Kent and Medway Cancer Collaborative

Colorectal Tumour Site Specific Group meeting
Tuesday 5th April 2022
Microsoft Teams
09:30 – 12:30
Final Meeting Notes

Present	Initials	Title	Organisation
Pradeep Basnyat (Chair)	**PB**	Consultant General & Colorectal Surgeon	EKHUFT
Zach Tsiamoulas	**ZT**	Consultant Gastroenterologist & Specialist in GI Endoscopy / Clinical Lead - Endoscopy	EKHUFT
Ruth Burns	**RBu**	Macmillan Lead Colorectal CNS	EKHUFT
James Bowyer	**JBo**	Deputy General Manager – General & Colorectal Surgery	EKHUFT
Kathleen Coleman	**KC**	Colorectal CNS	DVH
Fay Fawke	**FF**	Deputy Lead Cancer Nurse	DVH
Farrah Errington	**FE**	Colorectal MDT Coordinator	DVH
Kathleen Mutwale	**KM**	Macmillan Colorectal Cancer Support Worker	DVH
Julie Beszant	**JBe**	Programme Manager for Bowel Cancer Screening - West Kent & Medway	DVH
Rakesh Bhardwaj	**RBh**	Consultant Laparoscopic, General and Colorectal Surgeon	DVH
Hannah Fotheringham	**HF**	Macmillan Lead Colorectal CNS	DVH
Michelle McCann	**MM**	Operational Manager for Cancer & Haematology	DVH
Camilla Dobinson	**CD**	HPB Service Manager	King's College Hospital
Serena Gilbert	**SGi**	Cancer Performance Manager	KMCA
Sarah Barker	**SB**	Project Manager - Early Diagnosis	KMCA
Sue Green	**SGree**	Project Manager – Living With and Beyond Cancer	KMCA
David Osborne	**DO**	Data Analyst	KMCA
Claire Mallett	**CMal**	Programme Lead – Living With and Beyond Cancer	KMCA
Stefano Santini	**SS**	Macmillan GP & Cancer Lead	KMCA
Cathy Finnis	**CF**	Programme Lead – Early Diagnosis	KMCA
Tracey Ryan	**TR**	Macmillan User Involvement Manager	KMCC
Colin Chamberlain (Notes)	**CC**	Administration & Support Officer	KMCC
Karen Glass	**KG**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Facilitator	KMCC
Karen Hills	**KHi**	Macmillan Colorectal Cancer CNS	MFT
Rosalind Coppard	**RC**	Colorectal Cancer Support Worker	MFT
Leeja John	**LJ**	STT Nurse	MFT
Glynis Corry	**GC**	STT Nurse	MFT
Jennifer Priaulx	**JP**	Macmillan Cancer Transformation Project Manager	MFT
Chris Wright	**CW**	Consultant Colorectal & General Surgeon	MTW
Albert Edwards	**AE**	Consultant Clinical Oncologist	MTW
Meeta Durve	**MD**	Consultant Clinical Oncologist	MTW

