Kent and Medway Cancer Collaborative

Breast Tumour Site Specific Group meeting
Tuesday 7th May 2024
Mercure Hotel, Ashford Road, Maidstone, ME17 1RE
09:00-12:30
Final Meeting Minutes

Present	Initials	Title	Organisation
Deepika Akolekar **(Chair)**	**DA**	Breast and Oncoplastic surgery (Breast TSSG Chair)	MTW
Pawel Trapszo	**PT**	Consultant Oncoplastic & Reconstructive Breast Surgeon	DVH
David Westbroek	**DW**	Breast Surgeon	DVH
Michelle McCann	**MMC**	Interim General Manager for Cancer	DVH
Charmain Walker	**CW**	Cancer Performance Manager	DVH
Adeyinka Pratt	**AP**	MDM Streamlining Project Manager	DVH
Ceepa Vijayamohan	**CV**	Macmillan Breast CNS	DVH
Sylvia Hurley	**SH**	Breast CNS	DVH
Chinedu Chianakwalam	**CChi**	Consultant Breast and General Surgeon	EKHUFT
Nicholas Williams	**NW**	Consultant General Surgery	EKHUFT
Mehvish Nazeer	**MN**	Specialty Doctor	EKHUFT
Vicky Stevenson	**VS**	Breast Support Worker	EKHUFT
Claire Bingham	**CB**	Macmillan Personalised Care Facilitator	EKHUFT
Vanessa Potter	**VP**	Lead Breast Care CNS	EKHUFT
Rebecca Greene	**RG**	Metastatic Breast CNS	EKHUFT
Krishnamurthy Murthy	**KM**	Consultant Breast Surgeon	EKHUFT
Serena Gilbert	**SGi**	Cancer Performance Lead	KMCA
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
Karen Glass **(Minutes)**	**KG**	PA / Business Support Manager	KMCA & KMCC
Annette Wiltshire	**AW**	Service Improvement Lead	KMCC
Colin Chamberlain	**CCha**	Administration & Support Officer	KMCC
Sam Williams	**SW**	Administration & Support Officer	KMCC
Ennio Agabiti	**EA**	Breast Surgeon	MFT

Uzma Andaleeb	**UA**	Specialty Doctor Breast Surgery	MFT
Suzanne Bodkin	**SB**	Cancer Service Manager	MFT
Emma Bourke	**EB**	Macmillan Personalised Care & Support Facilitator	MFT
Vasileios Karydakis	**VK**	Consultant Oncoplastic Breast Surgeon	MFT
Louise Black	**LB**	Macmillan Deputy Lead Cancer Nurse	MFT
Louise Farrow	**LF**	Head of Nursing Cancer Services	MFT
Danielle Freeman	**DF**	Breast CNS	MFT
Samantha Tomlin	**ST**	Breast CNS	MFT
Helen Coote	**HC**	Macmillan Metastatic Breast CNS	MFT
Adeniyi Oluwafunmilayo	**AO**	Breast CNS	MFT
Delilah Hassanally	**DH**	Consultant Oncoplastic Breast Surgeon	MFT
Ibrahim Ahmed	**IA**	Consultant Surgeon	MFT
Tracy Pound	**TP**	Breast Screening Nurse	MFT
Deepa Bhana-Nathoo	**DBN**	Consultant Radiologist	MFT
Naomi Butcher	**NB**	General Manager Surgical Specialities	MTW
Victoria Stringer	**VS**	Service Manager	MTW
Amanda Rabene	**AR**	Consultant Radiologist	MTW
Fiona Andersen	**FA**	Breast CNS	MTW
Jan Hackney	**JH**	Breast CNS	MTW
Dhalvir Midda	**DM**	Head of Pharmacy – Cancer	MTW
Juanita Caseley	**JC**	Breast ANP	MTW
Rudo Chaza	**RChaz**	Breast CNS	MTW
Charlotte Moss	**CM**	Consultant Medical Oncologist	MTW
Jennifer Glendenning	**JG**	Consultant Clinical Oncologist	MTW
Russell Burcombe	**RB**	Consultant Clinical Oncologist	MTW
Gemma McCormick	**GM**	Consultant Clinical Oncologist	MTW
Elizabeth Whitehouse	**EW**	Breast CNS	MTW
Gemma Hegarty	**GH**	Consultant Clinical Oncologist	MTW
Layloma Hamidi Latifi	**LHL**	Consultant Oncoplastic Breast Surgeon	MTW
Savita Honakeri	**SH**	Consultant Histopathologist	MTW
Michal Uhercik	**MU**	Consultant Breast Surgeon	MTW
Karina Cox	**KC**	Consultant Breast and Oncoplastic Surgeon	MTW
Nicki Perry	**NP**	**Guest Speaker** – Clinical Lead GP – West Kent	NHS Kent & Medway ICB

