathway and treatment took place between the 70th and 120th day of the pathway. CB then presented the audit recommendations which included offering patients their first appointment within seven days. It was also recommended that the MDT should take place within 7 days of the results and OPD to take place within 7 days of the MDT. CB explained that subsequent to the results of the audit, a new cancer access policy had been developed and was awaiting agreement by commissioners.

EC thought that if diagnoses of results were required within 7 days, time should be allocated within job plans to reflect this. VR explained that radiology departments are struggling with the current workload and that cases are getting more complex. CB explained that she will be undertaking an audit of the pathway at Pennine and will communicate the results to the Board.

(d) Annual report and plan

SD explained that Pathway Board will be required to produce an annual report and plan by July and presented the objectives that were agreed last year which were:

1. To increase screening uptake to above the national average
2. Improve patients experience of care in line with the NCSI
3. Enhance recruitment of patients to clinical trials
4. To update network guidelines
5. Monitor, measure and assess colorectal cancer services across the region

SD explained that most of the actions of in relation to these objectives had taken place within the year and suggested that the plan for the next year should include a screening objective which could be less ambitious but reflect current activities undertaken by the Board to improve screening uptake. There will also be objectives to; improve patient's experience of care linked to the LWBC initiatives; enhance recruitment of trials; data monitoring and update network guidelines. SD explained that she would be circulating the list of guidelines that require updating and would like support in doing this. SD asked the Board to contact her with additional objectives they would like to include.

(e) Peer Review and trust reports

SD explained that Manchester Cancer have produced a briefing to support Peer Review at both the network and Trust level and indicated that clinical trial reports will be produced for each Trusts by the Clinical Research Network Manager.

(f) MMR guidelines

SD highlighted that she had not received any comments regarding this guideline and indicated that the MRI are happy to take referrals and the cost of MMR test would be £200 which the MRI will invoice Trusts for. **ACTION:** **SCPRT to be amended to reflect discussion** **List of guidelines requiring an update to be disseminated** **Updated MMR guidelines to be circulated**	 **LD/MS** **SD** **SD/MW**
8. A.O.B. SD presented a flyer on a Pelvic Cancer education event which will be taking place at the Christie on 24th June.	
(g) **Date of next meetings** Wednesday 15th July , Pathway Board, 2-4pm, Nightingale Lecture Theatre Tuesday 22nd September, CSG, 2-4 pm CTCCU	