David Merrett	**DMerre**	Consultant Radiographer	MTW
Jorge Gomes	**JG**	Surgical Care Practitioner	MTW
Raza Moosvi	**RM**	Consultant General, Laparoscopic and Colorectal Surgeon / Colorectal Clinical Lead	MTW
Annaselvi Nadar	**AN**	Team Leader - STT Service	MTW
Naomi Butcher	**NB**	General Manager - Cancer Services	MTW
Stefanie Outen	**SO**	Colorectal Advanced Nurse Practitioner	MTW
Rosemeen Parkar	**RP**	Consultant Medical Oncologist	MTW
Monika Verma	**MV**	Consultant Histopathologist	MTW
Rakesh Koria	**RK**	Macmillan GP Associate Advisor for Kent & Medway / NHSE GP Appraiser	NHS Kent & Medway CCG
Liz Shannon	**LS**	Macmillan Primary Care Workforce Support	NHS Kent & Medway CCG
Holly Groombridge	**HG**	Cancer Commissioning Project Manager	NHS Kent & Medway CCG
Julia Addison	**JA**	Patient Representative	
Apologies			
Jo & David Gascoyne	**J&DG**	Patient Representatives	
Hazel Craig	**HC**	Interim Trust Cancer Recovery Lead	DVH
Catherine Neden	**CN**	GP	East Cliff Pracrice
Deniece Merrall	**DMerra**	Macmillan Colorectal CNS	EKHUFT
Eelco Boorsma	**EB**	Consultant Radiologist	EKHUFT
Joanne Cooke	**JC**	Consultant General & Colorectal Surgeon	EKHUFT
Sue Travis	**ST**	Interim Operations Director - Surgery & Anaesthetics Care Group	EKHUFT
Ayman Hamade	**AH**	Consultant General & Colorectal Surgeon	EKHUFT
Stella Grey	**SGrey**	General Manager-General Surgery & Colorectal	EKHUFT
Ashish Shrestha	**AS**	Consultant Colorectal & General Surgeon	EKHUFT
Sue Drakeley	**SD**	Oncology (Solid Tumour) Research Team Leader	EKHUFT
Larissa Williams	**LW**	Macmillan Colorectal CNS	EKHUFT
Sudhakar Mangam	**SMa**	Consultant General, Laparoscopic and Colorectal Surgeon	EKHUFT
Gandra Harinath	**GH**	Consultant General & Colorectal Surgeon	EKHUFT
Nichola Atkins	**NA**	Divisional Support Manager	King's College Hospital
Clarissa Madla	**CMad**	Senior Clinical Research Practitioner	MFT
Gill Donald	**GD**	Consultant Medical Scientist	MTW
Karen Hopkins	**KHo**	Bowel Cancer Screening Practitioner	MTW
Sharon Melville	**SMe**	Night Nurse Practitioner	MTW
Mark Hill	**MH**	Consultant Medical Oncologist	MTW
Riyaz Shah	**RS**	Consultant Medical Oncologist	MTW
Sona Gupta	**SGu**	Macmillan GP & Cancer Lead	NHS Kent & Medway CCG

Item		**Discussion**	**Action**
1	**TSSG Meeting**	**<u>Apologies</u>** • 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 to the members with the final minutes from today's meeting. **Review previous minutes** • The final minutes from the last meeting, which took place on 26.10.2021, was reviewed and agreed as a true and accurate record.	
2	**Transfers of Care**	• SGi had left the meeting at this point so was unable to provide an update on Transfers of Care.	
3	**Listening & Learning**	**Presentation provided by Tracey Ryan** • TR presented research on barriers to patients attending endoscopy appointments. • Feedback had been received from providers indicating there was a reluctance by some patients to attend endoscopy appointments. To explore reasons behind the reluctance with a view to improving attendance, TR made a successful application for research funding for system-wide co-production. • A cohort of 76 male patients included those: living in areas with high indices of deprivation, in BAME communities, living with a disability, and identifying as part of the LGBTQIA+ community. Of these 76 patients: - 92% confirmed they would attend if the need was greater than the fear. - 62% felt information about the details of the procedure could help them overcome their concerns about attending an endoscopy appointment. • The research highlighted the importance of providing patients with a detailed understanding of the procedure, and the reasons for needing it. TR proposed having a video or videos in place to provide easily accessible information which could support patient understanding. • The research identified three main issues/areas for further exploration: - Information and communication considerations (for example not knowing approximate timescales for when patients should receive the results following their procedure and what support may be available for them). - Patient anxieties (for example with regard to the nature of the procedure and feelings of embarrassment). - Hidden factors (for example people with mental health issues). • TR believes it would be helpful to involve patients in letter writing so they can advise the professionals on what content they believe would be helpful for patients to know and to use non-medicalised terms where possible in order to support patient understanding. • TR is working with endoscopy managers and screening teams to look at how to use the information collected in order to improve patient experience and hopefully increase hospital attendance/reduce cancellation and DNA rates. • TR feels it may be helpful to include a flag on referral forms for additional needs. • TR believes FAQs would be helpful to include either on appointment letters or as an accompanying document. There is a plan to trial this in one Trust for a period of 3 months as suggested by the focus group and the outcomes of this can then be reviewed. TR added that before the FAQs are sent out, the focus group can work on obtaining figures for cancellation/DNA rates at the trial Trust and then after 3 months review whether any improvements were made. • TR is working with a colleague named Becky from EKHUFT around the potential for filming a patient having an endoscopy in order to educate others (including those who require an endoscopy) of the procedure. • TR highlighted the importance of taking in to account that patients may prefer to be contacted in a format of their choosing, for example in the form of an easy read document.	

