Kent & Medway Cancer Collaborative

Colorectal Tumour Site Specific Group meeting
Tuesday 30th April 2024
Mercure Great Danes Hotel - Maidstone
09:00-12:30

Final Meeting Notes

Present	Initials	Title	Organisation
Pradeep Basnyat (Chair)	**PB**	Consultant General & Colorectal Surgeon	EKHUFT
Larissa Williams	**LW**	SCP	EKHUFT
Ruth Burns	**RB**	Lead Colorectal CNS	EKHUFT
Vicki Hatcher	**VH**	Clinical Lead – FDS	EKHUFT
Sue Travis	**ST**	Head of Operations	EKHUFT
Ruth Mount	**RMou**	Improvement Practitioner	EKHUFT
Stella Grey	**SGr**	General Manager	EKHUFT
Jade Pilcher	**JP**	Programme Manager – Bowel Cancer Screening	EKHUFT
Joseph Sebastian	**JSe**	Consultant Surgeon	EKHUFT
Anna Lamb	**AL**	Cancer Performance Manager	EKHUFT
Hannah Washington	**HW**	Faster Diagnosis Manager	EKHUFT
Catherine Flannelly-Kemp	**CFK**	SSP – Bowel Cancer Screening	EKHUFT
Julie Ironmonger	**JI**	Lead SSP – Bowel Cancer Screening	EKHUFT
Laura Abdey	**LAb**	Lead SSP – West Kent Bowel Cancer Screening Programme	DVH
Helena Price	**HP**	Rapid Access CNS	DVH
Michelle McCann	**MM**	Operational Manager for Cancer & Haematology	DVH
Louise Rafferty	**LR**	Macmillan Lead Colorectal CNS	DVH
Sue Stubbs	**SSt**	Colorectal STT CNS	DVH
Ian Vousden	**IV**	Programme Director	KMCA
Emma Forster	**EF**	Head of Service Improvement for Cancer	KMCA
Ann Courtness	**AC**	Macmillan Primary Care Nurse Facilitator	KMCA
Tracey Ryan	**TRy**	Macmillan User Involvement Manager	KMCA
Ritchie Chalmers	**RCh**	Medical Director	KMCA
Karen Glass	**KG**	Business Support Manager	KMCA/KMCC
Colin Chamberlain (Notes)	**CC**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Lead	KMCC
Samantha Williams	**SW**	Administration & Support Officer	KMCC
Rosalind Coppard	**RCo**	Metastatic CSW	MFT
Suzanne Bodkin	**SBo**	Cancer Service Manager	MFT
Angela Bell	**ABe**	Colorectal CNS	MFT
Louise Black	**LB**	Deputy Lead Cancer Nurse	MFT

