Kent & Medway Cancer Collaborative

Colorectal Tumour Site Specific Group meeting Tuesday 29th October 2024 Mercure Great Danes - Maidstone 09:30-12:30			
Final Meeting Notes			
Present	**Initials**	**Title**	**Organisation**
Pradeep Basnyat (Chair)	**PBas**	Consultant General & Colorectal Surgeon	EKHUFT
David Bogard	**DB**	DM01 Recovery Lead	EKHUFT
Sue Travis	**ST**	Head of Operations – Surgery/Colorectal/Endoscopy	EKHUFT
Joseph Sebastian	**JSe**	Consultant General and Colorectal Surgeon	EKHUFT
Katherine Hills	**KatHills**	Consultant Gastroenterologist/Endoscopy Lead	EKHUFT
Vicki Hatcher	**VH**	Head of Nursing	EKHUFT
Alexis Warman	**AWa**	Head of Operations Director	EKHUFT
Ruth Burns	**RBu**	Lead Colorectal CNS	EKHUFT
Nicola Chaston (via Microsoft Teams)	**NCh**	Consultant Cellular Pathologist	EKHUFT
Hannah Washington	**HW**	Faster Diagnosis Manager	EKHUFT
Ruth Mount	**RMou**	Improvement Practitioner RGN	EKHUFT
Gandra Harinath	**GH**	Consultant General & Colorectal Surgeon	EKHUFT
Larissa Williams	**LW**	SCP	EKHUFT
Julie Beszant	**JBe**	Bowel Cancer Screening Manager - West Kent & Medway	DVH
Charli Selvage-Owen	**CSO**	Bowel Cancer Screening Manager - West Kent & Medway	DVH
Trish Sewell	**TS**	Colorectal STT CNS	DVH
Isabelle Borg	**IB**	Early Diagnosis Coordinator	DVH
Louise Rafferty	**LR**	Lead Colorectal CNS	DVH
Jane Abrehart	**JA**	Nurse Endoscopist	DVH
Sue Stubbs	**SSt**	STT Colorectal CNS	DVH
Rakesh Bhardwaj	**RBh**	Consultant Laparoscopic, General and Colorectal Surgeon	DVH
Farrah Errington	**FE**	MDT Coordinator	DVH
Joanne Goncalves	**JG**	Clinical Endoscopist	DVH
Charmaine Walker	**CW**	Cancer Performance Manager	DVH
Bana Haddad	**BH**	Clinical Lead – Living With and Beyond Cancer/Personalised Care & Support	KMCA
Sharon Middleton	**SM**	Workforce Programme Lead	KMCA

Ann Courtness	**ACo**	Macmillan Primary Care Nurse Facilitator	KMCA
Emma Forster	**EF**	Head of Service Improvement	KMCA
Colin Chamberlain (Notes)	**CC**	Administration & Support Officer	KMCC
Karen Glass	**KG**	Business Support Manager/PA	KMCA/KMCC
Samantha Williams	**SW**	Administration & Support Officer	KMCC
Annette Wiltshire	**AWi**	Service Improvement Lead	KMCC
Suzanne Bodkin	**SB**	Service Manager	MFT
Prudence Banda	**PBan**	Faster Diagnosis Lower GI CNS	MFT
Karen Hills	**KarHills**	Metastatic Colorectal CNS	MFT
Francesca Dunn	**FD**	Service Manager	MFT
Richard Dickson-Lowe	**RDL**	Consultant General and Colorectal Surgeon	MFT
Raza Moosvi	**RMoo**	Consultant Colorectal Surgeon	MTW
Adrian Barnardo	**ABa**	Consultant Gastroenterologist	MTW
Meeta Durve	**MD**	Consultant Clinical Oncologist	MTW
Helen Lloyd	**HL**	Consultant General, Colorectal & Laparoscopic Surgeon	MTW
Ritchie Chalmers	**RC**	Medical Director	MTW
Victoria Buzza	**VB**	CTC Lead Radiographer	MTW
Eleanor Brace	**EB**	Macmillan Development CNS	MTW
Hayley Geere	**HG**	Anal Cancer CNS	MTW
Nikki Jagger	**NJag**	Endoscopy Programme Manager	NHS Kent & Medway ICB
Apologies			
Claire Lambert	**CL**	Endoscopy Theatre Scheduler	DVH
Marie Payne	**MP**	Lead Cancer Nurse	DVH
Molly White	**MW**	Metastatic Colorectal Cancer Clinical Nurse Specialist	EKHUFT
Jade Pilcher	**JPi**	Programme Manager for Bowel Cancer Screening	EKHUFT
Jann Yee Colledge	**JYC**	Consultant Radiologist	EKHUFT
Joanne Cooke	**JC**	Consultant General & Colorectal Surgeon	EKHUFT
Nipin Bagla	**NB**	Consultant Histopathologist	EKHUFT
Pippa Enticknap	**PE**	Deputy General Manager	EKHUFT
Samantha Hughes	**SH**	Colorectal Specialist Nurse	EKHUFT
Shady Zeidan	**SZ**	Consultant Colorectal Surgeon	EKHUFT
Katy Sherwood	**KS**	Service Manager – General Surgery and Colorectal Services	EKHUFT
Sue Drakeley	**SD**	Senior Research Nurse	EKHUFT

