Colorectal Tumour Site Specific Group meeting
Tuesday 26th October 2021
Microsoft Teams
09:30-12:30
Final Meeting Notes

Present	Initials	Title	Organisation
Pradeep Basnyat (Chair)	**PB**	Consultant General & Colorectal Surgeon	EKHUFT
Larissa Williams	**LW**	Macmillan Colorectal CNS	EKHUFT
Ruth Burns	**RBu**	Macmillan Lead Colorectal CNS	EKHUFT
Sudhakar Mangam	**SM**	Consultant General, Laparoscopic and Colorectal Surgeon	EKHUFT
Deniece Merrall	**DM**	Macmillan Colorectal CNS	EKHUFT
Gyorgy Vittay	**GV**	Consultant Cellular Pathologist	EKHUFT
Nipin Bagla	**NB**	Consultant Histopathologist	EKHUFT
Gandra Harinath	**GH**	Consultant General & Colorectal Surgeon	EKHUFT
Julie Beszant	**JB**	Acting General Manager - General Surgery, Colorectal and Urology	DVH
Hazel Craig	**HC**	Interim Trust Cancer Recovery Lead	DVH
Piero Nastro	**PN**	Consultant Laparoscopic, General and Colorectal Surgeon	DVH
Farrah Errington	**FE**	Colorectal MDT Coordinator	DVH
Trish Sewell	**TS**	2ww Colorectal Rapid Access CNS	DVH
Michelle McCann	**MM**	Operational Manager for Cancer & Haematology	DVH
Marie Payne	**MP**	Lead Cancer Nurse & Clinical Services Manager	DVH
Rakesh Bhardwaj	**RBh**	Consultant Laparoscopic, General and Colorectal Surgeon	DVH
Adam Shaw	**AS**	Consultant Clinical Geneticist	GSTT
Parthi Srinivasan	**PS**	Consultant Surgeon - Liver Transplantation, HPB & Pancreatic Surgery	King's College Hospital
David Osborne	**DO**	Data Analyst	KMCA
Karen Glass	**KG**	Administration & Support Officer	KMCC
Colin Chamberlain (Notes)	**CC**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Facilitator	KMCC
Karen Hills	**KHi**	Colorectal CNS	MFT
Jennifer Priaulx	**JP**	Macmillan Cancer Transformation Project Manager	MFT
Sue Green	**SGree**	Macmillan Recovery Package Facilitator	MFT
Isabel Gilbert	**IG**	Assistant General Manager - Cancer Performance	MTW
Jorge Gomes	**JG**	Surgical Care Practitioner	MTW
Gemma Luff	**GL**	Colorectal CNS	MTW
Stefanie Outen	**SO**	Colorectal CNS	MTW
Meeta Durve	**MD**	Consultant Clinical Oncologist	MTW
Hayley Geere	**HGe**	Colorectal CNS	MTW
Rosemeen Parkar	**RP**	Consultant Medical Oncologist	MTW
Albert Edwards	**AE**	Consultant Clinical Oncologist	MTW
Chris Singleton	**CS**	Senior Programme Manager – KMCA	NHS Kent & Medway CCG

Julia Addison	**JA**	Patient Representative	
Apologies			
Jo & David Gascoyne	**JDG**	Patient Representatives	
Catherine Neden	**CN**	GP	East Cliff Practice
Eelco Boorsma	**EB**	Consultant Radiologist	EKHUFT
Louise Gladwell	**LG**	Clinical Trials Administrator	EKHUFT
Stella Grey	**SGrey**	Acting General Manager - General Surgery, Colorectal and Urology	EKHUFT
Joanne Cooke	**JC**	Consultant General & Colorectal Surgeon	EKHUFT
Samantha Hughes	**SH**	Straight to Test Colorectal Nurse	EKHUFT
Sue Drakeley	**SD**	Oncology (Solid Tumour) Research Team Leader	EKHUFT
Susan Travis	**ST**	Interim Operations Director - Surgery & Anaesthetics Care Group	EKHUFT
Hannah Fotheringham	**HF**	Lead Macmillan Colorectal CNS	EKHUFT
Tracey Rigden	**TR**	Development Chemotherapy Nurse Consultant	EKHUFT
Nichola Atkins	**NA**	Divisional Support Manager	King's College Hospital
Serena Gilbert	**SGi**	Cancer Performance Manager	KMCA
Henk Wegstapel	**HW**	Consultant General, Laparoscopic and Colorectal Surgeon	MFT
Clarissa Madla	**CM**	Senior Clinical Research Practitioner	MFT
Ellie Thomas	**ET**	Deputy Director of Operations for Planned Care	MFT
Karen Hopkins	**KHo**	Bowel Cancer Screening Practitioner	MTW
Antony Gough-Palmer	**AGP**	Consultant Radiologist	MTW
John Schofield	**JS**	Consultant Pathologist	MTW
Samantha Seker	**SS**	Colorectal CNS	MTW
Amanda Clarke	**ACl**	Consultant Clinical Oncologist	MTW
Mark Hill	**MH**	Consultant Medical Oncologist	MTW
Raza Moosvi	**RM**	Consultant General, Laparoscopic and Colorectal Surgeon	MTW
Sona Gupta	**SGu**	Macmillan GP & Cancer Lead	NHS Kent & Medway CCG
Bana Haddad	**BH**	Macmillan GP & Cancer Lead / KMCA Clinical Lead – LWBC/PC&S	NHS Kent & Medway CCG
Ann Courtness	**ACo**	Macmillan Primary Care Nurse Facilitator	NHS Kent & Medway CCG
Kate Regan	**KR**	Macmillan Primary Care Nurse Facilitator	NHS Kent & Medway CCG
Helen Graham	**HGr**	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 with the final minutes from today's meeting.	

