

Colorectal Tumour Site Specific Group meeting
Tuesday 17th November 2020
Microsoft Teams
09:30 – 12:30

Final Meeting Notes

Present	Initials	Title	Organisation
Pradeep Basnyat (Chair)	PB	Consultant General & Colorectal Surgeon	EKHUFT
Biju Aravind	BA	Consultant Colorectal Surgeon	EKHUFT
Stella Grey	SGrey	Service Manager	EKHUFT
Sudhakar Mangam	SMa	Consultant General and Colorectal Surgeon	EKHUFT
Nipin Bagla	NB	Consultant Histopathologist	EKHUFT
Ruth Burns	RBu	Lead Colorectal CNS	EKHUFT
Deniece Merrall	DM	Colorectal CNS	EKHUFT
Mansoor Akhtar	MA	Consultant General Surgeon	EKHUFT
Sue Stubbs	SSt	Colorectal CNS	DVH
Julie Beszant	JB	Bowel Cancer Screening Manager	DVH
Rakesh Bhardwaj	RBh	Consultant Laparoscopic, General and Colorectal Surgeon	DVH
Piero Nastro	PN	Consultant General and Colorectal Surgeon	DVH
Marie Payne	MP	Lead Cancer Nurse / Clinical Services Manager	DVH
Claire Mallett	CM	Programme Lead – LWABC/PC&S	KMCA
Irene Nhandara	IN	Programme Lead – Early Diagnosis	KMCA
Serena Gilbert	SGi	Cancer Performance Manager	KMCA
Colin Chamberlain (Notes)	CC	Admin Support	KMCC
Karen Glass	KG	Administration & Support Officer	KMCC
Annette Wiltshire	AW	Service Improvement Facilitator	KMCC
Esther Adebajo	EA	Clinical Research Practitioner	MFT
Sue Green	SGree	Macmillan Recovery Package Facilitator	MFT
Angela Bell	AB	Colorectal CNS	MFT
Melisa Goodwin	MG	Colorectal CNS	MFT
Henk Wegstapel	HW	Consultant General Surgeon	MFT
Will Garrett	WG	Consultant Colorectal Surgeon	MFT
Anna Nadar	AN	STT Colorectal Nurse	MTW
Elaine Ellis	EE	STT Colorectal Nurse	MTW
Meeta Durve	MD	Consultant Clinical Oncologist	MTW
Monika Verma	MV	Consultant Histopathologist	MTW

Kent and Medway Cancer Collaborative

Raza Moosvi	RM	Consultant Colorectal Surgeon	MTW
Stefanie Outen	SO	Colorectal CNS	MTW
Chris Wright	CW	Consultant Colorectal and General Surgeon	MTW
Amanda Clarke	AC	Consultant Clinical Oncologist	MTW
Stefano Santini	SSa	Macmillan GP	NHS Kent & Medway CCG
Jack Jacobs	JJ	Macmillan GP	NHS Kent & Medway CCG
Andrew Roxburgh	AR	GP Commissioner	NHS Kent & Medway CCG
Bana Haddad	BH	Macmillan GP / Clinical Lead – LWABC/PC&S	NHS Kent & Medway CCG / KMCA
Julia Addison	JA	Patient Representative	
Apologies			
Stephen Morgan	SMo	Consultant Radiologist	
Andrew Muller	AM	Consultant Gastroenterologist	DVH
Chris Fox	CF	Consultant Gastroenterologist	EKHUFT
Larissa Williams	LW	Colorectal CNS	EKHUFT
Joanne Cooke	JC	Consultant Surgeon	EKHUFT
Louise Gladwell	LG	Clinical Trials Administrator	EKHUFT
Mohamed Rabie	MR	Specialty Registrar – Surgery	EKHUFT
Samantha Hughes	SHu	STT Colorectal Nurse	EKHUFT
Sandra Holness	SHo	Cancer Pathway Tracker Coordinator	EKHUFT
Natalie Jarrett	NJ	Colorectal CNS	EKHUFT
Mark Hill	MH	Consultant Medical Oncologist	MTW
Karen Hopkins	KH	Bowel Cancer Screening Practitioner	MTW
Samantha Seker	SSe	Colorectal CNS	MTW
Hayley Geere	HG	Colorectal CNS	MTW
Sona Gupta	SGu	Macmillan GP	MTW
Riyaz Shah	RS	Consultant Medical Oncologist	MTW
Jo & David Gascoyne	J&DG	Patient Representatives	NHS Kent & Medway CCG

