Kent and Medway Cancer Collaborative

Breast Tumour Site Specific Group meeting
Tuesday 5th November 2024
Mercure Hotel, Ashford Road, Maidstone, ME17 1RE
09:00-12:30
Final Meeting Minutes

Present	Initials	Title	Organisation
Deepika Akolekar **(Chair)**	**DA**	Consultant Oncoplastic Breast Surgeon	MTW
Marie Payne	**MP**	Macmillan Lead Cancer Nurse	DVH
Sylvia Hurley	**SH**	Breast CNS	DVH
Vanessa Ashby	**VA**	Metastatic CNS	DVH
Nicholas Williams	**NW**	Consultant General Surgeon	EKHUFT
Vicky Stevenson	**VS**	Breast Support Worker	EKHUFT
Claire Bingham	**CB**	Macmillan Personalised Care Facilitator	EKHUFT
Vanessa Potter	**VP**	Lead Breast Care CNS	EKHUFT
Suzannah Fitzgerald	**SF**	Nurse Specialist Oncology	EKHUFT
Wendy Cunningham	**WC**	Breast CNS	EKHUFT
Rebecca Greene	**RG**	Metastatic Breast CNS	EKHUFT
Fiona Mahon	**FM**	Breast CNS	EKHUFT
Louise Barker	**LB**	Breast CNS	EKHUFT
Anil Poddar	**AP**	Consultant General Surgeon	EKHUFT
Doraline Phillips	**DP**	Consultant Histopathology	EKHUFT
Claire Mallett	**CM**	Programme Lead – Personalised Care and Support	KMCA
Bana Haddad	**BH**	Clinical Lead – Personalised Care and Support	KMCA
Sue Green	**SGr**	Macmillan Project Manager – Personalised Care and Support	KMCA
Sharon Middleton	**SM**	Workforce Programme Lead	KMCA
Jo Bailey	**JB**	Early Diagnosis Programme Lead	KMCA
Karen Glass **(Minutes)**	**KG**	PA / Business Support Manager	KMCA & KMCC
Tracey Ryan	**TR**	Patient Involvement Manager	KMCA & KMCC
Annette Wiltshire	**AWilt**	Service Improvement Lead	KMCC
Colin Chamberlain	**CCha**	Administration & Support Officer	KMCC
Sam Williams	**SW**	Administration & Support Officer	KMCC

Matt Hine	**MH**	InfoFlex Application Manager	KMCC
Ashley Wilson	**AWils**	Project Manager	KMCC
Suzanne Bodkin	**SB**	Cancer Service Manager	MFT
Vasileios Karydakis	**VK**	Consultant Oncoplastic Breast Surgeon	MFT
Louise Black	**LB**	Macmillan Deputy Lead Cancer Nurse	MFT
Samantha Tomlin	**ST**	Breast CNS	MFT
Cathie Cooper	**CCo**	Breast CNS	MFT
Delilah Hassanally	**DH**	Consultant Oncoplastic Breast Surgeon	MFT
Claire Ryan	**CR**	Macmillan Consultant Nurse	MTW
Dhalvir Midda	**DM**	Head of Pharmacy – Cancer & Technical Services	MTW
Juanita Caseley	**JC**	Breast ANP	MTW
Michal Uhercik	**MU**	Consultant Oncoplastic Surgeon	MTW
Charlotte Moss	**CM**	Consultant Medical Oncologist	MTW
Catherine Harper-Wynne	**CHW**	Consultant Medical Oncologist	MTW
Jennifer Glendenning	**JG**	Consultant Clinical Oncologist	MTW
Russell Burcombe	**RB**	Consultant Clinical Oncologist	MTW
Michal Uhercik	**MU**	Consultant Breast Surgeon	MTW
Gemma McCormick	**GM**	Consultant Clinical Oncologist	MTW / KOC
Liz Simmons	**LS**	Patient Partner	
Christine Lee	**CL**	Patient Partner	
Janice Strevens	**JS**	Patient Partner	
Apologies			
Pippa Enticknap	**PE**	Deputy General Manager	EKHUFT
Ritchie Chalmers	**RC**	Medical Director	KMCA
Jonathan Bryant	**JB**	Primary Care Clinical Lead	KMCA / NHS Kent & Medway ICB
Olena Dotsenko	**OD**	Consultant Histopathologist	MTW
Rema Jyothirmayi	**RJ**	Consultant Clinical Oncologist	MTW
Priya Palanisamy	**PP**	Consultant Radiologist	MTW
Victoria Teoh	**VT**	Breast Consultant	MTW
Jan Hackney	**JH**	Breast CNS	MTW
Christine Howarth	**CH**	Patient Partner	
Lin Douglas	**LD**	Patient Partner	