		Review previous minutes • The minutes from the last meeting which took place on 11.05.2021 was reviewed and agreed as a true and accurate record.	
2	**Lynch Syndrome SOP & proformas update**	**Presentation provided by Adam Shaw** • AS was asked to lead, alongside Kevin Monohan (Consultant Gastroenterologist – St Mark's Hospital), a national infrastructure project through NHSE by implementing better diagnosis for Lynch syndrome and to identify barriers which exist in failing to diagnose it. • Lynch Syndrome could affect 1 in 350 patients and 95% of people with it are undiagnosed. Identifying the syndrome is important in terms of deciding which treatment and surveillance measures should be put in place. • In 2017, NICE recommended everyone diagnosed with colorectal cancer be tested for Lynch syndrome. • There are now 7 Genomic Laboratory Hubs (GLHs) in place nationally. • AS provided an overview of the GMSAs which necessitate a collaboration between labs and genetic clinicians in order to facilitate genetic testing for the individual regions. • AS referred to the 'Implementing Lynch syndrome testing and surveillance pathways' handbook which was created by NHSE to support local systems. • Around 5% of patients with Lynch syndrome receive the diagnosis and genetic testing for it is only being performed in 25% of eligible cases. • NICE has recommended pembrolizumab for untreated metastatic colorectal cancer with dMMR tumours. • The handbook refers to how low cost interventions can reduce the cancer risk in Lynch syndrome. • AS provided an overview of the handbook's 'Testing for Lynch syndrome using IHC' pathway which can be modified to suit local needs. • AS referred to the South East Genomic Laboratory Hub Test Request Form for non-WGS Genetic Tests. • AS believes local MDT meetings should have a champion who would: encourage the development of this pathway and have oversight/ownership of it, work with the team to deliver the DG27 or DG42 NICE guidance, allocate specific responsibilities within the team and decide as a team whether to take on the mainstream genetic testing or ensure there are processes in place to make sure the right patients are being referred. Sometimes abnormal results are found but nothing gets actioned, which AS feels needs to be addressed. • Online training modules are in place and there is the intention to set up regional networks to help facilitate this. CPD accreditation can also be offered. The modules can be found here: Lynch Syndrome Early Diagnosis Pathway – RM Partners. • NHS North Thames and South East Genomic Medicine Service Alliances will also be running workshops on 10.11.2021 and 29.11.2021 with a particular focus on the delivery of testing, team responsibilities and pragmatic solutions. • Patients with a dMMR tumour can be referred by emailing the clinical genetics team, the email address of which AS will share with SM. • PB stated he likes the idea of having a local champion for the MDT meetings and will therefore discuss this with his colleagues. • CS informed the group funding has been made available to Cancer Alliances by NHSE. The KMCA will be meeting with the pathology team at MTW in November 2021 to work on a Kent & Medway-wide benchmarking exercise in order to understand the current availability of the tests and what further, if anything, needs to be done to the pathway. They will then subsequently link in with the genomics regional service and make this uniform across the patch as soon as possible.	
3	**NICE quality standard on colorectal cancer update**	**Presentation provided by Pradeep Basnyat** • PB provided a presentation relating to the NICE guidance (NG151) published on 29.01.2020. The guidance covers the management of colorectal cancer for those aged 18 and over and aims to improve the quality of life and survival for patients through management of local disease and of secondary tumours (metastasis). The recommendations were developed before the COVID-19 pandemic. • The slides provided information for people with colorectal cancer and gave recommendations on: - The reduction in risk of colorectal cancer in people with Lynch Syndrome. - The management of local disease in early rectal cancer (cT1-2, cN0, M0), specifically in relation to Trans Anal Excision including TAMIS & TEMS, ESD and TME, and the pros and cons of each. - The complications associated with TAMIS/TEMS, ESD and TME. - Pre-operative treatment for people with rectal cancer. - Surgery for people with rectal cancer. - Surgical technique for people with rectal cancer. - People with locally advanced or recurrent rectal cancer. - Surgical volumes for rectal cancer operations.	