Item		Discussion	Agreed	Action
1	TSSG Meeting	<p>Apologies</p> <ul style="list-style-type: none"> The apologies are listed above. <p>Introductions</p> <ul style="list-style-type: none"> PB welcomed the members to the meeting and asked them to introduce themselves. PB stated there had been a number of mini TSSG meetings since the last full TSSG meeting and they have been very productive. This is his first full TSSG meeting as chair. 		

		<p><u>Action log Review</u></p> <ul style="list-style-type: none"> The mini TSSG action log was reviewed, updated and will be circulated with the final minutes from this meeting. It was agreed the mini TSSG action log would be merged with the full TSSG action log for ease of reference going forward. <p><u>Review previous minutes</u></p> <ul style="list-style-type: none"> The final minutes from the last mini TSSG meeting which took place on 10.09.2020 were reviewed and agreed as a true and accurate record. 		
2	Follow up after Rectal Brachytherapy	<p><u>Update provided by Alexandra Stewart</u></p> <ul style="list-style-type: none"> Alexandra Stewart did not attend this meeting so will be allocated an agenda slot at the next TSSG. 		
3	qFIT	<p><u>Audit of patients – presentation provided by Chris Wright</u></p> <ul style="list-style-type: none"> CW mentioned the NICE FIT study on 10000 patients is due to be published imminently. There is a high negative predictive value for qFIT and it is perceived as a good ruling out test. CW stated patients find the qFIT kit a lot simpler to use than that of the faecal occult blood test kit. Upon lockdown, they were unable to perform colonoscopies/virtual colonoscopies. This prompted the need for the Trust to start utilizing qFIT. At the peak of Covid, weekly referral rates reduced from 100 to below 30 at one point and a decision was made to initiate telephone clinics for all patients. The qFIT analyser was already in the laboratory at Maidstone Hospital prior to the collection of data due to work on the low-risk pathway. MTW decided the positivity level was to be set at 10ug/g and results greater than this would be offered a test. A limited virtual colonoscopy (CT with oral contrast) was offered to those with a result of 10-149ug/g and a colonoscopy for 150ug/g+ cases based on NICE FIT data. They had some issues with posting the kit due to Royal Mail raising concerns around samples being sent during the height of the pandemic. The audit was based on the first 500 qFIT kits sent out by MTW. The information was sourced from a prospective database (which AN, EE and their administrator have been maintaining) with pathology, PAS and radiology systems collating additional data. CW mentioned they are sending out 30-40 kits each week, although it is sometimes more or less as was the case during the audit. There was an overall decrease in the time it took from referral to the return of the qFIT. It was initially taking 10-12 days but this reduced to 7-8 days. It then typically took 2 further days for the sample to be analysed as the qFIT analyser ran 3 times per week (and still does). 17 kits were not returned, with each patient chased up on days 7 and 14 before they were discharged. Of the 500 cases: 69% had a qFIT result of below 10ug/g, 22.4% had a result of 10-149ug/g 		