Stella Grey	**SGr**	General Manager-General Surgery & Colorectal	EKHUFT
Tina Barnard	**TBar**	Deputy Operations Manager	EKHUFT
Toni Bancroft	**TBan**	Colorectal Surgical Care Practitioner	EKHUFT
Jonathan Bryant	**JBr**	Primary Care Cancer Clinical Lead	KMCA
Joanne Bailey	**JBa**	Early Diagnosis Programme Lead	KMCA
Claire Mallett	**CMal**	Programme Lead – Living With and Beyond Cancer/Personalised Care & Support	KMCA
Clarissa Madla	**CMad**	Senior Clinical Research Practitioner	MFT
Shirley Chan	**SC**	Consultant General, Colorectal & Paediatric Surgeon	MFT
Kirsty Hearn	**KHe**	Service Manager	MFT
Elisabet Sanchez	**ES**	Service Manager for Oncology & Haematology	MFT
Joanne Jones	**JJ**	Team Lead for MTW FDS Upper/Lower GI	MTW
Joanne Patterson	**JPa**	Lead Clinical Trials Pharmacist	MTW
John Schofield	**JSc**	Consultant Pathologist	MTW
Mark Hill	**MH**	Consultant Medical Oncologist	MTW
Natalie Jarrett	**NJar**	Colorectal Cancer Support Worker	MTW
Sarah Eastwood	**SE**	Macmillan Personalised Care Project Manager	MTW
Daniel Lawes	**DL**	Consultant General, Laparoscopic and Colorectal Surgeon	MTW
David Merrett	**DM**	Consultant Radiographer	MTW
Sukanya Ghosh	**SGh**	Consultant Radiologist	MTW
Supriya Joshi	**SJ**	Consultant Chemical Pathologist	MTW
Bronwyn Tetley	**BT**	Lead Pathway Nurse Coordinator	MTW
Samantha Seker	**SSe**	Oncology CNS - Colorectal	MTW
Amanda Clarke	**ACl**	Consultant Clinical Oncologist	MTW
Rakesh Raman	**RR**	Consultant Clinical Oncologist	MTW
Stef Outen	**SO**	Colorectal Advanced Nurse Practitioner	MTW
Carole Grey	**CG**	FDS NSS Team Lead	MTW
Sarah-Jane Taylor-Seres	**SJTS**	Associate Director – Endoscopy Programme	NHS Kent & Medway ICB
Neil Cripps	**NCr**	Regional Clinical Advisor | Endoscopy – Diagnostics Programme	NHSE (Southeast region)

