Colorectal Cancer Pathway Clinical Subgroup
Tuesday 4th September2014 2 pm – 4 pm
CTCCU Seminar Room – UHSM

Attendance

Sarah Duff	Consultant Colorectal Surgeon, UHSM
Michael Braun	Consultant Medical Oncologist, The Christie
David Bisset	Consultant Histopathologist, 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
Anna Davenport	Consultant Histopathologist

Apologies

Rai Sajal	Consultant Colorectal Surgeon, Stockport
Vivek Misra	Clinical Oncologist, The Christie
Dominic Slade	Consultant Colorectal Surgeon, Salford
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
Paul Harriss	Consultant Colorectal Surgeon, Bolton

Agenda Item	Action
1. Apologies were noted	
2. The minutes of the previous Pathway Board meeting were reviewed and the minutes of the previous Clinical Subgroup agreed.	
3. Matters arising <u>Data review queried</u> SD explained that at the Pathway Board meeting in July the 62 day cancer wait data was queried and specifically members from the Christie felt that the data was very inaccurate. This is to be addressed under the data review agenda item. In addition, the indications for short course radiotherapy were questioned by members of the Christie team who felt that this would equate to a reduction in activity. This is to be addressed under the short course radiotherapy agenda item. <u>Bowel Cancer Screening Project</u> SD informed the meeting that the screening project to identify and re-engage all patients who do not attend for a colonoscopy following a positive FOB test would begin this week. The contact will be made via a standardised letter from the Screening Centre to the GP and will also include some GP education regarding the process and the outcomes for patients who are screened early. It is estimated that 300 – 400 patients a year could be re-engaged via this process. The letter has been finalised today and will be going out to the GP's this week. Feedback will be provided to GP's on the numbers of patients that have re-engaged and the positive findings identified. <u>Annual report and plan</u> These documents have now been finalised and will be circulated with the minutes. MW explained that the executive summary of the annual reports and the annual plans went to the Provider Board in August and there will be a programme developed for Pathway Directors to attend the Provider Board to present some of the issues regarding their pathway and a progress update.	
4. Data Review SD explained that the Board have regularly reviewed 2WW data, 31 day data and 62 day data. In regards to the 2WW data, it was noted that Bolton's performance had improved in quarter 1 of 2014-15. SD highlighted that for the 31 day data, which identifies performance from cancer diagnosis to first treatment, all Trusts perform well. The performance in regards to 62 day data is poor for most Trusts. SD explained that the data was generated from the National Cancer Wait times section of the NHS England website, which is publically available. Subsequent to this data being recorded, local adjustments are made to the allocation of breaches based on the local agreements for referrals to be made within 42 days by the referring Trust. This will have an impact on all Trusts, but particularly the Christie. Due	

to the difference between the published data and the actual numbers SD queried the relevance of regularly reviewing the the 62 day data at the PB and CSG. MW suggested it may be useful to internally audit the 62 day data to understand the true performance of each Trust in regards to this target. AD felt that as this was a national target it would be important to get a steer of what the true picture was via an audit. **ACTION: MW to discuss undertaking of 62 day data audit with Trust Cancer Managers**	**MW**
5. Radiotherapy choices in rectal cancer SD explained that MS and LD had put together a guideline for the pathway for patients requiring short course radiotherapy (SCPRT) for patients with rectal cancer. This was discussed at the Pathway Board and the principle that all patients were to receive short course radiotherapy with surgery the following week was established and an email has been circulated by LD and there will be an audit of the guideline in a few months. There was some concern regarding a sentence in the background to the guidelines that stated that 'SCPRT should be considered for T3 cancers that do not threaten the CRM and also some low T2 tumours that are considered to be anatomically very close to the CRM'. The Christie team thought that this meant that the use of SCPRT would be reduced but SD emphasised that MD and VM have assured that this was not the intention. MS and VM have provided SD with some slides that highlight the issue. The local guidelines for radiotherapy choices are based on guidance from both ESMO treatment guidance and NICE guidelines. Treatment decisions are made on the basis of tumour location and its risk factors. NICE recommends discussion regarding the risks and benefits of radiotherapy should take place with patients and no radiotherapy should be offered to low risk patients unless they are part of a clinical trial. NICE also states that SCPRT should be considered for patients with a moderate risk, which is probably a less aggressive approach than the treatment that is offered in Greater Manchester. The view of MS and VM is that all patients should be considered individually and that SCPRT could be an option for patients with a T2 tumour in the mid and low rectum with high risk factors as well as for patients with a T3 upper rectal tumour with high risk factors. It was proposed that the original sentence in the local guidelines would be changed to 'SCPRT should be considered for T3 cancers that do not threaten the CRM and also considered for some T2 tumours in the mid and low rectum on an individual basis'. This change in the guidelines was agreed, they will be altered accordingly.	
6. Oncological outcomes after complete clinical response in patients with rectal cancer: a case control study. September 2014 update SD introduced LM from the Christie who presented an update on the complete response study. LM explained that in 2009 it was identified that 15-20% of rectal cancers treated with long-course chemoradiotherapy result in a complete disappearance of the disease and this suggested that a 'watch and wait' pathway option could be considered for these patients. The Complete Response registry was established in 2009 encompassing Greater Manchester, Cheshire, North Wales and Lancashire and Cumbria. Work on Phase 2 of this project began in April this year and this would evaluate oncological outcomes.	

