Kent & Medway Cancer Collaborative

Colorectal Tumour Site Specific Group meeting
Tuesday 18th April 2023
Activation Room - The Village Hotel (Maidstone)
09:00-12:30

Final Meeting Notes

Present	Initials	Title	Organisation
Pradeep Basnyat (Chair)	**PB**	Consultant General & Colorectal Surgeon	EKHUFT
Larissa Williams	**LW**	Macmillan Colorectal CNS	EKHUFT
Shady Zeidan	**SZ**	Advanced Fellow	EKHUFT
Ruth Burns	**RBu**	Lead Macmillan Lower GI CNS	EKHUFT
Gandra Harinath	**GH**	Consultant General & Colorectal Surgeon	EKHUFT
Danielle Mackenzie	**DMa**	High Risk qFIT Project Facilitator	EKHUFT
Rakesh Bhardwaj	**RBh**	Consultant Laparoscopic, General and Colorectal Surgeon	DVH
Petr Hanek	**PH**	Consultant General & Colorectal Surgeon	DVH
Julie Beszant	**JBe**	Programme Manager for Bowel Cancer Screening - West Kent & Medway	DVH
Farrah Errington	**FE**	Colorectal MDT Coordinator	DVH
Kathleen Coleman	**KC**	Colorectal CNS	DVH
Colin Chamberlain (Notes)	**CC**	Administration & Support Officer	KMCC
Karen Glass	**KG**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Lead	KMCC
Will Garrett	**WG**	Consultant General Surgeon	MFT
Melisa Goodwin	**MG**	Macmillan Colorectal CNS	MFT
Suzanne Bodkin	**SB**	Cancer Service Manager	MFT
Louise Black	**LB**	Macmillan Deputy Lead Cancer Nurse	MFT
Rosalind Coppard	**RC**	Colorectal Cancer Support Worker	MFT
Karen Hills	**KHi**	Metastatic Colorectal CNS	MFT
Rebecca Walton	**RW**	Senior MDT Coordinator	MTW
Stefanie Outen	**SO**	Colorectal Advanced Nurse Practitioner	MTW
Hayley Geere	**HGe**	Specialist Nurse in Anal Cancer	MTW
Samantha Seker	**SS**	Oncology CNS – Colorectal	MTW
Meeta Durve	**MD**	Consultant Clinical Oncologist	MTW
Holly Groombridge	**HGro**	Cancer Commissioning Project Manager	NHS Kent & Medway ICB
Laura Alton	**LA**	Senior Programme Manager – KMCA Commissioning	NHS Kent & Medway ICB
Apologies			
Kathleen Mutwale	**KM**	Macmillan Colorectal Cancer Support Worker	DVH
Louise Rafferty	**LR**	Macmillan Lead Colorectal CNS	DVH
Stephen Morgan	**SM**	Consultant Radiologist	DVH