Item		Discussion	Agreed	Action
1.	TSSG Meeting	**Apologies** • The formal apologies are listed above. **Introduce new TSSG Chair** • DA welcomed the members to today's face to face meeting. **Introductions** • If anyone attended the meeting and has not been captured within the list above please email karen.glass3@nhs.net directly. **Action log Review** • The action log was reviewed and the updated version will be circulated together with the final minutes from today's meeting. **Review previous minutes** • The minutes from the previous meeting which took place on the 7th May 2024 were reviewed at today's meeting and signed off as a true and accurate record.		
2.	Discuss the GIRFT report	**Verbal update provided by Deepikar Akolekar** • DA thanked the trusts for their participation and engagement with the GIRFT team regarding their breast surgery service for Kent & Medway Cancer Alliance. • DA highlighted specific areas of excellence in K&M:		

		i) There has been improved performance against the Cancer Waiting Times with all trusts above 84% for their Faster Diagnosis Standard particularly the significant improvement at MFT recently. ii) The percentage of patients diagnosed at stage 1 and 2 is > 88% which is above the national average. iii) 70% of first surgery is breast conserving – upper quartile nationally. iv) Onco-plastic surgery service. v) Metastatic Breast Service at MTW with plans to level up provision across the other trusts. (Meeting set up after the TSSG to discuss further) vi) Open access follow-up pathways have been established across all trusts. vii) The development of the Clinical Dashboard providing real time oversight to clinical and operational teams – detailing performance against the CWT and GIRFT clinical metrics - including median delays to key pathway milestones. **FYI - access to the dashboard** • Register for access to Kent and Medway ICB Power BI reports at https://forms.office.com/r/svyPSvktHw. (If you already have access to the Cancer in Primary Care dashboard, you can use your existing login) • Once access has been granted, you can access the dashboard at https://app.powerbi.com/home?ctid=4cfbd3c4-a42e-48a1-b841-31ff989d016e. Click on the **KM ICB Main** app and you will see **Cancer Pathways** listed on the left-hand menu. (ICB employees can also access the dashboard under the Data section of KAM) • Specific challenges and opportunities outlined from the GIRFT report: • There is no plastics service at any Kent & Medway Trusts; low immediate reconstruction rates compared to the national average, particularly at EKUHFT (7%). • There is treatment variation across the system, particularly mastectomy and re-operation rates. An audit has outlined the unwarranted clinical factors and variance in patient characteristics.		

		• Increasing demand - pressure on workforce and diagnostic services. Breast Pain pathway implementation - to ensure patients at high risk of cancer are prioritised to triple-assessment clinics. • Metastatic disease – inequity of access to a CNS for patients with secondary breast cancer, working with the support of Novartis to develop a new model of care and invest in new nursing roles to level up service provision across Kent and Medway. • Workforce challenges, particularly breast radiologists. This is a national challenge but there has been some success in training consultant mammographers in advanced clinical practice. However, this has been hampered by lack of national agreement on the banding. • Data completeness for national data submissions, particularly HER2 status – ensure each MDT has a nominated data lead. • In terms of actions moving forward it was suggested: i) To establish a clear pathway across all of the trusts to ensure there is a robust and efficient out of hours service for breast surgery patients. Currently, there is variation in the service offered across K&M. ii) Improved pathology turnaround times as this is impacting patient care. 3 weeks for first operations and 7-8 days for core biopsies. RB asked what provisions are in place to address seasonal / term-time variation in pathology turnaround times. RB highlighted this is on the red risk register. It would be helpful to have Cancer Alliance support and for the trusts pathologists to report back their issues. iii) An opportunity to establish breast pain pathways across the patch. iv) To ensure staffing levels are safe and able to offer and monitor all NICE approved treatments for their breast cancer patients. v) It was agreed Consultants should be job planned for their MDT prep and for offering a skin sparing mastectomy service at QVH. There needs to be an Associate Specialist / Surgeon in place at QVH who is able to provide a mastectomy service, as this is a long journey for a surgeon travelling from QEQM. vi) A clear pathway should be agreed with the surgeons/oncologists/plastic surgeons for patients having neoadjuvant chemotherapy and wish to have a reconstruction.		