Annaselvi Nadar	**AN**	Matron – Faster Diagnosis	MFT
Meeta Durve	**MD**	Consultant Oncologist	MTW
Liam Poynter	**LP**	Consultant Surgeon	MTW
Ryan Johnson	**RJ**	MDT Team Leader	MTW
Kane Ruse	**KR**	MDT Coordinator	MTW
Adrian Barnardo	**ABa**	Consultant Gastroenterologist	MTW
Bronwyn Tetley	**BT**	Lead Pathway Nurse Coordinator	MTW
Lorna Kviat	**LK**	Consultant Oncologist	MTW
Joanne Jones	**JJ**	FDS Specialist Nurse Team Lead	MTW
Debora Primerano	**DP**	Deputy General Manager	MTW
Raquel Souto	**RS**	Endoscopy Practice Educator	MTW
Carmen Duran	**CD**	FDS Nurse	MTW
Jodie Hotine	**JH**	Lead Research Radiographer	MTW
Helen Lloyd	**HL**	Consultant Colorectal Surgeon	MTW
Supriya Joshi	**SJ**	Consultant Chemical Pathologist	MTW
Laura Alton	**LAl**	Senior Programme Manager - KMCA Commissioning	NHS Kent & Medway ICB
Ian Nurdin	**IN**	Patient Representative	
Apologies			
Charli Selvage-Owen	**CSO**	Bowel Cancer Screening Manager, West Kent & Medway Bowel Cancer Screening	DVH
Julie Beszant	**JBe**	Programme Manager for Bowel Cancer Screening-West Kent & Medway	DVH
Steve Morgan	**SMo**	Consultant Radiologist	DVH
Marie Payne	**MP**	Lead Cancer Nurse	DVH
Carly Price	**CP**	Colorectal CNS	EKHUFT
Carolyn Maynard	**CMay**	Lead Cancer Nurse	EKHUFT
Gandra Harinath	**GH**	Consultant General and Colorectal Surgeon	EKHUFT
Jann Yee Colledge	**JYC**	Consultant Radiologist	EKHUFT
Joanne Cooke	**JC**	Consultant General & Colorectal Surgeon	EKHUFT
Pippa Enticknap	**PE**	Deputy General Manager	EKHUFT
Sudhakar Mangam	**SMa**	Consultant General, Laparoscopic and Colorectal Surgeon	EKHUFT
Sue Drakeley	**SD**	Senior Research Nurse	EKHUFT
Toni Bancroft	**TB**	Colorectal Surgical Care Practitioner	EKHUFT
Tracey Rigden	**TRi**	Chemotherapy Nurse Consultant	EKHUFT
Arun Dhiman	**AD**	Consultant Gastroenterologist	EKHUFT
Mohan Harilingam	**MHa**	Consultant Surgeon	EKHUFT
Imran Hafeez	**IH**	SELCA Cancer Improvement Manager	GSTT
Jonathan Bryant	**JBr**	Primary Care Cancer Clinical Lead	KMCA
Serena Gilbert	**SGi**	Cancer Performance Manager	KMCA
Emma Bourke	**EB**	Macmillan Personalised Care and Support Facilitator	MFT

John Schofield	**JSc**	Consultant Pathologist	MTW
Karen Hopkins	**KH**	Bowel Cancer Screening Practitioner	MTW
Maria Blanco-Criado	**MBC**	Deputy Chief Pharmacist - Cancer & Technical Services	MTW
Monika Verma	**MV**	Consultant Histopathologist	MTW
Raza Moosvi	**RMoo**	Consultant General, Laparoscopic and Colorectal Surgeon / MTW Colorectal Clinical Lead	MTW
Sam Enefer	**SE**	Consultant Clinical Oncologist	MTW
Samantha Seker	**SSe**	Oncology CNS – Colorectal	MTW
Simon Bailey	**SBa**	Consultant General & Colorectal Surgeon	MTW
Victoria Earl	**VE**	Clinical Trials Coordinator - Colorectal/Upper GI	MTW
Mark Hill	**MHi**	Consultant Medical Oncologist	MTW
Elaine Ellis	**EE**	Colorectal Oncology CNS	MTW

Item		**Discussion**	**Action**
1	**TSSG Meeting**	**Apologies** • The apologies are listed above. **Introductions** • PB welcomed the members to the meeting and asked the new patient rep, Ian Nurdin, to introduce himself. **Action log Review** • The action log was reviewed, updated and will be circulated to the members along with the final minutes from today's meeting. **Review previous minutes (10.10.2023)** • The final minutes from the previous meeting were not reviewed but had previously been agreed as a true and accurate record.	
2	**Performance data**	• FDS performance is well below the England average (51.1% compared with 60.7%). • FDS and 62d performance are below the England average at DVH, EKHUFT and MFT. • The presentation provided the group with an overview of: - The median waiting time from referral to FDS diagnosis in days at each Trust from March 2023 to February 2024. - The Colorectal Cancer Pathway dashboard (in development in Power BI). The Dashboard will be updated on a monthly basis and it is hoped it will go live within the next few weeks. • EF posed the question of whether there could be any learning from MTW, particularly with regard to their superior 62d performance. Similarly, PB stated it would be helpful for there to be a sub-group focused on sharing learning. • MTW have a performance lead who focuses on the FDS pathway. This is micromanaged daily with a lot of resource in place to keep on top of the PTL.	

