

Acute Oncology, CUP & NSS Forum Tumour Site Specific Group meeting
Thursday 3rd October 2024
Mercure Great Danes Hotel - Maidstone
13:30-16:30

Final Meeting Notes

Present	Initials	Title	Organisation
Tracey Spencer-Brown (Chair)	TSB	Head of Nursing for Oncology & Haematology	MTW
Sarah Eastwood	SE	Macmillan Personalised Care Project Manager	MTW
Ruth Palfrey	RP	FDS Nurse	MTW
Ruby Einosas	RE	FDS NSS Nurse	MTW
Jenny Weaver	JW	IO CNS in AOS	MTW
Hannah Goren	HG	AOS CNS	MTW
Megan Lumley	ML	New Cancer Presentation CNS	MTW
Nicole Green	NG	AO Navigator	MTW
Kelly Pickles	KP	Macmillan Nurse	MTW
Carole Grey	CG	FDS Lead	MTW
Clare Reeder	CR	Lead Cancer Psychologist	MTW
Charlotte Moss	CM	Consultant Medical Oncologist	MTW
Jennifer Pang	JP	Consultant Clinical Oncologist	MTW
Zoe McDonald-Burrows	ZMB	Consultant – NSS/MAU	MTW
Adriana Kadungure	AK	Trainee Palliative Consultant Radiographer	MTW
Ofeoritse Okome	Ooko	AOS Support Nurse	DVH
Laura Burns	LB	Registered Nursing Associate	DVH
Charmaine Walker	CWa	Cancer Performance Manager	DVH
Ella Milan	EM	Pathway Navigator	DVH
Sebastian Urruela	SU	NSS Consultant	DVH
Billie-Jo Beacroft	BJB	AO CNS	DVH
Stacie Main	SMa	AO Lead CNS	DVH
Krupa Solanki	KS	Physician Associate – Oncology	DVH
Hannah Weston-Simons	HWS	GP Lead – NSS	DVH
Carrie Barton	CB	NSS CNS	DVH
Claire Whiteley	CWh	Lead NSS Nurse Practitioner	EKHUFT
Declan Cawley	DC	Consultant in Palliative Care/AO	EKHUFT

Chris Singleton	CS	Senior Programme Manager – KMCA Commissioning	KMCA
Sharon Middleton	SMi	Workforce Programme Lead	KMCA
Tracey Ryan	TR	Macmillan User Involvement Manager	KMCA
Colin Chamberlain (Notes)	CC	Administration & Support Officer	KMCC
Samantha Williams	SW	Administration & Support Officer	KMCC
Annette Wiltshire	AW	Service Improvement Lead	KMCC
Priyanka Egin	PE	AOS CNS	MFT
Mayank Patel	MP	NSS Consultant Lead	MFT
Hannah Taylor	HT	NSS GP	MFT
Louise Farrow	LF	Macmillan Lead Cancer Nurse	MFT
Vicky Kidner	VK	Macmillan Lead SACT Nurse	MFT
Suzanne Bodkin	SB	Cancer Service Manager	MFT
Apologies			
Kevin Bonham	KB	NSS MDM Coordinator	DVH
Clare Wilkins	CWi	Consultant - Palliative Medicine / AO	EKHUFT
Jennifer Jewell	JJ	Macmillan Lead AONP	EKHUFT
Lavinia Davey	LD	Haemato-oncology (Blood Cancers) Research Team Leader	EKHUFT
Danielle Mackenzie	DM	Macmillan Lead Nurse for Personalised Care	EKHUFT
Jonathan Bryant	JB	Primary Care Cancer Clinical Lead	KMCA
Ann Courtness	AC	Primary Care Nurse Facilitator	KMCA
Karen Glass	KG	Business Support Manager/PA	KMCC/KMCA
Rosalyn Yates	RY	Clinical Lead for Palliative Care Services for Medway and Swale	Medway Community Healthcare
Ifeoluwa Alayo	IA	NSS and MUO CNS	MFT
Deborah Willcox	DW	Senior Haematology Research Nurse	MTW
Emma Hughes	EH	FDS Senior Team Lead	MTW
Clare Wykes	CWy	Consultant Haematologist	MTW
Maher Hadaki	MH	Consultant Clinical Oncologist	MTW
Mathilda Cominos	MC	Consultant Clinical Oncologist	MTW
Ola Okuwa	Ooku	Senior Oncology Pharmacist	MTW
Philippa Moth	PM	Chief of Cancer Services / Consultant Obstetrician and Gynaecologist	MTW
Riyaz Shah	RS	Consultant Medical Oncologist	MTW
Stephanie McKinley	SMc	Matron - Faster Diagnosis	MTW
Steve Dann	SD	Consultant Radiographer in Palliative Care	MTW