		<p>and 8.6% had a result of 150ug/g+.</p> <ul style="list-style-type: none"> • No cancer was detected in those with a qFIT level of below 10ug/g. 17 patients were re-referred but none of them had serious lower GI pathology. • Of those with a qFIT result of 10-149ug/g, 6 had colorectal cancers. • Of those with a qFIT result of 150ug/g+, 13 had colorectal cancers. • 78 referrals were received due to rectal bleeding (53 with a qFIT result of below 10ug/g, 12 with a result of 10-149ug/g and 13 with a result of 150ug/g+). CW stated there may be a role for qFIT in intermittent rectal bleeding as a rule out test. • When compared to 500 referrals from the same period in 2019, 337 patients would have been eligible for a qFIT this year. • Compared with a symptomatic referral, CW stated qFIT is a much better predictor of the likelihood of bowel cancer and significant polyps. • A qFIT result of below 10ug/g is highly predictive of the absence of bowel cancer. A result of 150ug/g+ is highly predictive of lower GI pathology which CW states helps them to identify who needs what test. • CW advised the current level of 2ww referrals (90-100 a week) is unsustainable. They have implemented additional 2ww clinics on Saturdays and Sundays and the endoscopy service is running 7 days a week with the help of insourcing. • CW advised MTW could save £40000 each month by utilizing qFIT instead of colonoscopies. • CW suggested the TSSG consider adopting the qFIT piece in the community for all colorectal symptoms regardless of whether they are deemed high-risk or low-risk. • JJ asked whether the audit took in to account iron deficiency anaemia patients with rectal bleeding. CW confirmed it did, although the numbers were few. • CW emphasised the importance of safety netting patients to ensure inevitable missed cancers are found. • CW stated patients should not re-enter the 2ww pathway unless a cancer is found on further investigations. • They are looking to implement a one-stop fresh rectal bleeding clinic in order to streamline patients and to try and avoid them from being put on a 2ww pathway. • CW paid thanks to the CNS' and STT team along with Supriya Joshi and her laboratory team for their involvement in this audit. He also praised GP's for their involvement in getting the samples to secondary care. • MA stated a YouTube video on what causes a sample to be rejected is something they should consider and suggested they update the information leaflet to reflect this. • CW informed the members that qFIT is not a predictor of upper GI malignancies. <p><u>Experience of commencing qFIT from a nurse prospective – presentation provided by Anna Nadar & Elaine Ellis</u></p> <ul style="list-style-type: none"> • The laboratory initially supplied them with 20 kits. 		
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		<p>trained nurses and 1 administrator.</p> <p><u>CCG Perspective – update provided by Jack Jacobs</u></p> <ul style="list-style-type: none"> • JJ thanked CW, AN and EE for sharing a comprehensive overview of the qFIT piece. He believes there is strong data to support qFIT being the gold standard diagnostic for both low-risk and high-risk patients. • At the last KMCA Early Diagnosis Working Group meeting, there was a consensus that it would be advisable to rollout low-risk qFIT K&M-wide in December 2020. However, JJ highlighted the importance of ensuring there is sufficient primary care education in place before this is implemented. SGi suggested using the 2 qFIT presentations provided today to assist in the education piece for primary care colleagues. • BA stated a number of his patients have refused to do the qFIT test. In such cases, the nursing team call the patient to follow this up. • JJ stated there had been some initial issues with patients not doing the test properly but this seems to have been rectified as they have not had any rejections from secondary care. • CW highlighted the importance of ensuring it is rolled out properly as failure to do so could result in the benefits of the test being lost. • Action: qFIT Working Group to compile a K&M qFIT SOP for both low-risk and high-risk patients with input from primary and secondary care. Safety netting measures to be included in this. 		<p>qFIT Working Group</p>
<p>4</p>	<p>Performance</p>	<p><u>DVH – update provided by Marie Payne</u></p> <ul style="list-style-type: none"> • DVH failed to meet the 2ww standard in June, July and August 2020. A clinician retired and this resulted in some delays. The Trust has asked for transformational funding in order to recruit a 0.5 WTE STT CNS. • They recently recommenced the use of qFIT and are starting to see the benefits of this. • They achieved the 31d standard in June, July and August 2020. • The Trust failed to hit the 62d standard in June, July and August 2020. • They had 1 104d+ case in June but none in July and August 2020. • Breach analysis reasons included endoscopy delays and complex surgery cases. • DVH failed to meet the 28d compliance standard in June but did so in July and August 2020. In terms of overall data completeness, they were at 27% as of October 2020. They are working with the MDT Coordinators in order to improve the 28d completeness data capture. • MP mentioned endoscopy delays are mainly due to capacity issues rather than patient choice. <p><u>EKHUFT – update provided by Stella Grey</u></p> <ul style="list-style-type: none"> • EKHUFT met the 2ww standard in July, August and September 2020. They had 180 2ww referrals last week and are now seeing more cases coming through than they were pre-Covid 		