		- People with either colon or rectal cancer. - Colonic stents in acute large bowel obstruction (LBO) and the use of molecular biomarkers to guide systemic anti-cancer therapy. - Management of metastatic disease. - People with metastatic colorectal cancer in the liver, lung and peritoneum. - Ongoing care and support, in particular for follow-up for detection of local recurrence and distant metastases. - Management of low AR Syndrome. • PB stated some of the recommendations listed above can be incorporated in to the HOP/PoC documents.	
4	**CRC Liver mets**	**<u>Presentation provided by Parthi Srinivasan</u>** • PS provided a background to his update on colorectal liver metastases at King's College Hospital. • The liver is the most common site of colorectal cancer metastasis and will affect 20-30% of patients at the time of diagnosis. During the disease course, 50% of patients will develop colorectal liver metastasis. 10-20% of these will be considered suitable for curative resection. • 5 year survival is currently 40% and 10 year survival is currently 25%. • In terms of early recurrence (within 12 months) post-resection of colorectal liver metastasis, this is currently 30%. Mortality is currently 15%. • PS provided an update in relation to the role of SACT, non-resectional treatments, the approach to synchronous disease and surgery for bilobar disease/small liver remnants. • PS' slides provided an overview of: - The theoretical benefits of neoadjuvant therapy as well as a summary of the new EPOC trial. - Non-resectional treatments in addition to DEBIRI. - The optimal treatment sequence in synchronous disease. - The optimal surgical sequence in synchronous disease. - The argument for combined vs staged resections. - Current strategies for small FLR. - Laparoscopic liver resections. • In summarising: - Advances in treatment, routine MDT meeting discussion, centralisation and other factors have conferred an improvement in median overall survival. - The role of perioperative chemotherapy is well-established but controversy exists about the longer term overall and progression-free survival benefits. - The sequence of surgery and the option of combined resection remain for local MDT meeting preference (there is no high-level evidence to support one approach over the other). - Minimally invasive surgery will become more widespread and current evidence demonstrates benefits (a number of RCTs ongoing). - Locoregional treatments such as SIRT and DEBIRI have increased access to treatment for those with advanced disease. - With innovative volume augmentation strategies, patients with extensive and bilobar disease are now increasingly being considered candidates for resection. • PB thanked PS for agreeing to help update the liver sections of the PoC document. • PS stated King's College Hospital have invited colorectal surgeons, including PB, to come to their hospital to perform synchronous disease surgery jointly. With regard to left-sided tumours, PS believes it would be advisable to do more combined surgery. The situation regarding ITU bed availability for these patients is not currently a problem and cancer cases are being given priority.	
5	**Performance**	**<u>DVH</u>** • DVH failed to meet the 2ww standard in July and August 2021 but are predicted to meet it in September 2021. An increase in RAC clinics has been put in place to meet the demand and bring the booking slots down to 3 days (which is reflected in the September 2021 performance despite the increase in referrals). • The Trust failed to meet the 31d standard in July and August 2021 and are predicted to fail it in September 2021 too. • DVH failed to meet the 62d standard in July and August 2021 and are predicted to fail it in September 2021 too. Breach reasons include: multiple diagnostics being required, surgeries being booked between 30-60 days due to ITU bed availability, patient choice, complex pathways, EMR capacity and the clearing of legacy patients.	

- The Trust had 8 104d+ cases in July 2021, 4 in August 2021 and are predicted to have 8 in September 2021.
- DVH's backlog as of 22.10.2021 is:
  10 patients >104d (2 of which have confirmed cancer and 1 has surgery in the next 7 days).
  29 patients >62d (4 of which have confirmed cancer).
- With regard to the 28d data compliance piece, the Trust failed to achieve this in July, August and September 2021.
- In relation to the 28d data completeness standard, DVH achieved this in July, August and September 2021.
- The Trust had issues with endoscopy during the pandemic but this has now been resolved and is working well. Surgical capacity due to no available ITU beds has also been an issue.
- The service has in place: a daily PTL, a daily endoscopy PTL and huddles, an escalation process with the surgical team and weekly meetings, recovery meetings, forecast planning and new post-MDT meeting OPD slots.
- The service has been experiencing issues with lack of theatre capacity due to one theatre being utilised for ITU due to COVID.
- Additional outpatient appointments are being implemented when required for patients to be seen in a timely manner whilst working around the availability of consultants.
- The colorectal team are receiving an increase in 2ww referrals with patients not being seen in primary care before the referral is made and with no relevant symptoms to justify the referral.