Liz Simmons	**LS**	Patient Partner	
Christine Howarth	**CH**	Patient Partner	
Apologies			
Marie Payne	**MP**	Macmillan Lead Cancer Nurse	DVH
Seema Seetharam	**SS**	Consultant Breast & Oncoplastic Surgeon & Clinical Lead for Breast Cancer Services	DVH
Suzannah Fitzgerald	**SF**	Nurse Specialist Oncology - Family History / Genetics	EKHUFT
Ritchie Chalmers	**RC**	Medical Director	KMCA
Jonathan Bryant	**JB**	Primary Care Clinical Lead	KMCA / NHS Kent & Medway ICB
Denise Thompson	**DT**	Assistant Project Manager	MFT
Olena Dotsenko	**OD**	Consultant Histopathologist	MTW
Rema Jyothirmayi	**RJ**	Consultant Clinical Oncologist	MTW
Catherine Harper-Wynne	**CHW**	Consultant Medical Oncologist	MTW
Nicky Dineen	**ND**	Radiology Consultant	MTW
Annabel Kennedy	**AK**	Breast Research Nurse	MTW
Claire Ryan	**CR**	Macmillan Consultant Nurse	MTW
Rebecca Phipps	**RP**	Breast Care Nurse	MTW
Julia Sunnucks	**JS**	Clinical Trials Coordinator for Gynaecology & Urology	MTW
Pam Golton	**PG**	Macmillan Breast Reconstruction CNS	QVH
Rebecca Spencer	**RS**	Macmillan Breast Reconstruction CNS	QVH
Alexandra Molina	**AM**	Consultant Plastic Surgeon	QVH
Lin Douglas	**LD**	Patient Partner	

Item		**Discussion**	**Agreed**	**Action**
1.	**TSSG Meeting**	**<u>Apologies</u>** • The formal apologies are listed above. **<u>Introduce new TSSG Chair</u>** • DA welcomed the members to the meeting and introduced herself as the new Chair of the Breast TSSG meeting. DA thanked the former Breast TSSG Chairs Seema (Seetharam) and		

		Catherine (Harper-Wynne) who were unfortunately unable to join today's meeting as they were on AL. **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** • JG highlighted a typo in the previous agenda minutes - item 14. ANC stands for Axillary Node Clearance and **NOT** Absolute Neutrophil Count. KG has corrected the previous minutes. • There were no further corrections to the previous meeting minutes and were signed off as a true and accurate record of the meeting.		
2.	**Review GIRFT data and set the scene**	**Update provided by Deepikar Akolekar** • DA presented an overview of the GIRFT Breast data taken from Model Hospital. The K&M data was compared with National Median figures during 2023/24 Q2. The following data was discussed: i) Percentage of patients with re-operation (re-excision or mastectomy) on same breast within one year following breast excision for cancer. ii) Percentage of first-time operations on patients with invasive cancer or DCIS that are breast conserving. iii) Percentage of all breast conserving operations for cancer that are oncoplastic.		**GIRFT data was circulated to the group on the 7th May 2024**

		iv) Emergency re-admission rate (within 30 days) following a breast excision. v) Emergency re-admission rate (within 30 days) following a mastectomy with no reconstruction. vi) Emergency re-admission rate (within 30 days) following a mastectomy with immediate implant only reconstruction. vii) Day case rate for breast excision for malignant disease. viii) Day case rate for mastectomy with no reconstruction. ix) Day case rate for mastectomies with implant only reconstruction. x) Percentage of patients with a complication during a mastectomy with no reconstruction or within 30 days of the procedure. xi) Percentage of patients with a complication during a mastectomy with immediate implant only reconstruction or within 30 days of the procedure. xii) Percentage of patients who have a delayed reconstruction within 5 years following a mastectomy for malignant disease with no immediate reconstruction for 2018/19 Q2. **Action – SGi asked the trusts to check the accuracy of the GIRFT data produced due to the variation across trusts.** • PRADA clinical trial – is a study which provides radiotherapy first and then surgery within 6-weeks. Capacity may be an issue for K&M. RB stated the importance of this trial and envisaged a small numbers of patients. DA agreed it would be beneficial for K&M to be part of this trial.		**Trusts**
3.	**New Surgical Guidelines**	**<u>Radial surgical margins after breast conserving surgery for invasive disease and DCIS – presentation provided by Karina Cox</u>** • KC outlined the definitions of invasive disease, DCIS, breast conserving surgery and radial margins. • There is extensive evidence dating back 50 years showing there is no difference in overall survival between Breast Conserving Surgery and whole breast radiotherapy (WBRT) and Mastectomy.		**Presentation circulated to the group on the 7th May 2024**

