

Colorectal Tumour Site Specific Group meeting

Tuesday 7th October 2025

Microsoft Teams

09:00-12:30

Final Meeting Notes

Present	Initials	Title	Organisation
Pradeep Basnyat (Chair)	PBas	Consultant General & Colorectal Surgeon	EKHUFT
Claire Bingham	CB	Macmillan Personalised Care Facilitator	EKHUFT
Ruth Burns	RBu	Macmillan Lead Colorectal CNS	EKHUFT
Victoria Grange	VG	Cancer Data Manager	EKHUFT
Stella Grey	SGr	General Manager - General Surgery & Colorectal	EKHUFT
Julie Ironmonger	JI	Lead Specialist Screening Practitioner	EKHUFT
Jennifer Tutt	JT	Colorectal Cancer CNS	EKHUFT
Sue Travis	ST	Head of Operations – General Surgery/Colorectal/Gastroenterology/Endoscopy (WHH)	EKHUFT
Jade Pilcher	JP	Programme Manager for Bowel Cancer Screening	EKHUFT
Larissa Williams	LW	Macmillan Colorectal CNS	EKHUFT
Deniece Merrill	DMe	Macmillan Colorectal CNS	EKHUFT
Katherine Hills	KatHills	Consultant Gastroenterologist	EKHUFT
Rakesh Bhardwaj	RBh	Consultant Laparoscopic, General and Colorectal Surgeon	DGT
Charli Selvage-Owen	CSO	Bowel Cancer Screening Manager - West Kent & Medway	DGT
Charmaine Walker	CWa	Service Manager for Gastroenterology and Hepatology	DGT
Helena Price	HP	Colorectal Early Diagnosis CNS	DGT
Sue Stubbs	SSt	Macmillan Colorectal & Early Diagnosis CNS	DGT
Laura Horton	LH	Lead SSP - Bowel Cancer Screening	DGT
Michelle Crosbie	MC	Operational Manager for Cancer & Haematology	DGT
Mark Stewart	MS	Consultant General Surgeon	DGT
Louise Rafferty	LR	Macmillan Lead Colorectal CNS	DGT
Samantha Searle	SSea	Macmillan Metastatic Colorectal CNS	DGT
Victoria Lynn	VL		DGT

Laura Alton	LA	Senior Programme Manager for KMCA Commissioning	KMCA
Claire Mallett	CM	Programme Lead – LWBC/PCS	KMCA
Ann Courtness	AC	Macmillan Primary Care Nurse Facilitator	KMCA
David Osborne	DO	Data Analyst	KMCA
Emma Lloyd	EL	Cancer Pathways Improvement Project Manager	KMCA
Bana Haddad	BH	Clinical Lead	KMCA
Jonathan Bryant	JB	Primary Care Cancer Clinical Lead	KMCA
Karen Glass	KG	PA/Business Support Manager	KMCA/KMCC
Colin Chamberlain (Notes)	CC	Administration & Support Officer	KMCC
Samantha Williams	SW	Administration & Support Officer	KMCC
Prudence Banda	PBan	Faster Diagnosis LGI CNS	MFT
Suzanne Bodkin	SB	Cancer Service Manager	MFT
Will Garrett	WG	Consultant General Surgeon	MFT
Melisa Goodwin	MG	Macmillan Colorectal CNS	MFT
Hayley Martin	HM	PCS Facilitator	MFT
Angela Bell	ABe	Macmillan Colorectal CNS	MFT
Karen Hills	KaHills	Macmillan Metastatic Colorectal CNS	MFT
Francesca Dunn	FD	Service Manager	MFT
Richard Dickson-Lowe	RDL	Consultant Surgeon	MFT
Samantha Seker	SSek	Oncology CNS – Colorectal	MTW
Adenike Williams	AW	Clinical Oncologist for DVH at MTW	MTW
Victoria Buzza	VB	CTC Lead Radiographer	MTW
Chris Wright	CWr	Consultant Colorectal & General Surgeon	MTW
Adrian Barnardo	ABa	Consultant Gastroenterologist	MTW
Meeta Durve	MD	Consultant Clinical Oncologist	MTW
Sarah Eastwood	SE	Macmillan Personalised Care Project Manager	MTW
Elaine Ellis	EE	Colorectal Oncology CNS	MTW
Hayley Geere	HG	Specialist Macmillan Nurse in Anal Cancer	MTW
Sukanya Ghosh	SGh	Consultant Radiologist	MTW
Mark Hill	MHi	Consultant Medical Oncologist	MTW
Katie Ruse	KR	MDT Co-ordinator	MTW

