Kent & Medway Cancer Collaborative

Colorectal Tumour Site Specific Group meeting
Tuesday 4th October 2022
Great Danes (Mercure) Hotel
09:30-12:30

Final Meeting Notes

Present	Initials	Title	Organisation
Pradeep Basnyat (Chair)	**PBasn**	Consultant General & Colorectal Surgeon	EKHUFT
Stella Grey	**SGr**	General Manager - General Surgery & Colorectal	EKHUFT
Danielle Mackenzie	**DMac**	High Risk qFIT Project Facilitator	EKHUFT
Ruth Burns	**RBu**	Macmillan Lead Colorectal CNS	EKHUFT
Nipin Bagla	**NB**	Consultant Histopathologist	EKHUFT
Chris Fox	**CFo**	Consultant Gastroenterologist	EKHUFT
Michelle McCann	**MM**	Operational Manager for Cancer & Haematology	DVH
Louise Rafferty	**LR**	Macmillan Lead Colorectal CNS	DVH
Claire Mallett	**CMal**	Programme Lead – Living With and Beyond Cancer	KMCA
Colin Chamberlain (Notes)	**CCh**	Administration & Support Officer	KMCC
Karen Glass	**KG**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Lead	KMCC
Suzanne Bodkin	**SB**	Cancer Pathway Manager	MFT
Emma Bourke	**EB**	Personalised Care & Support Facilitator	MFT
Angela Bell	**AB**	Macmillan Colorectal CNS	MFT
Chris Wright	**CW**	Consultant Colorectal & General Surgeon	MTW
Helen Lloyd	**HL**	Consultant General, Colorectal & Laparoscopic Surgeon	MTW
Elaine Ellis	**EE**	Oncology CNS – Colorectal	MTW
Hayley Geere	**HGe**	Specialist Nurse in Anal Cancer	MTW
Stefanie Outen	**SO**	Colorectal Advanced Nurse Practitioner	MTW
Mark Hill	**MHi**	Consultant Medical Oncologist	MTW
Meeta Durve	**MD**	Consultant Clinical Oncologist	MTW
Laura Alton	**LA**	Senior Programme Manager – KMCA Commissioning	NHS Kent & Medway ICB
Holly Groombridge	**HGro**	Cancer Commissioning Project Manager	NHS Kent & Medway ICB
Julia Addison	**JAd**	Patient Representative	
Apologies			
Karen Hopkins	**KHo**	Bowel Cancer Screening Practitioner	DVH
Rakesh Bhardwaj	**RBh**	Consultant Laparoscopic, General and Colorectal Surgeon	DVH
Catherine Neden	**CN**	GP	East Cliff Practice
Deniece Merrall	**DMe**	Macmillan Colorectal CNS	EKHUFT
Mansoor Akhtar	**MA**	Consultant Colorectal, General & Emergency Surgeon	EKHUFT