		Additionally, for those patients that require further systemic therapy after surgery are counselled appropriately about timing of their reconstruction. vii) JG highlighted that there is an NHSE-recognised inequity for metastatic breast cancer patient support. New patient appointments should be an hour in length with metastatic patient's appointments being 30 minutes. This isn't standardised currently. **viii)** MTW have the highest re-excision rates (29%) for K & M compared to national standards. An audit has been initiated to look at reducing re-excision rates. Margin imaging is working progress. ix) Implant loss rate in K&M is 3 times the national average. Reconstruction might not be an option for some patients and further discussion maybe required to understand their reasons.		
3.	**Validation of digital pathology across KMPN network**	**<u>Digital Pathology Benefits and Go Live Impact – update provided by Doraline Phillips</u>** • DP outlined the benefits of launching Digital Pathology and the impact this will have on their pathology service when it goes live. The validation phase was due to be launched in October 2024 but this has been delayed to March 2025 due to circumstances outside of their control. • DP highlighted the benefits of digital pathology for laboratory staff (including pathologists and admin staff) preparing for the MDM when the service goes live. • It was noted there is a global shortage of pathologists and therefore they need to find smarter ways of working. • The Laboratory Information Management System (LIMS) is the software used in K&M which allows for the effective management of pathology testing and reporting. • DP explained the difference between analog and digital workflow in pathology. It was noted that within Cytology they will still continue to use a microscope for tissue specimens.		**Presentation was circulated to the group on the 13th November 2024**

		• DP highlighted the benefits of digital pathology in terms of: i) Efficiencies and Improved Workflow ii) Improved Workforce Factors and Collaboration iii) Improved Patient Safety iv) Evolving Technology / Research & Development Opportunities • The initial implementation impact and mitigation includes: i) System training will be provided by the supplier with ongoing support from the Kent & Medway Pathology Network team. ii) Each pathologist will need to verify their digital reporting against their analogue reporting to ensure clinical care level continuity. iii) This will impact the rate of reporting for the duration of verification which will vary for each pathologist estimated at a period of 1-3 months. No more than five pathologists will be validating at one time. To mitigate against this there is extra NHSE funding in place to recruit 2 locums to help during the validation phase. iv) The digital pathology project has accessible funding in order to utilise other resources during the validation phase. v) Removing patients from cancer pathways when endoscopic findings are normal / benign will help alleviate the pressure and allow pathologists to concentrate on cases of clinical significance. • DP explained Digital Pathology will be an enabler for AI platforms which can help report biopsies quicker. The plan is to commence with Prostate and then Breast. • CHW asked if strict parameters for pathology turnaround times could be put in place for the safety of some of their high risk / priority breast cancer patients as they are not able to wait 6-8 weeks. This cohort relates to about 10-15% of their patients. CHW added K&M are an outlier compared to nationally by about 3-weeks and as such are under close scrutiny nationally. This issue has been escalated and as a result weekend working has been put in place at MTW. It was agreed to discuss this further offline.		

4.	**Open Access Follow-Up (OAFU) workshop**	**<u>Update provided by Claire Mallett</u>** • CM outlined the aims of the Breast OAFU pathway: i) To standardise Breast OAFU care across K&M. ii) Resource and staff development where required. iii) Share good practice and learning. • CM referred to the number of active patients on the PSFU pathway across the trusts including the numbers who are Consultant / Nurse led or on a Supported Self-Management pathway. These numbers have increased across K&M from 2023 to 2024. The NHSE expectation states at least 75% of patients should be eligible for PSFU. • The three key priorities include: i) Staff development / resources – trust / teams / CA support required ii) Eligibility criteria – equity of access / exclusion criteria iii) 5-year discharge process – MTW / DVH have a process in place. • OAFU resource including a dedicated OAFU role: i) **MTW** – JC - OAFU resource – the only dedicated open access role. ii) **MFT** – OAFU post (WTE CNS) agreed for 7-months with CA funding. The business case is being written for a substantive role. iii) **EKHUFT** – no OAFU service at QEQM. Business case in progress but not prioritised. EKHUFT used tight exclusion criteria due to limited CNS/CSW capacity. iv) **DVH** – OAFU service / no service at Queen Mary's Hospital • VS stated the importance of having pathway navigator / admin support in place. • It was noted the most underfunded trust (EKHUFT) had the largest number of patients. The group agreed the OAFU service needs to include a dedicated role as the CNS's are unable to take on this additional work as it stands.		**Presentation was circulated to the group on the 13th November 2024**