		<p>(with an average of 160 per week). Additional capacity is in place to support this and they hope to achieve the target in October and November 2020. They have been utilizing qFIT for cases with altered bowel habit in order to try and speed the process up.</p> <ul style="list-style-type: none"> • They met the 31d target in July and September but failed to do so in August 2020 due to theatre capacity issues. • EKHUFT failed to achieve the 62d standard in July, August and September 2020. In July there were a number of diagnostic delays and in August and September 2020 there were medical treatment delays and complex pathway cases. • They had 3 104d+ cases in July, 3 in August and 1 in September 2020. • The Trust failed to achieve 28d compliance in July, August and September 2020. In terms of 28d completeness, they achieved the standard in July and September but failed to do so in August 2020. • SGrey stated they have approximately 15 patients on their 62d PTL breaching at any one time but they are working on focussed clinical validation to ensure that everyone on the PTL is suitable to be on there. <p><u>MFT</u></p> <ul style="list-style-type: none"> • A verbal update was not provided due to James Shaw having to leave the meeting before the performance section was discussed. • They achieved the 2ww standard in August, September and October 2020. • The Trust failed to achieve the 31d, 62d and 28d compliance targets for August, September and October 2020. • MFT had no backlogs in August, September and October 2020. <p><u>MTW – update provided by Chris Wright</u></p> <ul style="list-style-type: none"> • They achieved the 2ww standard for July, August and September 2020. • They hit the 31d target in July but failed to do so in August and September 2020. • With regards to the 62d standard, they did not achieve this in July and August but did in September 2020. • MTW had 1 104d+ case in July, none in August and 1 in September 2020. • They had a backlog of 16 in July, 8 in August and 17 in September 2020. • In relation to 28d compliance, they did not achieve the target in July and August but did so in September 2020. They failed to reach the 28d completeness standard in July, August and September 2020. They have had a reduction in admin time and this has had an impact. • CW stated virtual colonoscopy results are not sent to patients but colonoscopy results are. PB believes this needs to be looked in to, although CW feels there may be a reluctance from radiology to change this. • They are receiving an increasing number of referrals and this is proving challenging, especially as they are currently down by 1 colorectal surgeon. 		
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5	Clinical Pathway Discussion	<p>HOP & POC</p> <ul style="list-style-type: none"> Action: PB/AW to set up a meeting with specific colleagues in order to update both documents. Trust information needs to be reviewed by the providers and updates included accordingly. PB stated the documents need to include sections on qFIT, telephone clinics, updated pathology guidance and TNM staging. Reference also needs to be made detailing the Trusts' Covid responses, how they functioned during the first peak and what they are now dealing with following the second national lockdown. MD stated the anal cancer pathway needs to be updated as there have been some patient flow issues. With regards to the anal cancer pathway, CW stated MTW use a different PACS system to the other Trusts. Their radiologists have stated the image resolution is of inferior quality on a browser and asked the other Trusts to send the documents to them through the IEP method. Failure to do so can delay the patient pathway. CW stated the MDT Coordinator will recirculate the MTW generic email address. 		PB/AW
6	Stratified Pathways	<p>Presentation provided by Claire Mallett & Bana Haddad</p> <p>CM provided an overview of the following:</p> <ul style="list-style-type: none"> The Covid pandemic response resulted in a number of patients being informed they could not come in to hospital for their appointments unless it was deemed clinically necessary. In view of this, clinical teams were asked to utilise virtual consultations for patient appointments. This is paving the way to stratify patients and develop supported self-management pathways. Throughout lockdown, NHSE asked cancer alliances to continue prioritising the rollout of personalised stratified follow-ups. eHNA's have been implemented in all 4 Trusts and uptake has been increasing by CNS teams and support workers throughout the pandemic. Colorectal remote tracking systems have entered extended testing periods for CNS' and support workers with the piloting phase expected imminently. Action: CM stated she would circulate the SWAG Cancer Alliance treatment summaries to the K&M CNS', colorectal MDT leads and Trust clinical leads following the meeting for their review and comments. CM highlighted the importance of having input from the group in order to collate ideas for patient self-management. RBu agreed to liaise with her colleagues at EKHUFT regarding today's discussions. CM 		CM