Item	Discussion	Action
<p>1. TSSG Meeting</p>	<p><u>Apologies</u></p> <ul style="list-style-type: none"> The apologies are listed above. <p><u>Introductions</u></p> <ul style="list-style-type: none"> TSB welcomed the members to the meeting. <p><u>Action Log</u></p> <ul style="list-style-type: none"> The action log was reviewed, updated and will be circulated to the members along with the final minutes. <p><u>Previous minutes</u></p> <ul style="list-style-type: none"> The previous minutes were not reviewed but had previously been agreed as a true and accurate record. 	
<p>2. CRG New Modelling of TSSG</p>	<p><u>Presentation provided by Tracey Spencer-Brown</u></p> <ul style="list-style-type: none"> All four Kent & Medway NHS Trusts agreed it is their responsibility to support the provider-led TSSGs, including support to the TSSG chair, by a Clinical Reference Group (CRG) and the associated impact on the members Trust-based job plan. The Cancer Alliance Delivery Board will hold the ultimate responsibility for ratifying all high-level TSSG documentation, of which the Kent & Medway Cancer Collaborative (KMCC) and the Kent & Medway Cancer Alliance (KMCA) will disseminate and make available where appropriate, to the Integrated Care Systems (ICs) or other Commissioners of services e.g. NHS England. 	<p>Presentation sent to group on 04.10.2024</p>

		<ul style="list-style-type: none"> • All TSSG CRG members are responsible and accountable to the TSSG chair and ultimately to the Kent & Medway Cancer Alliance Medical Director and Director. • The CRG will act as a TSSG-based committee to provide clinical support to the chair of the TSSG in discharging their responsibilities for the development and the coordination of cohesive, integrated, multi-professional Kent & Medway-wide cancer guidance for a specific tumour/service site. • This role will attract payment of 0.5PA to be paid by the KMCA and reimbursed through Trust-based job planning. The TSSG CRG position is in term for one year, then the arrangement is re-assessed. • In terms of the Clinical Governance responsibilities, these include ensuring the TSSG agrees, reviews and monitors Kent & Medway-wide referral guidelines, investigation protocols, patient management and treatment protocols, and integrated care pathways. • Particular attention should be given to: <ul style="list-style-type: none"> i) Prevention and early diagnosis. ii) The early recognition, and appropriate management, of relapse/metastatic disease. iii) End of Life Care. iv) The collection of clinical data. v) Supporting the Clinical Research Network (CRN) in ensuring awareness and recruitment of eligible trials. vi) Encouraging the promotion of patient information which is consistent across Kent & Medway. vii) Ensuring the views of users and carers are taken into consideration by the TSSG. • The CRG will have an MDT-like approach and Expressions of Interest have been circulated to the group for applications. Nursing interest has been expressed and there is a GP in place to support. TSB encouraged the members to promote the CRG offer within their Trust teams. 	
--	--	--	--

		<ul style="list-style-type: none"> • <u>Action</u>: AW to resend the EOI email in addition to the SOP. 	AW
3.	<p>Nursing Associate Role, Acute Oncology</p>	<p><u>Presentation provided by Laura Burns</u></p> <ul style="list-style-type: none"> • The Nursing Associate is a clinical support role which bridges the gap between healthcare support workers and registered nurses. It has been created to deliver hands-on, person-centred care as part of nursing teams. • Some of LB’s responsibilities as a Nursing Associate include: <ul style="list-style-type: none"> i) Preparing the ward list in the mornings. ii) Reviewing patients on the ward, providing supportive visits, reviewing bloods and ensuring AO advice is being followed. iii) Calling patients to carry out assessments, supporting with concerns and seeking advice from colleagues where appropriate. iv) Assisting with bleeps and managing calls if able to/escalating if unable to. v) Assisting site specific nurses, attending breaking bad news meetings and supporting patients and their families. vi) Sending and filing emails, filing notes, sending EDNS, booking transport, sending documents to scanning and updating teams with relevant information. vii) Handing over patients to other healthcare professionals, Ellenor Hospice, site specific nurses, Consultants and to other wards. viii) Communicating with ED regarding patients the team have advised to attend for medical review and ensuring ED have the latest clinic letter. • Essentials for being an AO RNA include: a knowledge in oncology; having good communication with patients, families and other healthcare professionals; being a team player; listening; being supportive and empathetic; supporting patients and families when they are faced with a life-changing diagnosis; understanding and helping with any questions or concerns patients/families may have; supporting the CNSs/other teams to reduce workload; contributing to freeing up the CNSs so they can focus on more complex clinical care; integrated 	<p>Presentation sent to group on 04.10.2024</p>