		• DVH have noticed an increase in complex patients with other comorbidities and these can result in delays. The Trust also have issues with inappropriate referrals. • It is hoped that with the pathway redesign, overall performance will improve. • RC highlighted the importance of undertaking work on identifying where the biggest challenges lie and working as a network to address these in order to improve performance.	
3	**CNS Updates**	**DVH** • The Early Diagnosis CNS joined the team in October 2023 and the Metastatic CNS joined the team in December 2023. • Patients who are eligible are put on the SSM pathway. • Lynch mainstreaming clinics commenced earlier this month. • A Band 7 Macmillan nurse is due to retire next year. **EKHUFT** • The STT service is doing well in terms of triaging their patients. • The stratified pathways piece is functioning well. There are currently around 400 patients on SFU at William Harvey Hospital and around 100 patients at QEQM. • The PTL is very challenged, with around 1000 patients currently on the system. • There is a system in place for endoscopy patients with agreed follow-up but this needs to be further discussed. **MFT** • The CNS' support the Shared Decision Clinic on a monthly basis. • Marie-Francoise Jakarasi is leaving the CNS team. • The new CSW has embedded well within the team. • Health and Wellbeing events are running well. • The team are undertaking a lot of HNAs. • There are currently long waits for surveillance colonoscopies (which are outsourced). • The SFU pathway continues to evolve. • There is a pre-MDM in place on a Thursday. • There has been a significant increase in the number of metastatic patients, including complex cases and those with advanced disease. • The metastatic team are working on setting up a nurse-led metastatic clinic. They also attend the oncology clinic at MTW. • There are issues with 2ww imaging at present, both in terms of securing appointments as well as for reporting. PB believes this needs to be escalated. **MTW**	

		• No update provided.	
4	**qFIT validation - long wait endoscopy**	**<u>Presentation provided by Pradeep Basnyat</u>** • With regard to the aims of the project, these included: - Risk stratifying long waiters on routine colonoscopy waitlists. - Ensuring patients at highest risk were upgraded to the cancer pathway. - Ensuring patients had access to clinical review prior to colonoscopy where appropriate. - Improving Trust colonoscopy wait times without any significant risk to patients. - Improving the diagnostic pathways for lower GI referrals avoiding invasive procedures to asymptomatic low qFIT patients. • With regard to the current situation: - There are 2037 patients on the routine endoscopy waitlist. - The longest waiter was added to the DM01 waitlist on 03.04.2022. - Many patients were not assessed or reviewed since the original request. - Not all patients were on an RTT pathway. - A qFIT Endoscopy Recovery SOP has been written by Gastro/Surgical lead clinicians. • PB outlined the proposed pathway formulated following the colorectal workshop in January 2024 for those with a qFIT result of <10, 10-40, 41-80 and >80. • Of the 2037 patients on the routine endoscopy waitlist (validated chronologically), 1000 did not meet the criteria and 1037 had a qFIT sent. The exclusion criteria included: - Colorectal cancer pathway patients. - Patients on surveillance for polyps, colorectal cancer and IBD. - Family History/surveillance patients. • Of the 1037 patients who had a qFIT sent: 516 did not return the kit, 444 had a result of <10, 38 had a result of 10-40, 10 had a result of 41-80 and 29 had a result of >80. • PB provided the group with a summary of the gastro-led clinics at EKHUFT overseen by Dr Kate Hills, Matteo Caneva and Kalinka Maneva particularly in relation to what they do with patients with a qFIT result of <10, 10-40 and 41-80. • As of 26.04.2024: - 281 patients had a colonoscopy or were already dated prior to when the qFIT result was assessed. - 87 patients remain on the routine waitlist. - 25 patients were upgraded to the cancer pathway. - 458 patients were removed from the waitlist. • With regard to learning from the project:	

