Meeting of the *London Cancer* Colorectal Pathway Board

Date: Tuesday 10th September 2018 16:00-17:30

Venue: 6th Floor East 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. National Colorectal Timed Pathway

- MM presented the new national colorectal timed pathway which all trusts are in the process of implementing. This pathway relies on trusts to increase the number of patients being diagnosed through the STT route.
- The NCEL network has been asked by NHS England to produce a recovery plan that highlights actions that will be taken to improve cancer waiting times performance. A focus of these actions is to agree a network wide tariff for STT which will support trusts to increase their STT capacity.
- RN questioned if patients who have been cleared of colorectal cancer but need further investigations in other tumour sites can be taken off the 62 day pathway.
- The board agreed that patients who need further investigations should be referred to the relevant MDT but should not be taken off the pathway to ensure they are still tracked through their pathway.
- MH highlighted that the implementation of the new 28 day faster diagnosis standard will require a big change in current practice. Preliminary discussions have already taken place at BHRUT.
- In order to provide a STT service for all target patients, this pathway will need support from endoscopists who do not currently see suspected cancer patients. ES stated that an SOP will be required to standardise practice and ensure all patients follow the same pathway.
- PJ raised concerns of this new pathway for patients who do not have a simple primary tumour. The board agreed that the new MDC clinics support the diagnosis of patients without an obvious primary tumour.
- CS asked the board if the range and quality of imaging is known across the sector. MM highlighted that this is not something known by the colorectal pathway board but this can be referred to the Radiology ERG.
- MH highlighted that BHRUT see a lot of patients returning onto the 2ww pathway that have previously been investigated for colorectal cancer and discharged. 9% of patients diagnosed

with colorectal cancer have had a colonoscopy in the last three years, these are considered cancer misses. At UCLH these are discussed in the monthly M and M meetings.

- The range of cancer misses varies nationally between 4-13%, ES stated that this is currently being reviewed at a national level.
- Patients who are discharged after investigation are provided with dietary advice and support to control their symptoms. CS highlighted that this advice could be included into the GP read codes meaning that when a patient is seen by their GP this will be flagged during their consultation. This could help to reduce the number of patients being re-referred to secondary care.
- MM asked the board to feedback how their trust are planning to meet the new 28 day faster diagnosis standard.

ACTION:

- **Ask the Radiology ERG if the quality and range of imaging is understood across the network.**
- **Board members to feedback to JG and MM how their trust is planning to meet the new 28 day faster diagnosis standard.**

3. Cancer Waiting Times

- MM presented an overview of cancer performance for each trust since April 2017. This shows that the all but one trust within London Cancer were not compliant over 14 months however the number of breaches that needed to be saved in order to reach compliancy was low.
- MH stated that a lot of effort has been put in at BHRUT to improve cancer performance; this is highlighted in the analysis.
- The board agreed that this analysis should be refreshed for each board meeting.

ACTIONS:

- **Include CWT performance as a standing item on the agenda including a refresh of monthly performance.**

4. MDT Improvement

- MM highlighted that there is now a large programme of MDT improvement within the UCLH Cancer Collaborative. This includes supporting MDTs to establish and implement protocolised pathways and a clinical coaching offer.
- The UCLH Cancer Collaborative has currently recruited 16 clinical members of MDTs to be trained in coaching techniques. These coaches will be allocated an MDT outside of their particular tumour specialty and will work with this MDT for a period of 3-6 months to support them through an improvement programme.
- MM asked if anyone would be interested in signing their MDT up for this programme. MH highlighted that BHRUT would be interested in this programme.
- The colorectal protocolised pathways we signed off by the pathway board at the last meeting. These are due to be piloted within the Whipps Cross MDT.
- It was requested that the board email JG and MM if they are interested in becoming a pilot site for these protocolised pathways. ES highlighted that UCLH may be interested.

ACTION:

- **Board members to email JG and MM if interested in piloting the colorectal protocolised pathways**

5. qFIT

- HL updated the board on the progress of the qFIT pilot that has now received over 3000 samples.
- The recruitment of research nurses has led to the uptake in samples; this support is now being gradually removed. The pilot is now aiming to collect 3500 samples.
- There are several research studies happening across the country, these are looking at how the FIT test can be used including for low risk patients and all symptomatic patients.