		• TR highlighted the benefits of providing admin staff with training as they are normally the first port of call for patients. She believes it would be helpful if they had a script/prompts to assist them and then pass on information to clinical teams who can call patients back to answer any clinical questions they may have. • One Trust is putting on admin training so TR will link in with them, review the process and then share the findings with the other Trusts. • TR emphasised the importance of staff being aware of patient anxieties and to provide reassurance. • TR's presentation was circulated to the members on 14.04.2022.	
4	**qFIT update** **Role of CT Cologram in a positive qFIT**	**<u>Update provided by Holly Groombridge</u>** • The MTW/West Kent pilot for the high-risk pilot went live in October 2021. To date 83% of colorectal referrals on a 2ww are accompanied by a qFIT at the point of referral. NHSE have requested a soft trajectory target that 80% of all lower GI colorectal referrals should be accompanied by either a qFIT or a qFIT result throughout 2022/23. • Philippa Moth and HG are presenting an update to the Kent & Medway Clinical Cabinet on 07.04.2022 on the MTW pilot. • NHSE have requested monthly performance returns to monitor primary care utilisation of qFIT and have provided additional qFIT implementation funding which has been allocated to Trusts to support rollout of the MTW/West Kent Model. • NHSE have indicated that NICE will publish guidance in June 2022 that is accredited by BSGE. This will not be approved formal NG12 guidance which may be expected later this year. • Primary care initiation of qFIT has been included in the new 2022/23 GP contract and PCN/Practices. Access to the Impact Investment Fund (IFF) can be accessed based on qFIT utilisation at PCN level. • Further training and education including PLTs and targeted practice visits where required is planned across Kent & Medway to further improve utilisation and awareness by primary care cancer leads. RK specifically highlighted the need to identify/target and work with those practices who are low utilisers of qFIT. • New leaflets and information will be available for practice staff and patients to help reduce sample rejection rates due to poor labelling (currently at 7%). • There is a review of how the AccuRx text messaging system can be used in primary care to prompt patients to carry out and return samples in a timely manner. • The role of CT colonography and the flux of capacity and demand on CT services has caused some issues. HG would welcome a discussion on the role of CT colonography within the pathway and whether there is any clinical consensus/views on this. **<u>Update provided by Pradeep Basnyat</u>** • The EKHUFT radiology service is inundated with CT scan/CTC scan requests which is impacting on the staging for their cancer patients. In view of this, radiology have informed the services they need to streamline and minimise these requests. In view of this, CTC scans are only being offered to highly selected cases such as for patients who have had failed colonoscopies or for those who have had a previous bad experience of the procedure. • RM stated MTW were having a number of issues with the volume of CTCs being requested. If a patient is qFIT positive, they are generally offered either a colonoscopy or a capsule endoscopy. Due to the issues the service has had in obtaining CTCs, they are not using as many in the high qFIT cases as they had done previously. Additionally, if they were to identify a concern on a CTC the patient would then require another test and this would delay the pathway further. In view of this, the service have tried to streamline the process by sending higher risk patients for colonoscopies. As a general standard, the service offers a capsule endoscopy to patients with a qFIT result of 10-100ug/g and a colonoscopy to patients with a qFIT result of over 100ug/g. • DMerre confirmed MTW had trained more radiographers to perform the procedure but this has often caused bottlenecks on the reporting side which EKHUFT are then experiencing with the staging and every other tumour group needing scans. • With the support of the hub and RM, DMerre feels the service is now able to protocolise a lot better in order to send patients for the right tests.	

