Kent & Medway Cancer Collaborative

Colorectal Tumour Site Specific Group meeting
Tuesday 10th October 2023
Microsoft Teams
09:00-12:30

Final Meeting Notes

Present	Initials	Title	Organisation
Pradeep Basnyat (Chair)	**PB**	Consultant General & Colorectal Surgeon	EKHUFT
Gandra Harinath	**GH**	Consultant General & Colorectal Surgeon	EKHUFT
Jade Pilcher	**JP**	Programme Manager for Bowel Cancer Screening - EKHUFT	EKHUFT
Danielle Mackenzie	**DMa**	High Risk qFIT Project Facilitator	EKHUFT
Ruth Burns	**RB**	Macmillan Lead Colorectal CNS	EKHUFT
Carly Price	**CP**	Macmillan Colorectal CNS	EKHUFT
Stella Grey	**SG**	General Manager	EKHUFT
Nipin Bagla	**NB**	Consultant Pathologist	EKHUFT
Larissa Williams	**LW**	Macmillan Colorectal CNS	EKHUFT
Fiona Cull	**FC**	Macmillan Colorectal CNS	EKHUFT
Julie Beszant	**JBe**	Programme Manager for Bowel Cancer Screening - West Kent & Medway	DVH
Trish Sewell	**TS**	2ww Colorectal Rapid Access CNS	DVH
Michelle McCann	**MM**	Operational Manager for Cancer & Haematology	DVH
Adeyinka Pratt	**AP**	MDM Streamlining Project Manager	DVH
Helena Price	**HP**	Early Diagnosis CNS	DVH
Kathleen Coleman	**KC**	Colorectal CNS	DVH
Ritchie Chalmers	**RCh**	Medical Director	KMCA
Jonathan Bryant	**JBr**	Primary Care Clinical Lead	KMCA
Colin Chamberlain (Notes)	**CC**	Administration & Support Officer	KMCC
Karen Glass	**KG**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Lead	KMCC/KMCA
Jo Down	**JD**	Cancer Care Navigator	Malling PCN
Louise Black	**LB**	Macmillan Lead Cancer Nurse	MFT
Emma Bourke	**EBou**	Macmillan Personalised Care and Support Facilitator	MFT
Marie-Francoise Jakarasi	**MFJ**	Colorectal CNS	MFT
Rosalind Coppard	**RCo**	Metastatic Colorectal CSW	MFT
Karen Hills	**KHi**	Metastatic Colorectal CNS	MFT
Stefanie Outen	**SO**	Colorectal ACP	MTW
Hayley Geere	**HG**	Anal Cancer CNS	MTW
Rebecca Walton	**RW**	MDT Coordinator	MTW

