Kent and Medway Cancer Collaborative

Colorectal Tumour Site Specific Group meeting
Tuesday 11th May 2021
Microsoft Teams
09:30 – 12:30

Final Meeting Notes

Present	Initials	Title	Organisation
Pradeep Basnyat (Chair)	**PB**	Consultant General & Colorectal Surgeon	EKHUFT
Gyorgy Vittay	**GV**	Consultant Histopathologist	EKHUFT
Sudhakar Mangam	**SMa**	Consultant General, Laparoscopic and Colorectal Surgeon	EKHUFT
Tracey Rigden	**TRi**	Development Chemotherapy Nurse Consultant	EKHUFT
Mohan Harilingam	**MHa**	Consultant General, Emergency and Colorectal Surgeon	EKHUFT
Larissa Williams	**LW**	Colorectal CNS	EKHUFT
Ashish Shrestha	**ASh**	Consultant Surgeon	EKHUFT
Nipin Bagla	**NB**	Consultant Histopathologist	EKHUFT
Zac Tsiamoulos	**ZT**	Consultant Gastroenterologist	EKHUFT
James Bowyer	**JB**	Operations Manager	EKHUFT
Amjad Khushal	**AK**	Consultant Colorectal Surgeon	EKHUFT
Rakesh Bhardwaj	**RB**	Consultant Laparoscopic, General and Colorectal Surgeon	DVH
Michelle McCann	**MM**	Operational Manager for Cancer & Haematology	DVH
Piero Nastro	**PN**	Consultant General and Colorectal Surgeon	DVH
Farrah Errington	**FE**	MDT Coordinator	DVH
Sue Stubbs	**SSt**	Colorectal CNS	DVH
Parthi Srinivasan	**PS**	Consultant Surgeon - HPB, Pancreatic and Liver Transplant	King's College Hospital
Debashis Sarker	**DS**	Senior Lecturer within the Comprehensive Cancer Centre & Consultant Medical Oncologist	King's College Hospital
Tracey Ryan	**TRy**	Macmillan User Involvement Manager	KMCA
Claire Mallett	**CM**	Programme Lead – LWBC/PC&S	KMCA
Colin Chamberlain (Notes)	**CC**	Administration & Support Officer	KMCC
Karen Glass	**KG**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Facilitator	KMCC
Henk Wegstapel	**HW**	Consultant General, Laparoscopic and Colorectal Surgeon	MFT

Angela Bell	**AB**	Colorectal CNS	MFT
Sue Green	**SGree**	Macmillan Recovery Package Facilitator	MFT
Albert Edwards	**AE**	Consultant Clinical Oncologist	MTW
Stefanie Outen	**SO**	Colorectal CNS	MTW
Jorge Gomes	**JG**	Surgical Care Practitioner	MTW
Raza Moosvi	**RM**	Consultant General, Laparoscopic and Colorectal Surgeon	MTW
Meeta Durve	**MD**	Consultant Clinical Oncologist	MTW
Laura Alton	**LA**	Senior Programme Manager – KMCA	NHS Kent & Medway CCG
Andrew Roxburgh	**AR**	GP Commissioner	NHS Kent & Medway CCG
Bana Haddad	**BH**	Macmillan GP / Clinical Lead – LWBC/PC&S	NHS Kent & Medway CCG
Stefano Santini	**SSa**	Macmillan GP & Cancer Lead	NHS Kent & Medway CCG
Alexandra Stewart	**ASt**	Consultant Clinical Oncologist	Royal Surrey County Hospital NHS Foundation Trust
Julia Addison	**JA**	Patient Representative	
Apologies			
David & Jo Gascoyne	**D&JG**	Patient Representatives	
Catherine Neden	**CN**	GP	East Cliff Practice
Eelco Boorsma	**EB**	Consultant Radiologist	EKHUFT
Susan Travis	**ST**	Service Manager	EKHUFT
Pippa Miles	**PM**	Senior Service Manager	EKHUFT
Joanne Cooke	**JC**	Consultant General Surgeon	EKHUFT
Louise Gladwell	**LG**	Clinical Trials Administrator	EKHUFT
Martine Henniker	**MHe**	Colorectal and Upper GI CNS	EKHUFT
Sue Drakeley	**SD**	Clinical Trials Practitioner	EKHUFT
Ayman Hamade	**AH**	Consultant General Surgeon	EKHUFT
Deniece Merrall	**DM**	Colorectal CNS	EKHUFT
Gandra Harinath	**GH**	Consultant General Surgeon	EKHUFT
Jann Yee Colledge	**JYC**	Consultant Radiologist	EKHUFT
Mohammad Imtiaz	**MI**	Consultant Surgeon	EKHUFT
Stella Grey	**SGrey**	Service Manager	EKHUFT
Nichola Atkins	**NA**	Divisional Support Manager	King's College Hospital
Stewart Nisbet	**SN**	General Manager – General Surgery	MFT
Bronwyn Tetley	**BT**	Colorectal CNS	MTW
Karen Hopkins	**KH**	Bowel Cancer Screening Practitioner	MTW
Sharon Melville	**SMe**	Night Nurse Practitioner	MTW
Ciara O'Hanlon-Brown	**COHB**	Consultant Medical Oncologist	MTW
Sona Gupta	**SGu**	Macmillan GP & Cancer Lead	NHS Kent & Medway CCG

