Meeting of the *London Cancer* Colorectal Pathway Board

Date: Tuesday 19th June 2018 09:30-11:00

Venue: 6th Floor West Meeting Room, 6th Floor, 250 Euston Road, NW1 2PG

Chair: Michael Machesney

1. Welcome, Introductions and Apologies and Minutes from last meeting

- MM welcomed members of the board, introductions were made and apologies heard. The minutes of the last Pathway Board were accepted as an accurate record.

2. MDT Improvement – Draft protocols

- MM provided background to the project which follows on from the UCLH Cancer Collaborative MDT Improvement report. A programme of MDT Improvement has been started within the cancer alliance with a focus on the creation and implementation of MDT protocolised pathways of which Colorectal is a focus.
- A workshop was held in March 2018 with colleagues from Barts Health to discuss MDT improvement locally. From this a draft set of protocolised pathways have been developed.
- The draft protocols have been circulated to the board prior to this meeting. 12 pathways have been developed in which it is felt patients can be streamlined through without a full MDT discussion onto the next stage in their pathway. These patients would still need to be listed on the MDT agenda for governance and to ensure clinical safety.
- MDT triage meetings will need to be held and only patients with all information available should be discussed.
- HM pointed out that sometimes not all information was available as clinicians wanted to discuss investigations at the MDT before they were performed.
- MM suggested that these patients can be labelled for discussion, however, HM said there was pressure from management to discuss patients without all the information.
- MH said that removing people from MDT lists adds another week to the pathway and pressures histology and imaging to report. Someone needs to have time to triage and there is a clinical risk if it is not your patient. MM clarified that the triage meeting would be assisting the efficiency of the MDT. Clinical decisions would remain the responsibility of the 'owning' clinician (the consultant with primary responsibility for future patient care).

- JW said that creating a second MDT for triage would add to job plans which are already full and often MDT lists are not available until 24 hours before the meeting.
- MH said that removing people from MDT lists adds another week to the pathway and pressures histology and imaging to report. Someone needs to have time to triage and there is a clinical risk if it is not your patient. MM clarified that the triage meeting would not be to make clinical decisions.
- It was agreed all rectal cancers should be discussed.
- AA felt that these protocols were appropriate for high volume centres, but his MDT at HUH was not pressured and works well.
- It was agreed that the responsibility for bringing appropriate patients to the MDT was with the 'owning' clinician and the protocolised pathways could be used by individual clinicians removing the need for a pre MDT triage meeting. The concern was that with truly complex cases there was not enough time for discussion and the protocols would triage out those that did not need extensive discussion leaving time for more discussion of complex cases.
- It was clarified that the protocols had been produced with oncologist input.
- MH thanked MM and JG for producing the protocols. He expressed a concern that if patients are not brought to the MDT, they would be lost sight of; MM stated that patients on a protocolised pathway would still need to be tracked and could be included on the MDT list.
- JH will use the protocols to triage his own patients. He agreed adding the name and details to the MDT list under a separate section that lists the patients who were on a protocolised pathway.
- JW said that often the first time pathology and imaging is seen is at the MDT. MM suggested using this as an opportunity to make reporting more efficient.
- AA felt that everyone with a cancer diagnosis should be discussed at the MDT and the discussion documented. It was suggested that this does not need to be a lengthy discussion.
- MM asked the group to discuss the protocols at their MDTs and feedback comments to JG.

ACTION:

- **ALL to ask MDTs for their comments on the protocolised pathways and feedback to JG.**
- **JG to work with BHRUT MDT to audit a pilot of these protocolised pathways**

3. Stratified follow-up

- SC provided feedback on the next steps of the stratified follow up implementation document. Only HUH have been reporting on the patients stratified onto the self-care pathway.
- JW said that the Whittington have over 150 patients on the pathway. These have not been reported.
- There was a discussion about how the patients are managed on the pathway and how it can be ensured that patients do not miss tests.

- JW informed the Board that the Whittington uses Anglia ICE to manage patients on the pathway. A pathway coordinator runs a print out from the system every Monday of all the investigations due. The system also sends an alert within 30 days of a test date and updates that a test has been booked. IT spent time configuring the system to manage patients.
- AA said that they are not putting patients on the pathway until their systems are up to speed. VL said they currently have a database of patients on a spreadsheet. There were concerns that a database is susceptible to human error.
- SC reported that the Cancer Collaborative has undertaken an options appraisal of IT systems to manage the pathway and that there is £20k available for each Trust from Transformation funding to support implementation of IT systems.
- MH reported that IT is a constraint for Barts and BHRUT. SC said that Barts are advertising for an 8a Stratified Pathway Lead and suggested that this person could push for the implementation of an IT system.
- MH would welcome guidance from the group as he was reluctant to use a spreadsheet.
- JW said the Whittington also has a traffic light system which the nurses use and all can see. He offered to send screen shots of the system used at the Whittington.
- SC will provide more detail at the next meeting and will chase Somerset and Infoflex to find out whether they can provide a system to manage the self-care pathway, e.g sending alerts for tests.

