

Colorectal Tumour Site Specific Group meeting
Wednesday 22nd April 2026
Conference Room (Education Centre) – William Harvey Hospital
09:00-12:30

Final Meeting Notes

Present	Initials	Title	Organisation
Pradeep Basnyat (Chair)	PBas	Consultant General & Colorectal Surgeon	EKHUFT
Stella Grey	SG	General Manager - General Surgery & Colorectal	EKHUFT
Joanne Cooke	JC	Consultant General & Colorectal Surgeon	EKHUFT
Samantha Hughes	SH	Colorectal Specialist Nurse	EKHUFT
Ruth Burns	RBu	Macmillan Lead Colorectal CNS	EKHUFT
Mohan Harilingam	MHa	Consultant General & Colorectal Surgeon	EKHUFT
Sudhakar Mangam	SMan	Consultant General, Laparoscopic and Colorectal Surgeon	EKHUFT
Prashant Naik	PN	Consultant Colorectal Surgeon	EKHUFT
Sanjeev Madaan (via Microsoft Teams)	SMad	Consultant Urological Surgeon	DGT
Farrah Errington	FE	Colorectal MDM Coordinator	DGT
Fay Fawke	FF	Macmillan Deputy Lead Cancer Nurse	DGT
Rakesh Bhardwaj	RBh	Consultant Laparoscopic, General and Colorectal Surgeon	DGT
Laura Alton	LA	Senior Programme Manager for KMCA Commissioning	KMCA
Emma Lloyd	EL	Cancer Pathways Improvement Project Manager	KMCA
Ann Courtness	ACo	Macmillan Primary Care Nurse Facilitator	KMCA
Karen Glass	KG	Business Support Manager and PA	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
Will Garrett	WG	Consultant General Surgeon	MFT
Meeta Durve	MD	Consultant Clinical Oncologist	MTW
Adrian Barnardo	AB	Consultant Gastroenterologist	MTW
Samantha Seker	SSe	Oncology CNS – Colorectal	MTW
Hayley Geere	HG	Specialist Macmillan Nurse in Anal Cancer	MTW
Hannah Little	HL	Colorectal CNS	MTW

Supriya Joshi	SJ	Consultant Chemical Pathologist	MTW
Neil Cripps	NC	Regional Clinical Advisor Endoscopy – Diagnostics Programme	NHSE (Southeast region)
Apologies			
Jane Abrehart	JA	Nurse Endoscopist	DGT
Charli Selvage-Owen	CSO	Bowel Cancer Screening Manager - West Kent & Medway	DGT
Laura Horton	LH	Lead Bowel Cancer Screening Practitioner based at MTW - West Kent & Medway Bowel Cancer Screening Programme	DGT
Danielle Mackenzie	DMa	Macmillan Lead Nurse for Personalised Care	EKHUFT
Deniece Merrall	DMe	Macmillan Colorectal CNS	EKHUFT
Pippa Enticknap	PE	Senior Service Manager - CCHH Care Group	EKHUFT
Jann Yee Colledge	JYC	Consultant Radiologist	EKHUFT
Joseph Sebastian	JSe	Consultant - MDT Lead	EKHUFT
Doraline Phillips	DP	Head of Service of Cellular Pathology	EKHUFT
Stefano Santini	SSa	Clinical Director	Gravesend Alliance PCN
Anju Kulkarni	AK	Consultant Clinical Geneticist	GSTT
Tracey Squire	TS	Macmillan User Involvement Manager	KMCA
Jonathan Bryant	JB	Primary Care Cancer Clinical Lead	KMCA
Clarissa Madla	CM	Senior Clinical Research Practitioner	MFT
Shirley Chan	SC	Consultant General, Colorectal & Paediatric Surgeon	MFT
Richard Dickson-Lowe	RDL	Consultant General and Colorectal Surgeon	MFT
Bronwyn Tetley	BT	Lead Pathway Nurse Coordinator	MTW
Amanda Clarke	ACI	Consultant Clinical Oncologist	MTW
Christopher Wright	CW	Consultant Colorectal & General Surgeon	MTW
Daniel Lawes	DL	Consultant General, Laparoscopic and Colorectal Surgeon	MTW
Sarah Eastwood	SE	Macmillan Personalised Care Project Manager	MTW
John Schofield	JSc	Consultant Pathologist	MTW
Maria Blanco-Criado	MBC	Deputy Chief Pharmacist - Cancer & Technical Services	MTW
Mark Hill	MHi	Consultant Medical Oncologist	MTW
Raza Moosvi	RM	Consultant General, Laparoscopic and Colorectal Surgeon	MTW
Stefanie Outen	SO	Colorectal Advanced Nurse Practitioner	MTW

If you attended this meeting but did not sign the attendance sheet and therefore can't see yourself listed as an attendee, please email c.chamberlain3@nhs.net so the minutes can be updated accordingly.