Meeta Durve	**MD**	Consultant Clinical Oncologist	MTW
Mark Hill	**MHi**	Consultant Clinical Oncologist	MTW
Laura Alton	**LA**	Senior Programme Manager – KMCA Commissioning	NHS Kent & Medway ICB
Roberto Laza-Cagigas	**RLC**	Operations Lead	QuestPrehab
Apologies			
Kathleen Mutwale	**KM**	Macmillan Colorectal Cancer Support Worker	DVH
Lisa Middleton	**LM**	Colorectal Support Nurse	DVH
Catherine Neden	**CN**	GP	East Cliff Practice
Mohamed Rabie	**MR**	Specialty Registrar (StR) – Surgery	EKHUFT
Sandra Holness	**SHo**	Cancer Pathway Tracker Coordinator	EKHUFT
Sarah Hyett	**SHy**	TBC	EKHUFT
Sue Drakeley	**SD**	Senior Research Nurse	EKHUFT
Deniece Merrall	**DMe**	Macmillan Colorectal CNS	EKHUFT
Eelco Boorsma	**EBoo**	Consultant Radiologist	EKHUFT
Jann Yee Colledge	**JYC**	Consultant Radiologist	EKHUFT
Joanne Cooke	**JC**	Consultant General & Colorectal Surgeon	EKHUFT
Pippa Enticknap	**PE**	Senior Service Manager – CCHH Care Group	EKHUFT
Shady Zeidan	**SZ**	Consultant in Surgery	EKHUFT
Shirley Chan	**SC**	Consultant General, Colorectal & Paediatric Surgeon	EKHUFT
Mohan Harilingam	**MHa**	Consultant Surgeon – General, Emergency and Colorectal Surgery	EKHUFT
Tracey Ryan	**TR**	Macmillan User Involvement Manager	KMCA
Leeja John	**LJ**	STT (Upper GI) CNS	MFT
Clarissa Madla	**CM**	Clinical Research Delivery Manager	MFT
Karen Hopkins	**KHo**	Bowel Cancer Screening Practitioner	MTW
Victoria Earl	**VE**	Clinical Trials Coordinator - Colorectal/Upper GI	MTW
Simon Bailey	**SB**	Consultant General, Laparoscopic and Colorectal Surgeon	MTW
Chris Wright	**CW**	Consultant Laparoscopic Colorectal and General Surgeon	MTW
Andrea Hodges	**AH**	Cancer Care Coordinator	West Kent Primary Care

Item		**Discussion**	**Action**
1	**TSSG Meeting**	**<u>Apologies</u>** • The apologies are listed above. **<u>Introductions</u>** • PB welcomed the members to the meeting and asked them to introduce themselves. **<u>Action log Review</u>** • The action log was reviewed, updated and will be circulated to the members along with the final minutes from today's meeting.	

		Review previous minutes • The final minutes from the previous meeting were reviewed and agreed as a true and accurate record.	
2	**Introduce Cancer Alliance Medical Director**	**Update provided by Ritchie Chalmers** • RCh believes strong collaborative clinical leadership is imperative for driving the TSSGs forward and would like to make this forum the repository of expertise in the region. • RCh highlighted the importance of identifying the specific problems KMCA have and identifying what she described as 'sticking points', areas requiring more input from specialties to expedite issues. • RCh stated there is an aim to develop a clinical strategy which dovetails with the ICB clinical strategy and KMCA (which will be hosted by NHS Kent & Medway ICB from December 2023) believe the TSSG is the most appropriate forum to drive this forward for the region. • RCh emphasised the importance of reviewing available data in order to help inform the clinical strategy. • RCh is keen for the TSSGs to introduce lead roles such as a Lead Radiologist, Lead Pathologist and Lead CNS and she welcomes views from others regarding implementing these. • RCh welcomes any feedback from colleagues regarding ideas for improvement. • RCh believes KMCA are exemplary with regard to implementing the national cancer strategy. • RCh and the wider KMCA team are keen to support MDMs, the standardisation of pathways and for mutual aid to be provided where possible. • RCh stated there is a need to review the tertiary services provided and for this to be included in the strategy. • MTW have the worst data completeness for SACT nationally, something which MHi feels requires further discussion with RCh outside of this meeting. • RCh introduced JBr as the Primary Care Clinical Lead for KMCA. JBr is keen to support the TSSGs and to improve communication/relationships between both primary and secondary care in order to standardise practice as much as possible.	
3	**Standards of care for endoscopy and level of qFIT screening**	**Presentation provided by Ritchie Chalmers** • RCh provided the group with an overview of: - Data pertaining to the routes to diagnosis in Kent & Medway as a whole, at the individual Trusts and in England between 2018 and 2022. - Colorectal >62d backlogs at each of the individual Trusts as well as in Kent & Medway as a whole between 26.03.2023 and 17.09.2023. - FDS performance at each of the Trusts and in Kent & Medway as a whole between February and July 2023. - The median waiting time to diagnosis (in days) at each of the Trusts between February and July 2023. - The number of qFITs carried out per month by FIT score in each of the HCP areas between 04.01.2022 and 07.01.2023. qFIT is being utilised more in West Kent than the other HCP areas. - The number of 2ww referrals for urgent suspected lower GI cancer by FIT score at each of the Trusts between 04.01.2022 and 06.01.2023. The four Trusts cover similar areas to the four HCPs.	