		- Patients may have benefited from a phone call and assessment prior to the sending of the qFIT in the post. This was deemed time-consuming due to the volume of patients but may have saved time as many patients required support calls and had queries over the test. - This project required a dedicated team including nursing and admin support. The project was overseen by the qFIT lead nurse but there was no agreed admin support or other agreed nursing support which hindered the project. • TRy stated that it is of vital importance to ensure patient communication is comprehensible. She believes this, in turn, could result in an increase in the number of patients using the qFIT. • **<u>Action</u>: Findings of the project to be shared at the next meeting.**	**PB**
5	**Colorectal Pathway redesign document**	**<u>Presentation provided by Emma Forster</u>** **<u>Colorectal Pathway redesign document</u>** • CWT performance for upper GI and colorectal pathways is not being achieved. • Current FDS performance is below the national average (51.1% compared to 60.7%). • 62d performance for January 2024 is 54.4% • DM01 performance for endoscopy modalities is challenged – over 65% of patients across Kent & Medway are waiting beyond six weeks for investigation. • There is variation in standards, waiting times and outcomes across the system. • The consensus is that there is a need to fix the benign pathway and reduce low-value endoscopy demand if Kent & Medway are to deliver the optimal cancer pathway for their patients. • A workshop was held in January 2024 to co-design the optimal pathway for patients who present to their GP with colorectal symptoms. • Colleagues from across primary care, secondary care and diagnostic services came together to share best practice and learning, and to co-design the optimal diagnostic pathway for their patients, based on: - qFIT result. - Risk factors. - Presenting symptoms. • In terms of a reminder to the changes agreed: - There is to be one pathway for Kent & Medway, removing variation for patients. - There is to be work on reducing low-value colonoscopy demand. - There is a need for a revised minimum dataset from primary care to support the STT triage process and reduce delays for patients in the next event. - There is to be support for primary care so patients with a qFIT result of <10 with no high-risk symptoms can be managed in primary care. - There is a need to standardise the straight to test protocols and tools. - There is to be risk stratification of patients by age to factor radiation risks. • The group reviewed the Kent and Medway Low Risk Q-Fit Pathway document presented on screen and provided some feedback which will be articulated under agenda item 9. The pathway is separated in to three groupings – the	

		primary care lower GI referral, the STT triage protocol and the FDS pathway. • With regard to primary care, the aim is for: - All USC to be sent with a qFIT result with agreed MDS. - Safety netting to be in place for patients with a qFIT result of <10. • With regard to STT triage/the FDS pathway, the aim is for: - All USC to be triaged through STT nurses. - Patients to be risk stratified by age, qFIT result and symptoms to the most appropriate first test. - There to be clear pathways and protocols for alternative investigations such as VC/CCE when an invasive investigation is not indicated. - There to be a clear process to expedite patients when cancer is suspected. • EF provided the group with an overview of qFIT data on: - FIT group at referral by first diagnostic test at each of the Trusts between January and December 2023. - What the service impact is. - The impact on diagnostic tests. - The impact on colonoscopy. The new pathway has the potential to save: 4743 colonoscopies per annum, 9486 points, 790 lists per year and 15 lists per week (1.5 endoscopy rooms). • It was highlighted that there are still a number of referral forms sent in from primary care where the patient has a qFIT result of <10 but where the GP has ticked the box for suspicion of cancer without adding any additional information. • RCh stated there is a need for more guidance on those patients who re-return to secondary care. • **<u>Action</u>: Following a brief discussion around the sharing of diagnostic results across the patch, RCh agreed to link in with the ICB to discuss this further.** • PB stated that there is an aim to have standardised clinic letters for cancer pathways across Kent & Medway and for the quality of reports to be standardised across the patch too.	**RCh**
	Action plans	**<u>Action plans</u>** • With regard to qFIT and primary care, the objectives are for >80% of USC cancer referrals to be accompanied by a qFIT result and to reduce the number of USC referred with qFIT <10. In terms of what is being done to achieve this: - There is targeted support and engagement with PCNs to promote qFIT testing and work is underway to understand the challenges in primary care and develop solutions accordingly. - A revised minimum dataset to make a qFIT result a mandatory requirement before referral is being worked on. Referrals without MDS will be returned to the referrer for completion. - Work is ongoing to implement safety netting processes in primary care (using Ardens Pro) for repeat qFIT testing for patients with results <10 with ongoing low-risk symptoms. - There is upscaling of qFIT testing volumes to accommodate double testing in primary care. • With regard to qFIT results accompanying a referral, there has been an improvement across all localities between January and March 2024. Kent & Medway have increased by approximately 20% in the last three months. • Emails have been sent to the PCN managers and clinical leads which had less than 40% recorded qFITs. There	

