Kent & Medway Cancer Collaborative

Colorectal Tumour Site Specific Group meeting Tuesday 29th April 2025 Park View Meeting Room – Mercure Great Danes Hotel 09:00-12:30			
Final Meeting Notes			
Present	**Initials**	**Title**	**Organisation**
Pradeep Basnyat (Chair)	**PBas**	Consultant General & Colorectal Surgeon	EKHUFT
Mansoor Akhtar	**MA**	Consultant Colorectal, General & Emergency Surgeon	EKHUFT
Ruth Burns	**RBu**	Lead Colorectal CNS	EKHUFT
Claire Bingham	**CB**	Macmillan Personalised Care Facilitator	EKHUFT
Sue Travis	**ST**	Head of Operations - General Surgery/Colorectal/Gastroenterology/Endoscopy (WHH)	EKHUFT
Alexis Warman	**AWa**	Head of Operations	EKHUFT
Kate Lynes	**KL**	Consultant Surgeon	EKHUFT
Stella Grey	**SG**	General Manager	EKHUFT
Deniece Merrall	**DMe**	Colorectal CNS	EKHUFT
Tracey Rigden	**TRi**	Chemotherapy Nurse Consultant	EKHUFT
Jade Pilcher	**JP**	BCS Programme Manager	EKHUFT
Joseph Sebastian	**JSe**	Consultant General Surgeon	EKHUFT
Larissa Williams	**LW**	SCP	EKHUFT
Jaime-Leigh Shadwell	**JLS**	BCS Admin Supervisor	EKHUFT
Catherine Flannelly-Kemp	**CFK**	BCS – Specialist Screening Practitioner	EKHUFT
Julie Ironmonger	**JI**	BCS – Specialist Screening Practitioner	EKHUFT
Ruth Mount	**RMou**	Improvement Practitioner	EKHUFT
Charli Selvage-Owen	**CSO**	Bowel Cancer Screening Manager - West Kent & Medway	DVH
Rakesh Bhardwaj	**RBh**	Consultant Laparoscopic General and Colorectal Surgeon	DVH
Laura Horton	**LH**	Lead SSP - Bowel Cancer Screening	DVH
Piero Nastro	**PN**	Consultant Laparoscopic, General and Colorectal Surgeon	DVH
Jane Abrehart	**JA**	Nurse Endoscopist	DVH
Laura Alton	**LAl**	Senior Programme Manager – KMCA Commissioning	KMCA
Ann Courtness	**AC**	Macmillan Primary Care Nurse Facilitator	KMCA
David Osborne	**DO**	Data Analyst	KMCA
Claire Mallett	**CM**	Programme Lead – Living With and Beyond Cancer/Personalised Care & Support	KMCA