Fay Fawke	**FF**	Deputy Lead Cancer Nurse / Lead Macmillan Uro-oncology CNS	DVH
Catherine Neden	**CN**	GP	East Cliff Practice
James Bowyer	**JBo**	Deputy General Manager – General & Colorectal Surgery	EKHUFT
Stella Grey	**SG**	General Manager - General Surgery & Colorectal	EKHUFT
Sue Travis	**ST**	Interim Operations Director - Surgery & Anaesthetics Care Group	EKHUFT
Jann Yee Colledge	**JYC**	Consultant Radiologist	EKHUFT
Joanne Cooke	**JC**	Consultant General & Colorectal Surgeon	EKHUFT
Carolyn Maynard	**CMay**	Deputy Head of Nursing - Cancer & Patient Experience	EKHUFT
Sandra Holness	**SH**	Cancer Pathway Tracker Coordinator	EKHUFT
Sue Drakeley	**SD**	Senior Research Nurse	EKHUFT
Hasmath Montgomery	**HM**	Clinical Research Practitioner	EKHUFT
Mohamed Rabie	**MR**	Specialty Registrar (StR) - Surgery	EKHUFT
Mohammad Imtiaz	**MI**	Consultant Emergency & Colorectal Surgeon	EKHUFT
Deniece Merrall	**DMe**	Macmillan Colorectal CNS	EKHUFT
Tracey Rigden	**TR**	Chemotherapy Nurse Consultant	EKHUFT
Harvey Dickinson	**HD**	SELCA Cancer Improvement Manager	GSTT/SELCA
Emma Bourke	**EB**	Macmillan Personalised Care and Support Facilitator	MFT
Dilukshi Wickramasinghe	**DW**	Senior Clinical Research Practitioner	MFT
Clarissa Madla	**CMad**	Senior Clinical Research Practitioner	MFT
Leeja John	**LJ**	STT Nurse	MFT
Kirsty Hearn	**KHe**	Service Manager	MFT
Joanne Patterson	**JP**	Lead Clinical Trials Pharmacist	MTW
Rakesh Raman	**RR**	Consultant Clinical Oncologist	MTW
Maria Blanco-Criado	**MBC**	Deputy Chief Pharmacist - Cancer & Technical Services	MTW
John Schofield	**JS**	Consultant Pathologist	MTW
Karen Hopkins	**KHo**	Bowel Cancer Screening Practitioner	MTW
Francois Porte	**FP**	Consultant Radiologist	MTW
Mark Hill	**MH**	Consultant Medical Oncologist	MTW
Riyaz Shah	**RS**	Consultant Medical Oncologist	MTW
Victoria Earl	**VE**	Clinical Trials Coordinator - Colorectal/Upper GI	MTW
Rosemeen Parkar	**RP**	Consultant Medical Oncologist	MTW
Raza Moosvi	**RM**	Consultant General, Laparoscopic and Colorectal Surgeon / MTW Colorectal Clinical Lead	MTW
Albert Edwards	**AE**	Consultant Clinical Oncologist	MTW
Elaine Ellis	**EE**	Colorectal Oncology CNS	MTW
Ann Courtness	**AC**	Macmillan Primary Care Nurse Facilitator	NHS Kent & Medway ICB
Helen Graham	**HGra**	Research Delivery Manager (Cancer)	NIHR

Item		Discussion	Action
1	**TSSG Meeting**	**Apologies** • The apologies are listed above. **Introductions** • PB welcomed the members to the meeting and asked them to introduce themselves. **Action log Review** • 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 minutes from the previous meeting were reviewed and agreed as a true and accurate record.	
2	**Endoscopy update**	**EKHUFT** • PB stated there is a high volume of patients awaiting an endoscopy/colonoscopy at EKHUFT, although the Trust are looking to utilise qFIT as a triage tool in order to remove some of these from the waiting list and, to reflect this, are in the process of compiling a SOP. There will be a surgeon and gastroenterologist working together at both WHH and QEQM, hopefully from August 2023, to support diagnostic pathways. • LW stated approximately 70% of patients at EKHUFT have had a qFIT before they come through to secondary care. **MFT** • WG mentioned the bowel screening service at MFT had a successful Quality Assurance visit recently. • MFT are currently experiencing an issue with regard to endoscopy room space, although there plans to secure 2 more rooms at some point. • Medway Maritime Hospital are due to have a JAG visit today. • qFIT has been utilised a lot recently for rapid access referrals. **MTW** • MTW are experiencing issues with regard to waits for polypectomies. • WG believes the goal going forward is for a colonoscopy not to be a diagnostic test but a therapeutic one. It was highlighted across the board that there has not been a decrease in referrals from primary care with an accompanying qFIT.	