EKHUFT

- EKHUFT met the 2ww standard in July and August 2021 and are predicted to achieve it in September 2021 too. The colorectal service is consistently compliant with this standard. Daily calls with the team ensure capacity is managed to ensure compliance. The team have seen a surge of 2ww referrals and are trying to work towards booking before day 14 but capacity is currently challenging.
- With regard to the 31d target, EKHUFT achieved this in July and August 2021 and are predicted to do so in September 2021 too. Daily calls with the team ensure capacity is managed to ensure compliance.
- In relation to the 62d standard, the Trust failed to achieve this in July and August 2021 and are predicted to fail it in September 2021 too. The service is working with the team to highlight patients earlier in the pathway which may need additional support and CNS' are reviewing patients 30d+ to expedite investigations and appointments. Surgical capacity, patient choice and long waits for colonoscopies and VCs are contributing to their not being compliant for this standard.
- The Trust had 3 104d+ cases in July 2021, 6 in August 2021 and are predicted to have a total of 3 in September 2021.
- With regard to 62d+ backlogs, the service had 44 in July 2021, 43 in August 2021 and are predicted to have 41 for September 2021. Breach reasons include: waits for colonoscopies and VCs, patient choice to delay, surgical capacity issues and MRI waits.
- In relation to the 28d data compliance for July to September 2021, EKHUFT failed to achieve this and they account for the Trust's largest volume of 28d breaches each month. There are 2 Navigators in post and the service continues to put in place weekly Navigator training/refresher/education meetings where challenges and successes are discussed to help improve the front end of the pathway. The service is reviewing clinic letter templates to increase compliance and improve the turnaround time for qFIT results.
- With regard to the 28d data completeness standard for the period of July to September 2021, the service achieved this. Additional admin support for the 28d piece is in place to improve data collection and accuracy. The Trust are retraining Navigators so they are able to enter the 28d data on InfoFlex as soon as it becomes available.
- Extra clinics are being scheduled to accommodate the surge of referrals, regular clinical reviews are being carried out, theatre capacity is gradually being increased, early escalation calls with radiology and endoscopy continue to take place daily and the team have daily PTL calls to review the pathway for each patient and escalate issues accordingly.

MFT – update provided by Jennifer Priaulx

- MFT achieved the 2ww standard for July and August 2021 and are predicted to achieve it in September 2021 too. The Trust have achieved this standard for the past 12 months.
- The Trust achieved the 31d target for July and August 2021 but are predicted to fail it in September 2021. Performance has considerably improved since December 2020.
- The service achieved the 62d standard in July 2021, failed it in August 2021 and are predicted to fail it in September 2021 too. 20 patients

		are currently waiting over 62d, excluding bowel screening, of which there are 3 over 104d. • The Trust had no 104d+ cases in July 2021, 3 in August 2021 and are predicted to have 1 in September 2021. • With regard to 28d data compliance, MFT failed to reach the standard in July, August and September 2021. • There is pressure on the endoscopy service due to increased demand and reduced capacity. • There have been improvements to the MDT coordination team due to the following: - The recruitment of additional staff. - A new training pack has been put in place. - The appointment of a team leader. - The implementation of PTL workshops. - Additional diagnostic PTL meetings have been put in place. - The collation of a 14 point plan to improve 62d performance (which includes pathway mapping and actions to improve diagnostic turnaround times and reducing polling times). - Attendance at a Cancer Summit workshop. - Additional outpatient clinics being implemented. • Breach reasons include: 2ww: patient choice, patient unable to attend appointment and an administrative delay (ERS to PAS). 62d: bowel screening patients, delays with colonoscopies, the need for multiple diagnostics including EUA/biopsies, delays to treatment date, a patient being unfit for surgery, a patient going on holiday, CPEX testing, a qFIT delay, Sharepoint, a patient did not receive an MRI date, a patient DNA for the first appointment and an MRI delay. • There are challenges to outpatient capacity due to a large number of referrals. **MTW – update provided by Isabel Gilbert** • The Trust achieved the 2ww standard in July and August 2021 and are predicted to achieve it in September 2021 too. MTW have continued to meet this standard due to an efficient STT pathway and an expansion of the STT team. Clinical leadership on the revision of cancer 2ww pathways with the introduction of qFIT has also been undertaken. • MTW failed to achieve the 31d standard in July 2021, met it in August 2021 and are predicted to meet it in September 2021 too. The reduced performance in July 2021 was due to an increase in cancer surgeries (which itself was due to an increase in screening and 2ww referrals into the organisation). • The service failed to achieve the 62d standard in July and August 2021 and are predicted to fail it in September 2021 too. The Trust has noted an increased volume of both 2ww and screening referrals which is impacting on surgical capacity. Furthermore, delays due to qFIT at the front end of the pathway and oncology service provision (particularly in West Kent) are additionally impacting on 62d performance. • The service had no 104d+ cases in July and August 2021 but are predicted to have 1.5 in September 2021. • In terms of 62d+ backlogs, the service had 33 in July 2021, 23 in August 2021 and are predicted to have 19 in September 2021. The backlog over the past three months has continued to reduce due to a continued focus and clinical leadership of the pathway, particularly with the flow of patients through MDT meeting and allocation to operating surgeon. The backlog number includes referrals into the organisation for oncology treatment and delays in screening pathways (front end). Approximately ¼ of the backlogs are due to screening patients. • In relation to the 28d data compliance target, MTW achieved this. Performance against the standard is high due to a supportive and well-established STT team and an efficient consultant review process on patient investigations. Work has been undertaken in introducing a generic letter which will be sent to patients when they come off the pathway. Additional admin support is also now in place. • With regard to the 28d data completeness standard, this requires improvement in order to meet the 80% target. The service is working with the teams to highlight this and identify how they can improve data availability and recording. • Key risks include: patient choice and isolation, staff illness and periods of isolation, site pressures and the impact on bed capacity (not yet an issue for cancer patients but listed as a risk). • The service is putting in place the following: - Continued clinical engagement with pathway management (the introduction of qFIT into primary care stage 1 started on 18.10.2021 and	