		<p>working to ensure effective communication amongst teams; a passion for the role; looking for ways to adapt and improve the service; advocating for the patient with the aim to improve communication and ensuring they are listened to and involved in the planning of their care; delivering and monitoring care which has been planned and assessed by registered nurses; escalating concerns around patients with deteriorating health/new symptoms/concerns with bloods/poor performance status/deteriorating whilst on treatment; and recognising when an RNA is being asked to do something which is above their scope of practice, ensuring concerns are raised appropriately.</p> <ul style="list-style-type: none"> • Challenges of the job role include: acceptance of the role by other healthcare professionals; a poor understanding and awareness of the role; others not understanding a RNA’s limitations and the scope of their practice; the high-intensity environment/emotional demands associated with the role; and the medical terminology. • In conclusion, the role: is vital in terms of ensuring safe, effective care for cancer patients; provides essential support to both patients and clinical teams; and is integral to the future of oncology nursing and patient care. 	
<p>4.</p>	<p>Trust AO &CUP Updates</p>	<p><u>DVH</u></p> <ul style="list-style-type: none"> • The team are looking to set up an SDEC service but will require support from site specific CNSs. • The team are also hoping to eventually have a dedicated AO Consultant for the service. <p><u>EKHUFT</u></p> <ul style="list-style-type: none"> • The team have two new starters and a post has gone out to ad. • The team are working with A&E teams regarding the setting up of an SDEC service. 	

		<ul style="list-style-type: none"> • The Neutropenic Sepsis stratified pathway continues to evolve. • The service is working on building educational opportunities for immunotherapy. <p><u>MFT</u></p> <ul style="list-style-type: none"> • The chemotherapy emergency triage line will be held by the AO team from next week (09:00 to 17:00 daily). • The team are in the process of pathway mapping for the acutely unwell patient pathway for SDEC and ED. • MFT are now a seven day service. • LF believes it would be helpful to have a centralised triage line for Kent & Medway and has raised this with Ian Vousden (Director – KMCA). • The team have unfilled posts for a CNS and Band 4 Support Worker position. <p><u>MTW</u></p> <ul style="list-style-type: none"> • The Trust have commenced with the SDEC service and operate two days a week. • There are a number of new starters to the team. • The team have regular meetings with CM regarding MUO and CUP patients. • The team run a seven day service (from 08:00 to 16:00) with weekly MDTs in place. 	
5.	Trust NSS Updates	<u>DVH</u>	

- DVH have two or three NSS clinics per week depending upon available clinic space.
- Referral numbers continue to increase. In 2023, the conversion rate to cancer was 6.5%.

EKHUFT

- The number of referrals continues to increase.
- The team are in the process of building more formal pathways.
- The team are also working with other teams/organisations regarding patient care, including: haematology, Stanmore (bone pathway with an Orthopaedic Surgeon) and the Royal Marsden.
- EKHUFT are trying to increase their NSS team to meet service demands.
- The service has received overwhelmingly positive patient feedback.

MFT

- MFT are in the process of looking at a proforma for the intended SDEC service.
- Referral rates have increased since last year.

MTW

- Emma Hughes has left the team and ZMB is now the Clinical Lead for NSS.
- There are two NSS clinics in place per week.
- The service has experienced challenges, including receiving vague information on referrals for example.

<p>6.</p>	<p>Patient Experience & Feedback</p>	<p><u>Presentation provided by Tracey Ryan</u></p> <ul style="list-style-type: none"> • TR provided the group with an overview of her role which includes to: listen to patient partners; gather patient partner views; advocate for patients, ensuring the patient voice is heard in all of the work and priorities of the Cancer Alliance; work with national and regional colleagues; and get involved with the development of patient stories. • TR highlighted that the Patient Group wanted to work on top tips for chemo patients by patients. She explained that everyone is different and may not experience the same issues others do but these are things which patients have learnt through having treatment which they wanted to share with others going through the same process: <ul style="list-style-type: none"> i) Do not be afraid to ask anything even if you feel it might be ‘silly’. ii) Chairs should recline, especially for when a patient may feel drowsy. iii) Be aware that you may form associations, for example, with the clothing you wear, sounds and smells – do not be afraid to talk about it. iv) If something does not feel quite right, ask your nurse about it. v) Drink plenty of water after your chemotherapy - this will help. vi) Keep a diary of how you are feeling, what medication you are taking and your temperature. This will help with pre-chemotherapy and help you understand the way your body reacts to the treatment - for example you may feel sick for two days then feel fine after this. • TSSGs should ideally have two patient partners per group. TR asked the Trusts to let her know if they have any patients who they believe would be interested in supporting the patient workstreams she oversees. • Patient Partners are experts by experience and are an invaluable part of service improvement and design. 	<p>Presentation sent to group on 04.10.2024</p>
-----------	---	---	--