Katherine Pidwell	KP	FDS STT Colorectal Nurse	MTW
Rakesh Raman	RR	Consultant Clinical Oncologist	MTW
Raza Moosvi	RM	Consultant General, Laparoscopic and Colorectal Surgeon	MTW
Jodie Hotine	JH	Lead Radiotherapy Research Radiographer	MTW
Liam Poynter	LP	Consultant Lower GI Surgeon	MTW
Izabela Boniecki	IB	MDT Coordinator	MTW
Siny Sasidharan	SSa	Locum Consultant Histopathologist	MTW
Monika Verma	MV	Consultant Histopathologist	MTW
Nikki Jagger	NJ	Endoscopy Programme Manager	NHS Kent & Medway ICB
Apologies			
Danielle Mackenzie	DMa	Macmillan Lead Nurse for Personalised Care	EKHUFT
Jann Yee Colledge	JYC	Consultant Radiologist	EKHUFT
Pippa Enticknap	PE	Senior Service Manager - CCHH Care Group	EKHUFT
Mohan Harilingam	MHa	Consultant General & Colorectal Surgeon	EKHUFT
Suzie Chate	SC	InfoFlex Development Manager	KMCC
Bushra Ansari	BA	STT (Upper GI/Lower GI CNS)	MFT
John Schofield	JS	Consultant Pathologist	MTW
Phoebe Brown	PBr	Assistant General Manager – Cancer Performance	MTW
Stef Outen	SO	Colorectal Advanced Nurse Practitioner	MTW
Bronwyn Tetley	BT	Lead Pathway Nurse Coordinator	MTW
Janine Ramilo	JR	FDS STT Colorectal Nurse	MTW
Item		Discussion	Action
1	TSSG Meeting	<u>Apologies</u> - The apologies are listed above. <u>Introductions</u> - PBas welcomed the members to the meeting. <u>Action log review</u> - The action log was reviewed, updated and will be circulated to the group along with the final minutes from today's meeting.	

		<u>Review previous minutes</u> The minutes from the previous meeting were reviewed and agreed as a true and accurate record.	
2	Colorectal Pathway Sign Off	- The colorectal pathway has been signed off and sent to Trusts for implementation. Trusts are now responsible for embedding the pathway locally. - MFT reported ongoing challenges with referrals received without qFIT results, leading to pathway breaches and additional workload chasing missing information. - Members questioned whether such referrals can be returned to GPs if mandatory fields (e.g. qFIT, bloods) are incomplete. In response to this, PBas confirmed that referrals cannot currently be outright refused but that letters requesting missing information can be sent back to primary care. - Existing letters for incomplete referrals (developed by the Colorectal CNS group) will be redistributed and uploaded to e-RS systems. - There is strong consensus across the Trusts that referrals lacking essential clinical information undermine pathway integrity. Furthermore, several members (including CWr, WG and KH) argued for rejecting incomplete referrals to prevent unsafe or un-triageable cases. - AC clarified the agreed approach: do not refuse referrals, but return them requesting completion of missing data. - A query was raised regarding patients being unavailable due to holidays. LA confirmed that the new national CWT guidance advises GPs not to refer if the patient is unavailable within 28 days. She will circulate the updated guidance. 76.4% of referrals now include qFIT results across Kent & Medway. - Data is being used to identify and target under-performing GP practices, mainly in the Medway and Folkestone/Hythe areas. - There is ongoing engagement with PCNs and GP education to improve compliance. - The electronic referral system (Rego) is being developed to include mandatory completion fields, preventing submission of incomplete referrals. Implementation has been delayed due to IT challenges, but once live, it will ensure data completeness before referrals reach secondary care. <u>Action:</u> CC to re-circulate the final version of the colorectal pathway. <u>Action:</u> All Trusts to embed the newly signed-off colorectal pathway locally and update at	CC All