	CCG/Cancer Alliance update	• JP stated MFT's CTC scans are outsourced to Spire Healthcare where there are long turnaround times resulting in a considerable delay to the pathway. In view of this, there is minimal use of the diagnostic. DMerre confirmed he had been approached by Lorraine Becconsall to see if he could help to initiate a process whereby the MFT patients are sent to MTW for the procedure. • PB believes a colonoscopy is still the gold standard for a high qFIT result. • **<u>Action</u>: DMerre to provide an update on the CTC pathway at the next meeting.** **<u>Presentation provided by Cathy Finnis</u>** • CF provided the group with an overview of the various projects relating to the following workstreams (please refer to the presentation circulated on 14.04.2022 for a detailed breakdown of what these are): - Faster diagnosis and operational improvement. - Early Cancer Diagnosis. - Treatments & Personalised Care. - Cross Cutting Themes.	**DMerre**
5	**Stratified pathway update / Treatment Summary sign off**	**<u>Update provided by Claire Mallett</u>** • CMal stated the WHH team have been the frontrunners in terms of being up and running with the piloting of the SFU piece, with the other Trusts to follow suit shortly. MTW are looking to go live this month with the other Trusts intending to go live in May 2022. • The SSM pathway is dependent on the remote monitoring system to manage ongoing surveillance. CMal highlighted the importance of having an effective needs assessment (HNA) to identify/address any outstanding needs and to ensure the patient has the knowledge and confidence to self-manage. She also believes good communication between specialists and primary care teams is important and a system which allows rapid re-access to the specialist team if needed. CMal feels the treatment summaries can hone down on the communication and the information which patients and primary care need. • CMal believes it is important for patients to have a document they can use to support them, for example when they are in contact with primary care professionals or in a hospital (A&E for example). • The treatment summary aims to provide an overview of: the treatment received, the treatment aim, prognosis, an ongoing management plan in secondary care, recurrence alert symptoms, potential consequences of treatment, recommended actions for primary care should there be any questions or concerns and also the relevant read codes. • The treatment summary can help prompt secondary care professionals to share key information to an agreed level of detail and clarity and enable GPs to provide more effective care and potentially reduce unnecessary hospital readmissions. The treatment summary can also help primary care professionals to identify signs of recurrence and their consequences. • In summarising, treatment summaries aim to: standardise information, be timely, be clear and consistent about the treatment and any potential consequences from the treatment needed and manage any post-treatment modalities patients may have. • CMal stated the InfoFlex data will pull across and self-populate information to the treatment summaries to an extent. She believes by piloting this they would have the opportunity to identify which elements may need to be ironed out/altered. • CMal mentioned patients would receive a newly-created treatment summary following each treatment modality and they may therefore have more than one for their entire pathway. • CMal confirmed the treatment summaries have been circulated to CNS' and the TSSG previously for comment (and they have also had feedback from both patients and primary care). She would like the group to agree the content and sign them off so they can be trialed in InfoFlex with the intention of being discussed again at the next TSSG meeting. RBu confirmed this sounded reasonable and encouraged the Trusts to start using them. • **<u>Action</u>: It was agreed the treatment summaries (specifically the ones which have already been circulated) would be piloted by all 4 Trusts and added to InfoFlex for trial and use. The InfoFlex team will then collate data on this. The findings of the pilot will then be presented at the next TSSG meeting.**	**All Trusts / CMal**