		- The proportion of 2ww referrals for urgent suspected lower GI cancer with a colonoscopy within 120 days from the start of the pathway between 04.01.2022 and 04.01.2023 at each Trust. The only Trust where colonoscopy rates are decreasing over time is MFT. - The proportion of 2ww referrals for urgent suspected lower GI cancer with a colonoscopy within 120 days from the start of the pathway between April 2022 and May 2023 at each of the Trusts. There is not much relationship between FIT score and colonoscopy rates for DVH and EKHUFT. At MTW, FIT is used much more often and there is a stronger relationship between FIT score and colonoscopy. At MFT, the Trust does a FIT if no FIT is provided with the referral, so the data shown on slide 11 of the presentation is incomplete. Colonoscopy rates are lowest at MFT and there is a strong relationship with FIT score. - The number of days from referral to a colonoscopy by month of colonoscopy at each of the Trusts between August 2022 and July 2023. - The proportion of colorectal pathway referrals for people who had a colonoscopy in the previous five years at each of the Trusts with referrals between August 2022 and July 2023. On average, 300 referrals per month were for people who had a colonoscopy in the previous five years, out of an average of 2120 referrals per month. - The colorectal 28-day best practice timed pathway. - The number of days from referral to milestones on the pathway at each of the Trusts between February and July 2023. - The proportion of 2ww referrals for urgent suspected lower GI cancer resulting in a cancer diagnosis at each of the Trusts between September 2022 and May 2023. At MTW, a higher proportion of patients without a FIT score resulted in a cancer diagnosis than at the other Trusts. - Data pertaining to the percentage of patients with a qFIT of <10 going on to further tests at each Trust. • RCh highlighted the importance of having a clinical consensus on establishing a standardised pathway across Kent & Medway, perhaps drawn up by a working group, agreed at the TSSG, supported by the ICB and then adopted by the four Trusts. • RCh stated pathways should provide a diagnostic alternative to the suspected cancer referral route (low-risk group). • RCh added that pathways should run from symptomatic to actual diagnosis (cancer, IBD, diverticular disease, IBS) to facilitate appropriate further management and prevent re-referral. • RCh believes pathways should include the safety netting of the qFIT <10 group (which should be clinically safe, aim to reduce the endoscopy burden and result in a diagnosis). • Amongst other challenges, bottlenecks in pathology and radiology are causing delays in telling patients whether they do or do not have cancer. • It was noted that GPs are increasingly using qFIT, although this is higher in West Kent/DVH. A number of patients are, however, still being referred in to secondary care without a qFIT result.	