		<ul style="list-style-type: none"> • TSB raised a query to the Trusts in relation to how they manage patient experience in AO/NSS. The consensus was that it is difficult to obtain this information as patients are often followed up by other tumour site specific teams. • DC highlighted the need for there to be a standardised patient questionnaire and for this to be rolled out in a timely manner. 	
<p>7.</p>	<p>Kent & Medway Psychological Service Project</p>	<p><u>Presentation provided by Clare Reeder</u></p> <ul style="list-style-type: none"> • The prevalence of anxiety/depression severe enough to warrant specialist psychological services is 10% in the year following diagnosis, 50% following cancer recurrence and 10-15% with advanced disease. • For carers, 67% experience anxiety and 42% experience depression. • Healthcare costs for people with long-term conditions is 50% higher with anxiety/depression (reduced by 20% with psychological therapy). • With regard to the CaPS-KM patient survey in the Kent Oncology Centre (66 patients and 47 relatives), 25% scored in the moderate or severe range on GAD-7 or PHQ-8. • The two year aims include: <ol style="list-style-type: none"> i) To build on the KMCA scoping document with a more granular analysis of existing NHS, statutory and third sector psychological services. ii) To demonstrate unmet psychological need. iii) To set up a Kent & Medway-wide cancer psychological service. iv) To evaluate the new service. v) To secure permanent NHS funding. 	<p>Presentation sent to group on 04.10.2024</p>

		<ul style="list-style-type: none"> • Key outcomes for the service include: <ul style="list-style-type: none"> i) Financial sustainability: cost-saving/improved efficiency. ii) An improvement in patient quality and experience. iii) A reduction in health inequalities. iv) Equitability across the four Trusts. v) A move towards integration with existing cancer psychological services and standardisation across the patch. • The CaPS-KM team comprises of Janet Bates (Band 8a Counsellor - 0.9wte), Chris Bonner (Band 8a Clinical Psychologist - 0.8wte) and Clare Reeder (Band 8c Consultant Clinical Psychologist and service lead - 0.8wte). • CR outlined the actions taken so far in relation to team development, service development and granular scoping. • In terms of the listening exercise at MTW and EKHUFT, key messages include: <ul style="list-style-type: none"> i) Delivering high-quality psychological care is a key priority across the cancer workforce. ii) The emotional demands of delivering psychological care are high. iii) The oncology counselling service is a highly valued, well-integrated service. iv) A small cohort of patients require complex formulation-based psychological assessment and interventions. • The proposed offer from CaPS-KM includes: early delivery of training and supervision; local delivery of a specialist psychological service; a cascade approach to service development; and the introduction of a Steering Group. • In terms of who CaPS-KM will see: 	
--	--	--	--

		<ul style="list-style-type: none"> i) Those with urgent needs (e.g. those who pose a risk, have very high levels of distress, very high levels of physical burden e.g. disfigurement/treatment window). ii) Those with complexity issues (trauma history, social isolation, deprivation, stigma/discrimination, dependents, physical complexity, additional needs – e.g. addiction, mental health history, learning disabilities, neurodiversity). iii) Those with complex treatment decisions and difficulties in engagement. iv) Those who have already completed counselling and the need remains high. v) Those unable/unwilling to engage with counselling – e.g. who need in-clinic input. vi) Those in need of liaison with mental health services and the broader care system. vii) Those who have a high impact on MDT time. <ul style="list-style-type: none"> • In terms of how CaPS-KM is different to counselling: <ul style="list-style-type: none"> i) It is a psychological therapy using other evidence-based models. ii) It focuses on multi-service liaison (e.g. mental health services). iii) It has a flexible outreach to patients. iv) It works indirectly to support MDTs. v) Referrals will eventually be via the oncology counselling team (electronic referral form on the intranet). 	
<p>8.</p>	<p>Personalised Care & EHNAs</p>	<p><u>Presentation provided by Sarah Eastwood</u></p> <ul style="list-style-type: none"> • The NHS Long Term Plan for Cancer states “where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support.” Personalised care is based on ‘what matters’ to people and their individual strengths and needs. • Personalised Care and Support Planning (based on holistic needs assessments) ensures people’s unmet needs are identified and addressed. 	<p>Presentation sent to group on 04.10.2024</p>