3	**MDT Streamlining**	**EKHUFT** • 2 MDTs take place at EKHUFT – one at WHH and one at QEQM. The lists are consultant-led/nurse-led. • EKHUFT are struggling with time management at MDT meetings due to the volume of patients on their caseload. • EKHUFT are experiencing some issues in relation to streamlining cases prior to MDT. • On average, 40 patients are discussed at the MDT – although 55 were discussed last week. **MFT** • Prior to the pandemic, MFT had pre-MDT meetings in place (on Friday afternoons) in order to work on reducing the number of patients discussed at the main MDT. The duration of the meetings (which take place on Tuesday afternoons) tends to take between 1 hour and 90 minutes. • SB stated there are a lot of patients not diagnosed until they are past their 62 day target. **DVH** • DVH have sent out to advert a project manager position which, as part of their duties, would include working on the MDT streamlining piece. **Action: Update to be provided by the new project manager (if successfully appointed) at the next meeting relating to MDT streamlining.** • DVH do not have a colorectal pre-MDT in place like other tumour sites at the Trust do. • RBh stated he and oncology colleagues at DVH have experienced some issues in relation to processes, communication and delays in patient referrals with the King's College Hospital liver service, something which he has raised with Ian Vousden. • A number of the other Trusts represented at today's meeting also highlighted concerns in relation to liver patients referred to King's College Hospital. PB mentioned that the WHH MDT does not have any liver surgeon representation from King's College Hospital. • **Action: PB believes it is worth the Kent & Medway Trusts articulating the concerns they have with the King's College Hospital liver service and to then share this with him and AW so a meeting with the team can be put in place to work through these. Following on from this, they will be asked to attend the next meeting in order to discuss pathway processes to King's College Hospital from other hospitals and the data pertaining to Kent & Medway patients treated there.** • WG feels it would be beneficial if Kent & Medway had a liver service somewhere conveniently located to all 4 Trusts. • **Action: All Trusts to collate information on King's College Hospital liver surgeon attendance at their local MDTs over the last year and send this to PB/AW.**	**AW** **All Trusts** **All Trusts**
4	**Performance**	**DVH – presentation provided by Michelle McCann** • Please refer to the performance slide pack circulated on 18.04.2023 for an overview of the Trust's data. • The team review the PTL daily, with a particular focus on the front end of the pathway. The service has a particularly helpful radiology pathway navigator in place.	

		EKHUFT – presentation provided by Pradeep Basnyat • Please refer to the performance slide pack circulated on 18.04.2023 for an overview of the Trust's data. • The junior doctors' strikes have had an impact on clinics, particularly 2ww ones. • RBu highlighted some issues in relation virtual colonoscopies. • PB stated histopathology reporting is also an issue and the service has worked on standardising discharge letters. • Escalation meetings have been taking place to try and reduce the backlogs. **MFT – presentation provided by Suzanne Bodkin** • Please refer to the performance slide pack circulated on 18.04.2023 for an overview of the Trust's data. • There have been endoscopy and CT colonography delays. • There have also been issues in getting prisoners to come in to hospital for diagnostics in a timely manner. **MTW – presentation provided by Rebecca Walton** • Please refer to the performance slide pack circulated on 18.04.2023 for an overview of the Trust's data. • There have been some issues recently with data completeness due to staff leave/absence. • Radiotherapy capacity is currently a challenge, mainly due to staffing issues. • There have been issues with iron transfusions.	
5	**qFIT pathway & National updates**	**Update provided by Laura Alton** • The qFIT flowchart presented on screen (and circulated to members on 14.04.2023) was presented to the LMC two weeks ago and although it was not opposed there, it was not endorsed either. • LA stated GPs will now only receive payment if their referral to secondary care is accompanied with a qFIT result. • Data is being collected on qFIT utilisation and is submitted to the national team on a quarterly basis. • MM highlighted that 48% of DVH's PTL is taken up by colorectal patients, many of which are not being seen face-to-face by a GP. This appears to be both a local and national problem. • LA stated 50% of referrals are coming in to secondary care with a qFIT result, with the aim being 80%. The figures for this are better in East and West Kent than they are in North Kent and it is felt providing some education to primary care colleagues there could be of benefit. • Some suggested changes with regard to wording on the flowchart were made. Some of these suggestions include: - Removing the terms ***"if possible"*** and ***"where possible"*** in order to put more of an onus on GPs to undertake the necessary steps prior to referring a patient in to secondary care. - ***"GP to refer patient on 2ww pathway and request a q-FIT where possible, including the full history/WHO performance status on referral form."*** Remove ***"where possible"***. - ***"Clinical history, examination (including DRE) and initial investigations undertaken (to include appropriate blood tests & q-FIT, where possible)."*** Remove ***"initial"*** and replace it with **'essential'**. Also remove ***"where possible"***. The list of blood tests should include FBCs and U&Es plus any others which are felt appropriate in addition to the qFIT and whether the patient is considered fit for a colonoscopy. - ***"GP to refer patient on 2ww pathway to their local Trust, including the full history/WHO performance status on referral form."***	