6	**Performance**	**DVH – update provided by Michelle McCann** • Please refer to the presentation slide pack circulated on 14.04.2022 for an overview of the Trust's data. **EKHUFT – update provided by James Bowyer** • Please refer to the presentation slide pack circulated on 14.04.2022 for an overview of the Trust's data. **MFT – update provided by Jennifer Priaulx** • Please refer to the presentation slide pack circulated on 14.04.2022 for an overview of the Trust's data. **MTW – update provided by Naomi Butcher** • Please refer to the presentation slide pack circulated on 14.04.2022 for an overview of the Trust's data.	
7	**Update on Colorectal**	**PCCRC – update provided by Pradeep Basnyat** • PB provided the group with an overview of the PCCRC audit document. • PB expressed concerns relating to the fact that DVH have yet to register for the audit and not all Trusts are reviewing their cases. **Action: CC to email those listed as the endoscopy leads on the PCCRC document to ensure they have received it and to highlight the fact that: 1. Not all sites have registered for the audit. 2. Not all sites are reviewing their cases.** • ZT confirmed EKHUFT have run the PCCRC audit since 2018, even before it was published by JAG as a benchmark, and the service has collected data on this. The deadline for the Trust to submit their information this year is 25.04.2022 and they are therefore compliant with this. • ZT feels privileged to have been involved with the PCCRC taskforce since 2016 along with Professor Matt Rutter and Dr Roland Valori. • ZT believes the post-colonoscopy cancer rate is unique and EKHUFT found it very beneficial to review all cases (which included all screening and symptomatic colonoscopies). In 2021 the service discovered most of the cases they had missed related to the rectosigmoid area. The main learning objective from this was to therefore be more meticulous during the rectosigmoid junction. **Lynch diagnosis & surveillance – presentation provided by Cathy Finnis** • CF's presentation (which was circulated to the members on 14.04.2022) provided the group with an overview of: - The Lynch Syndrome planning guidance. - The NICE NG42 and DG27 guidance in relation to both endometrial and colorectal cancer and Lynch Syndrome. - A brief summary of the pathology pertaining to Lynch Syndrome. - An overview of the data pertaining to Lynch Syndrome for Kent & Medway (including its prevalence in the population). - An introduction to the Lynch Syndrome pathway. - The testing for Lynch Syndrome using immunohistochemistry (IHC). - The germline testing process following either immunohistochemistry (IHC) testing or microsatellite instability (MSI) testing. - The management of index cases. - Cascade testing and surveillance of family members. • CF asked the members to consider the following questions: - Do you know who your Trust Surveillance Lead is? - Who in your MDT is responsible for the pathway? - How does Lynch Syndrome currently get recorded?	**CC**

		- Is surveillance for these patients offered locally? - How/what are GPs currently informed about these patients? (in terms of red flags/follow-up and so on). - Do you have any training needs? • PB stated pathologists discuss Lynch Syndrome cases at the MDM meetings and they are then sent to the Guy's Hospital genetics department. • PB stated CF's slides indicate consent is required for germline testing and asked what the process is for sending a patient for this. CF was unsure but will consult the relevant guidance and contact him once she has clarity. • With regard to surveillance leads, CF mentioned there is no information in the handbook to indicate who these can be. • If anyone would like to know more about the training piece, CF would be happy to link them in with the South East Genomics service team. • ZT believes it would be helpful to set up an offline meeting with gastroenterologists, surgeons, pathologists and CF to discuss the creation of a Lynch Syndrome registry for Kent & Medway. • CF mentioned that the cost for immunohistochemistry (IHC) testing is £40.	
8	**Clinical Pathways Discussion**	**<u>HOP & POC – update provided by Annette Wiltshire</u>** • The POC is currently in the process of being updated and AW hopes this will be finalised by October 2022. • The HOP is also in the process of being updated and AW stated certain areas of the document, including names, will need to be updated. CW specified he is happy to provide input to the documents with regard to the qFIT pathway. **<u>Colorectal cancer pathway</u>** • SMa was unable to attend today's meeting so a formal update was not provided. • The colorectal cancer pathway document will be shared with the group in due course. PB asked the members to review the document and, where appropriate, provide SMa with comments following circulation, with a view to finalising it by October 2022. **<u>Anaemia pathway</u>** • GH and LW were on leave today so did not attend the meeting. PB confirmed they had both worked on the anaemia pathway and have presented it to primary care colleagues (including Jack Jacobs) where it was well-received and will be incorporated in to their practice. RK stated he had had similar conversations with some of the colorectal surgeons and gastroenterologists across the patch and is keen to meet with colleagues to discuss the item further. RK confirmed he would forward the email he had sent pertaining to this to PB so he is aware of what has taken place already. • PB stated primary care feedback to the anaemia pathway is important and their comments will be reflected in the document once it is finalised.	
9	**Research & Clinical Audit**	**<u>Presentation provided by Rosemeen Parkar</u>** • RP's slides (which were circulated to the members on 14.04.2022) provided the group with an overview of current research trials which she wanted to bring to their attention. These include: - ORCHESTRA. - NEOPRISM. - Metastatic colorectal - 3rd line MK4280A-007c. - MYRATIKRYSTAL - 2nd line. - CORGI-2.	
10	**MDT feedback**	**<u>DVH – update provided by Rakesh Bhardwaj</u>** • The DVH MDM takes place on Microsoft Teams and is well-attended.	