	Cancer Alliance update	• Capacity issues with colonoscopies remains an issue whilst demand remains the same, something which RCh believes requires further exploration. • PB believes a qFIT negative clinic would be helpful to have and should be run by senior clinicians. 70-80% of referrals are now coming in with a qFIT result which he feels is encouraging. • PB stated there needs to be additional education within primary care regarding qFIT. • PB highlighted the importance of having further conversations involving both primary and secondary care colleagues around ensuring there are robust cancer and non-cancer pathways. • LA feels consideration needs to be given to how to commission and sustain having low-risk qFIT clinics. • In terms of taking patients off of the PTL and putting them on to alternative pathways, MM believes there are limited resources in the Trusts to do this. • PB emphasised the need to agree a standardised diagnostic algorithm across the Trusts. **<u>Cancer Alliance update</u>** • It was felt this item did not require further discussion as issues pertaining to the colorectal tumour site were discussed throughout the meeting.	
4	**qFIT update**	**<u>Update provided by Laura Alton</u>** • LA confirmed qFIT has been formally commissioned in Kent & Medway. • 8000 qFITs are utilised each month in Kent & Medway. • Nationally, there has not been a decrease in referrals. • A primary care dashboard is evolving which will incorporate a RAG status relating to qFIT utilisation at each GP practice. This will be shared with secondary care colleagues in due course. • With regard to the lower GI urgent suspected cancer form, a review of the document was shown on screen. LA confirmed the form can be uploaded to the GP clinical system and the old form removed. There is an intention in due course to make the completion of fields mandatory to ensure the quality of referrals is improved. • **<u>Action</u>: LA asked the members to review the lower GI urgent suspected cancer form and provide any feedback/comments with a deadline of 2 weeks.** • JBr stated a lot of work in primary care has taken place incorporating the new qFIT guidance and educational opportunities put in place accordingly. • JBr believes calprotectin should be available to primary care colleagues across all surgeries in Kent & Medway as there is currently a disparity with regard to this. • JBr is aware there are issues in Dartford with primary care colleagues not using the DART system and work will therefore be undertaken to try and expedite this. • LA highlighted the importance of ensuring the right resources are in place for implementation of negative/<10 qFIT clinics.	**All**

		• RCh emphasised the need to address issues with the benign pathways which she believes will then help with cancer pathways as the former often impacts the latter. • RCh believes a working group should be set up in order to discuss the above points in further detail.	
5	**Prehabilitation**	**<u>Presentation provided by Roberto Laza-Cagigas</u>** • RLC provided the group with a definition of prehab - an intervention which aims at optimising an individual's health before facing a major stressor (e.g. surgery). • QuestPrehab, currently funded by KMCA, is a free mixed-model multimodal prehabilitation programme for patients diagnosed with cancer in Kent & Medway. • QuestPrehab provide patients with tools to improve their lifestyle and get healthier before (prehab), during and after (rehab) cancer treatment. • The QuestPrehab service can be delivered via telephone call, video call, and/or face-to-face and often includes giving advice around diet/nutrition, physical activity, psychological support and signposting where appropriate. • The Craetus app helps patients to log their progress and structure their activities during the week. • QuestPrehab provide regular live streaming exercise sessions during the week covering different modalities. • There is also a patient-led peer-support group and coffee chats are available. • RLC provided the group with an overview of studies on prehab outcomes. • RLC also provided a summary of case studies highlighting health improvements as a result of patients adhering to QuestPrehab advice. • In terms of patient referrals, this can be done by: - HCPs completing an online form via the QuestPrehab website (although patients can also self-refer via the same route). - Completing a form embedded within InfoFlex. • RLC encouraged the members to take the leaflets he brought to today's meeting articulating the QuestPrehab service and share with both colleagues and patients. • RCh suggested the Trust representatives link QuestPrehab in with their pre-assessment teams in order for them to establish relationships. • RLC stated *You First* offer services to patients who do not have cancer. • QuestPrehab do not currently have any issues with capacity. • QuestPrehab are not able to offer their services to patients on an end of life pathway.	
6	**Performance**	**<u>Performance Questions</u>** • Kent & Medway currently have the third worst FDS and eighth worst 62d performance nationally. • Kent & Medway currently have the second worst USC backlog in the country.	