Item		Discussion	Agreed	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 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	**Follow up after Rectal Brachytherapy**	**Update provided by Alexandra Stewart** ASt's slides provided an overview of: • The post-treatment effects of the Papillon MRI scan. • The standard of surgical care, which for mid and upper rectal cancer is Total Mesorectal Excision (TME) and Abdominoperineal Excision of Rectum (APER) for early low rectal cancer. • Screen detected tumours by stage. • The mortality and morbidity associated with TME. • Postoperative mortality in elderly people. Colorectal cancer is presenting at an older age and there is a clear need to determine which treatments would be appropriate for elderly patients. • When it is not appropriate to operate. • The importance of External Beam Radiation Therapy (ERBT). • When brachytherapy can be considered and how contact brachytherapy can be delivered. • The results of the Lyon trial. • The comparison between initial response and local regrowths. • The selection criteria for potentially operable patients. • Options available for both low-risk and high-risk patients following local excision in addition to the options available for patients with no prior excision. • The personalised treatment approach. • Post-treatment adverse effects associated with contact x-ray brachytherapy. • The close surveillance measures in place for operable patients. • The OPERA trial, which has now closed to recruitment. • The national colorectal cancer database (www.colorectaldatabase.com), which was developed in Guildford and funded by charities. The database collects PROMS.		

		• The PROMS schedule for the CITRuS trial. • The one-stop clinic which is now in place. The team provide patients with written or electronic information prior to their appointment so they can decide whether to proceed with treatment. Once they come in for their first appointment they are sent to the Papillon suite for an enema and assessed further there. If the team deem it safe to continue, the patient is then given the treatment. • ASt and her colleagues published a paper entitled *'Radiological and clinical findings following rectal contact X-ray brachytherapy (Papillon technique) – how to assess response'*. They also won the 'Cancer team of the year' BMJ award in 2018 for their work on rolling out the Papillon programme. • ASt confirmed they accept patients from across the south of England, which includes K&M. • **Action: ASt to send CC the Guildford protocols and guidelines.**		**ASt**
3	**Genomics**	**Update provided by Debashis Sarker** DS' slides provided an overview of: • The 7 Genetic Laboratory Hubs (GLH). • The need to address the variation in quality and access to genetic testing across the country, especially for cancer. • The principles of the South East GLH operating approach. • NHSE objectives for the Genomic Medicine Service Alliances (GMSA) and a summary of the South East GMSA programme for cancer. • National transformational projects for 2021/2022, including ones for: Dihydropyrimidine Dehydrogenase (DPYD), Lynch Syndrome and pathology. • The National Genetic Test Directory. • The South East GLH colorectal pathway and how it is being reviewed. • The Molecular Tumour Board structure. • DS stated NHSE have a strategy in place to utilise genomic medicine for the purpose of revolutionising care and providing a personalised approach. • DS confirmed comms would be sent out shortly, which will include pathologists such as NB, detailing a timeline for when patient samples can be sent to the GLH at GSTT. He highlighted the importance of optimising and streamlining the process. Jason Wang, the pathology lead for the GLH at GSTT and the link between there and local pathology laboratories, would be happy to discuss this piece of work further should anyone wish to find out more.		
4	**Complex Polyp Management and Pathway**	**Update provided by Zac Tsiamoulos** • The service was set up in 2018 and has input from endoscopy, gastroenterology, radiology, pathology and surgical colleagues. • A complex polyp MDM was implemented in 2018, with an MDT Coordinator in place. Approximately 15 patients are discussed at each meeting.		