- Since the last meeting, there has been a change in the radiology workforce.
- Andreas Prachalias links in with the DVH MDM on a fortnightly basis.
- RBh feels admin support could be better funded, especially in view of the additional workload associated with the FDS piece.
- MDM caseload has increased since the last meeting.
- The MDM meetings are consultant-led and consultant-delivered.
- RBh feels the 2ww service places a lot of pressure on the cancer performance targets.
- The Trust have been provided with extra funding for the qFIT piece which HF feels has been helpful.
- RBh has an MDM clinic following the MDM meetings in order to consolidate post-MDM patients.

EKHUFT – update provided by Pradeep Basnyat

- 2 MDM meetings exist at EKHUFT (one at WHH and one at QEQM). The MDM meetings take place on Microsoft Teams and this has worked well. AE confirmed he is supportive of virtual MDM meetings.
- At WHH, the 2ww service is mostly run by the surgical specialist nurses and is protocol-driven via the Altered Bowel Clinic (which falls under the 2ww service). The nurses run most of the qFIT tests and PB hopes they will be able to provide an update on their work at the next meeting. Middle grade doctors, along with surgical care practitioners, also help to run the clinics.
- The MDM meetings continue to follow the same TSSG and national guidance as part of their protocols.
- The MDM meetings now fully utilise electronic notes.
- The volume of patients discussed at the MDM meetings has increased and RBu and her colleagues often spend a lot of time calling patients to inform them of next steps with regard to their pathway.
- AE highlighted the importance of screening cases prior to the MDM meetings as a number of patients may not require discussion there and this could therefore help to reduce the volume of patients requiring review.

MFT – update provided by Karen Hills

- The Trust are having to send a number of complex patients out to other hospitals and managing patient expectations is a challenge.
- The Trust have their MDM meetings on Tuesday afternoons.
- Bowel screening patients are sent from MFT to MTW.

MTW – update provided by Razi Moosvi

- The Trust's MDM meetings take place on Thursday mornings (08:00-10:00) via Microsoft Teams and are well-attended.
- The MDM has sections on anal cases (which Rakesh Raman from EKHUFT joins them for) and liver cases (which Nigel Heaton from King's College Hospital joins them for).
- RM praised the CNS' who work hard on booking patients in to clinics for the following week.
- AN is in charge of the STT 2ww clinics which is a telephone nurse-led service. 22 slots are available each day from Monday to Friday (totaling 110 slots per week).
- A number of GPs are referring in performance status 3 and 4 patients on a 2ww referral as well as those aged 90+ years old which RM feels is difficult to manage. These patients are brought in to clinic and tend to see an associate specialist as opposed to a nurse.
- Inputting data for NBOCAP has been an issue as the team lack surgical data. RM hopes this is something which can be resolved by recruiting/utilising staff to input this data. At EKHUFT, the MDT Coordinator is responsible for entering this information. RBu is not sure how the information is pulled across exactly but suspects it is sourced from the MDT fields in terms of staging, surgery and other relevant sections.
- The Trust's qFIT pathway has been modified 4 or 5 times to accommodate the different diagnostic modalities the service use (for