		<u>All Trusts</u> **<u>DVH – presentation provided by Michelle McCann</u>** • Please refer to the performance slide pack for an overview of the Trust's data. **<u>EKHUFT – presentation provided by Stella Grey</u>** • Please refer to the performance slide pack for an overview of the Trust's data. **<u>MFT – presentation provided by Emma Bourke</u>** • Please refer to the performance slide pack for an overview of the Trust's data. • **<u>Action</u>: AW to email Suzanne Bodkin to request additional information/context regarding MFT's performance data presented today.** **<u>MTW – presentation provided by Rebecca Walton</u>** • Please refer to the performance slide pack for an overview of the Trust's data. • RCh highlighted the importance of having lead roles within the MDM (such as Lead Pathologist, Lead Radiologist and so on), although she is aware there is a shortage of histopathologists nationally.	**AW/ Suzanne Bodkin**
7	**Clinical Pathways**	**<u>IDA Pathway – presentation provided by Gandra Harinath</u>** • GH provided the group with an overview of: - What to look out for in terms of the identification of IDA in patients. Serum ferritin level is the biochemical test which most reliably correlates with relative total body iron stores. Low levels indicate low iron stores except in women who are in the second or third trimester of pregnancy. In all people, a serum ferritin level of less than 30 micrograms/L confirms the diagnosis of iron deficiency. - The primary care investigations used in identifying IDA. - Whether a referral is needed for certain patients, such as: menstruating young women, pregnant women, terminally ill people or those unable to undergo invasive investigations, and people who refuse further investigations. - A flow chart outlining what should happen in Hb <120g/L female patients/Hb <130g/L male patients with a ferritin level of <30µg/L **OR** a ferritin level of <100µg/L plus transferrin saturation ≤20% and Coeliac Screen (TTG). - A flow chart outlining what should happen in confirmed IDA patients under the age of 60 with no GI symptoms and a negative qFIT. - The responsibility of secondary care and the considerations they need to take in to account such as: confirming the patient's history and investigations; identifying whether there is a previous/family history of IDA and the patient's fitness for investigations; the potential utilisation of an OGD/colonoscopy; the potential role of a CT scan; and whether parenteral iron via ambulatory care can be considered.	

		• GH stated treatment should not be put on hold while investigations are being planned. • In terms of service considerations, all service providers should have clear points of referral and management pathways for patients with IDA. To ensure efficient use of resources, IDA pathways should be delivered by a designated team led by a senior clinician. Service providers should aim to have an ambulatory care base for the administration of parenteral iron. • With regard to the further management of patients once cancer has been excluded, GH stated they should be sent back to primary care for further monitoring of Hb and iron. • In terms of points to consider, GH highlighted the need to agree: - What vetting measures should be in place where IDA is not proven. - If and when it is appropriate to send patients back to primary care. If no cancer is identified, patients should be referred back to primary care. - What secondary care investigations could be carried out. - What resources are in place for those patients deemed unfit. - Where IDA patients should sit upon diagnosis, be it in an anaemia clinic or a colorectal clinic. - What, if any, haematology input is required as part of the anaemia pathway. • It was raised that there is a need to agree an IDA pathway for both upper and lower GI.	
8	**Clinical Audit updates**	• This item was not discussed.	
9	**Research update**	• MHi referred to the TRACC trial which is currently open in East Kent and hopes to expand in to West Kent. This study looks at using small pieces of the DNA of bowel cancer which circulate in the blood (ctDNA) to work out whether cancer might return. • NP referred to the CVLP (Cancer Vaccine Launchpad), a project which acts as a bridge to enable NHS patients with cancer to participate at the earliest possible opportunity in cancer vaccine trials and to accelerate the development of cancer vaccines. The aim of the CVLP is to provide a basis for accelerated development of personalised cancer vaccine treatment, by providing a standardised, high quality, expanded standard of care pathway for tumour molecular analysis and sequencing incorporating elements of the NHS Genomic Medicine Service. The primary objective is to identify and recruit cancer patients who might be suitable for personalised cancer vaccine trials.	
10	**K&M Bowel Screening Programme & Lynch Syndrome**	**<u>Presentation provided by Jade Pilcher & Julie Beszant</u>** • JP and JBe provided the group with an overview of: - The Kent & Medway Bowel Cancer Screening Programme. - The West Kent & Medway Screening Centre set-up. - The East Kent Screening Centre set-up. - Workforce planning. - Future issues.	