ACTIONS:

- **JW to share screenshots of the self-care pathway management system with the Pathway Board.**
- **SC to follow-up with Somerset and Infoflex whether they can provide the systems needed to support the self-care pathway.**

4. qFIT Update

- HL presented an update on the qFIT project. It is currently being investigated what the impact will be on secondary care if the qFIT test is rolled out.
- The study is trying to establish whether it is safe to use qFIT as a 'rule-out' test and therefore reduce the need for a colonoscopy.
- MH said the BHRUT are encouraging the use of qFIT.
- MM said that once the study is complete, NICE may amend the guidance.
- HL reported that London is behind other areas of the country (Nottingham, Leicester, Coventry, Warwick) where qFIT is commissioned by CCGs. MM pointed out that the London population is different and there is a lower response rate.
- HL highlighted the potential benefits
    - Improved patient experience
    - Potential decrease in colonoscopies, freeing up capacity and funds
- MH suggested this would release capacity for low risk patients and MM suggested the capacity could be used for screening.
- AA queried why the test cannot be introduced. MM responded that the safety is not yet known and NICE will not amend the guidance unless it is based on a study, not a service evaluation.

- Bank nurses have been employed to recruit patients in clinics and this has led to an increased uptake of the test. Funds are available until the end of August to employ nurses.
- There are also 70 GP practices participating in the study and uptake via these is being monitored.
- MM said it should be made clear to commissioners that the aim was to stem an increase in colonoscopies, not to decrease them. The freed up capacity should be used for more screening.
- MM also highlighted that there is a danger qFIT may reduce the identification of polyps if total number of colonoscopies for the population are reduced. There is a need when qFIT is implemented to record any change in the adenoma detection rate at trusts and across the cancer alliance.

ACTION:

- **HL to explore nurse bank staff to cover out of hours clinics at weekends at BHRUT**
- **Board members to let HL know of any extra clinics that they run where patients can be recruited to qFIT.**

5. National colorectal timed pathway

- MM presented the new national colorectal timed pathway recently published by NHSE which the UCLH Cancer Collaborative led on developing as part of the national cancer vanguard.
- This pathway aims to support trusts in meeting the new 28 day faster diagnosis target that trusts will be measured on by April 2020.
- It was agreed that the most effective way to achieve this was with a straight to test (STT) pathway.
- JW said that since all referrals have been made electronically through the new ERS system, they are missing triage to the STT pathway.
- MH queried the possibility booking into triage via choose and book (CAB).
- It was queried whether this will replace the 2 week wait pathway. MM will find out when this is due to happen.
- JG pointed out that the difference with this target is that a non-cancer diagnosis is also included in the measurement.
- There was a discussion about charges for the triage as some Trusts are not charging for this and this is a constraint to service provision.
- MM requested that the Board members share their per patient charges for triage and calculate a suggested nurse tariff for CCGs.

ACTION:

- **ALL to share their Trust's charges for triaging referrals on the STT pathway.**
- **ALL to suggest a nurse tariff for CCGs**

6. Next Meeting

Monday 10th September, 16:00-17:30, 6th Floor East Meeting Room, 6th Floor, 250 Euston Road, NW1 2PG.

ACTION LOG

Action reference	Action	Owner	Date Due	Status
19/06/2018	Ask MDTs for their comments on the protocolised pathways and feedback to JG.	ALL/JG	10/07/2018	
19/06/2018	JG to work with BHRUT MDT to audit a pilot of these protocolised pathways	JG/JH/MH	01/09/2018	
19/06/2018	share screenshots of the self-care pathway management system with the Pathway Board	JW	01/07/2018	
19/06/2018	follow-up with Somerset and Infoflex whether they can provide the systems needed to support the self-care pathway	SC	01/09/2018	
19/06/2018	HL to explore nurse bank staff to cover out of hours clinics at weekends at BHRUT	HL	10/07/2018	
19/06/2018	Board members to let HL know of any extra clinics that they run where patients can be recruited to qFIT.	ALL	01/07/2018	
19/06/2018	Share Trust's charges for triaging referrals on the STT pathway.	ALL	10/07/2018	
19/06/2018	Suggest a nurse tariff for CCGs	ALL	10/07/2018	

Attendees

Name	Trust/Organisation
Michael Machesney	Chair
Joseph Huang	BHRUT
Matt Hanson	BHRUT
Sharon Cavanagh	UCLH Cancer Collaborative
Jacob Goodman	UCLH Cancer Collaborative
Helga Laszlo	UCLH Cancer Collaborative
Caroline Cook	UCLH Cancer Collaborative
Vi Lazarescu	Homerton
Adnam Alam	Homerton
John Wilson	Whittington
Hasan Mukhtar	Whittington

Apologies

Name	Trust/Organisation
John Bridgewater	UCLH
Andy Mcmeeking	TCST
Anna Nott	Holborn Medical Centre