		<ul style="list-style-type: none"> • End of Treatment Summaries provides the person and GP with valuable information, including a detailed summary of treatment completed, potential side effects, signs and symptoms of recurrence and contact details to address any concerns. • The Primary Care Cancer Care Review is a discussion between the person and their GP/primary care nurse about their cancer journey. • Health and Wellbeing Information and Support is accessible information about emotional support, coping with side effects, financial advice, getting back to work and making healthy lifestyle choices. • The HNA process comprises three parts: <ul style="list-style-type: none"> i) The Macmillan HNA Concerns Checklist which is embedded in InfoFlex. ii) A conversation to discuss the responses recorded on the checklist. iii) A Personalised Care and Support Plan. • The HNA offer must be proactive, fully explained to the patient, should be focused on the individual and be accessible, have a safety net so patients not offered one are followed up, and the response/outcome is to be recorded on InfoFlex. • The benefits of offering an HNA include: <ul style="list-style-type: none"> i) The opportunity to identify issues early in the patient’s pathway allowing for timely support and intervention to improve the patient’s quality of life. ii) Improved patient outcomes by addressing needs identified through the HNA through a therapeutic conversation. iii) It enabling the development of a co-produced, personalised care plan. iv) Increased patient satisfaction by ensuring patients have felt heard and valued and had their concerns acknowledged with a plan put in place. 	
--	--	--	--

		<p>v) Patients being central in the decision-making process.</p> <p>vi) It supports an early positive relationship between the patient and the CNS teams and timely intervention supports a positive experience through their pathway.</p> <p>vii) It can reduce the number of ad-hoc contacts by the patient to the clinical teams enabling teams to work more efficiently.</p> <ul style="list-style-type: none"> • Information collated via InfoFlex is used to identify gaps in services and supports service improvement opportunities and resource allocation. • The key points to offer an HNA are: at diagnosis/start of treatment; around/after the end of treatment; at each new diagnosis of disease recurrence; at the transition to a palliative care pathway; during prehabilitation; during palliative or end-of-life care; and at any other time that the patient requests one. • In terms of expectations around HNA/PCSP completion, there should be an increase in the number of offers in addition to an improvement in the quality of the HNA. • Agreed expectations for implementation include: a consistent approach; patients being managed equitably; and the minimisation of variation. • SE outlined the actions for improvement and the progress made so far with regard to HNAs/PCSPs. • None of the Kent & Medway Trusts do eHNAs for CUP patients. • It was highlighted that MTW use KOMS for the recording of HNAs whereas the other Trusts use InfoFlex. 	
<p>9.</p>	<p>Cancer Alliance and ICB Updates</p>	<p><u>Update provided by Chris Singleton</u></p> <ul style="list-style-type: none"> • All four sites are now live with the NSS service. 	

		<ul style="list-style-type: none"> • CS is aware of the often poor quality of referrals but stated that a high percentage of GPs across Kent & Medway are locums. • The Galleri GRAIL trial has now ended and CS is unaware of its future. The three years' worth of data will be reviewed and CS thanked all of those involved for their work on this trial. 	
<p>10.</p>	<p>Acute Oncology SDECC</p>	<p><u>Presentation provided by Tracey Spencer-Brown</u></p> <ul style="list-style-type: none"> • SDECC is a model of care which allows specialists, where possible, to care for patients within the same day of arrival as an alternative to hospital admission, removing delays for patients requiring further investigation and/or treatment. • SDECC should be considered for all patients where clinically appropriate to support alternatives to admission. • Models can be specific to a speciality or within another SDECC as complimenting specialist services such as medical SDECC. • TSB highlighted the importance of improved access to elective pathways, patients having a positive experience, reducing the number of unnecessary A&E attendance and admission avoidance. • TSB outlined the three phases which constitute the evolution of the AO SDECC service in addition to the flowchart. MTW are in phase one of this workstream and operate twice a week but they hope to increase this to five days a week in due course. • TSB outlined both the inclusion and exclusion criteria for the service. • With regard to challenges, these include: Consultant Roster capacity; SPR/SHO Specialist clinical support; workforce recruitment; training and upskilling (AOS Nursing team); space; and the difficulties associated with 	<p>Presentation sent to group on 04.10.2024</p>