		<p>confirmed the treatment summaries are embedded in InfoFlex along with HNA's and care plans.</p> <ul style="list-style-type: none"> • CM referred to the Cancer Care Map, an online directory which assists people in locating cancer care and support services in their local area. Cancer patients as well as their friends and family can either manually search for a service or browse the types of services available. There are a number of stories and videos which display how the services have benefited other people living with cancer and signposts services across the country whether they are NHS-led, charity-funded or community-based. The directory was given clinical and governance support by St Thomas' Hospital. CM has encouraged clinical colleagues to inform their patients of this resource being available to them. 		
7	Research	<ul style="list-style-type: none"> • A number of trials were shut down during the Covid peak but some are now reopening. • PB advised he had been in contact with Rakesh Raman who stated MTW are looking in to conducting an Aspirin phase 4 trial in an adjuvant setting which MD confirmed was an observational study following LONSURF. MD advised the Trust is also looking in to the ENCORE trial. • MD also made reference to the following trials: <ul style="list-style-type: none"> - PLATO (MD stated she needs to complete the QA for this trial before they can recruit to it) - Add-Aspirin for early stage colon or rectal tumours (open for recruitment) - Empress study (currently recruiting to) - ARISTOTLE (currently in follow-up) - FOCUS4 (currently closed) - NeoART (currently closed) - POLEM (currently closed) - TRACC (currently closed but may reopen in the next 2 months) - CRYSTAL-10 (currently closed but may reopen in the next 2 months). • WG stated MFT are taking part in the ALLEGRO and SERENADE trials. • PB recommended a colorectal TSSG research hub be formed to review what trials other Trusts are recruiting to. He added trainee doctors may also be interested in the opportunity to link in with this piece of work. • MD advised some patients are being sent to other Trusts to take part in trials. 		
8	Clinical Audit	<p><u>Histopathology Reporting Standards for CRC at EKHUFT in 2019 – presentation provided by Oreoluwa Suleiman</u></p> <p>OS's presentation referred to the following:</p> <ul style="list-style-type: none"> • The recommendation that regular audits of colorectal pathology reports are completed to make sure overall results are within, or close to, the expected standard. • The recommended audit standards by the Royal College of Pathologists. • Audit data (301 patients were seen and 263 cases were analysed). • A comparison of colorectal data with the recommended Royal College of Pathologists 		

		<p>standards.</p> <ul style="list-style-type: none"> • The median number of lymph nodes examined (21) and the percentage of cases with lymph nodes examined (89%). • The number of cases with vascular invasion. • The number and percentage of cases with serosal involvement. • The number of cases seen per Consultant. • OS stated standards are being met and it is important to undertake this audit each year. 		
<p>9</p>	<p>CNS update across Kent & Medway</p>	<p><u>EKHUFT – update provided by Ruth Burns</u></p> <ul style="list-style-type: none"> • There have been some new nursing appointments since the last full Colorectal TSSG meeting. One of these has been leading on the qFIT piece. • Involvement with the PTL piece has been time-consuming due to the volume of cases. • They have not worked in the wards during the pandemic. • They had a few issues with oncology support but RBu hopes this will be rectified. • They are now working with the support workers to embed HNA’s and this has progressed well. • They would like to get started on the stratified pathways piece at some point in the near future. <p><u>MTW – update provided by Stefanie Outen</u></p> <ul style="list-style-type: none"> • A number of staff were redeployed during Covid, with some working in ITU and others in the swabbing team. • The Trust is currently down by 2 WTE CNS’ and is therefore struggling with the workload. However, 2 new CNS’ will be starting at the end of November 2020. • The oncology team has had a lack of support from CNS’ given the challenges presented by Covid and how services then had to be changed accordingly. • Elective surgery has been transferred from Maidstone Hospital to Tunbridge Wells Hospital. <p><u>MFT – update provided by Angela Bell & Melisa Goodwin</u></p> <ul style="list-style-type: none"> • Half of the team were redeployed during Covid and workload suffered as a result. • There have been some discussions with senior management regarding the possibility of them being redeployed again due to the increase in Covid cases and the aftermath of the second lockdown. • They are working with SGr regarding moving forward with the stratified pathways piece. • A telephone support service has been initiated. • They have struggled with a lack of oncology support. <p><u>DVH – update provided by Sue Stubbs</u></p> <ul style="list-style-type: none"> • SSt stated she works alongside Kathleen Coleman (a Band 6 CNS who works 3 days a week) and Trish Sewell (2ww Colorectal Rapid Access CNS) who leads on the early diagnosis piece. • They have noticed a significant increase in the number of rapid access referrals. 		