Item		**Discussion**	**Action**
1.	**TSSG Meeting**	**<u>Apologies</u>**	

		• The apologies are listed above. **<u>Introductions</u>** • PBas welcomed the members to the meeting and asked them to introduce themselves. **<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. **<u>Review previous minutes</u>** • The final minutes from the previous meeting were reviewed and agreed as a true and accurate record.	
2.	**CRG update**	**<u>Update provided by Pradeep Basnyat</u>** • There is currently no CRG representation from radiology and pathology. • All roles, which are for 0.5PA, require filling by the end of this year. • **<u>Action</u>: AWi to circulate the CRG Job Description to the group again.**	**AWi**
3.	**Dashboard**	**<u>Presentation provided by Pradeep Basnyat</u>** • 62d performance improved from 54.4% to 59.8% in the last six months, but Kent & Medway is still one of the lowest Alliances for FDS performance. • EKHUFT and MFT are well below the England average for FDS performance, and DVH is well below the England average for 62d performance.	**Presentation circulated to the group on 29.10.2024**

		• PBas provided the group with an overview of data on: i) The number of referrals first seen on the colorectal USC pathway by Trust and month first seen between December 2022 and July 2024. ii) The proportion of urgent suspected lower GI cancer referrals where the first diagnostic test done was full colonoscopy at each of the Trusts between December 2022 and July 2024. iii) The proportion of urgent suspected lower GI cancer referrals with a valid FIT result where the FIT result was less than 10 at each of the Trusts between December 2022 and July 2024. • PBas encouraged the members to let David Osborne (Data Analyst – KMCA) know which parts of the pathway they want to target for improvement and what additional data they would like to see. • HL highlighted that a huge amount of resource has been put in to managing the PTLs at MTW, hence why the FDS and 62d figures are better than those of the other Trusts. • RBh emphasised the importance of working together as a cohesive unit across the patch to address variation. • It was highlighted that there is still a problem with referrals not being accompanied with a qFIT result. This is, however, an improving picture. • There is also a need to address issues with benign pathways which would then result in a reduction in USC referrals.	
4.	**East Kent Hospitals Endoscopy Recovery Journey and into the future**	**<u>Presentation provided by David Bogard</u>** • EKHUFT are one of the largest Trusts in the country. They have 10,000 staff and serve a population of >750,000. • EKHUFT have eight endoscopy theatres over three sites. • There has been an increase in demand for endoscopy procedures over a number of years which was initially met with increasing amounts of additional activity. • The COVID-19 pandemic compounded the backlog which then ballooned to over 13,500 patients by the end of	**Presentation circulated to the group on 29.10.2024**

		2023 with some surveillance overdue by four years. • Analysis showed that a sustainable waiting list size was 4,700 patients (3,000 surveillance plus 1,500 urgent and routine cases). • The Trust launched a recovery plan in early 2024 - today the waiting list is 4,850. • The service is now thinking not just about recovery but what a good service looks like. • DM01 is on target to be compliant by November 2024. • Until May 2024 there was no gatekeeping for requests for an endoscopy procedure. A historic triage process had been in place but was no longer used. Working with IT, the service has amended the PAS system to reduce the volume of triage required and relaunched the process. • The service now rejects around 40 scopes a week for an investment of six hours of Consultant time and have enhanced feedback and learning. **Pathway management** • With such an overwhelming number in the backlog the team had divided the waiting list into 21 different lists but this added to the confusion. • A programme of waiting list consolidation began with twice weekly access meetings with the operational team to identify priority bookings. **Validation** • With so many patients being on the waiting list for many years, validating the waiting list was essential. • The service began by validating specific patient groups in manageable cohorts in a systematic way. • All validation was conducted against agreed guidelines/SOPs. **Optimising capacity and insourcing**	