Item	Discussion	Action
1	<p>TSSG Meeting</p> <p><u>Apologies</u></p> <ul style="list-style-type: none"> The apologies are listed above. <p><u>Introductions</u></p> <ul style="list-style-type: none"> PBas welcomed the members to the meeting and asked them to introduce themselves. <p><u>Action log review</u></p> <ul style="list-style-type: none"> The action log was reviewed, updated and will be circulated to the group along with the final minutes from today's meeting. <p><u>Review previous minutes</u></p> <ul style="list-style-type: none"> The minutes from the previous meeting were reviewed and agreed as a true and accurate record. 	
2	<p>Early Experience and Future Plan on Robotic Assisted Surgery</p> <p><u>Summary of early robotic-assisted colorectal surgery experience and next steps - presentation provided by Prashant Naik</u></p> <ul style="list-style-type: none"> There is growing interest in integrating robotic surgery into colorectal practice. Indications include: right hemicolectomy, anterior resection, TME and selected complex minimally invasive colorectal procedures. With regard to implementation, a multidisciplinary planning and governance framework was utilised. The structured training pathway includes: Medtronic ASCEND programme, Touch Surgery e-learning, console simulation, ORSI robotic training course, clinical immersion visits and pre-case dry runs. There was proctorship during early cases. There was also a gradual increase in case complexity. From a governance perspective, there are regular robotic strategy meetings, development of a business case and the creation of robotic-assisted surgery policies. Early case selection included elective patients only, those with a favourable anatomy and those with non-advanced disease. 	

		<ul style="list-style-type: none"> • There was a particular emphasis on patient safety, workflow familiarisation and proctor support. • With regard to intraoperative outcomes: procedures are feasible across standard colorectal operations, there were acceptable operating times during the learning phase, there was reliable docking and instrument control and a safety-first approach was maintained. • With regard to postoperative outcomes, there was no increase in complications, a standard length of hospital stay, early bowel recovery and oncological standards were maintained. • There were a total of 25 cases - 10 were for right hemicolectomies and 15 for anterior resections (2 with ileostomy). • The length of stay for those who had a right hemicolectomy was 2–3 days, anterior resection was 3–4 days and those with ileostomy 5–6 days. • In relation to technical metrics, docking time was 5–9 minutes and redocking time was 4–7 minutes (selected cases). • From a learning curve/feedback perspective, there has been rapid familiarisation with the robotic console, improved surgeon ergonomics, positive feedback from theatre staff and flexible, modular system setup. • Advantages included: enhanced precision, better ergonomics and standardised workflow. • Challenges and limitations included initial setup and docking time, a team learning curve, limited long-term outcome data and the need for comparison with laparoscopic and other robotic approaches. • Future directions include: expansion to more complex procedures, prospective data collection, comparative studies (laparoscopic vs robotic systems) and integration into surgical training programmes. • In conclusion, early implementation is safe and feasible, initial outcomes are promising and further evaluation and scaling are required. 	
3	<p>Streamlining Urology MDT - Implementation, Outcomes and Hurdles</p>	<p><u>Overview of learning from Urology MDT changes and relevance to wider pathway improvement – presentation provided by Sanjeev Madaan</u></p> <ul style="list-style-type: none"> • The project evaluated a pre-MDT streamlining model in urology cancer at DGT in order to improve efficiency while maintaining both safety and quality. • It was based on NHS England guidance introducing Standards of Care . • Certain low-risk or protocol-driven cases can be managed without full MDT discussion. • The MDT still retains oversight of all cases with periodic audit. 	

		<ul style="list-style-type: none"> • Cancers included in the streamlining process included bladder, prostate and kidney. • Testicular and penile cancers are always discussed. • The MDT streamlining team comprises of a Consultant Urologist (with protected time), MDT Coordinator and CNS. Middle grade/specialist doctors are optional. • Radiology, pathology and oncology staff are not required for the streamlining stage. • Between January and December 2024, MDT duration reduced from 158 to 135 minutes and discussion time per case reduced from 4.9 to 3.6 minutes. • ~35% of cases were streamlined. • Some cases had minor amendments after full MDT review, e.g. imaging clarification and surveillance tweaks. • No safety concerns were reported. There were no treatment reversals and no patient harm identified. • There has been generally positive clinician feedback and an acknowledgement that MDT streamlining works well when properly implemented. • There has been some resistance to change with some staff adopting an attitude of why change something which is not broken. • Concerns were raised in relation to patient safety and a loss of MDT educational value. • Practical issues include job planning, incomplete data (radiology/histology not ready) and engagement from staff. • In concluding, SM highlighted that this was a first study of its kind in Urology MDT streamlining. It demonstrates improved efficiency, maintained safety and good clinician confidence. • With regard to future direction: <ul style="list-style-type: none"> - AI-assisted triage (e.g. PROSAIC-DS) has resulted in one-third of cases bypassing MDT safely. - There is an acknowledgment that MDT platforms improve workflow and documentation. - There is ongoing research into AI and MDT optimisation. 	
4	<p>qFIT Data Across Kent & Medway (Last 4 years)</p>	<p><u>Key system trends, impact and insights from qFIT use across the network - presentation provided by Supriya Joshi</u></p> <ul style="list-style-type: none"> • FIT should not be used as a simple binary test. • Cancer risk depends on patient factors (age, sex, anaemia, symptoms) as well as the FIT result. 	