		• With regard to Lynch Syndrome: - People with Lynch Syndrome have a higher risk of developing bowel cancer due to these gene mutations. - Regular surveillance aims to find cancer at an early stage when treatment can be more effective. This can help reduce the number of people dying from bowel cancer. - BCSP surveillance for patients diagnosed with Lynch Syndrome is carried out every two years by colonoscopy and will start depending on which gene mutation is confirmed. - Lynch Syndrome is a common disease, with an estimated population prevalence of 1 in 250. - NICE DG27 reports that around 3.3% of colorectal cancers are due to Lynch Syndrome with an estimated 1,100 cases per annum in England. - It is estimated that around 170,000 people in the UK are living with Lynch Syndrome, many of whom are unaware of this diagnosis. - MLH1, MSH2, EPCAM surveillance starts from age 25 years. PMS2, MSH6 surveillance starts from age 35 years. - There is no known cure, therefore it is crucial people with Lynch Syndrome receive coordinated, timely and high-quality care to reduce their lifetime risk of bowel cancer. • JBe/JP provided the members with a summary of: - The process involved relating to how the BCSP receive Lynch Syndrome referrals. - What the BCSS does with the data received. BCSS has been updated to include a new icon which will appear next to an individual's name if BCSS has received a confirmed Lynch Syndrome diagnosis from the Registry. - The BCSS invitation process. - The process involved for those patients who do not wish to have surveillance/choose to permanently opt-out. • JBe stated there are no formal safety measures in place if the programme identifies a negative screening result and patients are simply informed to remain vigilant of symptoms and contact their GP practice if required.	
11	**CNS Update**	**<u>DVH – update provided by Trish Sewell & Kathleen Coleman</u>** • The colorectal surveillance group is up and running. • A new metastatic nurse will be starting with the team next month. • A new STT nurse is in place. **<u>EKHUFT – update provided by Ruth Burns</u>** • Around 600 patients are currently on the supported self-management (SSM) pathway. • End of Treatment Summaries (EOTS) are being utilised. • Support from oncology colleagues has vastly improved in recent months. • An STT service has commenced. • The team are currently spending a lot of time reviewing the PTL with around 1300-1400 patients currently on there. This has caused considerable pressure. • The nursing workforce has grown since the last meeting.	

		MFT – update provided by Marie-Francoise Jakarasi • The service has recruited a CSW who will be starting with the team next month. • MDT streamlining work is underway in order to make the meetings more effective for both staff and patients. • MFJ has commenced Lynch Syndrome training. • The service hope to go live with the Padlet system shortly. • The metastatic service continues to evolve with around 120 patients currently on record. • A shared decision clinic runs once a month. • A number of MFT patients utilise the QuestPrehab service. • The team are performing well with regard to completion of HNAs. **MTW – update provided by Samantha Seker** • Stratified pathways are up and running. • Oncology surgical treatment summaries are being utilised. • Three Band 6 Development Nurses have been recruited and will rotate between tumour sites. • A CNS is now picking up enhanced recovery work. • The service has recruited a further metastatic nurse.	
12	**AOB**	**Patient Partners Engagement** • Tumour Site Specific Groups should ideally have two patient partners per group. • Patient Partners are experts by experience and are an invaluable part of cancer improvement and service design. • TR (User Involvement Manager – KMCA) would like the help of the group in finding Patient Partners as they see and know their patients, and if the time is right for them to support. • TR's is for staff to ask their patients if they would be interested in this opportunity and if they would mind her contacting them. If so, TR asks for their details to be sent to her so she can contact them. Her email address is tracey.ryan1@nhs.net. • GH highlighted the importance of collaborative working in order to streamline STT pathways. • GH also emphasised the need to be vigilant of what technological developments can be harnessed (for example robotics) across the patch in order to improve clinical practice. • **Action: PB to liaise with KMCA in order to request their support in trying to resolve issues pertaining to tertiary referrals, particularly with regard to King's College Hospital.**	**PB**
	Next Meeting	• To be confirmed.	