		Add in **'essential investigations'**. - ***"FIT >10ug/g"*.** Replace with **'qFIT 10ug/g'**. - Including a reference to the document as being the **'NHS Kent & Medway ICB & KMCA commissioned pathway'**. - Including a key for abbreviations/acronyms in order to avoid any potential confusion. • MM stated it would be helpful if the document, once approved, could be laminated and displayed in the consultation rooms of GP practices. • Once the document has been amended in line with the suggested changes, it will be circulated for comments prior to finalisation. • Jonathan Bryant, the recently appointed NHS Kent & Medway ICB Primary Care Cancer Clinical Lead, will serve as the local champion for this workstream. • **<u>Action</u>: PB believes it would be helpful to have some data presented at the next meeting regarding the impact on practice of publishing the qFIT pathway document.** • As an adjunct to the points mentioned above, Chris Wright (who was unable to attend today's meeting) reviewed the flowchart and wished to register a comment about it, as per the below: ***"The document should reflect that the expectation (and actually the correct best practice) is to do a qFIT for lower GI symptoms before deciding on a referral and the qFIT helps to triage the referral to 2ww or routine/urgent (it is also important to note that a negative qFIT does not preclude referral to a specialist but not as a 2ww)."*** Chris Wright highlighted the importance of specificity on this otherwise the system will continue as it is - which he described as a ***"muddy puddle of variable practice"***.	**All Trusts**
6	**Pathology update**	• No update provided.	
7	**The Management of Colorectal Cancer Pathway of Care / Operational Policy**	**<u>Update provided by Pradeep Basnyat</u>** • The Pathway of Care/Operational Policy will incorporate sections on qFIT, stratified pathways and MDT streamlining developments. Once these have been included, the document will be circulated to the MDT teams and hopefully be finalised by the next meeting at which point it can be added to the new KMCA website.	
8	**STT pathway**	**<u>Update provided by Ruth Burns</u>** • EKHUFT now have a STT service in place and are in the process of recruiting additional staff. 4-5 cancers have been identified through the service so far. • DVH, MFT and MTW also have a STT service in place.	

