

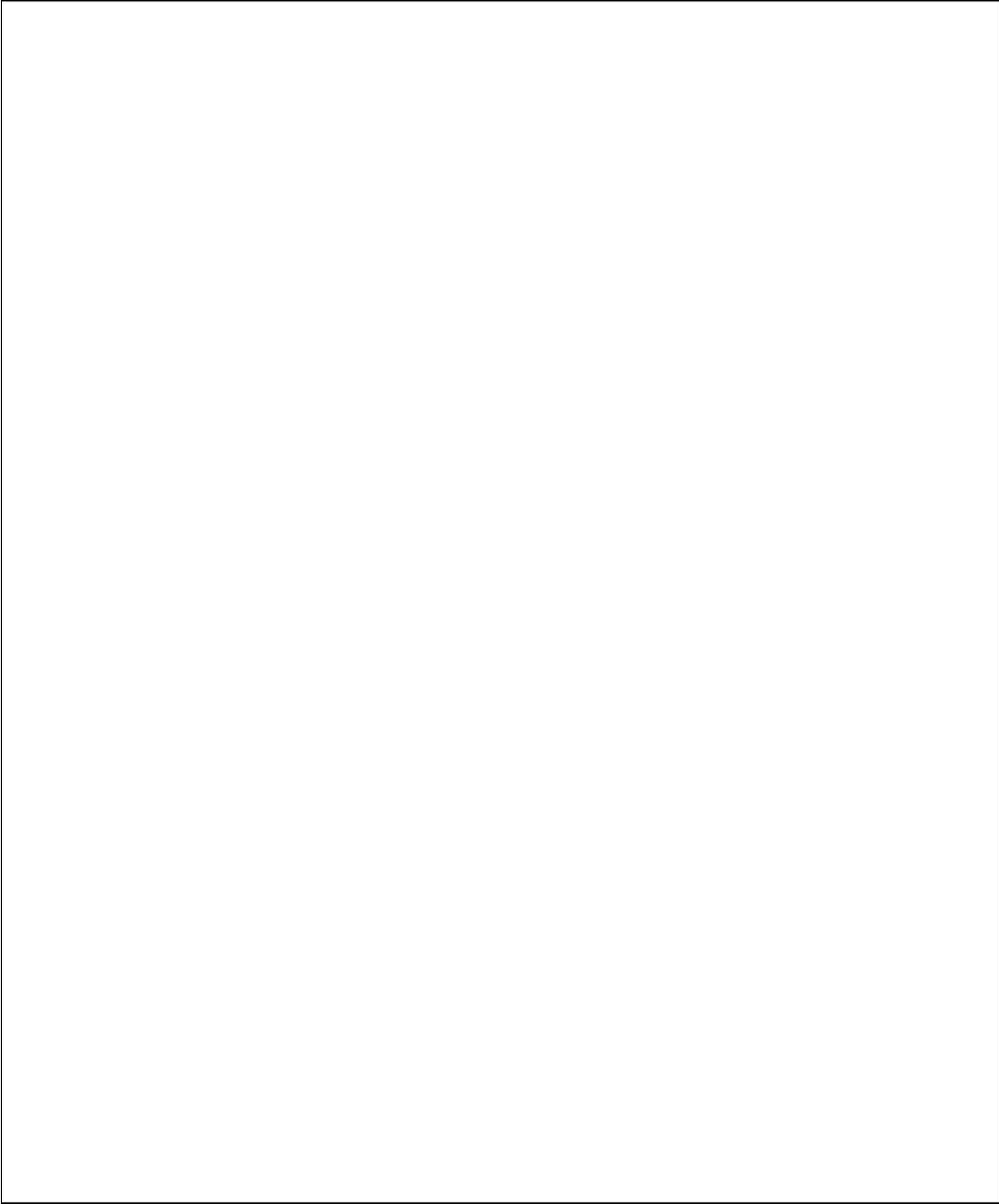
**Colorectal Cancer Pathway Clinical Subgroup
Tuesday 20th May 2014 2 pm – 4 pm
CTCCU Seminar Room – UHSM**