Arun Dhiman	**AD**	Consultant Gastroenterologist	EKHUFT
Carly Price	**CP**	Colorectal CNS	EKHUFT
Gyorgy Vittay	**GV**	Consultant Cellular Pathologist	EKHUFT
Deya Marzouk	**DMar**	Consultant Colorectal, Laparoscopic & General Surgeon	EKHUFT
Ashish Shrestha	**AS**	Consultant Colorectal & General Surgeon	EKHUFT
Sandra Holness	**SH**	Cancer Pathway Tracker Coordinator	EKHUFT
Larissa Williams	**LW**	Macmillan Colorectal CNS	EKHUFT
Ayman Hamade	**AH**	Consultant General & Colorectal Surgeon	EKHUFT
Jann Yee Colledge	**JYC**	Consultant Radiologist	EKHUFT
Joanne Cooke	**JC**	Consultant General & Colorectal Surgeon	EKHUFT
Susan Travis	**ST**	Interim Operations Director (Surgery & Anaesthetics Care Group)	EKHUFT
Mohan Harilingam	**MHa**	Consultant General & Colorectal Surgeon	EKHUFT
Toni Bancroft	**TB**	Colorectal Surgical Care Practitioner	EKHUFT
Michelle Burrough	**MBu**	Macmillan Deputy Head of Nursing - CCHH Care Group	EKHUFT
Sudhakar Mangam	**SM**	Consultant General, Laparoscopic and Colorectal Surgeon	EKHUFT
Caroline Clark	**CCl**	Cancer Services Manager	KIMS
Serena Gilbert	**SGi**	Cancer Performance Manager	KMCA
Cathy Finnis	**CFi**	Programme Lead – Early Diagnosis	KMCA
Tracey Ryan	**TR**	Macmillan User Involvement Manager	KMCC
Karen Hills	**KHi**	Macmillan Colorectal Cancer CNS	MFT
Will Garrett	**WG**	Consultant General Surgeon	MFT
Clarissa Madla	**CMad**	Senior Clinical Research Practitioner	MFT
Natalie Jarrett	**NJ**	Colorectal Cancer Support Worker	MTW
Riyaz Shah	**RS**	Consultant Medical Oncologist	MTW
Paulette Basham	**PBash**	Clinical Trials Coordinator - Colorectal/Upper GI	MTW
Karen Nightingale	**KN**	Colorectal CNS	MTW
Julie Akers	**JAk**	Macmillan Specialist Radiographer	MTW
John Schofield	**JS**	Consultant Pathologist	MTW
Rakesh Raman	**RR**	Consultant Clinical Oncologist	MTW
Michael Berski	**MBe**	Surgical Care Practitioner	MTW
Ann Courtness	**AC**	Macmillan Primary Care Nurse Facilitator	NHS Kent & Medway ICB
Stefano Santini	**SS**	Macmillan GP & Cancer Lead	NHS Kent & Medway ICB
Chris Singleton	**CS**	Senior Programme Manager (KMCA Commissioning)	NHS Kent & Medway ICB
Helen Graham	**HGra**	Research Delivery Manager (Cancer)	NIHR

Item		Discussion	Action
1	**TSSG Meeting**	**Apologies** • The apologies are listed above. **Introductions** • PBasn welcomed the members to the meeting and asked them to introduce themselves. **Action log Review** • The action log was reviewed, updated and will be circulated with the final minutes from today's meeting. **Review previous minutes** • The final minutes from the previous meeting was reviewed and agreed as a true and accurate record.	
2	**Three Perspectives of qFIT**	**qFIT Pathway** • LA has been attending national qFIT meetings and colorectal 2ww referrals accompanied with a qFIT result is currently at 37% for Kent & Medway (the national expectation is 80%). • The national team will be sending out a letter to primary and secondary care regarding their qFIT expectations for Q3 and Q4. • The national team have asked the KMCA to report on the data Kent & Medway have on a monthly basis and this is to be recorded on InfoFlex. • 5600 qFITs are performed monthly across the patch. • PBasn emphasised the need to develop a robust safety netting pathway and for primary and secondary care to work closely together to ensure this is achieved. • CW highlighted the need for more qFIT education to be delivered to primary care colleagues. MM believes these educational opportunities should also be extended to locum GPs. • PBasn believes the pandemic encouraged the utilisation of qFIT due to the resultant reduction in diagnostic capacity during this time. • NB questioned whether private providers could be included in education sessions. PBasn believes they could benefit from this. • PBasn highlighted the importance of following national guidance regarding qFIT. • MM stated DVH are receiving an increase in inappropriate referrals and half of their PTL is taken up by colorectal cases. • PBasn believes the intention is for GPs to perform the qFIT, await the results and then refer the patient in to secondary care. • CW feels referral forms should clearly stipulate who a qFIT would not be appropriate for and for them to include mandatory fields so a referral will not be sent unless completed in the hope this will result in a reduction in inappropriate referrals. • LA stated qFIT utilisation is being tracked at practice-level. • JA believes it would be helpful to provide qFIT education to PPG chairs in order for them to encourage GPs to take	