		the next meeting.	Trusts
3	Cancer Dashboards and performance data	<u>Update provided by David Osborne</u> • Overall cancer waiting times performance across Kent & Medway has improved slightly (by ~2%) compared with 6 months ago. • Kent & Medway continues to perform strongly on 62d targets, though remains below average on FDS. • MTW currently leads performance across both measures (55% FDS; 66% 62d), with MFT and DGT performing lower. • PBas highlighted the wide variation across Trusts, querying whether MTW could share insights or approaches contributing to their stronger performance. • It was agreed that it would be helpful to explore opportunities for shared learning and mutual support across sites. • It was noted that there are significant differences in histopathology turnaround times between Trusts, particularly between DGT/MFT and MTW/EKHUFT. Discussion identified possible factors including specimen transport times and prioritisation of urgent requests, but further analysis is required. • Members reported delays across multiple tumour sites and questioned the extent to which transport explains the variation. • RM and CWr emphasised that FDS performance is multifactorial, with early pathway steps (e.g. triage and first assessment) being critical. • Analysis showed EKHUFT assesses 6.6% of patients by day 7, compared with 71.3% at MTW, a key factor driving performance variation. • CWr noted that delays beyond day 7 make achieving 28d FDS targets highly unlikely. • RBU raised questions regarding STT definitions and InfoFlex recording, noting wide variation across sites and a higher number of colonoscopies performed in EKHUFT for patients with qFIT <10 (19.5% vs 2.9–10.8% elsewhere). • DO clarified that STT data derives from 2 sources (the ICB Data Warehouse and InfoFlex) with differing definitions of first appointment and triage. • Referral trends for qFIT <10 are declining overall but remain highest in EKHUFT. • DO demonstrated the live colorectal dashboard, covering referral trends, diagnostic turnaround times, and treatment variation indicators. The dashboard is updated monthly or quarterly and	