Karen Glass	**KG**	Business Support Manager/PA	KMCA/KMCC
Colin Chamberlain (Notes)	**CC**	Administration & Support Officer	KMCC
Samantha Williams	**SW**	Administration & Support Officer	KMCC
Annette Wiltshire	**AWi**	Service Improvement Lead	KMCC
Amy Whale	**AWh**	Colorectal CNS	MFT
Prudence Banda	**PBan**	Lower GI FDS CNS	MFT
Suzanne Bodkin	**SB**	Cancer Service Manager	MFT
Meeta Durve	**MD**	Consultant Clinical Oncologist	MTW
Hayley Geere	**HG**	Anal Cancer CNS	MTW
Victoria Buzza	**VB**	CTC Lead Radiographer	MTW
Adrian Barnardo	**AB**	Consultant Gastroenterologist	MTW
Raza Moosvi	**RMoo**	Consultant General, Laparoscopic and Colorectal Surgeon	MTW
Elaine Ellis	**EE**	Colorectal CNS	MTW
Lindsey Jubb	**LJu**	Cancer Support Worker	MTW
Hannah Little	**HL**	Colorectal CNS (Surgery)	MTW
Chris Wright	**CW**	Consultant Colorectal & General Surgeon	MTW
Supriya Joshi	**SJo**	Consultant Chemical Pathologist	MTW
Clare Reeder	**CR**	Macmillan Consultant Clinical Psychologist and Service Lead	MTW
Neil Cripps	**NC**	Consultant Surgeon	NHSE South East
Nikki Jagger	**NJ**	Endoscopy Programme Manager	NHS Kent & Medway ICB
Katie Ruse	**KR**	MDT Coordinator	MTW
Shilpa James	**SJa**	Pathway Navigator	MTW
Apologies			
Laura Abdey	**LAb**	Lead SSP - Bowel Cancer Screening	DVH
Lawrence Ribero-Moreno	**LRM**	Nurse – Endoscopy	DVH
Mohan Harilingam	**MHa**	Consultant General & Colorectal Surgeon	EKHUFT
Ayman Hamade	**AH**	Consultant General & Colorectal Surgeon	EKHUFT
Danielle Mackenzie	**DMa**	Macmillan Lead Nurse for Personalised Care	EKHUFT
Pippa Enticknap	**PE**	Senior Service Manager - CCHH Care Group	EKHUFT
George Tsavellas	**GT**	Consultant Colorectal, Laparoscopic & General Surgeon	EKHUFT
Sarah Hyett	**SH**	Head of Operations	EKHUFT
Jann Yee Colledge	**JYC**	Consultant Radiologist	EKHUFT
Joanne Cooke	**JC**	Consultant General & Colorectal Surgeon	EKHUFT

Sue Drakeley	**SD**	Senior Research Nurse	EKHUFT
Stefano Santini	**SSa**	Clinical Director	Gravesend Alliance PCN
Camilla Dobinson	**CD**	HPB Service Manager	King's College Hospital
Tracey Ryan	**TRy**	Macmillan User Involvement Manager	KMCA
Ritchie Chalmers	**RC**	Medical Director	KMCA
Jonathan Bryant	**JB**	Primary Care Cancer Clinical Lead	KMCA
Ian Nurdin	**IN**	Patient Partner	KMCA
Leeja John	**LJo**	STT Nurse	MFT
Denise Thompson	**DT**	Assistant Project Manager	MFT
Hayley Martin	**HM**	PCS Facilitator	MFT
Karen Hills	**KH**	Metastatic Colorectal CNS	MFT
Daniel Lawes	**DL**	Consultant General, Laparoscopic and Colorectal Surgeon	MTW
Sarah Eastwood	**SE**	Macmillan Personalised Care Project Manager	MTW
Carole Grey	**CG**	FDS Team Lead	MTW
John Schofield	**JSc**	Consultant Pathologist	MTW
Mark Hill	**MHi**	Consultant Medical Oncologist	MTW
Samantha Seker	**SSe**	Oncology CNS – Colorectal	MTW
Stef Outen	**SO**	Colorectal Advanced Nurse Practitioner	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 members along with the final minutes from today's meeting.	

		Review previous minutes • The final minutes from the previous meeting were reviewed and agreed as a true and accurate record.	
2.	**Colorectal Pathway**	• PBas confirmed that the colorectal pathway has buy-in from primary care colleagues. • RMoo stated that MTW have essentially implemented this pathway in to their practice. • Following a review of the pathway (which has been agreed by the CRG), PBas asked for a consensus on whether it could be signed off by the TSSG. The consensus was that it could be agreed and it will be implemented from 01.06.2025, with comms to be sent out in due course. **Action: Update on implementation of the Colorectal Pathway to be provided at the next meeting.**	**TSSG**
3.	**qFIT presentation**	**Presentation provided by Supriya Joshi & Neil Cripps** • FIT was introduced for symptomatic patients primarily to improve the detection of colorectal cancer and other significant bowel diseases while reducing unnecessary colonoscopies. Key reasons for its introduction include: better risk stratification, reducing colonoscopy burden; and, cost-effectiveness. • Despite national guidance, there has been a reluctance in secondary care to accept non-investigation in those with low FIT scores (<10). The FIT threshold is the same for all age groups irrespective of cancer risk and there is a feeling that increases in FIT usage is increasing the colonoscopy burden and may not be leading to a considerable increase in cancers diagnosed. Despite increases in colonoscopy, improvement in late-stage diagnosis is not being seen. • There is an ambition to reduce the screening threshold from 120 to 80µg/g to diagnose 1000 more cancers in England each year yet systems are struggling to create the endoscopy capacity to do so. • Bowel cancer is predominantly a disease of the later years, mostly over the age of 50. There is national concern about a rapid increase in cancers in younger age cohorts, age <50. • Despite limited evidence supporting the use of FIT at low thresholds to diagnose cancer, FIT use has increased 8-	