		• They noticed a 55% increase in referrals after the MDT Coordinator was appointed. • Between 2018 and 2020, they discussed 869 patients at the MDM. • They have a complex polyp proforma and are awaiting the finalisation of a SOP. • They have weekly dedicated slots for GA lists. • A complex polyp MDM audit is carried out monthly in order to look at outcomes. The complex polyp service audit is carried out annually. • The complex polyp service audit (operating from 2018 to the first half of 2020) focused on: short-term and long-term outcomes, complications, cancer prevalence, endoscopic treatment as well as en-bloc and piecemeal resections. • The 4th KENT course took place on 14.12.2020 and 15.12.2020. 700 people registered for the course, 60% of which attended. The course is a BSG-endorsed national and international course and has received a lot of positive feedback. • Risk assessments had to be put in place for the external faculty members.		
5	**Performance**	**DVH – update provided by Michelle McCann** • DVH failed to reach the 2ww standard in January, met it in February and are likely to achieve it in March 2021 too. They have noticed an increase in 2ww referrals, especially in May 2021, which has made planning and meeting demands challenging. • In relation to the 31d target, they achieved this in January and February and are likely to fail it in March 2021. They have experienced surgical capacity issues. • With regard to the 62d standard, DVH failed this in January and February and are likely to fail it in March 2021 also. There have been a number of delays in oncology, endoscopy and for GA scopes. They have also had a number of complex cases and a large backlog. • The Trust had 1 104d+ case in January, none in February and are likely to have a total of 6 in March 2021. • In relation to the 28d data compliance piece, they failed to reach the target in January and February 2021. With regard to the 28d data completeness standard, they achieved this according to the data available at the end of March 2021. The Trust are working with their MDT Coordinators to improve data entry. • Key risks include endoscopy and surgical capacity, EUS' and patient choice. • An endoscopy hub has been put in place. They have also recruited a 0.5 WTE STT nurse and a full-time administrator to support early diagnosis work. The administrator will also help the team with the administrative aspects of qFIT. • In relation to safety netting, CNS' are now calling patients. • Outpatient capacity has been limited due to there being only 1 STT nurse in place. • From a theatre capacity perspective, there is currently no flexibility in being able to bring patients forward. There is also limited capacity for GA scope lists and EUS'. • qFIT has been helpful for patients who did not require scoping.		

		EKHUFT – update provided by James Bowyer • With regard to the 2ww standard, they achieved this in January, February and March 2021. They are seeing an increase in 2ww referrals and work closely with their teams to ensure compliance and resolve any issues which may arise. • In relation to the 31d target, they reached the standard in January and February but failed to do so in March 2021. There has been limited surgical capacity due to the pandemic and a lack of HDU beds. • EKHUFT failed to achieve the 62d standard in January, February and March 2021. They have had issues with: radiology delays, limited outpatient capacity for face-to-face appointments, reduced capacity for heavy sedation lists, complex pathways, elective capacity, medical delays and patient-initiated delays. • The Trust had 3 104d+ cases in January, 5 in February and 6 in March 2021. Patient choice and their decision to wait until they have been vaccinated before proceeding with treatment has resulted in delays. • EKHUFT had 64 62d+ backlogs in January, 42 in February and 31 in March 2021. There have been some capacity issues for virtual colonoscopies. • Between January and March 2021, they achieved 50% for 28d data compliance. 2 Pathway Navigators are in post and they have recently commenced weekly Navigator training/refresher/education meetings where challenges and successes are discussed in order to help improve the front end of the pathway. Clinic letter templates are in the process of being reviewed in order to increase compliance. • Between January and March 2021, they achieved 95% for 28d data completeness. Dedicated administrative support is in place to improve 28d data collection and accuracy. The Pathway Navigators are also supporting with data entry now. • Clinic capacity has reduced in order to maintain social distancing. • There has been a surge in 2ww referrals as a result of patients presenting to their GP practice. As a result, additional clinics are being scheduled to accommodate this. • Regular clinical reviews are in place and theatre capacity is gradually being increased. • They have daily calls with radiology and endoscopy colleagues in order to escalate cases. • Daily PTL calls are also in place in order to review pathways for each patient and escalate when required. **MFT – update provided by Henk Wegstapel** • They achieved the 2ww standard in January and February and are likely to reach it in March 2021 too. • The Trust failed to reach the 31d target in January, met it in February and are likely to also reach it in March 2021. • With regard to the 62d standard, they failed to achieve the target in January and February and are likely to fail it in March 2021 too. Diagnostic delays have had an impact on the service.		