Attendance

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| Sarah Duff | Consultant Colorectal Surgeon, UHSM |
| Michael Braun | Consultant Medical Oncologist, The Christie |
| David Bisset | Consultant Histopathologist, Bolton |
| Paul Harris | Consultant Colorectal Surgeon, Bolton |
| Mohammed Sadat | Consultant Colorectal Surgeon |
| Deborah Hitchen | Colorectal CNS, CMFT |
| Angela Jeff | Colorectal CNS, East Cheshire |
| Velauthan Rudralingam | Consultant Radiologist, UHSM |
| Peter Byrne | Consultant Colorectal Surgeon, Pennine |
| Malcolm Wilson | Consultant Colorectal Surgeon, The Christie |
| Lee Malcomson | Complete Response Research Associate |
| Julie Jones | Colorectal Stoma Care Nurse, East Cheshire |

Apologies

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| Rai Sajal | Consultant Colorectal Surgeon, Stockport |
| Vivek Misra | Clinical Oncologist, The Christie |
| Dominic Slade | Consultant Colorectal Surgeon, Salford |
| Anna Davenport | Consultant Histopathologist, UHSM |
| Caroline Bruce | Consultant Colorectal Surgeon, Mid Cheshire |
| Scott Brown | Colorectal CNS, The Christie |
| Lucy Davidson | Specialist Radiographer, The Christie |
| Mark Saunders | Clinical Oncologist, The Christie |
| Chelliah Selvasekar | Consultant Colorectal Surgeon, The Christie |
| Rubeena Razzaq | Consultant Radiologist, Bolton |
| Heather Hughes | Macmillan Colorectal CNS, Mid Cheshire |
| Kate Downing | Colorectal CNS, Mid Cheshire |
| Amanda Ogden | Colorectal CNS, Salford |
| Edwin Clark | Consultant Colorectal Surgeon, Stepping Hill |



| Agenda Item | Action |
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| <p>1. Apologies were noted</p> | |
| <p>2. The minutes of the previous Pathway Board meeting were reviewed and the minutes of the previous Clinical Subgroup agreed.</p> | |
| <p>3. Matters arising – BCSP pilot update</p> <p>SD provided an update to the bowel cancer screening project discussed at the last Pathway Board. Alistair Makin had presented data and highlighted the poor uptake in screening rates in some within Greater Manchester. To better understand these issues SD and MW met with representatives from NHS England, who were keen to undertake a joint piece of work and engage primary care.</p> <p>SD explained that the focus on the proposed pilot project will be patients who screen positive on faecal occult blood testing, but who do not present for their colonoscopy. The plan is to financially incentivise their GP's to encourage them to re-engage with the bowel cancer screening programme and complete their colonoscopy. Based on figures from last year, this may involve around 400 patients in the pilot.</p> | |
| <p>4. Peer Review Update – Manchester Cancer Briefing Series</p> <p>SD explained that Manchester Cancer have begun to produce a series of briefing documents to support and guide Pathway Directors in their roles. The Peer Review briefing clarified the role of Pathway Boards in supporting the network peer review process. In particular SD referenced point 13 on the briefing in regards to the management of up-to-date clinical guidelines. SD clarified that she had been in contact with members of both the Clinical Subgroup and Pathway Board to support with the updating of these guidelines.</p> | |
| <p>5. Pathway guideline: RAS testing</p> <p>MB presented the reviewed RAS testing clinical guidelines. Patients with a RAS gene mutation are unlikely to benefit from EGFR targeted chemotherapies. MB highlighted the main changes in this policy review were the source of funding for RAS testing will now be via the Cancer Drugs Fund not from the drug company, and that only stage 4 patients would be tested. MB highlighted that the guidelines were not intended to be too prescriptive within the MDT and that the Oncologist interpreting the RAS status would be the lead for testing.</p> <p>MB explained that at MRI they identify the best block for testing on histopathology reports and this could be something that units could consider. It was highlighted that a Cancer Drugs Fund number is required before processing a request</p> <p>ACTION: The RAS testing guidelines were accepted by the CSG. MB and MS to discuss how to access CDF numbers. MB to make minor amendment to guidelines when this is clarified.</p> | <p>MB/MS MB</p> |
| <p>6. Research Update</p> <p>MB gave an update on research performance and indicated that in the last financial year, Greater Manchester had exceeded their targets for both RCT and non-RCTs, largely due to the surgical portfolio of trials.</p> <p>MB explained that the Aristotle trial is up and running but slow to recruit although it is</p> | |