6. NICE Guidance – DG30 Pathway Implementation

- ES presented the new DG30 guidelines which recommends using FIT within primary care to triage low risk patients. A pan London group has now proposed a pathway on how this can be implemented.
- Low risk patients are patients who have less than a 3% chance of having colorectal cancer.
- Bowel cancer screening will adopt the FIT test in November 2018.
- ES presented the NCL recommended pathway for using FIT as part of the new DG30 guidelines. This states that if patients have clinically obvious symptoms for colorectal cancer then they should be referred as a 2ww patient. If patients are considered low risk, then GPs have two options, they can either use FIT and refer the patient who will be consulted in secondary care with the result or can use FIT and consult the patient within primary care if they feel confident to do so.

7. Stratified Follow up

- SC updated the board on colorectal stratified follow up. The resource pack is now available on the UCLH Cancer Collaborative website. SC asked board members to contact her directly for further information and support with writing SOPs.
- Funding for clinical leadership support for stratified follow up will be available shortly as well as funding to support remote monitoring systems.
- SC has been in contact with both Somerset and Infoflex. Somerset will not be able to provide support for stratified follow up until their next software upload in autumn 2019. Infoflex are confirming the cost for each trust to implement a remote monitoring module.
- The team have also met with My Medical Records who operate a remote monitoring model. This would be within budget unless there were any significant integration costs.
- SC asked board members to discuss within their trust how they could be spend the funding available for electronic support for stratified follow up.
- UCLH Cancer Collaborative now has funding for a band 8b post to support the implementation of stratified follow up. This role will focus on Breast and Prostate in the first year but will spread out in year 2. A pan London IT manager is also being recruited to, this post will be hosted at RMPartners and will support trusts with any IT issues.

ACTION:

- **Board members to discuss with trusts how best to spend funding available for electronic support for stratified follow up**

8. AOB

Quality of Life

- SC introduced the quality of life programme that is being led by UCLH Cancer Collaborative. It will be starting this month and will be collecting information from all patients who have had treatment within the last 23 months. All patients that fit into this cohort will be sent a questionnaire about quality of life and this will be uploaded into a centrally located database that sits with NHS England.
- Pilot will be running until May 2019 and it is expected that this will become BAU after the pilot has ended.
- The pilot will be running at Barts Health and UCLH for all Prostate, Colorectal and Breast cancer patients.

Next Meeting: TBC

ACTION LOG

Action reference	Action	Owner	Date Due	Status
SEP01	Ask the Radiology ERG and MDTs if the quality and range of imaging is understood across the network.	JG/MM	01/11/2018	
SPE02	Board members to feedback to JG and MM how their trust plans to meet the new 28 day faster diagnosis standard.	ALL	01/11/2018	
SEP03	Include CWT performance as a standing item on the agenda including a refresh of monthly performance.	JG	ON GOING	
SEP04	Board members to email JG and MM if interested in piloting the colorectal protocolised pathways.	ALL	01/11/2018	
SEP05	Board members to discuss with trusts how best to spend funding available for electronic support for stratified follow up	ALL	01/11/2018	

Attendees

Name	Role	Trust/Organisation
Michael Machesney	Chair	UCLH Cancer Collaborative
Jacob Goodman	Project Manager – London Cancer	UCLH Cancer Collaborative
Larisssa Quinn	Programme Coordinator – London Cancer	UCLH Cancer Collaborative
Sharon Cavanagh	Programme Manager – MICA	UCLH Cancer Collaborative
Clare Stevens	GP	NCL
Ed Seward	Consultant Surgeon	UCLH
Matt Hanson	Consultant Surgeon	BHRUT
Anna Nott	GP	Camden CCG
Barbara Kruszynska	Programme Coordinator – MICA	UCLH Cancer Collaborative
Helga Lazlo	Programme Manager – Early Diagnosis	UCLH Cancer Collaborative
Romi Navaratnam	Consultant Surgeon	North Middlesex

Name	Role	Trust/Organisation
Maria Walshe	CNS	Whittington
Patricia Jupp	Patient Rep	

Apologies

Name	Role	Trust/Organisation
Joseph Huang	Consultant Surgeon	BHRUT
Andy Mcmeeking	Deputy Director - Improvement	TCST
John Bridgewater	Consultant - Oncologist	UCLH
Lee Dvorkin	Consultant Surgeon	North Middlesex
Jonathan Knowles	Consultant Surgeon	Royal Free
Adnan Alam	Consultant Surgeon	Homerton
Hasan Mukhtar	Consultant Surgeon	Whittington