		• MFT had 11 104d+ cases in January, 8 in February and are likely to have a total of 9 in March 2021. • In relation to 62d+ backlogs, they had 71 in January, 46 in February and are likely to have 23 in March 2021. • MFT failed to achieve the 28d data compliance target in January, February and March 2021. • Key concerns and barriers include: patient-initiated delays, patient isolation times, reduced HDU facilities for certain procedures, a reduction in endoscopy capacity (which is currently operating at 80% of its normal rate), patient triaging and swabbing. In order to expedite some of these issues, they continue to utilise qFIT and additional clinics are being put in place. • Breach reasons include: delays within the diagnostic pathway, theatre capacity and one patient was referred to another Trust for a second opinion. • Theatre capacity has yet to return to the level it had prior to lockdown. • Outpatient capacity has been reduced to 80% face-to-face. • All 2ww appointments take place by telephone. • They experienced a reduction in preassessment capacity due to a number of nurses being redeployed during the COVID peaks. **MTW – update provided by Raza Moosvi** • They met the 2ww standard in February and March and are likely to achieve it in April 2021 too. • MTW failed to meet the 31d target in February and March and are likely to fail it in April 2021 also. • The Trust did not achieve the 62d standard in February and March and are likely to also fail it in April 2021. • The Trust had no 104d+ cases in February and March and are likely to have 2 in April 2021. • In terms of 62d+ backlogs, they had 23 in February, 24 in March and are predicted to have 29 in April 2021. These are primarily attributable to patient choice, complex pathways and patients delaying their pathways until they have been vaccinated. • In relation to 28d data compliance, they achieved this in March 2021. In terms of overall 28d data completeness, they are regularly failing to achieve this. • Outpatient capacity is now being fully utilised. The availability of theatre scheduling is the same as it was prior to the second wave and the increase in utilisation is helping to manage routine and cancer work. • A number of patients have been hesitant to undergo high-risk surgery before they have been vaccinated. Patients have also been hesitant to attend hospital out of fear they may contract COVID. • A comprehensive clinical triage on patient risk is resulting in some breaches. • In order for high-risk surgery to be carried out at the Trust, a ‘green’ pathway at Tunbridge Wells Hospital was put in place.		

		• There was limited ITU capacity during the peaks of waves 1 and 2.		
6	**Clinical Pathway Discussions**	**HOP & POC** • PB stated he would liaise with AW in order to try and get both documents updated and finalised prior to the next meeting. He confirmed sections on both qFIT and the COVID recovery phase will need to be included in the documents. **Colorectal cancer pathway – update provided by Sudhakar Mangam** SMa's slides provided an overview of the colorectal cancer management update, which included: • The NICE guidelines published on 29.01.2020. • The 28d FDS piece (including the NHS' Long Term Plan to save 55000 more lives each year by diagnosing cancers earlier). • New guidance published during the pandemic. • The emerging role of qFIT (including EKHUFT's qFIT guidelines/pathway). • A reference to The Federation of Surgical Specialty Association (FSSA) prioritisation piece. • The need to update the KMCC PoC and HOP documents to reflect current practice. • The management of patients with early rectal cancer and the treatment options available (including their advantages and disadvantages): - Transanal Excision (TAE) which includes Transanal Minimally Invasive Surgery (TAMIS) and Transanal Endoscopic Microsurgery **(**TEMS). - Endoscopic Submucosal Dissection (ESD). - Total Mesorectal Excision (TME). • The impact of recommendations on practice. • The preoperative treatment for rectal cancer. • Locally advanced primary/recurrent rectal cancer. • Surgical volumes for rectal cancer patients. • The duration of adjuvant chemotherapy for patients with stage 3 colorectal cancer. • Colonic stents in acute large bowel obstruction. • Metastatic disease. • Follow-up for detection of local recurrence and distant metastases. **Anaemia pathway** • This item was not discussed.		
7	**Management of CR Liver Metastasis Pathway update**	**Update provided by Parthi Srinivasan** • There has been little change to the liver surgery pathway at King's College Hospital since the last meeting. • Due to COVID, a lot of their surgical cases were sent to London Bridge Hospital but they have since been repatriated back to King's College Hospital. • They have 12 HPB operating lists each week at King's College Hospital.		