		allows pseudonymised cross-system analysis. Members are encouraged to request access directly from DO and use the dashboard to inform MDT and local performance discussions. PBas emphasised the value of embedding dashboard reviews into routine Trust-level governance and MDT meetings. LR supported this approach, suggesting regular review of live data across sites.													
4	Review of Colorectal Follow-Up Protocol	<u>Update provided by Rakesh Bhardwaj</u> - RBh presented an overview of current colorectal cancer follow-up practices across Kent & Medway following curative resection. The purpose was to identify variation in follow-up protocols and agree a system-wide approach to optimise recurrence detection, resource use, and patient experience. - In terms of the current position, there is significant variation in follow-up duration, modality, and frequency across Trusts. - The group discussed the clinical evidence base, resource implications, and patient impact of surveillance extending beyond 3 years. - Questions raised included: - Appropriate follow-up duration (3 vs 5 years). - Optimum frequency of CEA, CT, and colonoscopy. - Responsibility for follow-up (CNS-led, Consultant-led, or GP-led). - Tailored approaches for younger and older patients. - Workforce and digital tracking implications. - In terms of a summary of current practice by Trust: <table border="1"> <thead> <tr> <th>Trust</th><th>Duration of Follow-up</th><th>Key Features</th><th>Notes</th></tr> </thead> <tbody> <tr> <td>DGT</td><td>5 years</td><td>CT at years 1, 2, and 5; 6-monthly CEA; colonoscopy at 1 and 4 years.</td><td>Reported detection of metastatic disease on 5-year CTs.</td></tr> <tr> <td>EKHUFT</td><td>5 years</td><td>CT at 1, 2, and 5 years; colonoscopy at 1 and 3 years.</td><td>Using InfoFlex to track follow-up; proposal to analyse recurrence</td></tr> </tbody> </table>	Trust	Duration of Follow-up	Key Features	Notes	DGT	5 years	CT at years 1, 2, and 5; 6-monthly CEA; colonoscopy at 1 and 4 years.	Reported detection of metastatic disease on 5-year CTs.	EKHUFT	5 years	CT at 1, 2, and 5 years; colonoscopy at 1 and 3 years.	Using InfoFlex to track follow-up; proposal to analyse recurrence	
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	Complete Responder Management	The presentation built upon earlier discussion regarding standardised post-resection follow-up and explored the rationale, outcomes, and variations in practice for patients managed by non-operative or organ-preservation pathways. • TNT involves the combination of neoadjuvant chemotherapy and radiotherapy prior to surgery, aiming to improve response rates and enable organ preservation in selected patients. • Multiple international trials (including RAPIDO and PRODIGE 23) have demonstrated improved disease-free survival, reduced distant metastases, and higher rates of pathological complete response (pCR) (~28% vs 10–14% with standard chemoradiotherapy). • There is heterogeneity across trials regarding patient selection, chemotherapy regimen (doublet vs triplet), radiotherapy fractionation, and sequencing. • Despite uncertainties, TNT is increasingly considered standard of care for locally advanced or high-risk rectal cancer (T3/T4, N2, CRM/EMVI+, lateral node involvement). • ESMO guidelines recommend TNT for high-risk patients, while NCCN endorses TNT for all Stage II–III cases — reflecting broader adoption trends internationally. • Data from the International Watch & Wait Database (IWWD) outlines that there is ~25% local regrowth at 2 years, the majority within the first 24 months; there is an 8% distant metastasis rate; and, there is a 5-year overall survival rate of ~85%. • The OPRA trial reinforced that 94–99% of local regrowths occur within the first 3 years, underscoring the need for intensive early surveillance. • Recurrences following cCR are associated with higher risk of distant metastases, particularly with delayed detection or larger regrowths. • MD compared international and national follow-up frameworks, noting significant variation between the following protocols: OPRA, TRIGGER (UK), Papillon Brachytherapy, Maastricht protocol; ESMO (2024) and NCCN (US). • Most protocols intensify surveillance during the first 2 years, reflecting the period of highest recurrence risk. • The consensus recommendation is at least 5 years of structured follow-up, though some Dutch centres now taper surveillance after 3 years. • It was identified that there is variation across Kent & Medway, with some centres following Maastricht, others ESMO, and minor modifications locally. • In terms of local practice and discussion: - MTW are following a model similar to ESMO — 3-monthly MRI and sigmoidoscopy in year 1,	
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		then 4–6 monthly in year 2. - EKHUFT are adopting the Maastricht approach. • There was consensus that most local protocols align on 3-monthly MRI/flexi-sig for 2 years, reducing frequency thereafter. • RR noted increasing numbers of patients being managed non-operatively or via rectal preservation protocols, reinforcing the need for network-wide consistency. • KatHills queried endoscopy preparation standards. It was confirmed by PBas that phosphate enema is sufficient for these surveillance procedures. • There was agreement that bowel prep and procedural protocols should also be standardised to support equitable practice and data collection. • In summarising: - TNT has become the new standard for locally advanced rectal cancer, increasing the cohort eligible for organ preservation. - Local and international protocols share broad similarity but differ in detail and duration. - The group agreed to standardise follow-up across Kent & Medway to ensure consistent patient outcomes, streamlined data collection, and equitable care delivery. - The CRG will oversee development and alignment of the new protocol, with engagement from surgical, oncology, and CNS representatives.	
6	Standardisation of Cancer Polyp Follow-Up	<u>Histopathology Reporting of Polyp Cancers – update provided by Monika Verma</u> • This presentation originated from CRG discussions to streamline the management of polypectomy cancer cases. • Early-stage colorectal cancers (often screen-detected) form a significant proportion of cases; local excision may be curative or palliative. • Reporting principles largely follow the RCPATH dataset for colorectal cancer, but specific parameters are critical for T1 (pT1) tumours to predict risk of lymph node metastasis and guide further surgery. • Key histopathological parameters include: - Tumour differentiation: assessed on worst area (well/moderate vs. poor). - Depth of invasion: measured differently for pedunculated (Haggitt levels 1–4) and sessile (Kikuchi SM1–3) polyps. SM3/Haggitt 4 are high-risk. - Lymphatic and venous invasion: strong predictors of nodal metastasis; reported separately.	

- Margins: involvement ≤ 1 mm currently considered positive, though RCPaH may move toward only 'at-margin' positivity. Discussion ongoing nationally.
- Tumour budding: now a core data item (graded BD1–3); BD2/3 are adverse features but should not be used in isolation.
- Other features: perineural invasion (recorded for consistency), background adenoma, MMR deficiency relevance in variant subtypes.
- Challenges in reporting include:
 - Fragmented or piecemeal specimens hinder margin and invasion assessment.
 - Orientation issues and artefacts (thermal or diathermy burn) may limit accuracy.