		• It was clear the service would need extra capacity to clear the backlog. • A tender was initiated and a contract in place at the end of 2023. • Core activity was about 400 cases a week. • Theoretical capacity with insourcing was 600 cases a week. • Booking was the rate-limiting step, with lists running at as little as 60% utilisation. • There were 400 core booking capacity patients a week. One in three calls resulted in a discharge not a booking. Insourcing theoretically could increase capacity by 200 cases a week, which generated 300 pieces of work for the booking team. The service also needed to be booking more than just one week ahead to reduce cancellation. There was therefore a total of 1,050 pieces of work for a team established to book 400 patients a week. • As the department moved from a five day service to a seven day service the booking team were also asked to cover two days of reception. As a result some lists were only booked to 60% as mentioned above. • In terms of the solution to optimising capacity: i) There was a titration to activity/the volume of insourcing to the rate limiting process (booking). ii) Reception staff and bookers were recruited (one insourcing list costs the same as a booker for a month). iii) The service now constantly does 550 cases a week. iv) The service is working with IT in order to improve the efficiency of all processes. v) The service is projecting a £400k underspend on the allocated insourcing budget and over £100k increase in income. • DB stated that systems in crisis produce compensatory processes which actually make the service more difficult to manage and harm the recovery. Breaking down the challenge into manageable tasks is essential. • DB believes it is important to describe what success looks like each week and to ensure there is a success to celebrate on a weekly basis. He also highlighted the importance of not being afraid to articulate the service's	

		vision. • With regard to the future: vi) There is a need to maintain the service's current levels of activity to meet demand but without the cost of insourcing. i) There will need to be alternative pathway working groups (e.g. cytosponge, CCE and TNE). ii) Alternative pathways will need to treat around 100 patients a week by March 2025. iii) There is a need to support excellence/advancement of skills (e.g. KENT course, complex polyp service, BCS, investment in training, the promotion of research and expand EKHUFT's extended role nurse programme including nurse endoscopists). • ABa highlighted the need to work out how to develop nursing roles to support endoscopy services.	
5.	**CNS Updates**	**DVH** • The team have not had a CSW in place since August 2024. However, a replacement has been found and they will be starting in November 2024. • A part-time Band 7 CNS will be leaving shortly. LR stated a full-time replacement is needed. • The team are doing well with HNA offers but they have yet to commence with End of Treatment Summaries. • The Lynch Mainstreaming service is in place. ED nurses will take this over in the next few months. • The STT service is evolving well. **EKHUFT** • The CNS team is fully staffed.	

		• The STT service is in place and is evolving well. • SFU is well-embedded at both WHH and QEQM. • The team are doing HNAs and End of Treatment Summaries. **MFT** • There is one Band 4 in place. • Referral numbers are increasing. • The surgical team is down a Band 7 CNS. A replacement has been recruited but there is no start date for this person yet. • There are no metastatic End of Treatment Summaries in place yet. **MTW** • The team have three Developmental CNS' in place. They are on an 18-month contract and are split across three tumour groups. • A Band 7 CNS will be going on maternity leave shortly and the Metastatic Lead has retired. • HNA offers are going well. • There are currently no Treatment Summaries for anal cancer patients. • **Action: It was felt it would be beneficial to reconvene Kent & Medway-wide Colorectal CNS meetings. These will take place following future Colorectal TSSG meetings.**	**Colorectal CNS'**

6.	**Colorectal pathway – next steps**	**<u>Presentation provided by Emma Forster</u>** • In terms of a reminder of the changes agreed, there is a need to: i) Have one pathway for Kent & Medway in order to remove variation for patients. ii) Reduce low-value colonoscopy demand. iii) Have a revised minimum dataset from primary care to support the STT triage process and reduce delays for patients in the next event. iv) Support primary care so patients with a qFIT result of <10 with no high-risk symptoms can be managed in primary care. v) Standardise the straight to test protocols and tools. vi) Consider patient cohorts for whom the low underlying risk of bowel cancer who may not need to undergo tests which may cause harm, and consider alternative investigations which are more appropriate. vii) Risk stratify patients by age to factor radiation risks. • In terms of feedback from the consultation process: i) The pathway needs to go further – patients need a diagnosis and not just be told they do not have cancer. ii) High-risk symptoms need to be simplified and evidence-based. iii) TSSG and LMC agreement is required. iv) qFIT test result must be mandatory as part of the minimum dataset before referral. v) There is a need for this work to run in conjunction with IDA and bleeding pathways. • In terms of the impact of the new pathway on additional activity:	**Presentation circulated to the group on 29.10.2024**