		<p>business cases.</p> <ul style="list-style-type: none"> In relation to concerns, these include: Acute/Emergency Medic input; the escalation of patients for admission following review; the patient concern escalation pathway; the wider impact of sustainability; and the impact on the wider AO Service which now has four workstreams and pathways - Emergency, SDECC, Triage and CNS roles (CUP & Immunotherapy/ICI). TSB provided an overview of the AO SDECC patient experience questionnaire in addition to service user feedback. Action: Data on MTW AO SDECC service to be provided at the next meeting. TSB added that a regular Working Group has been set up and they are reviewing what is and is not working well. The group are looking at how to integrate the Palliative Care team. 	<p>MTW</p>
<p>11.</p>	<p>Cancer Dashboard Data</p>	<p><u>Presentation provided by Tracey Spencer-Brown</u></p> <ul style="list-style-type: none"> TSB provided the group with an overview of: <ul style="list-style-type: none"> i) The NSS section of the Cancer Dashboard which displayed performance indicator data for the four Trusts. This included the number of referrals per month, FDS performance and the conversion rate (for both FDS and primary diagnosis). ii) Metastatic disease data between 2019 and 2023 by tumour site. iii) Emergency presentation data for Kent & Medway. The following tumour sites have a higher rate of emergency presentations than the England average: uterine cancer, haematological cancer and myeloma. The following tumour sites have a lower rate of emergency presentations than the England average: breast cancer, lung cancer, cancer of the brain and CNS and liver cancer. 	<p>Presentation sent to group on 04.10.2024</p>

		<ul style="list-style-type: none"> • TSB stated there is an intention to have an AO Dashboard in due course. She also encouraged the NSS teams to review their Dashboard data and feed back to David Osbourne. 	
<p>12.</p>	<p>Table Top Workshops</p>	<ul style="list-style-type: none"> • TSB asked the group to separate in to four groups and formulate some pertinent points based on the headings outlined below (Clinical Pathway, Data, Palliative Care EOL and Patient Experience). <p><u>Clinical Pathway</u></p> <ul style="list-style-type: none"> • With regard to the NSS pathway, what can be done to stratify patients more adequately? <p><u>Data</u></p> <ul style="list-style-type: none"> • <i>Making Data Count</i> - these practical guides, which can be found on the NHSE website, are suitable for those working at all levels in the NHS, from ward to board, and will show staff how to make better use of their data. • It is important to review data to identify whether patient needs are being met. <p><u>Palliative Care EOL</u></p> <ul style="list-style-type: none"> • DC emphasised the need for clinical staff to empower themselves to make important decisions early on, for example with regard to palliative care pathways. <p><u>Patient Experience</u></p> <ul style="list-style-type: none"> • There is a need to recruit at least two patient partners for this TSSG. 	
<p>13.</p>	<p>AOB</p>	<ul style="list-style-type: none"> • Action: SU feels the NSS service at DVH is receiving an increasing number of ‘defensive’ referrals from primary care. There appears to often be confusion as to the purpose and remit of the NSS service and TSB therefore believes it would be sensible to schedule a meeting with relevant colleagues across the patch to 	<p>TSB</p>

		<p>discuss this issue further. TSB to facilitate this.</p> <ul style="list-style-type: none"> • Following on from SU's point above, CS emphasised the need to review the NSS referral criteria. • CM asked the group if they feel it would be acceptable to produce an IO Directory. The consensus was that this was agreeable and TSB stated CC could assist with this outside of this meeting as a separate project. • CM highlighted that Kazumi Chia (Consultant Clinical Oncologist – GSTT) wished to convey a message to the group with a request to reduce the knee-jerk referrals sent to the Trust for review at the Neuro-oncology MDM without first having appropriately worked-up/provided interventions to their patients. TSB confirmed it would be advisable for a Microsoft Teams meeting to be set up between the Trusts and Kazumi Chia to discuss further. • TSB encouraged the members to let her know what topics they would like to discuss at future meetings. • TSB confirmed she has put a recommendation forward to Ian Vousden and Ritchie Chalmers to separate the TSSGs so that there would be one for AO and Palliative Care and another one for NSS and MUO. 	
<p>14.</p>	<p>Next Meeting Date</p>	<ul style="list-style-type: none"> • To be confirmed. 	