		has been a positive response from PCNs with some good increases seen. • In terms of engagement with PCNs, 10 practices have engaged so far with education and training – this has included looking at coding (ensuring the correct code is recorded and within the 21 days), text messaging and safety netting within practices and an emphasis on a change of practice. Good communication with patients ensures there will be less samples rejected and more returned in a timely manner. • It is important that there is an ongoing dialogue with primary care, to ensure they continue to improve, as this will provide the best care for the patients. • With regard to straight to test protocols, the objectives are: - To standardise the STT protocol and tools to embed one pathway for Kent & Medway. - To develop advice and guidance templates to support primary care management of low-risk patients. • An initial meeting with STT nursing colleagues identified that all Trusts are working to different protocols, using different tools with a range of challenges. • HL has been appointed as the STT Clinical Lead. • A Task and Finish Group is to be set up and this will look at: - The standardisation of protocols, tools and pathways. - Developing advice and guidance to GPs for patients where investigation is not indicated. - Workforce capacity. • With regard to Colon Capsule services, the objective is to develop a Kent & Medway Colon Capsule service. In terms of an update at each Trust on this: - MFT have a business case being processed through the Trust to establish a service. Staff are being trained although no formal start date has been confirmed yet. - EKHUFT's CCE service will be established within their CDC at Buckland. Cara Barlow is leading on implementation. A start date has yet to be agreed as staff will need to be trained and equipment purchased amongst other factors. - DVH have commenced discussions and a business case is in development. - MTW have a business case which is being supported within the Trust. Discussions have commenced with both MFT and EKHUFT regarding reading capacity. • A CCE Implementation Group is in the process of being established. • In terms of next steps, there is a need to: - Have the TSSG sign off the colorectal pathway and to socialise this with the ICB, Trust executive teams and primary care. - Establish a colorectal working group focused on supporting delivery of pathway changes and reducing treatment	

		variation.	
6	**Endoscopy GIRFT visit**	**Presentation provided by Emma Forster** • There was a joint National Endoscopy-GIRFT visit to Kent & Medway on 20.02.2024. • The visit to Kent & Medway was arranged due to serious concerns about GI endoscopy waiting times, and was undertaken by Dr Robert Logan (NHS England National Specialty Advisor for Endoscopy and Gastroenterology and the NHS Bowel Cancer Screening Programme (BCSP)), and Dr Bev Oates (National GIRFT (Getting It Right First Time) Lead for Gastroenterology). • The meeting was held in Maidstone and attended by Endoscopy and Clinical Leads as well as ICB representatives. • The report aims to support the ICB, providers and commissioners in recovering and transforming the current model of endoscopy and GI service provision across Kent & Medway. • In terms of key themes and findings, these include: - Executive support to clinical leadership within organisations. - A constrained workforce across the ICS with many locum GPs (leading to high volumes of referrals), and insufficient provider staff to manage the demand. - ERCP capability and capacity. Capacity will become more of an issue as ERCPists retire. - The huge variation in timely access to endoscopy services in Kent & Medway, with considerable volumes of low value endoscopy procedures being undertaken across all Trusts. - Inequity in endoscopy service provision, both in estate capacity and differing clinical approaches, with evidence of silo working amongst professional groups. - An absence of a coherent long-term strategic plan for Gastroenterology and GI endoscopy in Kent & Medway. • EF provided the group with an overview of the recommendations, particularly in relation to: - GI endoscopy utilisation/productivity in Kent & Medway. - Establishing a Kent & Medway GI endoscopy network. - CT Colonoscopy (CTC) and Colon Capsule Endoscopy (CCE). ABa stated CCE has been withdrawn from MTW due to monetary issues. However, IV stated this could be supported in terms of being reintroduced at the Trust with funding from the KMCA as this is a new pathway. - Developing a business case for a large GI endoscopy facility in Kent & Medway. - Developing an over-arching system GI endoscopy delivery plan. • With regard to next steps: - The Endoscopy Programme Manager has been appointed and their start date is June 2024. - Expressions of Interest for the Endoscopy Clinical Lead role will go out shortly, with an expected start date of June/July 2024. - An Upper GI Clinical Reference Group was held in April 2024 to discuss low value endoscopy activity and to agree interventions to drive change. - It was agreed the TSSGs will be the forum for discussing and agreeing clinical pathways until the new Network Board and sub-groups are established. - The Endoscopy strategy has been drafted and is being taken through relevant governance channels for agreement. - A follow-up national visit is planned for November 2024. • EF stated there is a plan to move to providing a therapeutic endoscopy service from a diagnostic endoscopy	