		initial teething problems are being worked through). A revision of the 2ww booking process and patient pathway took place as a result. - An increase to the STT nursing workforce to support the front end of the pathway. - Clinical mapping of patients into next available surgery slots at the MDT meetings. - Continued daily PTLs (including face-to-face) to provide service support. - A revision of the colorectal Pathway Navigator role to support the movement of high-risk patients through the pathway. • Breach reasons include: delayed diagnostics and cancer complexities requiring input from tertiary centres (e.g. The Royal Marsden Hospital). • With regard to theatre capacity, this is flexible in line with demand but may become more challenging depending on winter site pressures. • In terms of outpatient capacity, this is flexible in line with demand.	
6	**Update on Colorectal**	**<u>Clinical Pathway Discussions</u>** **<u>HOP & PoC</u>** • This item was discussed as part of the colorectal cancer pathway presentation which SM provided. **<u>Colorectal cancer pathway – update provided by Sudhakar Mangam</u>** • SM highlighted a number of changes to colorectal services have occurred since the HOP and PoC documents were last updated in 2019, particularly in relation to improving outcomes in colorectal cancer. • Since both documents were updated, there has been: - Updated NICE guidance (NG151). - Updated BSG guidance (November 2019) which changes the way colonoscopies are performed. - Progress with regard to the implementation of qFIT. - A NICE FIT study. - An incorporation of the Faster Diagnosis Standard piece within the Cancer Waiting Times guidance. • SM noted that the pandemic has resulted in some changes to practice, including the implementation of telephone and electronic/virtual clinics. • The FSSA guidance prioritises elective cases and cancers according to priorities 1, 2, 3 and 4. • SM noted referrals are increasing day-by-day and there is an increase in surgical volumes. • SM advocated the need to identify how a slot for specialised/complex cases can be incorporated in to the MDT meetings. • SM also emphasised the need to think about incorporating standards of care in to practice and to review them annually. • The NICE guidance brought in some significant changes, especially in the area of early rectal cancer, where a discussion with the patient on whether they are given rectal preservation surgery (such as TAMIS or ESD) or the standard TME is needed. • SM believes there needs to be further discussion around giving stage 2 cancer patients pre-operative radiotherapy or chemoradiotherapy, although he appreciates there is a lot of variation in practice amongst the MDTs and how they treat their individual patients. • With regard to advanced cancers, previously the teams used to send a lot of these patients to palliative care, but beyond the TME concept, SM believes there should be a bigger discussion with the specialist centres to offer exenterative surgery. • NICE believe hospitals which offer more than 10 major resections for rectal cancers each year should offer the service and surgeons should offer at least 5 of these operations a year. • The colorectal cancer overview published last month places more emphasis on symptoms of low anti-resection syndrome, amongst others, which SM feels requires more open and wider discussions with patients so they understand what they are signing up to. • There has been a big difference in how patients are followed up. The previous version of the TSSG guidance suggested patients be followed up for 5 years whereas the current guidance states it should be 3 years (including a CEA with 6 monthly follow-ups and CT scans in the first 3 years). • The BSG guidance has changed its criteria for colonoscopies. Formerly, EKHUFT used to offer a colonoscopy at 5 years but the updated guidance states they should do it at 1 year and 3 years thereafter. • In 2017, ACPGBI advocated following up patients for 3 years with a colonoscopy at 1 and 5 years. • With regard to qFIT, EKHUFT have produced some guidelines and SM wondered if these could be incorporated in to the pathway. The	

FSSA has also come up with guidance regarding prioritisation which EKHUFT are adhering to.