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| <p>hoped that this will build. There is also a large chemotherapy study that has recently opened across several units. MB also mentioned the Birmingham Surgical Trials Consortium launch, where 2 multi-site trials will be launched (details of these studies not yet clear).</p> <p>ACTION: MB to circulate details of event</p> | <p>MB</p> |
| <p>7. Pathway data review</p> <p>SD highlighted the challenges to accessing contemporaneous data on performance to support the assessment of problems within the pathway. At present Cancer Wait data from NHS England is the only dataset that provides up-to-date information on performance. This data identified that most Trusts are performing well against the 2WW target, but there are issues with waiting times as Bolton as well as wide variances in the numbers of patients seen over consecutive quarters, which, if this was to take place on a regular basis, may impact on the levels of service Trusts can provide. SD indicated that the 31 day performance (diagnosis to treatment time) for all Trusts looked good but there are some issues with 62 day performance (urgent GP referral to treatment time). SD explained that this is difficult to interpret but felt that as 31 day performance was good, the issues for the 62 day pathway may relate to the front end of the pathway, which may be caused by delays to diagnosis, repeats of diagnostics or delays to MDT review.</p> <p>SD asked the members what data they felt would be useful to look at as a group. DB identified that it would be useful to look at survival rates, SD explained that this is collected by the National Bowel Cancer audit but is a couple of years out of date.</p> <p>Stoma rates and local recurrence data was also suggested. SD outlined that stoma rate data are collected by the National Bowel Cancer Audit, but highlighted that local recurrence is not a nationally collected dataset and an audit may be required to highlight any issues. SD explained that Lee Malcomson, based at the Christie is collecting data that could be useful to conduct these types of audit.</p> <p>Metastasis resection data was also suggested and SD explained that, again, this is not collected nationally but it was identified that there were variance in resection rates regionally and Trusts that have a lung or liver resection unit nearby tend to have higher resection rates. SD felt that with the merger of the Greater Manchester HPB units and the development of a single pathway, this variance may change. SD will be attending the HPB Pathway Board meeting next month to get information on how they will be developing their pathway and to identify shared goals i.e. around data collection. SD also identified that the guideline on HPB metastasis management needs updating and this will be done in conjunction with the HPB Pathway Board.</p> <p>ACTION: SD to work with MW to identify data that can be provided for pathway assessment</p> | <p>SD/MW</p> |
| <p>8. Network Audit of time to surgery from short-course radiotherapy for rectal cancer</p> <p>LD explained that her role at the Christie involved supporting colorectal patients within the radiotherapy pathway. She explained that the team wanted to look at surgical dates in relation to short course radiotherapy to get a better idea of the pattern within</p> | |