		service. • EF mentioned that there is a need for an ERCP network.	
7	**STT Standardisation**	**<u>Update provided by Helen Lloyd</u>** • HL highlighted the importance of working together as a network in order to share best practice and to review what processes can be streamlined/standardised across the patch (including STT assessments). • HL believes it would be helpful to carry out capacity and demand assessments/a review of STT activity in order to identify areas of concern/best practice and where further education could be provided. • HL feels it would be beneficial to review the STT SOPs available at each of the Trusts and to work on establishing a standardised STT SOP for Kent & Medway. • PB and HL believe STT should be incorporated in to the MDMs. • At MFT, STT nurses sit separately from colorectal nurses and have a named consultant to refer to. • At MTW, STT nurses often work hybrid and are not on site. There is a named consultant to refer to. • At DVH, STT nurses are not always sited at the hospital and have no consultant body they can refer to. When they triage patients, however, some will go on to a face-to-face appointment. • HL believes it would be sensible to establish a working group to discuss this matter further.	
8	**Streamlining of MDT**	**<u>Update provided by Ritchie Chalmers</u>** • RCh highlighted the need for the Trusts to consider whether their MDM meetings require optimisation. • There is a drive to implement streamlining across all tumour sites. • RCh stated there is a need to review how the MDMs work, their structures as well as membership. • RCh questioned whether the MDM teams should consider having pre-MDMs if these do not already exist for their Trust. • RCh believes it would be helpful to have a mini-MDT sit within the TSSG and encouraged the members to let her know if they would like to be involved in this. • It has been agreed that there will be an increase in clinical leadership within the TSSGs with the Chair of the TSSG to be offered 1 PA per week and additional personnel within the mini-MDT to be offered 0.5 PA per week. • IV is seeking primary care input and patient representation as part of the mini-MDT, which will be answerable to the TSSG. • RCh would like the mini-MDT to have representation from surgical colleagues, radiology, pathology, CNS' as well as the MDT Leads from each Trust.	
9	**Sign off Pathway redesign document**	• Following discussion earlier in the meeting, it was felt some alterations to the pathway need to be made. These include, but are not limited to, the following: - Renaming the pathway from '*Kent and Medway Low Risk Q-Fit Pathway*' to '*Kent and Medway Colorectal Pathway*'. - Including within the pathway a comment around the standardisation of clinic letters in addition to advice and guidance. - Embedding Personalised Care/follow-up protocols within the pathway.	

		- Calprotectin being done in primary care instead of secondary care and to be age stratified to 60. - Removal of the word 'triage' in the Straight to Test Triage protocol section of the pathway. • A query was raised in relation to identifying where NSS fits in to the pathway. • In summarising, IV and PB stated this pathway can be agreed in principle with some minor amendments to be made. Once these amendments have been made, the final version will be circulated. • PB mentioned that there will be a follow-up of the pathway and a meeting will be set up between now and October 2024. • **<u>Action</u>: Follow-up protocols to be an agenda item at the next meeting.**	**AW**
10	**AOB**	• No-one had anything to raise under any other business.	
	Next meeting date	• To be confirmed.	