		advantage of these learning opportunities. • PBasn questioned whether it would be helpful to draw up a safety netting algorithm for primary care. CW believes this would be of benefit. • PBasn stated a CT cologram takes the equivalent of 3 CT scan slots at EKHUFT. • MM mentioned DVH are experiencing issues with CT colograms. • PBasn believes it would be ideal to have a standardised qFIT pathway for Kent & Medway and for there to be standardisation with regard to safety netting for both primary and secondary care. **IDA Pathway** • The IDA pathway will be incorporated in to the HOP document. **qFIT Guidance** • It was felt this item had been discussed sufficiently under the qFIT pathway item.	
3	**Lynch Syndrome update**	**Presentation provided by Laura Alton** • Lynch Syndrome is the most common inherited cancer predisposition. It accounts for 5% of all colorectal cancers and 3% of all endometrial cancers. • Lynch Syndrome affects as many as 1 in 270 people in the UK according to RM Partners. • Only 5% of those affected have a diagnosis. • There is likely to be an increase in diagnostic rates nationally through more frequent testing. • The Planning Guidance requires that Lynch Syndrome testing is in place for colorectal and endometrial cancers. • All newly diagnosed colorectal and endometrial cancer patients who are identified as likely to have Lynch Syndrome should be referred for genetic testing (either locally or through specialised genetics centres) in line with NICE guidelines DG27 and DG42. • Each cancer MDT should identify a responsible local lead for the Lynch Syndrome diagnostic pathway (a 'Lynch champion'), who may identify specific tasks for others within the MDT. • Each cancer MDT is responsible for the delivery of the pathway locally. To deliver this pathway each cancer MDT should work with regional genetics expert centres/GMSAs. • LA highlighted the need to identify a Lynch Syndrome champion/genomics associate for each MDT. CF would like to form a group in order to develop this pathway and obtain support from regional/national leads (namely GSTT) with regard to putting in place training sessions. • NB believes the most appropriate individual to be the Lynch Syndrome champion would be someone who attends every MDT. Pathologists and GSTT can then be informed of who this individual is. • RB questioned whether there is national funding attached to this piece of work. LA confirmed there is funding in place from the national team which is fed through to the KMCA. • Kent & Medway Lynch Syndrome cases are currently sent to GSTT. • PBasn stated some genetic syndromes are treated in-house whilst others are referred to specialist centres. • PBasn highlighted the need to have a job description for the Lynch Syndrome champion role. • If anyone is interested in being a Lynch Syndrome champion, they are asked to contact CF.	

4	**Performance**	**DVH – presentation provided by Michelle McCann** • Please refer to the presentation slide pack for an overview of the Trust's performance. • MM stated DVH had received some NHSE/I pathway analyser support for the colorectal pathway. They are also working on a recovery plan. **EKHUFT – presentation provided by Stella Grey** • Please refer to the presentation slide pack for an overview of the Trust's performance. • There are currently 1100 patients on the PTL. • PBasn mentioned EKHUFT are also working on having a standardised clinic letter stating that if the results of a person's colonoscopy are normal, they can be taken off the pathway. • SGr stated Emma Forster is supporting the service with regard to endoscopy recovery. **MFT – presentation provided by Suzanne Bodkin** • Please refer to the presentation slide pack for an overview of the Trust's performance. **MTW – presentation provided by Chris Wright** • Please refer to the presentation slide pack for an overview of the Trust's performance. • MTW now have 10 or 11 nurse endoscopists in place. In view of this, all endoscopy lists are full. CW believes the other Trusts could learn from their service with regard to training. • CW stated MTW have funding for 11 new oncologists but have only managed to recruit 1 so far. Justin Waters and Philippa Moth are working hard to recruit to these posts on both a locum and substantive basis. **Action: PBasn suggested this matter be brought to Ian Vousden's attention.**	**CW**
5	**Clinical Pathway Discussions**	**HOP** • PBasn stated he had worked on this document with SM and AW. • PBasn confirmed Parthi Srinivasan will include a section on liver surveillance within the document. • Zach Tsiamoulos will incorporate a section on complex polyps within the HOP. • NB agreed to check whether there are any expected imminent changes to pathology guidance prior to the end of this year. • Once the above sections have been included, CC/AW will circulate the document to MDT colleagues for comment with the view to finalising it by the end of 2022. **Colorectal cancer POC pathway** • This document is in the process of being worked on by SM. **Anaemia pathway** • This pathway, which is being worked on by LW and Gandra Harinath, will be incorporated in to the HOP document.	
6	**Research & Clinical Audit**	**Presentation provided by Meeta Durve** • Studies open to recruitment include: - CodeBreak300.	