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| <p>the network.</p> <p>LD presented summarised the evidence surrounding short-course radiotherapy and national guidance and recommendations. NICE guidance does not specify a timeframe for pre-operative radiotherapy and the Association of Coloproctology identified that surgery should be performed within the week following completion of radiotherapy.</p> <p>LD then explained the current pathway at the Christie, in which the patient is seen a week after an MDT discussion, at which time their radiotherapy is booked in. A minimum of 3 weeks is usual to meet the patient, arrange planning scans and planning of radiotherapy. Specialist teams are contacted with the proposed dates. If the surgical teams have issues with the radiotherapy dates in regards to surgery, they are brought forward or postponed.</p> <p>The audit focused on 43 patients receiving short course radiotherapy from 1st January – 31st March 2014. 14 of the patients were on the 31 day pathway and 29 were on the 62 day pathway and of the 10 patients that breached waiting times, 9 were on the 62 day pathway. Most of the patients included within the audit were aged between 70- 80 years which is expected for this cancer group and the majority of patients were mid-rectal stage 3 patients.</p> <p>The audit looked at time to surgery time from the start and end of short course therapy, how many patients had resection within 3 days of finishing short course radiotherapy and time to surgery dependant on referral area. The audit also looked at how many patients would have breached if radiotherapy had been delayed to meet surgical times.</p> <p>The average time to surgery from the start of radiotherapy was 14 days with 30% of patients treated within this timeframe. With regard to time to surgery from the end of radiotherapy, the average was 11 days with 44% of patients treated within 10 days.</p> <p>If radiotherapy had been delayed to suit the surgery date, 5 extra patients (35%) would have breached. LD also highlighted that excluding weekends from the data, had a significant positive impact on the numbers of patients operated on within 10 (working) days from both the start and end of the short course therapy.</p> <p>LD thought it would be useful for the network to consider writing their own guidelines for this pathway to ensure a more standardised approach for patients. MS recognised the further complications delays to surgery had on elderly patients and felt that the easiest approach to take collectively would be to ensure surgery took place in the week following completion of short-course radiotherapy. For those Trusts with surgery lists on alternate weeks, the radiotherapy could be delayed. SD highlighted that the number of short-course patients varied significantly by different units. MS felt that this may relate to demographic issues and linked to when patients are presenting. Within the meeting it was recognised that many surgeons did not understand that it took 3 weeks for radiotherapy to take place following an MDT discussion.</p> <p>SD also reflected on the delays to treatment due to late referrals, which will also impact on wait times and breaches. MS felt that developing network guidelines based on best practice would support these concerns. Another audit could take place in 3 months to</p> | |
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| <p>evaluate performance against the guidelines.</p> <p>ACTION: Network guidelines for timing of surgery from short-course pre-operative radiotherapy to be developed A further audit of performance to take place 3 months following implementation of the guidelines</p> | <p>MS/SD LD</p> |
| <p>9. Survivorship and follow-up</p> <p>SD highlighted that this is an area that she is keen on promoting and discussed the National Cancer Survivorship Initiative. The NCSI published a comprehensive document in 2013 setting out the evidence to support initiatives that should improve patient experience. Specifically this relates to a survivorship framework, which would provide patients with a package of information and support across all areas of the pathway. The NCSI document summarises key interventions that could make a difference and these include structured holistic needs assessments and care plans, treatment summaries, patient education and support events, and advice regarding schemes that can support them. Although it is recognised that providers do support patients, data from patient surveys highlight that patients often don't feel they get enough support at particular points within their pathway. SD highlighted a few areas that within the patients' journey that could be improved. These included late effects and managing the consequences of treatment and promoting and sustaining recovery. It was felt that many patients feel lost and unsupported.</p> <p>SD thought it would be important to find out across the network what services Trusts offer in this area. SD recognised that not all Trusts are completing treatment summaries and highlighted that GP's were keen to receive this information to support their understanding of their patients needs' in particular if a patient is palliative or curative.</p> <p>SD described the model of a patient education event and highlighted that the event that was run recently at her Trust was very well received. Patients left with a lot of information and felt supported by this additional knowledge.</p> <p>AO discussed the experience at Salford, which participated in the NCSI pilot, and how such patient information events are well received. She also discussed the changes involved surrounding introducing new methods of patient directed follow-up.</p> <p>SD will be sending out a questionnaire to identify what types of survivorship initiatives are being undertaken in MDTs and how Trusts would like to develop this area.</p> <p>ACTION: SD to send out Survivorship and follow up questionnaire to Trust representatives and colorectal nurses</p> | <p>SD</p> |
| <p>10. Early rectal cancer management/questionnaire</p> <p>SD identified that the network guideline for early rectal cancer is quite old and that NICE guidance on this is being updated and local guidelines should be updated following this. The local guidelines at present state that patients who have a suspected T1 cancer should be assessed and considered for local resection. SD thought it would be</p> | |

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| <p>important to obtain local baseline data from each MDT as it was recognised that across the region people may be doing things differently and has prepared a questionnaire to support this.</p> <p>ACTION: SD to send out questionnaire regarding early rectal cancer to Trust representatives</p> | SD |
| <p>11. NCRI CRC applications</p> <p>SD explained that The National Cancer Research Institute are currently seeking applications for their colorectal clinical studies group. This would involve attending a couple of meetings a year. Applications need to be received by the end of next week.</p> | |
| <p>12. A.O.B.</p> | |
| <p>13. Date of next meetings Wednesday 16th July, Pathway Board – 2-4pm Nightingale Centre Thursday 4th September, Clinical Subgroup 2-4pmCTCCU Seminar Room</p> | |