		<ul style="list-style-type: none"> • The same FIT value can represent very different risks in different patients. <p>Current problem</p> <ul style="list-style-type: none"> • A single threshold ($\geq 10 \mu\text{g Hb/g}$) leads to over-investigation of low-risk patients and underestimation of risk in high-risk patients. • FIT is often over-relied on, with insufficient clinical risk assessment. • No threshold can perfectly separate cancer from non-cancer. <p>System impact - Kent & Medway</p> <ul style="list-style-type: none"> • There has been a large increase in FIT use, especially in younger patients. • There has been a ~51% rise in urgent colonoscopies. • This has resulted in increased pressure on services without proportional cancer detection. • More low-risk and some frail patients are undergoing unnecessary procedures. <p>Proposed approach: risk-based use</p> <ul style="list-style-type: none"> • There is a move from a fixed threshold to risk-based decision-making using age, sex, anaemia, symptoms and FIT. • Expected benefits include: fewer unnecessary colonoscopies (~33%), better alignment with true cancer risk and more equitable access. • This requires safety-netting, as some cancers will fall below thresholds. <p>Future direction - multivariable models</p> <ul style="list-style-type: none"> • Tools (e.g. COLOFIT) combine FIT with clinical data to estimate risk. • There is potential to reduce referrals (~8–23%) and improve accuracy. • There is a need for local validation and integration into practice. <p>Bottom line</p> <ul style="list-style-type: none"> • Binary FIT thresholds are simple but inaccurate. • Risk-based approaches are more effective but need careful implementation. 	
5	Proposed Single Point of	<u>Overview of the SPoA model, alignment with Colorectal TSSG pathway and draft IDA pathway, and use of local data to support pathway development - presentation provided by Neil Cripps</u>	

<p>Access (SPoA) Pathway</p>	<ul style="list-style-type: none"> • The current USC pathway for lower GI cancer is being overused and misused, largely due to an over-reliance on FIT instead of proper clinical assessment. • FIT is being used as a “rule-in” test, not just to rule out cancer. • It is often treated as more important than symptoms or examination and this often leads to unnecessary referrals and investigations. • In terms of clinical assessment, symptoms and physical findings are not accurately recorded/not properly interpreted. • Key signs (e.g. abdominal/rectal mass) should bypass FIT entirely. • There has been a significant increase in referrals (+22.3% in 2023). • Endoscopy services are under severe pressure, with only ~44% of colonoscopies being done within 6 weeks, and thousands of patients are waiting >1 year for the procedure. • Many low-risk patients are being investigated unnecessarily. • A number of frail or comorbid patients are included and may not benefit from invasive tests. • Patients who are low-risk cannot easily be removed once referred. <p>Scottish Consensus model</p> <ul style="list-style-type: none"> • NC drew the group’s attention to the Scottish Consensus model which argues for the raising of USC referral threshold to ≥ 20 $\mu\text{g/g}$ (instead of lower thresholds). • For IDA, FIT tests should be offered and if the results are both < 20 then the patient should be sent down a non-USC pathway. • If a patient has a FIT of < 20 but their concern remains, they should have a repeat test. • If symptoms resolve, no referral is required. • From a post-secondary care perspective, if a patient has a FIT of < 80 with no concerns, they should be discharged without investigation. <p>When FIT is appropriate</p> <ul style="list-style-type: none"> • FIT should be used for those with: persistent rectal bleeding with no obvious cause, blood mixed in their stool, a change in bowel habit > 4 weeks, IDA and patients experiencing persistent abdominal pain and weight loss. <p>When FIT is not appropriate</p> <ul style="list-style-type: none"> • FIT should not be used for those with: a rectal or abdominal mass (patients experiencing this 	
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		<p>should be referred through the USC route), unexplained weight loss alone, acute illness (e.g. gastroenteritis), long-standing mild symptoms (e.g. bloating). known haemorrhoids without red flags, and when there is family history screening (proper screening programmes should be used instead).</p> <p>Summing up</p> <ul style="list-style-type: none"> • Raising FIT thresholds reduces colonoscopy demand (up to ~33%) and increases the number of cancers missed below threshold. This is the key tension: efficiency vs risk of missed cancers. • The presentation argues for a reset of clinical thinking. • FIT should support decisions - not replace clinical judgement. • Better triage and assessment are deemed essential. • The goal is not just detecting cancer, but using resources where they truly benefit patients. 	
<p>6</p>	<p>Trust Updates - Ops Leads and CNS</p>	<p><u>Updates from each Trust on activity, pressures, capacity, and pathway developments.</u></p> <p>EKHUFT</p> <ul style="list-style-type: none"> • There is ongoing work to improve the 28d pathway, including a new STT admin process. • There are endoscopy and VC delays due to increased demand. • There is a rising number of long waiters, mainly from diagnostic delays (there is a particular focus on 50+ weeks cases). • Robotic surgery has now been established across sites. • Surgical capacity is fluctuating. • Referrals dipped over the Easter period and this is currently under review. <p>DGT</p> <ul style="list-style-type: none"> • There are workforce pressures, with a number of colorectal staff experiencing sickness. There is also an ongoing recruitment freeze. • Referral rates are increasing, with registrars supporting backlog clearance. • Lynch syndrome mainstreaming and stratified pathways are progressing well. • There have been challenges with HNAs and Breaking Bad News, not prioritised due to staffing. • Patient safety escalation is possible via CMO override if required. • There is no Endoscopy Lead at DGT currently. 	