	IDA pathway	**<u>Presentation provided by Shady Zeidan</u>** SZ provided the group with an overview of: • NICE guidance in relation to IDA in 2ww patients. If a patient is >60-years-old and identified as having IDA a GP should refer them in as a 2ww in order to rule out bowel cancer. • What to look out for in terms of the identification of IDA in patients. A blood test will need to be carried out to check a patient's complete blood count, haemoglobin levels, blood iron levels and ferritin levels. • What some red blood cell changes associated with IDA include: - A reduced mean cell Hb (hypochromia) level. - An increased percentage of hypochromic red cells. - Anisocytosis (a variation in the size of red blood cells). - Poikilocytosis (the presence of irregular shaped red blood cells). • Serum ferritin level being 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. If a referral to secondary care is to be made, primary care will need to disclose the results pertaining to the patient's: - Full blood count – Hb/MCV. An MCV result of >95 is unlikely to be IDA. - Ferritin levels. A serum ferritin level of <30µg/L for an adult is diagnostic of IDA. - TSI. - Coeliac screen (TTG). - Urine dip (1% renal tract pathology). Primary care should also state whether the patient is frail or is willing to undergo investigations if referred to secondary care. • Whether a referral is needed for certain patients, such as: - Healthy young people with an obvious cause for IDA. - Menstruating young women. - Pregnant women. - Terminally ill people or those unable to undergo invasive investigations. - People who refuse further investigations. • 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. - Whether parental iron via ambulatory care can be considered. • The further management of patients once diagnostics have been carried out by secondary care. • Further considerations such as: - Vetting 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. • LA is happy to support with developing this pathway into a GP friendly version with help from Jonathan Bryant. • The group agreed that to do a wide cross-cutting pathway would prove too complicated but to instead focus on supporting GPs to differentiate between anaemia and IDA as it was highlighted that 2ww clinics are flooded with anaemia patients who perhaps should be on alternative pathways if certain tests were carried out in primary care first or could indeed, if appropriate, be managed in primary care. • Once an agreed pathway is in place, this will be incorporated in to the operational policy.	
9	**Research & Clinical Audit**	• No update provided.	
10	**CNS Updates**	**<u>DVH – update provided by Kathleen Coleman</u>** • The team have commenced with stratified pathways. • A post for a colorectal metastatic nurse is due to go out to advert soon. • The service has asked for some additional STT and stratified pathways resources as part of the transformational bids piece. • Louise Rafferty is the Lynch Champion for DVH. **<u>EKHUFT – update provided by Ruth Burns</u>** • WHH have had the stratified pathways service in place for some time now, with QEQM commencing with it 2 months ago. • The Cancer Support Worker is due to be replaced. • The service is looking to recruit 3 new CNS' to support the STT service. Additional staffing will also be able to support with the PTL and 2ww workload. • EKHUFT are trialing end of treatment summaries. • RBu is the Lynch Champion for EKHUFT. **<u>MFT – update provided by Karen Hills</u>** • The team are up and running with the stratified pathways service. • A new Band 7 is in place for the team. • A Lunch & Learn session pertaining to the STT service has been provided to primary care colleagues. • The service currently has about 100 metastatic patients. • Marie-Francoise Jakarasi is the Lynch Champion for MFT. **<u>MTW – update provided by Samantha Seker</u>** • The stratified pathways service is functioning well and has received positive patient feedback. • SS stated she is the Lynch Champion for MTW and is undertaking genetic counselling learning. • The team have a very helpful Band 4 undertaking HNAs. • A Band 6 Colorectal Development Nurse is in place for the service.	

		• MTW currently have a vacant CNS position. • **Action: JBe to provide a presentation on the Lynch Syndrome/Bowel Cancer Screening Programme at the next meeting with Jade Pilcher from EKHUFT.**	**JBe/Jade Pilcher**
11	**Cancer Alliance update**	**Presentation provided by Holly Groombridge** • HGro provided the group with an overview of the various projects relating to the following workstreams (please refer to the presentation circulated on 18.04.2023 for a detailed breakdown of what these are): - Faster diagnosis and operational performance. - Early diagnosis. - Treatment and care. - Cross-cutting.	
12	**AOB**	• PB stated he, and the core colorectal team at EKHUFT, would appreciate the opportunity to attend other Trusts MDT meetings in order to obtain an understanding of how they operate. **Action: MFT, DVH and MTW MDT colleagues to provide AW with the joining details for these meetings which she will then share with PB.**	**MFT/ DVH/ MTW MDT teams**
	Next meeting date	• Tuesday 10th October 2023 (09:00-12:30). Venue to be confirmed in due course.	