- The Cancer Registration Statistics document was published last week (for 2019 data) which shows there has been an increase in cancers but the rate of death from cancer has fallen (about 1% in men and 2% in women).
- There are going to be some changes in the community with regard to commissioning with the abolition of the CCGs and the introduction of ICPs.
- SM feels the updating of the KMCC guidance needs to include:

- The changes to NICE guidance.
- 6 monthly follow-ups for 3 years (either telephonic or face-to-face).
- Colonoscopies at years 1 and 4 and CT scans should be done in the first 3 years (either at year 1 and 3 or years 1, 2 and 3 as the guidance outlines) for non-metastatic curative resections. Metastatic cancers will have different pathways depending on the stage of the disease.
- For complete responders, patients should be offered a resection or a wait and watch with an intensive follow-up protocol. The Royal Marsden protocol is currently being followed with three-monthly MRI scans and flexis in the first year and every 4 months in the second year.

- SM believes there should be a wider discussion on developing standards of care across the network to streamline MDT meetings in the future.
- With regard to early rectal cancers, EKHUFT has an ESD and EMR service and they have developed a very good complex polyp MDT. SM confirmed he had spoken to the lead of this MDT and it will be able to accept Kent-wide referrals in the near future. Having this local service in place will prevent the need for cases to be sent to London hospitals for discussion at their MDT meetings.
- SM mentioned the next KENT course, which runs annually, will take place in September 2022.
- SM believes the documents should be run past the Operational & Quality group, patient and public representatives and the TSSG itself before they are finalised.

Anaemia pathway – presentation provided by Gandra Harinath and Larissa Williams

- GH stated the revised BSG guidance was published on 29.09.2021 (first published on 11.05.2011).
- GH's slides provided the group with an overview of:

- How common IDA is, the fact it often presents in primary or secondary care, its insidious nature in that it can be quite difficult to identify, how it has not always been optimally managed despite the considerable burden of the disease, the fact inappropriate investigations are sometimes carried out or are incorrectly timed or incomplete and the fact iron replacement therapy is sometimes neglected.
- The initial investigations for IDA which should be carried out in primary care.
- The FIT test which is not currently recommended as an investigation of choice to rule out cancer and primary care should be made aware of this.
- The small bowel evaluation which is not recommended for everyone.
- The treatment of IDA. The recommended treatment for men and post-menopausal women newly diagnosed with IDA is a gastroscopy/colonoscopy or a CT cologram if the patient cannot proceed with endoscopic investigations.
- Iron treatment recommendations. Iron replacement therapy should not be deferred while awaiting investigations for IDA unless the colonoscopy is imminent.
- IDA in young women.
- IDA in young men.
- Specific comorbidities associated with IDA.
- IDA in irritable bowel syndrome (IBD). IDA is a common manifestation of IBD, particularly when the disease is active.
- Highly effective components of the IDA service.
- IDA service considerations. All service providers should have clear points of referral and management pathways for patients with IDA. To ensure sufficient use of resources, GH recommends IDA pathways be delivered by a designated team led by a senior clinician. It is also recommended that service providers should aim to have an ambulatory care base for the administration of parenteral iron therapy.

- In order to improve the iron deficiency anaemia pathway, GH believes there is a need to:

- Have a defined pathway in each Trust based on local audits.

		- Educate primary care clinicians and ensure good communication is in place to prevent any duplication of investigations. • With good pathways and robust leadership, GH believes emergency admissions for anaemia will be prevented. He also believes this will help the Trusts meet the 28d and 62d standards as anaemia will not be restrictive in proceeding with surgical treatment where surgery is necessary. • PB believes it would be helpful for GH to incorporate a pathway algorithm for IDA comprising of 2 sections: 1. The referral pathway for IDA. 2. The management and treatment of IDA. • GH stated he was thinking of contacting primary care clinicians, specifically the designated GPs in primary care who are interested in colorectal cancer management, to ensure they are aware of the pathway and should be following it prior to sending a referral to secondary care. These GPs can then disseminate this to their GP colleagues. • In the last 6 months, the EKHUFT nursing team have been triaging referrals and have identified a large (at least 50%) number of their IDA patients are being referred in without having had the appropriate investigations. LW and GH are in the process of creating a pathway which can be utilised within the Trust but can also be shared with GPs to try and expedite this issue. • **<u>Action:</u> PB to link GH and LW in with Jack Jacobs.**	**PB**
7	**MDT Streamlining**	**<u>Update provided by Ruth Burns</u>** • The guidance has been developed to enable cancer MDT meetings to respond to the changing landscape in cancer care, as recognised in the NHS Long Term Plan and the Independent Cancer Taskforce Report. • The guidance sets out how MDT meetings can continue to provide effective clinical management by remaining focussed on discussion of those patient cases which require full multidisciplinary input. This approach aims to support MDT meetings in three ways: - Firstly, it should help to ensure there is adequate time for discussion of cases where it is needed, by allowing more focus on complex cases in the MDT meeting. - Secondly, streamlining should ensure valuable diagnostic and clinical time is used most effectively by creating more flexibility in management of the MDT meeting. - Thirdly, the policy will increase the transparency and consistency of care by agreeing the treatment or care any patient should expect to receive across Cancer Alliances. • The key principle to achieve MDT meeting streamlining is that all patients remain listed and recorded at the MDT meeting, however patients will be stratified into two groups: - Cases where full discussion at the MDT meeting is required, for example due to clinical complexity or psycho-social issues. - Cases where a patient's needs can be met by a standard treatment protocol (or Standard of Care), and so do not require discussion at the MDT meeting. • MDT streamlining will be supported by agreeing Standards of Care (SoCs) across Cancer Alliances. These SoCs will set out the treatment or care patients should expect to receive. Introducing MDT streamlining is not mandatory however it is recommended that Cancer Alliances work with Trusts locally to identify how this approach could benefit patients, clinicians, and MDT meetings. • The principles set out here are not a one-size-fits-all approach and should be considered in relation to patient need, local circumstance, and by tumour site. Where Trusts introduce streamlining this guidance must be followed. • In summarising, the guidance provides an overview of: the successful implementation of MDT meeting streamlining, developing standards of care for MDT meeting streamlining, implementing standards of care in the MDT meeting, the pre-MDT meeting review of cases, case studies, audits and next steps and implementation.	
8	**Research & Clinical Audit**	**<u>Immunotherapy – presentation provided by Rosemeen Parker</u>** • RP provided an update in relation to immunotherapy in colorectal malignancies. Her slides included: - A definition of what dMMR and MSI-H are and a case study for each. - An overview of sporadic tumours which carry the mutations (with the most common deficient protein in the sporadic type being MLH1 which accounts for 12-13% of cases). The most common deficient proteins in Lynch syndrome are MLH1, MSH2, MSH6 and PMS2 and these account for 3% of cases. - An overview of the characteristics of dMMR tumours. - The mechanism of action for nivolumab and pembrolizumab.	