		- IMPRESS. - TRACC. - OnCoRe. • Recently closed trials include: - AddAspirin. - PROMETCO. • Studies in set up include: - KRYSTAL-10. - ARTEMIS. - PLATO. • MD confirmed there had been some issues with regard to research capacity at MTW. • PBasn asked RB whether trials tend to be discussed at the EKHUFT colorectal MDT. In response to this, she stated that it does not but it would potentially be worth picking this back up.	
7	**Pathology update**	**<u>Update provided by Nipin Bagla</u>** • A mandatory tick box on the endoscopy reports would help histopathology to prioritise real cancers and not be distracted by non-cancer CP/2ww cases. PB stated the Trust is already implementing this. • All EKHUFT cancer molecular pathology goes to the South East GLH now at GSTT which is centrally funded and does multiple gene panels on next generation sequencing. • Across the whole of Kent, all colorectal cancer cases get DNA Mismatch Repair (MMR) proteins staining which screens for Lynch Syndrome and also separates out the cohort of patients which have a very good prognosis (MMR deficient cases being an example of this). • HER2 is being increasingly asked for in colorectal cancer, for which there is no funding to the pathology departments. **<u>Action</u>: NB to email Ian Vousden regarding this matter.** • Sometimes the large polypectomy does not remove the adenoma completely and the infiltrative tethered part is left behind the base. NB stated these are worrisome cases and should be treated the same way as R1 (incompletely excised) polyp cancers. PB highlighted this is up to the MDT discussion on a case-to-case basis.	**NB**
8	**CNS Updates**	**<u>DVH – update provided by Louise Rafferty</u>** • The team are currently understaffed with regard to their nursing workforce with only 1 WTE CNS in place and 1 STT nurse. • The service is working on stripping back their rapid access pathway and placing more of a focus on triaging tools and the stratified pathways workstream. **<u>EKHUFT – update provided by Ruth Burns</u>** • The team are experiencing a high workload and seeing an increase in complex cases, with some staff members getting more involved in the PTL piece which is having a knock-on effect on the service. • The service is receiving an increase in telephone calls from patients due to their difficulties in getting through to their GP surgery (often with requests for pain relief medication). • The CNS workforce is currently slightly under-staffed.	

		MFT – update provided by Angela Bell • The service is seeing an increase in complex cases. • The SFU service was rolled out in May 2022 and a review of this is due in November 2022. • 2 CNS' recently moved over to the metastatic service but their former roles have now been recruited to. • Surveillance clinics will be put in place in November 2022. **MTW – update provided by Stefanie Outen** • The team are currently very busy and are seeing an increase in complex cases. • The service received funding for ACPs. • The team have a dedicated anal, oncology and surgical CNS. • The Trust have introduced the stratified pathways service. • The service would like to review both surveillance and complex pathways. • The team would also like to introduce a LARS clinic. • The Trust are looking at improving the enhanced recovery service.	
9	**Cancer Alliance update**	**Presentation provided by Holly Groombridge** • HG provided the group with an overview of the various projects relating to the following workstreams (please refer to the presentation circulated on 04.10.2022 for a detailed breakdown of what these are): - Faster diagnosis and operational improvement. - Early Cancer Diagnosis. - Treatments & Personalised Care. - Cross Cutting Themes.	
10	**AOB**	• HL stated the STT service, which has a clear protocol in place, is functioning well at MTW. • CMal thanked the Trust CNS' for their hard work on implementing/working towards implementing stratified pathways. • PBasn questioned whether there are any opportunities to educate the public regarding qFIT. RBu referred to the national bowel cancer day which takes place in March which could be potentially utilised for this purpose. • It was suggested that TR, as Macmillan User Involvement Manager for the KMCA, could be contacted in order to support in raising awareness of the qFIT piece and to highlight what takes place when a qFIT result is returned. CW also suggested a YouTube video be put in place explaining the process which could be of benefit to patients.	
	Next Meeting	• To be confirmed.	