Most of the data has been collected and analysis will begin shortly. The patients within the study have come from the Rectal Cancer Audit and individually from the different networks and are divided into clinical complete responders – those who do not go on to have surgery and pathological complete responders – patients who go on to have a resection. In total there are 100 clinical complete responders and 75 pathological complete responders. Patients receiving contact radiotherapy have been excluded from the study. The first question the study will address will be the oncological outcomes of patients with a clinical versus pathological complete response. The second question will be testing the outcomes of all patients versus the clinical complete response. There are more males in both complete responder groups and there is a wider age range within the clinical complete responder group. LM thought the younger patients in this group would include those who are adverse to having a stoma. Both groups have patients with similar BMI's. There is an average of 2 year follow-up data available. The majority of the tumours were staged at T3 and there were also some T4's. SD felt that the results of this data would be important and would inform clinical practice. SD commented on the numbers of T2 tumour patients involved in the study as it had been previously discussed that these patients should not be receiving long course radiotherapy. LM thought these patients could be looked at to identify why this treatment option was considered. LM agreed to come back to the Board in January to provide an update on the analysis. SD thanked LM for presenting the data to the CSG.	
7. Results of early rectal cancer and survivorship surveys <u>Early rectal cancer survey</u> SD explained that a survey was developed to identify baseline practice in the management of early rectal cancer in order to support the update of the network guidelines as the current guidelines were out of date. NICE guidelines are being developed and Mr Hill based at CMFT is involved in this process. The survey went out in the beginning of the summer and there were 5 Trusts who responded, which SD felt was disappointing. In summary, all trusts considered local excision options for appropriate T1 tumours. The actual numbers treated were not clear from the responses received from each Trust and it was also unclear who treated these patients, how they were treated and where they were treated. There was variable follow-up and variable use of adjuvant treatments. SD felt these responses identified a clear need for guidelines. MWi felt the poor response may be due to those Trusts not treating early rectal cancers. SD explained that every Trust identified that they did and therefore should have a policy as there was no consistency in treatment decisions. MWi thought that the national guidance should be adopted regionally and recognised the risk for patients who are not treated in a standardised way. He identified that there were new	

techniques and it would be important to identify if all patients should have access to these. **ACTION: SD to discuss progress of national guidance with Jim Hill and how these will be taken forward** <u>Survivorship Survey</u> SD explained that she would like to improve how follow-up and survivorship is undertaken. She recognised that the importance of this may be recognised more by the CNSs than surgeons as they see the impact of good follow up and survivorship initiatives on patients. SD highlighted that it was not about reducing follow-up but changing how this takes place to better meet the needs of patients in managing their conditions. SD identified that there was a cross cutting pathway for Living with and Beyond Cancer, chaired by Wendy Makin at the Christie and they will be encouraging all the site specific pathways to undertake survivorship initiatives. To identify a baseline in colorectal cancer a survey was sent out and 4 Trusts responded, which again SD felt was a disappointing response rate. In summary, it was recognised that follow-up is largely nurse-led with variable intensity. CEA is used widely with CT at 1 and 2 years. Living with and beyond cancer elements are not widely used within the Trusts. These include holistic needs assessments, treatment summaries, health and wellbeing events and patient directed follow-up. MB asked whether he could input into treatment summaries and holistic needs assessments. SD though that standard information could be included into a treatment summary template. MWi thought that in order to get Trusts engaged in this it will need to be linked to Peer Review or commissioning. He also explained that telephone follow-up had been introduced at the Christie and is working well. MW explained that there is an innovation fund linked to the Living with and Beyond pathway of around £100,000 to support pathways in implementing survivorship initiatives. SD asked members how they felt survivorship initiatives could be improved and identified that commissioners would like to see survivorship activities included within commissioning frameworks. MW agreed to contact non-responding Trusts to get their responses to the survey to provide more colorectal baseline data. **ACTION:** **MW to chase non-responding Trusts for survivorship data** **SD to talk to the commissioners regarding developing survivorship activities**	**SD** **MW** **SD**
8. Proposed laparoscopic surgery telephone survey SD explained that the laparoscopic guidelines were out of date. These were based on the original NICE guidelines, which have now been updated. CS has agreed to take the lead in updating these and through the laparoscopic group in the North West has developed a questionnaire that will ask individual clinicians about their current	

practice. Rebecca Fish, a registrar based at the Christie, will be phoning clinicians regarding the survey. The survey should take around 5 – 10 minutes and results of the survey will be brought back to the Board.	
9. Research Update MB explained that the targets for recruitment have changed and the target for total recruitment has changed from 12% to 20%. The 7.5% target for RCT studies now relates to interventional studies and MB will need to clarify the differentiation between 'intervention' and 'RCT' with the Clinical Research Network. These changes will have had an impact on all other networks and their performance and MB explained that Greater Manchester were still the 3rd or 4th highest recruiter. Recruitment has been slow however the new palliative chemotherapy study opened six weeks ago which will have an impact on local trial uptake. MB thought it may be worth thinking about developing 2-3 centre studies developed across Greater Manchester. MB identified that the Add-Aspirin study had gone through EU tender and they are now applying to MHRA and it is hoped to have the study up and running by the end of the year. This study has the potential to be a big recruiter. SD felt that as a region clinicians are aware of studies and were very good at recruiting patients when appropriate studies become available.	
10. A.O.B SD reminded the members that there were still free places at the Christie Robotic Symposium to be held on Wednesday 17th September. The flyer regarding this event will be sent out again to all members to circulate to their colleagues.	
11. Date of next meetings 26th November, Pathway Board – 2-4pm Nightingale Centre 20th January, Clinical Subgroup 2-4pm, CTCCU Seminar Room	