		- An overview of, and evidence for, the CheckMate 142 and KEYNOTE-177 studies. • There is now funding (via the CDF) to use either single agent nivolumab as a subsequent line of treatment after chemotherapy or combination ipilimumab-nivolumab. There is also the option to use pembrolizumab as a first line treatment in patients who have metastatic disease.	
9	**Pathology update on Colorectal cancer**	**Presentation provided by Nipin Bagla** • In terms of basic practice, the service is maintaining standards and doing an adequate number of lymph nodes (20 per case). The team are also doing a lot of vascular staining. • Cases are now being morphologically subclassified. • Molecular testing cases are sent to Maidstone. Funding has been centralised in to the GLH, which for the Kent & Medway region is situated at Guy's Hospital, and cases will be sent there in due course as part of a pilot. NB has been in contact with the team at Guy's Hospital regarding turnaround times and they informed him the national standard is 3 weeks. He believes the oncologists should be made aware of this as it helps to identify when chemotherapy can commence. • The team are seeing a lot of early resection cases. • The service is using locums and other companies to help alleviate staffing issues/decrease turnaround times and this has worked well. Staff grade doctors are also in place to help and clinical scientists have been trained to do malignant colon cut up cases.	
10	**qFIT update**	**Update provided by Chris Singleton** • Low-risk qFIT is now a fully commissioned and initiated service in primary care across Kent & Medway. The CCG is working with practices who are not utilising qFIT as much as they would expect to ensure they know how to use the test and the benefits of it. • There is currently a relatively high rate of sample rejections due to incorrect or incomplete labelling which means the samples cannot be processed and the lab struggle to identify which practices they have come from. This presents both clinical risk and waste. • The CCG is working with primary care colleagues and the Macmillan Primary Care Nurse Facilitators, who have put on training for practice nurses and other teams, to see how further training can be embedded along with an improved patient and practice information leaflet. There is a plan to incorporate a checklist for the person who takes the sample to fill in to ensure it is done properly and can therefore be processed by the lab accordingly. • With regard to the high-risk qFIT in primary care pilot which was mentioned by Laura Alton at the last meeting, this has been approved as individual pilots in individual Trusts and ICPs. MTW and West Kent went live in all of their GP practices on 18.10.2021 and they will be working with the CCG to evaluate lessons learnt so this can be taken in to account when rolling the service out to the rest of the patch. CS stated other Trusts and ICPs may wish to roll this out in a slower or more phased approach. • The CCG are having regular conversations with the lab at MTW (where the qFIT analyser is situated) to ensure it is not being inundated. There is a plan for MTW to purchase a bigger analyser in order to process more samples. • Following on from discussions which arose earlier in the meeting with regard to the HOP/PoC, RBu believes each Trust has their own internal policy in dealing with qFIT (for example results and safety netting) and asked whether there could be a standardised Kent & Medway-wide process for this which could then be included in the documents. CS believes this is the intention long-term when all Trusts are accepting both low-risk and high-risk referrals. • PB stated the NICE guidance on qFIT is clear with regard to safety netting for those with a result between 10-100ug/g and this will not change unless/until the national guidance is changed.	
11	**CNS Updates**	**DVH – update provided by Marie Payne** • The Trust's new lead colorectal CNS is HF. • The CNS' recently moved offices and are now based in the same area as the STT team which should help with cohesive working. • The team are working on the optimal pathway piece. • The team have had productive meetings regarding moving forward with the Faster Diagnosis Standard piece. A number of actions have come out of these meetings which the team will be looking to implement in order to ensure compliance with the standard. • The team are working with the Alliance regarding the stratified pathways piece and they hope to move forward with this next year. **EKHUFT – update provided by Ruth Burns** • At WHH, the stratified pathways piece was initiated in September 2021 and they currently have around 30 patients who are being moved	