		i) 8091 additional qFIT tests in primary care. ii) 700 additional CT CAP per annum. iii) 700 additional CCE per annum. iv) 300 additional CTC per annum. • With regard to the impact of the new pathway on savings: i) 5000 less referrals to secondary care compared to 2023/24. ii) 4700 less colonoscopies compared to 2023/24. • EF outlined the Implementation Framework. The qFIT workstream, STT workstream, CCE Working Group and CT and CTC Imaging Network sits under the ICB General Surgery Pathway Group. • With regard to qFIT and primary care, the objectives are: i) For >80% of USC cancer referrals to be accompanied by a qFIT result. ii) To reduce the number of USC referred with qFIT <10. iii) To commission additional qFIT activity and embed a safety netting process in primary care. • In terms of what is being done to meet those objectives: i) There is targeted support and engagement with PCNs to promote qFIT testing, understand challenges in primary care and develop solutions – practice safety netting, use of text messages and so on. ii) Revised minimum dataset to make qFIT result a mandatory requirement before referral. Referrals without MDS will be returned to referrer for completion. iii) Upscaling qFIT testing volumes to accommodate double testing in primary care. iv) Collaboration with ICB elective pathway leads to commission the colorectal pathway on to the EROS system.	

		• In terms of the latest IIF achievement for Primary Care (target 80% by Q4), no Alliance is reaching the target. 70.2% of referrals in Kent & Medway are accompanied by a qFIT result. • EF provided an overview of the data pertaining to Urgent suspected lower GI cancer referrals by FIT band across the Trusts between October 2023 and September 2024. • With regard to Straight to Test Protocols, the objectives are: i) To standardise the STT protocol/tools to embed one pathway for Kent & Medway. ii) To develop advice and guidance templates to support primary care management of low-risk patients. • In terms of what is being done to meet those objectives: i) A Task and Finish Group has been established. ii) Challenges have been identified and themed – protocols, referral quality, triage, workforce. iii) Key actions are being taken forward (agreeing a revised minimum dataset; standardising protocols, proformas and inclusion/exclusion criteria; frailty identification and guidelines; patient experience; and workforce profile). • With regard to Colon Capsule Services, the objective is to develop a Kent & Medway Colon Capsule service. • In terms of what is being done to meet that objective: **Phase 1:** i) A KMCA CCE Implementation Group has been established to support business case development, staff training and commencement of service. ii) KMCA have committed funding for 1st year consumables for each Trust and 12 additional reader courses: **MTW** – service commenced. Capacity for >18 per week. Nurse-led reading service. **EKHUFT** – business case awaiting approval. Expected commencement Q4. **MFT** – business case awaiting approval. Expected commencement Q4. **DVH** – business case in development. Earliest commencement Q1.	

		Phase 2: i) There is a hope for a cloud-based reading service to be in place by 2025/2026. • Following a review of the pathway flowchart, some suggestions for alterations were made. These include: 1) In the *"*1 High Risk Symptoms:"* box, remove *"4. Change In bowel habit to persistent diarrhoea with no intervening normal stool"*. 2) U's&E's/kidney function to be added to the *"USC Referral to include MANDATORY:"* box. 3) *"Discharge to GP with diagnosis and appropriate advice"* to be amended to read *"Discharge to GP with reassurance / diagnosis and appropriate advice"*. 4) Certain non-cancer diagnosis from endoscopy will require further follow-up within secondary care. Add additional box after *"Cancer Excluded"* to pathway document. • Pending the suggested changes being made, the group agreed the pathway could be signed off. The next step is to then take the pathway to the LMC for them to agree a minimum dataset. • **Action: EF to circulate finalised pathway document with changes to the TSSG members and Trust medical directors. Pathway agreement is subject to LMC sign off, which RC/JBr are taking forward on behalf of the TSSG.** • PBas highlighted the importance of patients on a benign pathway being safety netted. • It was highlighted that persistent diarrhoea is not generally a used clinical term – acute/chronic diarrhoea is used more often.	**EF**
7.	**Digital pathology across the**	**Presentation provided by Nicola Chaston** • The Laboratory Information Management System (LIMS) will have all relevant pathology data for Kent & Medway	**Presentation circulated to the group**