		<ul style="list-style-type: none"> The endoscopy unit was closed for 9 weeks which resulted in there being a significant endoscopy backlog. This is reflected in there being over 500 patients on their PTL. They have had very helpful support from their MDT Coordinator. A small number of elective surgery slots took place at KIMS (independent sector provider) but all surgery is now being performed at the Trust. They have received a number of emails from patients expressing their anxiety with regards to coming in to the hospitals due to Covid. Nurse-led clinics continue via telephone. CM stated she would be happy to set up a CNS group meeting to discuss moving forward with the stratified pathways piece if the Trusts would like this. 		
10	Update on Bowel Screening	<p><u>Presentation provided by Will Garrett</u></p> <ul style="list-style-type: none"> Staff were redeployed during the first Covid peak but a number of them have since returned to their original roles. The bowel screening programme was paused upon lockdown but recommenced in June 2020. A total of 3120 hub invitations are being sent out and they are now seeing all patients within 2 weeks. The backlog has reduced, available slots are open and they have reduced surveillance as per national guidance published last year. They are identifying an increasing number of high-risk cancers across the patch. JB stated lists at DVH have recommenced and they have been given approval to do these at QMH if needed. They are running a limited endoscopy service with 2 bowel screening lists per week. They are receiving an increasing number of referrals. Endoscopies at DVH are currently only allocated to ERCP and emergency cases with the rest going to QMH. WG advised he would send some documentation to CC who can then circulate these to the group. These documents include references to: <ul style="list-style-type: none"> The number of colonoscopies that took place at MTW (both Maidstone Hospital and Tunbridge Wells Hospital), MFT and DVH between 04.05.2020 and 02.11.2020. Bowel cancer screening backlogs (both FIT and surveillance cases) between April and October 2020. The number of backlog slots at MTW, MFT and DVH between April and October 2020. The results of diagnostic tests between March and October 2020 at MTW, MFT and DVH inclusive of detectable cancers and high-risk adenomas. The West Kent NHS Bowel Cancer Screening Programme BSG surveillance guidance. 		
11	Cancer Alliance update	<p><u>Update provided by Serena Gilbert</u></p> <ul style="list-style-type: none"> SGi referred to the Lynch Syndrome handbook which will be circulated to the members following today's meeting. 		

		<ul style="list-style-type: none"> The Alliance will be sending invites to the Trusts shortly regarding transformational funding allocation. Should the Trusts wish to discuss this further, they are advised to liaise with IN and CM. Emma Yale will be sharing an endoscopy comms plan at the designated Endoscopy meeting on 20.11.2020. This will include patient stories and other related matters and could have an impact on the volume of referrals coming in to secondary care. 		
12	AOB	<ul style="list-style-type: none"> AW confirmed the Papillon document was circulated following the last meeting but advised it could be sent out again. MD stated if clinical teams are going to refer patients for Papillon treatment to ensure they copy in their clinical oncologists as some will require whole pelvic radiotherapy. She asked the group to pay particular attention to the referral criteria and to contact her if they would like to discuss it further. SSSt manages the nurse-led Family History clinic at DVH and asked if the other Trusts refer their genetics cases to the Genetics service at Guy's Hospital, which they confirmed they did. SSSt mentioned she was invited to a virtual Genetics CNS meeting hosted by Guy's Hospital last week where they discussed an updated colorectal and Lynch syndrome proforma along with the Genetics SOP. She was unable to attend the meeting and asked if the other CNS' on today's call had joined, which they stated they had not. PB suggested AW contact the Trust to request the guidance from them. Action: AW to contact Guy's Hospital to request their updated colorectal and Lynch syndrome proforma in addition to the Genetics SOP. PB stated he would also like someone from their Genetics team to provide a talk at the next meeting. Mini TSSG meetings are to be set up on a monthly basis from January 2021 until the next full TSSG meeting in Spring 2021. The days and times of these meetings will vary to try and ensure there is equal input from all Trusts' clinical teams. 		AW
	Next Meeting	<ul style="list-style-type: none"> Next TSSG meeting – TBC. 		