		over from their existing follow-up (which is working well). RBu believes the real test of how it interfaces with everything else will be in 6 months' time when checking results. • The CNS team are struggling with the number of calls from patients, a number of which contact them because they cannot get through to their GP practice or have enquiries about matters such as COVID booster vaccines. • 2 new full-time cancer support nurses are now in place (1 at WHH and the other at QEQM) and this will be important in moving the service forward. • The team are struggling with the number of 2ww referrals and the size of their PTL, with a lot of nursing time being spent on overseeing these. • The team are picking up all new patients who come through endoscopy with positive colonoscopies for obvious cancers. • There is currently a pilot in place at William Harvey Hospital for picking up and referring patients directly for iron transfusions early in the pathway. Presently there are 10-11 patients they have done this for and when the team have some more patients an audit will be conducted. • Due to the increase in 2ww referrals, RBu and the deputy lead CNS are currently involved in a project looking at the front end of the pathway and revisiting the STT service. • Some of RBu's colleagues found the Motivational Interviewing training sessions insightful. **MFT – update provided by Karen Hills** • The CNS' do not tend to have any involvement with the PTL. • The CNS team are struggling with the amount of calls from patients, a number of which contact them because they cannot get through to their GP practice or have enquiries about matters such as COVID booster vaccines. • 3 generic STT posts have gone out to advert. • The team have noticed lots of new patients are coming through (8-9 per week). There is currently an imbalance in that they are not discharging patients as frequently as they are receiving new patients. • The service has a lot of complex patients who need to be seen in other areas (Basingstoke, Guildford, GSTT and King's College Hospital) and they therefore have some challenges in coordinating these cases. To help with this, a new database will be put in place (hopefully next month) which should make things easier. • MFT's oncologist for colorectal will be leaving the service later this week. **MTW** • No-one from MTW provided a CNS update.	
12	**Stratified pathway update**	• Claire Mallett was unable to attend today's meeting. **Action: AW to contact Claire Mallett to ask if she would like to present on this item at the next meeting.**	**AW**
13	**Cancer Alliance update**	**Presentation provided by Chris Singleton** • The National Cancer Programme includes information on: - The impact of COVID-19 on cancer services. - Recovery priorities (2021/2022 cancer services recovery aims, 2021/2022 key actions and cancer recovery funding). - Getting people into the system ('Help us help you' campaign). - Investigations and diagnoses (Rapid Diagnostic Centre pathways, Targeted Lung Health Checks and Accelerating innovation). - Treatments (Surgical hubs and 'COVID-friendly' treatments). • The Programme's key actions include: - Running the NHS' 'Help Us Help You' campaigns to raise awareness of cancer symptoms and encourage people to see their GP. - Delivering full recovery of cancer screening programmes. - Working with primary care to find and refer people with suspected cancer quickly. - Trialling new approaches to get people into the system quickly, such as 'cancer hotlines'. - Implementing Rapid Diagnostic Centre pathways. - Expanding the reach of Targeted Lung Health Checks.	

		- Adopting innovations such as Colon Capsule Endoscopy. - Introducing new clinic models such as tele-dermatology and nurse-led triage for prostate cancer. - Extending the use of surgical hubs. - Continuing to adopt COVID-friendly treatments and use the over 40 already introduced. - Implementing personalised stratified follow-up pathways. - Supporting access to the independent sector. • The presentation alluded to the following workstreams: Rapid Diagnostic Services, the Faster Diagnosis Standard (28 days), Earlier Cancer Diagnosis and Personalised Care & Stratified Follow Up.	
14	**CCG Update**	**<u>Update provided by Chris Singleton</u>** • The CCG is transitioning in to an ICP as per national direction. • The intention is to support system-level working and collaboration which is already in a good position from a cancer perspective. • The local ICPs are working with the relevant Community Diagnostic Hubs (of which there will be 6 for Kent & Medway), which can cover populations of up to 300,000. The Alliance is supporting this workstream from a cancer perspective and East Kent and West Kent will take this forward initially.	
15	**AOB**	• No-one had anything to raise under any other business.	
	Next Meeting Date	• To be confirmed.	