		fold in people aged <40 and 6-fold in people aged 40-49. • In all age cohorts, the cancer risk does not reach the NG12 threshold until FIT>40. In those aged <40, the risk of cancer does not reach the NG12 threshold until FIT>80. In the 40-49 age cohort, the cancer risk does not reach the NG12 threshold until FIT>60. In those aged 50-79, the risk of cancer does not reach NG12 threshold until FIT>40. • FIT use on the USC pathway between 2021 and 2024 has increased disproportionately in those age cohorts for whom a diagnosis of bowel cancer is unlikely. • Using FIT at the standard threshold of 10µg/g at all ages increases the numbers sent for colonoscopy and does not increase the numbers of cancers diagnosed. • In all age cohorts, the cancer risk increases with age and FIT score. • In people below the age of 40, the cancer risk does not reach 3% even at a FIT threshold of 100. • The volume of colonoscopy in people at low-risk of cancer increases year by year. Changing FIT thresholds in accordance with the evidence would reduce this substantially. • The number of colonoscopies needed per cancer is much higher for <40 than the other age groups. Over the last 3 years, the numbers of colonoscopies needed to diagnose each cancer has drifted higher. • There is evidence that increased FIT thresholds would preserve colonoscopy capacity which could be employed more effectively. • Differential FIT thresholds for colonoscopy could be supported thus: FIT>80 in those aged <40; FIT>60 in those aged 40-49; and, FIT>40 in those aged >50. • SJo outlined that NICE recommend that further research is required to determine appropriate qFIT thresholds in patients below the age of 40. • A number of studies from other areas state that the threshold of 10 µg/g in patients below the age of 40 (or indeed below the age of 50) subjects a large group of patients to unnecessary colonoscopy. This is bound to have an adverse impact on colorectal pathways and endoscopy capacity.	

		• Changing the threshold for older symptomatic patients to 40 µg/g would hit the NICE guidance threshold of 3%. In turn, this would create additional capacity needed to accommodate screening of asymptomatic patients at a threshold of 80. • NC feels the data around qFIT and colonoscopies needs to be in the public domain to influence NICE guidance. • In concluding: - As currently used, FIT does not increase effectiveness in the use of endoscopy. - Raising thresholds at which referral and colonoscopy become indicated will reduce low value examinations.	
4.	**Iron Deficiency Anaemia Pathway**	• Following a review of the IDA pathway, PBas stated there is a need to incorporate a comment around the GP examining the patient. • AB highlighted that the ICB are working on an IDA pathway and stated he would be happy to lead on this. • It was noted that there also needs to be a pathway for rectal bleeding.	
5.	**Colon Capsule**	• MTW have an established CCE service. • EKHUFT's business case for a CCE service has been signed off and they are now awaiting a go-live date. • MFT's business case for a CCE service is in the process of being signed off. • DVH are currently working on a business case for a CCE service.	
6.	**FDS sign off**	**<u>Presentation provided by Ann Courtness</u>** • The Colorectal FDS Task & Finish Group have focused on:	