		• DA said that OAFU came under the surgical directorate at MTW and believed that this had supported development of the service in their Trust. It had remained on the Trust risk register for two years prior to resources being secured. MTW did not advance the service without appropriate resource. • It was proposed that a GOLD standard equitable OAFU service needs to be set up across all of the trusts with a dedicated OAFU lead / admin support in place. As OAFU is a national directive the group felt that Cancer Alliance support was crucial in supporting Breast teams make the business case to their Trust. **Action – Juanita agreed to share her OAFU CNS role business case proposal and job description.** **Action – Meeting to be set up with Ritchie Chalmers, Lead Surgeons and COO's from MFT, DVH and EKHUFT in order to set up an equitable OAFU service for K&M patients.** • The group agreed the data which has been produced by the Alliance team is fantastic and very compelling. • The trusts eligibility criteria for OAFU was discussed in more detail and agreed to exclude: i) Patients aged < 40 – as deemed as high risk ii) Patients on a research trial requiring clinical examination iii) Patients unable to consent due to mental, physical or psychological issues iv) Known metastatic / recurrent disease v) High risk family history vi) Gene carrier vii) Clinical concern viii) Patient choice ix) Patient choice is a critical part of OAFU as part of the NHSE model. Patients should have the opportunity to make an informed choice to opt in/off the pathway. • There needs to be a definition of high-risk patients – to include metastatic patients, those on clinical trials and gene carriers.		**JC** **CM**

		Action – SG to finalise eligibility criteria with Trusts. • Many Trusts are coming up to the five-year discharge point and were keen to have a standardized approach where possible. The discussion to identify three good practice activities/actions at discharge was not concluded. It was noted however that there needs to be an end of treatment appointment in place so they can discuss ongoing hormone treatment (whether hormone treatment should cease, swap or continue) as well as highlight any potential red flags for patients. Consultants could also adopt a summary letter standardised and agreed across all of the trusts (based on an example by EKHUFT) • MTW categorise any high-risk patients and follow up on a yearly basis. **Action – SG to work with CNS teams to develop a good practice discharge process.** **Action – All Trusts to share OAFU patient leaflet with Tracey Ryan to comparison and develop agreed content across KMCA.** • Exercise and lifestyle are very important for the health and wellbeing of their breast cancer patients and the prevention of a cancer reoccurrence. Health and Wellbeing events are held at DVH and MFT these are well attended by their patients. • The Moving Forward Breast Cancer Now Programme is an excellent service which has won national awards. EKHUFT, MTW and MFT refer patients to the Moving Forwards Programme. DVH do not routinely refer patients. Patients can also self -refer online. • The K&M Moving Forward Courses run in: i) Canterbury – 4 times per year ii) Medway – 3 times per year iii) Tunbridge Wells – twice per year iv) Maidstone – twice per year • The Moving Forward Course – patients are booked in via the Breast team. The course is optional to attend and not all patients will take up the offer due to preference or limited		**SG/DA** **SG/Trusts** **SG/TR**

		time too if they are returning to work. Subsequent discussions suggested that more flexibility to the course around length/weekend / evening options may encourage others to attend. • The oncologists strongly advocated the importance of lifestyle to support recovery. They stated evidence that physical activity and weight management could reduce the impact of cancer treatment and increase survivorship. They proposed that health and wellbeing and lifestyle support appointments should be seen as part of the clinical pathway with patients opting out of attending. **Action – Tracey Ryan agreed to meet with the breast cancer partners for this meeting to understand what information is important to them and what courses they would be happy to attend.** **Action – Claire Mallett mentioned the End of Treatment letters for Oncology / Surgery are complete on InfoFlex but need a trust to pilot them. This includes CNS review, end of active treatment for each treatment modality and end of 5-years – patient discharged back to the GP. MFT and MTW CNS were keen to progress and pilot EOTS.** • DA thanked Helen and Gabrielle from Breast Cancer Now who kindly attended today's meeting to raise awareness of this charity and encourage donations.		**TR** **SG /CM/ Trusts**
5.	**Breakout groups**	**Regional oncoplastic MDM – update provided by Deepika Akolekar** • No notes were required for this agenda item. **Patient information and IT development in Oncology – update provided by Russell Burcombe** • No notes were required for this agenda item.		
6.	**AOB**	• There were no further comments raised under AOB.		

7.	**Next Meeting Date**	• **TBC – no agreement was made at the meeting.**		**KG to circulate the meeting invite details when confirmed**