		<p>MFT</p> <ul style="list-style-type: none"> • There is a significant shortage of CNSs with no planned increase and this is impacting on cancer care delivery. • MFT have lost JAG accreditation. • The recruitment freeze is impacting services, including screening. • The Trust are receiving support from MTW for Lynch syndrome pathways. <p>MTW</p> <ul style="list-style-type: none"> • The Trust are currently fortunate enough to have a strong staffing position, including Clinical Support Workers. • Treatment Summaries have been embedded in to oncology. • Stratified follow-up pathways are working well. • The Lynch syndrome pathway is effective, with additional support offered to MFT (as outlined above). • Action: It was identified that the Endoscopy Network has limited surgical engagement at meetings. AB to share meeting dates with CC who will circulate to the group, with the aim of increasing surgical attendance. 	<p>AB/CC</p>
<p>7</p>	<p>Any Other Business (AOB)</p>	<p><u>Data pack</u></p> <p>FDS</p> <ul style="list-style-type: none"> • Kent & Medway: 60.9% (slight improvement compared to previous 6 months but still below the England average). • By Trust: MTW (76.9%), DGT (65.5%), EKHUFT (54.0%) and MFT (51.1%). <p>62d</p> <ul style="list-style-type: none"> • Kent & Medway: 67.1%. • By Trust: MTW (87.3%), MFT (65.3%), EKHUFT (61.2%) and DGT (41.0%). <p>Key issues identified</p> <ul style="list-style-type: none"> • Endoscopy capacity is underutilised (e.g. unused rooms at DGT). 	

		<ul style="list-style-type: none"> • Low-yield endoscopy and unnecessary clinic appointments are limiting capacity. • There is a need to free up capacity for bowel screening. • This is a national challenge, not unique to the region. <p>Improvements and developments</p> <ul style="list-style-type: none"> • FIT uptake has increased significantly (40% → 80%). • A £2 million funding bid has been submitted for an endoscopy reporting tool. • There is a live performance dashboard available (contact David Osborne for access). <p>Additional points</p> <ul style="list-style-type: none"> • A greater focus is needed on lifestyle advice from GPs. <p>Survival outcomes</p> <ul style="list-style-type: none"> • Bowel cancer survival (2018–2022, followed to 2023): Kent & Medway ≈ England average. • This indicates no major regional disadvantage but also no clear outperformance. <p>Early diagnosis rates</p> <ul style="list-style-type: none"> • The proportion of cancers diagnosed at an early stage is similar to the England average. • The key implication is that early detection efforts are adequate but not leading. <p>Key takeaways</p> <ul style="list-style-type: none"> • FDS is improving, but not yet high-performing. • Treatment timelines are under active monitoring. • There should be a focus on improving diagnostic speed, reducing treatment delays and moving toward top quartile performance. 	
<p>8</p>	<p>Next Meeting</p>	<ul style="list-style-type: none"> • Thursday 22nd October 2026 (09:00-12:30) – location to be confirmed. 	