		example colonoscopy, capsule endoscopy, CTVC and plain CT).	
11	**Endoscopy & pathway of patients**	**Presentation provided by Zach Tsiamoulas** • **Action: ZT stated he is in the process of updating the Complex Polyp Service SOP document. Once it is ready to be circulated to the members, he would like the group to review the document and provide feedback. ZT will then be assigned an agenda item at the next meeting to provide an update on the new Complex Polyp SOP.** • The service has been running for the last 2 years and they utilise the BSG, ESGE and JGES Complex Polyps guidance. • ZT described the collaboration with surgeons as unique. • The team have open communication channels with the Colorectal MDM Leads and discuss all HGD cases. • EKHUFT are the only Trust in the South East of England who are currently in a position to perform endoscopic en-bloc dissections (ESD/SSD). • Through the Complex Polyp service, the team are trying to collaborate significantly with surgeons and refer patients back to the Lower GI MDM or refer them on for TAMIS or LACE. • Funding has been received for an advanced fellowship for the Complex Polyp service. • The KENT endo-surgery course will be taking place on 04.10.2022 and 05.10.2022. • ZT provided the group with an overview of the BSG guidelines for Complex Polyps in addition to the ones for ESGE/JGES. • ZT referred to the Complex Polyp MDM proforma which forms part of their SOP. • ZT provided the members with a summary of the outcomes of the Trust's Complex Polyp MDM. • ZT mentioned the team had been nominated for an NHS Parliamentary Award which he feels is an acknowledgement of their hard work in evolving the service. • ZT provided the members with a detailed overview of the data the service had collected for the past 2 years and its findings. • PB confirmed the Complex Polyp MDM has complemented the EKHUFT MDM. Formerly, large polyps cases were sent to King's College Hospital for management but this can now be done locally and cases which they may have operated on previously are now being treated in a minimally-invasive way. • The Complex Polyp MDM takes place on Thursdays (12:00-14:30). RBh asked if he could join one of the meetings to observe which ZT confirmed could be accommodated. • PB mentioned he is supportive of the idea of having a network-wide Complex Polyp MDM. • RM asked ZT what the rates are for finding an ESD outside of the rectum. ZT could not provide him with a specific percentage but estimated it is present in just over 40% of cases. • RM confirmed MTW are implementing a TAMIS service. • PB stated EKHUFT provide a TAMIS service and the polyp cases go through both the Colorectal MDM and Complex Polyp MDM. • ZT highlighted the importance of patients being made aware of their treatment options.	**ZT**
12	**CNS Updates**	**DVH – update provided by Hannah Fotheringham** • The team hope to roll out the stratified pathways service in May 2022. • HNA clinics are up and running and are offered 3 days a week. • An advertisement has gone out to recruit an additional CNS. **EKHUFT – update provided by Ruth Burns** • The stratified pathways work at WHH is underway with 200 patients on a SFU currently. RBu believes this is working generally well with good patient engagement, however some patients have found it challenging. • A Band 4 has been appointed at QEQM and will help in supporting the stratified pathways workstream as part of her role. • The team hope to work on developing a STT service building on the Altered Bowel Clinic piece which PB mentioned under agenda item 10.	

		MFT – update provided by Karen Hills • The Trust are hoping to start the stratified pathways service in May 2022 and are currently reviewing the necessary paperwork for submission. • There has been an increase in the number of patients coming in to the service, many of which are emergency cases and some patients are deteriorating in the community. • Some patients are struggling to get through to their GP practice and often end up calling the CNS team which is consequently having an impact on their workload. • The oncology service is now in a more stable position. **MTW** • No update provided.	
13	**AOB**	• If the members have any topics they would like added to the next Colorectal TSSG agenda please email PB and AW.	
	Next Meeting Date	• To be confirmed.	