		- Standardising the FDS pathway across Kent & Medway, aiming to improve triage rates and patient experience. - The inclusion and exclusion criteria to enable a template to be used across Kent & Medway. - Ensuring primary care are actively engaged in the process and aware of the need to have a FIT result prior to being referred on the FDS. - Discussions pertaining to the improvement of benign pathways. - Ensuring patient communication is good and that they are provided with all the information they would need. - Devising a letter for the acute Trusts to send to primary care practices if there is not enough information available to process the referral. • AC outlined what the proposed letter includes (please refer to the presentation to see this). • In terms of next steps, there is an intention to: - Obtain agreement for the primary care letter (which will go to both GP and patient). - Agree the inclusion/exclusion criteria. - Continue work on the benign pathways. - Ensure communication continues and improves for patients. • It was agreed that the letter will need a bedding in time of 6 weeks and for further education to be provided to primary care as part of an overall comms plan.	
7.	**MDT Streamlining**	• This item was not discussed.	
8.	**Dashboard**	**<u>Update provided by David Osborne</u>** • In the last 6 months, FDS performance improved from 51.7% to 55.8%, and 62d performance improved from 59.8% to 62.1%. • In the last 6 months, FDS performance improved at MTW from 59.4% to 70.9%. DVH, EKHUFT and MFT are below the England average.	

		• For 62d performance, DVH is well below the England average at 33.3%. • Triage/booking is later at EKHUFT. • At MTW, cancer is diagnosed at a similar time to patients with cancer ruled out. • Time from decision to treat to first treatment is longest at DVH. • Overall, use of full colonoscopy has decreased slightly at DVH and increased at MFT. • DO believes it is important to consider how use of investigations fits with the new colorectal pathway. • Use of full colonoscopy for FIT <10 has fallen at all Trusts and is under the 20% target. • Data completeness on InfoFlex needs improvement at MFT. Stage data completeness has recently fallen at MTW. • AWa noted that West London Cancer Alliance are top nationally for both FDS and 62d performance and believes it would be helpful to find out how they are managing to achieve this. • In order to access the Dashboard, follow these steps: - Complete the form: https://forms.office.com/r/svyPSvktHw. - Once access has been granted by the ICB, access the Dashboard at: https://app.powerbi.com/home?ctid=4cfbd3c4-a42e-48a1-b841-31ff989d016e - click on the KM ICB Main app and go to Cancer Pathways on the left-hand menu.	
9.	**qFIT update**	**<u>Update provided by Laura Alton</u>** • LA informed the members that 78% of referrals in Kent & Medway are now accompanied by a qFIT result (the target being 80%). • LA highlighted the need for primary care to be educated further with regard to qFIT parameters in order to refer in	

		to secondary care with confidence.	
10.	**PSFU overview**	**<u>Presentation provided by Claire Mallett</u>** • CM stated that it is a national requirement to deliver stratified pathways and is part of the elective care plan. • CM outlined the benefits of PSFU for both patients and professionals. • The Kent & Medway-wide clinical protocol has been agreed. • The End of Treatment summaries, which have been circulated to the group, are to be embedded in to the pathway. • The percentage of those on a self-managed pathway is expected to increase as all key components of the stratified pathway are embedded and teams develop confidence in the new model of care. In terms of expected impact, it is believed that 55% of colorectal patients can be under a professional-led pathway and 45% under a self-management pathway. • CM outlined the PSFU pathway process at each of the Trusts. **<u>MFT</u>** • There are currently approximately 300 patients in OAFU follow-up, and the last year's data suggests 600 patients are in traditional nurse-led follow-up. That is almost 1000 patients per year being followed-up currently with numbers increasing yearly. • In terms of what is working well: - Less hospital appointments for patients, meaning improved quality of life with reduced anxiety. - Reduced stress for patients with not having to park at the hospital. - Reduced financial outgoings for patients.	