	KMPN network	in one place and there will be more robust cover for cellular pathology. • There will be much easier information transferred between sites. With increased collaborative working, there will be more back-up for specialties. • The Digital Pathology programme will help with efficiencies in workflow, work allocation, the tracking of cases and the pulling of cases back for review. • From a collaboration perspective, the KMPN digital pathway will allow second opinions almost instantly from anywhere in the world. • In theory, the programme should help with the faster diagnosis of cancers. • Benefits of the digital pathology solution include: i) Reduced case transfer times between the laboratory and the diagnostic pathologist. ii) Improved workload allocation. iii) Rapid case tracking, archival and retrieval. iv) Clearer diagnostic audit trails. v) Increased diagnostic efficiency. vi) Faster diagnosis of urgent cases (in line with 28d faster diagnosis for cancer). vii) Faster access to external second opinions. viii) Faster access to molecular testing. ix) A reduced risk of patient/slide misidentification errors. x) A reduced risk of tissue/slide loss or damage. • The archive of images will be a valuable resource for research purposes, encouraging collaboration between diagnostic departments and higher education establishments, as well as for use in the development of computerised algorithms for Artificial Intelligence. • System training will be provided by the supplier with ongoing support from the Kent & Medway Pathology Network team.	**on 29.10.2024**

		• Each pathologist needs to verify their digital reporting against their analogue reporting to ensure clinical care level continuity. • Pathologists will validate in phases so no more than five pathologists at one time will be validating. • The digital pathology project has accessible funding to utilise other resources during validation phases. • Removing patients from cancer pathways alleviates the pressure and allows pathologists to concentrate on cases of significant clinical significance. • Support from clinical colleagues across the TSSG to understand and accept limited duration verification impact and to remove patients from cancer pathways when endoscopic findings are normal/benign is needed. **Specimens** • NCh stated that updated RCP guidance has outlined expected best practice for biopsies which includes reducing the number of specimens being sent through. She is happy to circulate the guidance to the group if they wish to see it. • NCh highlighted the need for there to be network-wide clarity with regard to what is deemed as urgent. She will meet with the surgical and endoscopy leads from across the patch, inclusive of all tumour sites, to formulate an agreement on this. The ultimate goal is for an improved pathway where resources are focused more on those patients who need histology the most.	
8.	**AOB**	**PSFU audit – update provided by Bana Haddad** • BH highlighted that NHSE has asked Cancer Alliances to support an audit of PSFU. The audit, which is optional, looks at all PSFU pathways and there is a hope the information will be of value both nationally and locally to understand how PSFU is being implemented and the impact. • The Alliance can complete some of the questions from the work which has been done to fund and implement	

		PSFU. It is mostly drop-down boxes with the option to comment with free text. Questions which require clarity include the following: i) Approximate start date of PSFU for each pathway. ii) Completed or planned audits for PSFUs - the Alliance is leading a breast OAFU review and there is a proposal to do the same for colorectal in the next year. Others will follow in due course. iii) Estimates of people on PSFU on or around 30.09.2024. iv) What is the usual status of written End of Treatment Summaries or equivalent information that supports patients to self-manage and to know when and how to re-access services with any concerns such as symptoms of recurrence (and document copied to GP). v) Optional - provide name, role and email address of person willing to be interviewed in confidence about PSFU implementation in their team or Trust. • **<u>Action</u>: PSFU audit to be discussed further at the next TSSG meeting.**	**AWi**
	Next Meeting	• To be confirmed.	