Audit Presentation – Compliance with RCPaH Dataset – update provided by Siny Sasidharan

- The aim of the audit was to assess compliance of local excision (polypectomy) colorectal carcinoma reports with the RCPaH dataset (January–December 2024).
- The number of cases audited was 48 (from Telepath database).
- 41 cases had polypectomies and the remainder had TAMIS or transanal excisions.
- In terms of sites, colon was the most common followed by rectum, rectosigmoid, anorectal.
- Compliance with core data items can be seen in the table below:

Parameter	Compliance
Size of polyp, tumour type, differentiation, background adenoma, deep margin distance	100%
Depth of invasion, lymphatic invasion	98%
Vascular invasion	96%
Peripheral margin involvement	94%
Haggitt/Kikuchi levels	92%
Template use	90%
Peripheral margin distance	88%
Resection status	81%
Perineural invasion, tumour budding	77%
Width of invasive tumour	73%
TNM stage	69% (lowest)

		• Key issues identified include: - Variable use of reporting template: some reports written as free text (especially outsourced or locum cases), leading to omissions. - Outdated templates still active in Telepath, lacking newer parameters (e.g. tumour budding). - Fragmented polyps limit applicability of some parameters. - TNM staging often missing - reporters may assume pT1 but fail to specify it explicitly. • Recommendations include: - Reinforcing the use of RCPATH-compliant template (available on Q-Pulse/Telepath). - Deleting outdated templates from Telepath to prevent accidental use. - Ensuring outsourced and locum pathologists have access to the correct templates. - Re-emphasising key parameters (e.g. tumour budding, staging) via departmental email to GI pathology team. - Re-auditing after 2 years to assess improvement. • PBAS queried whether changing the '<1 mm' rule to 'at-margin only' would affect R1/R0 categorisation and management. In response to this, MV confirmed this is under national discussion. • RM noted that some European centres (e.g. Netherlands) already use this nuanced approach. • PBAS suggested a pathology KPI framework, similar to endoscopy audits, to maintain reporting standards. • WG emphasised the need for individual accountability when parameters are missed, stating omissions render a report suboptimal. • MV clarified individual feedback is not routine but may be applied if recurrent issues are identified; locum/outsourced reports are particular challenges. • There is a plan to share audit results at the next governance meeting and potentially develop departmental QA actions. • Action: CRG/TSSG to explore the introduction of a pathology KPI framework to monitor reporting quality.	CRG/ TSSG
7	Standardising Quality of Letters from Secondary to	• PBAS introduced the agenda item, explaining that the proposal focuses on improving the quality and consistency of the first clinical letter sent from secondary care to primary care for cancer referrals. • The topic originated from feedback from primary care, which highlighted inconsistencies in letter	

	Primary Care following two-week rapid access referral	content and completeness. • It was noted that not all essential clinical details required for MDT discussions are consistently included in the letters. • The aim is to determine whether the TSSG should lead the development of a standardised template for these letters. • In terms of examples and current practice, LW described how the nurse-led clinics at EKHUFT had initially trialled a tick-box format for letters, but this was replaced by a summarised header section focusing on key clinical information. • The revised letter includes: - A summary of the patient's referral reason and background. - Performance status and clinical frailty score. - Relevant blood results (e.g. iron studies). - Planned next steps. • This format has proven clear and effective for MDTs, GPs, and patients, mirroring the style of oncology correspondence. • PBas suggested that inclusion of clinical presentation and referral indication would further enhance the letters' usefulness, particularly for triage and endoscopy teams. • KatHills highlighted that although letter quality is excellent, delays in uploading letters to electronic systems reduce their practical value for patient triage. • SSt reported that DGT's telephone clinic letters are completed directly onto a proforma and uploaded immediately to the patient record — a best-practice example of efficient documentation. • RBU explained that STT clinics use a standard InfoFlex proforma, largely composed of drop-down fields. LW noted, however, that this format lacks a concise clinical overview at the top, making MDT review less efficient. • RBU confirmed that the InfoFlex template can be modified, allowing inclusion of a free-text clinical summary box at the top. • There is strong support for introducing a standardised letter format for the first clinical correspondence following a cancer referral. • The preferred format should include a clinical summary header (referral reason, key findings, frailty/performance status, relevant tests, and management plan) and a concise body section for narrative detail.	
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		- Ensuring timely availability of letters on clinical systems which is as important as improving content quality. - Opportunities exist to align and enhance existing proformas (e.g. InfoFlex templates used in STT clinics). - In closing, the group acknowledged the value of improving both the content quality and timeliness of clinical letters. - There was consensus that standardisation would support better communication, more effective MDT discussions, and enhanced continuity of care across the cancer pathway. Action: CRG to discuss the development of a standardised clinic letter template for first cancer referral correspondence, including a summary header.	CRG
8	Colorectal Clinical Trials and Survivorship Programme	Update provided by Liam Poynter - LP provided a comprehensive update on the progress and expansion of colorectal cancer clinical trials within MTW, with a focus on embedding research discussions into the MDT process and harmonising opportunities across Kent & Medway. - The MTW Colorectal MDT has restructured its meeting format to incorporate discussion of open and planned clinical trials, aligning with practices at larger academic centres such as Imperial and The Royal Marsden. - Research updates are now a standing agenda item, ensuring trial eligibility is considered for every suitable patient. - Current and active trials include: PRESERVE and MERCURY 3 (Imaging/Early Rectal Cancer), FOXTROT Portfolio (F5, F2, F3) and the IMPRESS Study. - In terms of upcoming research, there is a: - New global metastatic study using a bispecific antibody combining PD-L1 and VEGF-A inhibition, led by MHi. - Regional collaboration planned across MTW, MFT, EKHUFT and DGT. - With regard to emerging evidence and translational impact, there are: - Discussions on findings from the ALASCCA study demonstrating benefit from adjuvant aspirin in PIK3CA-mutant patients, reinforcing the need for improved access to Next Generation Sequencing (NGS) post-resection. - Monthly research meetings. These are held post-MDT, lasting 30–45 minutes, and focus on troubleshooting study setup and delivery challenges. The meetings are attended by clinicians,	