		- Reduced footfall in to hospital. • Concerns/issues include: - A whole day clinic with jobs often spilling out to the rest of the week. - The service is very admin-heavy and there is no bespoke admin support in place. OAFU involves much more admin than traditional follow-up. - The addition of another clinic but no extra resource to match the additional workload is proving challenging. - OAFU will only get bigger over time as the team want to move new patients/appropriate existing patients to this pathway, but they are having to hold back on this due to capacity/workload. - Histology and imaging reporting times are delaying OAFU workload with jobs rolled over for weeks as reports are not ready. • In terms of what the team want going forward, this includes: - To standardise elements of OAFU across Trusts as they all work differently. - More time to expand and develop the service with their own specialist interests. - More staff to reflect their workload/capacity. - Improved team morale. **MTW** • MTW commenced with PSFU in 2022. • The majority of patients are stratified to SSM (774 patients). The remainder of the patients are on nurse-led follow-up (130 patients). These patients are either on polyp cancer follow-up or Maastricht follow-up. • MTW have 1 dedicated Band 7 CNS and a Band 4 Support Worker for PSFU. • In terms of what works well: - Face-to-face clinic space is saved.	

		- The service is well-received by patients. They prefer not having to come to the hospital for appointments. - It is flexible and puts patients in control. • Challenges include: - Delays in endoscopy. Surveillance scopes are running behind. - GPs still referring patients in on 2ww pathways when they are on surveillance. - Chasing patients to have bloods done. **DVH** • In terms of what is working well: - CEA alert. - Initial surveillance appointment. - Discharge MDT. - Autonomy. • Actions for improvement include: - Allocated time. - Radiology streamlining. - Incidental findings. - Patient information material. **EKHUFT** • 600 patients are on follow-up and they are overseen by the CSW/CNS. • The service receives good support from both the MDT and clinicians at EKHUFT – however, the MDT requires admin support. • Patients are scanned at years 1, 2 and 5. It has been queried whether the 5 year scan could be stopped but there is a need to look at the data for colorectal cancer recurrence at year 5 before any changes can potentially be made.	

		• **<u>Action</u>: Follow-up protocols to be an agenda item for the next meeting.**	**KMCC team**
11.	**CNS updates**	• It was felt this item had been sufficiently discussed under agenda item 10.	
12.	**CRG update**	• CRG meetings are taking place on a regular basis, however there is a lack of radiology support. In view of this, PBas encouraged the members to discuss this vacant role with radiologist colleagues to see if the position can be filled.	
13.	**'Cancer Psychological service for Kent & Medway – who we are and how to refer'**	**<u>Presentation provided by Clare Reeder</u>** • The Cancer Psychological Service for Kent and Medway (CaPS-KM) covers all 4 acute Trusts. The CaPS-KM team are separate from, but work closely with, the Oncology Counselling teams. • The service has received 2 years of funding from KMCA and Macmillan (May 2024-26). CR hopes that the service will then be fully commissioned after this. • The aims of the service are: to build on previous scoping to understand local psychosocial services; to demonstrate unmet psychological need; to set up and evaluate a Kent & Medway-wide cancer psychological service; and, to secure permanent NHS funding. • The team comprises of India Barton (Macmillan Assistant Psychologist), Sophie Lansdowne (Honorary Assistant Psychologist), Janet Bates (Macmillan Counsellor), Dr Chris Bonner (Macmillan Clinical Psychologist), Dr Clare Reeder (Macmillan Consultant Clinical Psychologist and Service Lead) and Rachel Maciag (Trainee Clinical Psychologist). • The team have: - Undertaken a widespread listening exercise with MTW, EKHUFT, hospices and other third sector colleagues. - Set up a Steering Group. - Compiled a patient survey. - Established a focus group.	