		• The team are managing their cancer workload well, especially for surgery. • They have had an increase in referrals recently and, as a result, surgical volume has increased. • The Trust have recruited an HPB CNS and HPB surgeon. • The team have been given a lot of support from South East London and EKHUFT colleagues. • PS stated he would be happy for K&M clinical colleagues to join their MDT meetings. **Action: CC to email the neuroendocrine, HPB and HCC MDT Coordinators at King's College Hospital in order to obtain the joining details for their MDT meetings. Once he has obtained this information, he will pass it on to the K&M MDT Coordinators.**		**CC**
8	**Research**	• This item was not discussed.		
9	**Clinical Audit** • **EAGLE study**	**Update provided by Ashish Shrestha** ASh's slides provided an overview of: • The burden of anastomotic leak (including its surgical outcomes, the patients' quality of life and the health system costs). • The origins, aims, trial design and educational modules of the safe anastomosis project. • The quality improvement intervention, with the 3 components of change being: patient-level risk stratification, the European Society of Coloproctology (ESCP) Safe Anastomosis Checklist and the harmonisation of the technique. • Post-intervention data collection. • A list of people who contributed to the study. • RM confirmed MTW are part of the study. HW is not sure whether MFT are currently taking part in this but if not, they may decide to do so at some point.		
10	**Adjuvant Chemotherapy for cancer surgery patients**	• This item was not discussed as Su Woollard did not attend the meeting. • **Action: AW to contact Su Woollard to ask if she would like to present on this item at the next meeting.**		**AW**
11	**qFIT update**	**Update provided by Laura Alton** • LA specified the aim is for primary care to take over the responsibility of the high-risk qFIT pathway. This, however, will take some time to be formalised and implemented. • There have been some issues with the supply of kits to GP practices. In view of this, LA highlighted the importance of reviewing the ordering process in order to expedite these issues. • The mislabeling of pots has also been an issue, resulting in some samples not being able to be processed. • LA stated clarification is required in relation to the flagging of high-risk and low-risk cases and how they need to be labelled accordingly. • There have been some safety netting issues. In view of this, there is a clear need to determine who should be responsible for chasing patients. • LA stated it would be helpful to have a generic K&M-wide qFIT pathway for both low-risk and		

		high-risk cases in order to standardise practice. Ian Vousden is keen to take a paper to the Kent & Medway Clinical Cabinet articulating this. BH agreed with LA and emphasised the importance of having a patch-wide SOP in place. • RM specified a negative qFIT result (<10ug/g) is helpful in indicating exclusion of cancer. • SSt mentioned pan-London referrals to DVH have decreased recently which she believes is due to them now utilising qFIT. • HW stated GP access to rapid diagnostics and CT scans is important. SSa mentioned GP direct access to CT or MRI scans is not available in all K&M ICP's. • NICE guidance does not currently include a section on qFIT for high-risk patients. • HW highlighted the importance of having both the qFIT and telephone assessment in place. He added most colorectal cancer is visible on a CT scan. • HW stated a qFIT kit is sent to all patients at MFT when a 2ww referral comes in and they do not order any tests until it has been returned. This has reduced the number of endoscopy referrals. Patients with a qFIT result of <10ug/g are taken off the rapid access colorectal pathway and discharged back to their GP or placed on another pathway. • MFT patients are called by the clinical team who encourage them to do the test and return it as soon as possible. The onus is with the patient to ensure they do this and if they fail to comply, they are removed from the pathway. RM confirmed MTW follow a similar process. He added that he hopes a process will be implemented whereby the GP does the test prior to a 2ww referral being made. • **<u>Action:</u> AR stated he would send CC and PB the pan-London colorectal pathway documentation which Chris Wright sent him in February 2021. Once received, CC will circulate to the members.** • LA confirmed she would take today's discussions to the next qFIT meeting (13.05.2021).		**AR/CC**
12	**CNS Updates**	**<u>DVH</u>** • SSt had left the meeting at this point so an update was not provided. **<u>EKHUFT</u>** • A CNS update from EKHUFT was not provided. **<u>MFT – update provided by Angela Bell</u>** • The Trust have noticed an increase in referrals. • They are working closely with SGree on the recovery package/stratified pathway elements. **<u>MTW – update provided by Stefanie Outen</u>** • They have noticed an increase in referrals. • New team members will be involved in moving the stratified pathways work forward. Before they can proceed with this, however, the colorectal MDM will need to agree on how it is to be implemented.		