		CNSs, trainees, and R&D leads. • Research is now embedded in MDT thinking; CNSs identify potential trial candidates pre-MDT. • Set-up of new studies (e.g. PRESERVE) typically takes 8–10 months, reflecting necessary governance processes. • Financial recompense is available through NIHR portfolio activity to offset clinical time and administrative burden. • MTW are establishing a regional research database (REDCap platform) to support integrated data collection and collaboration across Kent & Medway. • Focus areas for the regional research portfolio include health inequalities, access to care, and metabolic disease links with colorectal cancer. • Collaboration is in development with the University of Kent and ARC KSS. • PBAs suggested that the MTW monthly research meeting could be a shared network resource, with participation from other Trusts to promote consistency and collaboration. • LP supported regional attendance for relevant trials (e.g. FOxTROT) to ensure equitable access via the Kent Oncology Centre. • RM confirmed the inclusion of research discussions within MDTs, noting these are reviewed when relevant to individual cases. • MHi commended LP's leadership and noted the substantial progress in MTW's research culture. • It was highlighted EKHUFT's strong recruitment to the TRaCK-C study (top 5 nationally). • The launch of the new global metastatic trial using a bispecific antibody compound was confirmed. • In summarising: - In terms of consensus, the importance of network-level visibility of open trials to avoid postcode variation in access was highlighted. - There is a proposal for the TSSG to circulate an updated list of active colorectal trials to all MDT leads for inclusion in local MDT minutes. - There is strong momentum in embedding research within MDT processes. - There are clear opportunities for regional collaboration and improved patient access to trials. - There is recognition of a cultural shift required in non-academic hospital settings to normalise research as part of standard care.	
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9	AOB	- CM provided the group with an update in relation to 2 patient resources as outlined below. <u>Limbo Land videos</u> - Limbo Land comprises of a series of films capturing personal cancer experiences and the feelings of uncertainty following a cancer diagnosis. The films include professional perspectives on roles and support available. - Please refer to this link for further information: limbo land - personal cancer experiences Cancer Alliance <u>Fatigue Animation</u> - The video, created by a dedicated team of clinical nurse specialists, cancer support workers and allied health professionals, offers practical advice and emotional support to help patients and their families better understand and manage one of cancer's most common and disruptive side effects. It can also be a valuable resource for professionals working with cancer patients. You can watch the video on the Kent and Medway Cancer Alliance website – www.kentandmedwaycanceralliance.nhs.uk/cancer-related-fatigue - Listen to Dr Jonathan Bryant, GP and Kent and Medway Cancer Alliance Clinical Lead, talk about the film, in an interview with Sophie Sutton, on BBC Radio Kent Make a Difference - Radio Kent - Listen Live - BBC Sounds (around 1:42).	
	Next Meeting	To be confirmed.	