		- Attended support groups. - Provided video resources for patients. - Established a pilot service which is up and running in MTW (approximately 70 referrals have been received so far). The service can now also receive referrals from DVH, EKHUFT and will soon be able to do the same for MFT. - Focused on developing coherent, safe pathways with existing services. - Worked with other Trusts in Kent & Medway to commence with their service. - Delivered 2 Level 2 psychological skills training courses for cancer CNSs and AHPs and established 5 supervision groups. - Provided workshops for CSWs, chemo day unit staff and palliative care colleagues. - Provided induction teaching for haematology and oncology SHOs. • CR outlined: what the service is offering; who to refer to psychological services; who the service will see; and, how to refer to the service and what to expect. • In order to contact the CaPS-KM service, please email mtw-tr.caps-km@nhs.net or clare.reeder@nhs.net. • AWa asked whether the service could sit in on Best Interest meetings. CR confirmed that they could do this.	
14.	**Young patients referred on a LGI pathway**	**<u>Presentation provided by Chris Wright</u>** • Colorectal cancer is rare in people under the age of 30 and accounts for 1-2 people per 100,000 population in the 20-30 age bracket. It is exceptionally rare in people below the age of 20. • The index of concern for colorectal cancer to generate a 2ww referral is set at 3%. • However, there has been a 400% increase in the numbers of people below the age of 30 referred since 2019 – and there has been a 40% year-on-year increase (almost certainly attributable to qFIT). • An audit was carried out by MTW on 2021-2024 cases and was focussed on all 2ww referrals for people aged 30 and below at the time of referral. • Of the 382 patients, 1 cancer was identified in a person aged 26 who had multiple symptoms. • Since 2009 there have been 65,469 2ww referrals - 610 in those aged 30 and below, with a total of 3 cancers in	

		this age cohort. The incidence of colorectal cancer in this cohort is well below the 3% threshold for 2ww. • In terms of referral indications, bleeding was the predominant symptom followed by change in bowel habit (CIBH). All of those with IDA were female. • With regard to qFIT, this was first used at MTW in 2020. 14% of patients had no qFIT at the point of referral and 27% of patients were referred with a negative qFIT. • There was a total of 398 investigations (>1 per patient). 44% of patients were referred for investigations despite having a normal qFIT result or no qFIT result received. • In summarising: - Cancer is rare (0.2%). - Polyps are much less common in the <30 age group than in the general population. - IBD is very common in this cohort. - Lots of investigations are being done on qFIT-negative patients. - There was a total of 252 colonoscopies for this cohort (66% of all requested tests). • With regard to points for discussion/recommendations: - Patients under the age of 30 presenting with lower GI symptoms should have FCP done and if both qFIT and FCP are positive then IBD is very likely (almost 1 in 5). Is there scope for an IBD pathway to manage young patients with lower GI symptoms? - Those with a normal qFIT must not be referred on to the lower GI fast track pathway. - There is never any indication to refer children or even teenagers. These referrals should be returned to the GP or managed on alternative pathways. There is also a strong argument that patients under the age of 25 should not be referred on a 2ww. - The NPV of qFIT <100 is 100%. CW recommends that any patient considered for 2ww referral under the age of 30 should use the cut off of 100 rather than 10 (however, qFIT has apparently reduced DNA rates (14% of referrals with no qFIT compared with 5% referred with a qFIT)). • Patients referred on the lower GI pathway are supposed to be informed that there is a suspicion of cancer (although many are not).	

		• There is an extremely low incidence of serious pathology in this group. There is also an extremely low incidence of polyps (2% vs. 20-25% in the global adult population). • IBD is much more common than colorectal cancer in patients under the age of 30 presenting with lower GI issues. • CW believes patients under the age of 18 should not be referred in on a cancer pathway and should not be having a qFIT. Following on from this, RBu stated that 16–18-year-old patients are a grey area for EKHUFT, with PBas stating these patients should be on another pathway.	
15.	**AOB**	• PBas informed the members that this will be AWi's last Colorectal TSSG as she is retiring in June 2025. He thanked her for all the work she had done over the last 7 years and wished her all the best for the future.	
	Next Meeting	• Tuesday 7th October 2025 (09:00-12:30) – location of meeting to be confirmed.	