		• The Trust are looking to recruit an Advanced Clinical Practitioner (ACP) within the next few months. The ACP will help to support the HNA, surveillance and stratified pathways work in addition to taking on some of the clinical workload from consultants and registrars. • They have dealt with a number of complex cases throughout the pandemic.		
13	**Stratified pathway update**	**Update provided by Claire Mallett** • CM has worked with some of the K&M CNS' on stratifying patient pathways. • WHH CNS' have worked on putting together a number of stratified pathway documents and these are now awaiting sign off. • They have looked at the remote monitoring system piece in addition to a follow-up clinical protocol (which was signed off prior to the pandemic). The clinical protocol outlines a timeline detailing what patients can expect, and when to expect them, following surgery. • PB confirmed the stratified pathways piece had been discussed in the CCHH Care Group meetings at EKHUFT and they gave agreement for this piece of work to proceed.		
14	**Cancer Alliance update**	**Update provided by Claire Mallett** The predominant aims of cancer services across the patch are to: • Restore urgent cancer referrals at least to pre-pandemic levels. • Reduce the backlog at least to pre-pandemic levels on 62d (urgent referral and referral from screening) and 31d pathways. • Ensure sufficient capacity is in place to manage increased demand moving forward, including follow-up care. • Reduce health inequalities. • Support the 28d FDS piece. • Ensure patients and staff are confident services are COVID-protected. • Ensure the right workforce is in place. • Restart Long Term Plan activity.		
15	**CCG Update**	**Update provided by Laura Alton** • LA and Chris Singleton are the new Senior Programme Managers for cancer commissioning in Kent & Medway and are working as part of an integrated CCG and KMCA team. They believe this is a positive change from the previous locality-based commissioning approach, and is in line with the development of the Integrated Care System. It will support delivery of local and national cancer priorities, and brings together the expertise of the KMCA with commissioners under the leadership of Ian Vousden (Programme Director). • LA and Chris Singleton are keen to help support the development of clinical pathways which improve access to cancer services for the K&M population, navigating through the new CCG governance processes. The CCG will ensure they work at scale across the patch, whilst also making sure all voices are heard. • They are working closely with their planned care commissioning colleagues in each of the 4 Kent & Medway Integrated Care Partnerships, given the overlap between cancer and planned care pathways.		

		• Cancer is a clear priority in the recently published NHS Planning Guidance, and they will be working with all relevant colleagues to help deliver the priorities, particularly in terms of returning to pre-pandemic levels of cancer treatment. • They are currently focusing on a number of commissioning priorities for cancer, including pilots of a number of rapid diagnostic services including: - The Vague and Indeterminate Symptoms Service at DVH (which they are looking to make a substantive commissioned service there due to the success of the pilot). Discussions are underway to extend the VISS model more widely across the patch. - The rapid lymphadenopathy service at EKHUFT. - The low dose CT piece at EKHUFT. • LA and Chris Singleton have also been working with the provider of the K&M prehabiliation programme, which has been presented and discussed at a number of TSSG meetings, in order to extend the pilot of the service for patients and to help them prepare for surgery. • LA encouraged the members to contact her/Chris Singleton if they require commissioning support with any cancer pathway developments.		
16	**AOB**	• No-one had anything to raise under any other business.		
	Next Meeting Date	• To be confirmed.		