		• Recent data shows that BCS and WBRT local recurrence rates are decreasing and BCS and WBRT may be superior to mastectomy in terms of local control. • Factors influencing local recurrence include: i) Age – possibly more likely in younger patients ii) Tumour biology iii) BRCA gene carriers iv) Systemic / endocrine therapy – chemotherapy v) Radiotherapy • Published guidance on minimum threshold and 'No tumour on ink' was outlined. • ABS decided on 1mm margins – there was a comparison of studies and two different conclusions were reached: i) **Houssemi and colleagues (2014)** –demonstrated that both positive and close margins are associated with increased local recurrence. However, they concluded that increasing threshold distance was not significantly associated with reduced odds of local recurrence. ii) **Bundred and colleagues (2022)** – also demonstrated that close margins (as well as positive margins) are associated with increased local and distant recurrence. • DCIS is different, due to the different growth pattern and less likely to use systemic treatment. ABS / NICE Guidance to come in this year - 2mm is better for pure DCIS than 1mm. • Endocrine treatment for DCIS, reduces local recurrence but has no overall survival benefits. • NICE Guidance for DCIS (2024) / ABS position – follows NICE guidance and opt for 2mm margins surrounding DCIS. • As part of the decision-making process – to discuss the benefits / risks and what is in the		

		best interest of the patient.		
4.	**Stratified follow up pathways** • **DVH** • **MFT** • **MTW** • **EKHUFT**	**<u>Update provided by Claire Mallett</u>** • CM explained the Breast Personalised Stratified Follow-Up (PSFU) pathway has been embedded in InfoFlex since 2018. It is a programme for moving the follow-up care of appropriate patients from an outpatient clinic to remote monitoring. • Open Access Follow-Up (OAFU) is a system in place for breast cancer patients which allows them to continue to receive annual appointments for mammograms (if required) but not necessarily via an out-patient clinic. • CM explained the key principles of the OAFU pathway outlined in the National Cancer planning guidance. • Benefits of OAFU includes: i) **Patient benefits** – less travel / associated costs and direct access back to clinic if required. ii) **System benefits** – frees up valuable time within overstretched outpatient clinics. iii) **Post Covid** – part of the elective recovery programme iv) KMCA have funded the development of the Remote Monitoring Service (RMS) and recruitment of a Cancer Support Worker (CSW) for each team. • The majority of Breast HNA's are completed at the initial cancer diagnosis or 30% are completed at the end of treatment. • MTW uses KOMS to capture their data whilst the other K&M trusts use InfoFlex. • CM explained completion of Treatment Summaries for K&M is very low. There has been a lot of ongoing work to develop the content of Breast TS. KMCA are keen for the trusts to work with them to make them as user friendly as possible. Their aim is to set up a Task &		**All presentations were circulated to the group on the 7th May 2024**

Finish group to take this work forward.

- CM highlighted the aim of today's presentation:

  i) To review the pathway and share learning
  ii) Review clinical eligibility criteria
  iii) Review discharge process at 5 years
  iv) By introducing SSM what has this allowed your team to do (for example introduce new clinics / Service developments)

DVH – update provided by Sylvia Hurley

- Open Access has been offered to their patients since 2020 and have been suitably identified at the MDT. They experienced some challenges initially due to COVID.

- SH shared the OAFU pathway used and outlined the eligibility criteria.

- End of Treatment HNA's are confirmed at the MDT – approximately 4 months after the completion of Surgery / Radiotherapy or approximately 8 months after the completion of adjuvant Chemotherapy / Radiotherapy.

- Treatment summaries are not currently undertaken as part of the end of treatment HNA.

- SH outlined issues associated with OAFU including no dedicated OAFU at DVH.

MFT – update provided by Samantha Tomlin

- The OAFU pathway has been in place since September 2019 with 1100 active patients on the pathway all details are recorded on InfoFlex.

- ST highlighted the eligibility / ineligibility criteria for the OAFU pathway and the roles / responsibilities of the CNS, CSW and Clinician.

- HNA is offered to all patients at diagnosis, pre-op discussion and at the OAFU review with

		the CNS. • End of Treatment summaries are due to start in September 2024. • ST confirmed the successes of the OAFU pathway including: i) Pathway has been active for over 4 years ii) Large cohort of patients on the pathway – frees clinic availability iii) Consistent CSW cover iv) No issues with DEXA scans – organized by PCN. • Challenges include: i) Staffing gaps ii) OAFU review appointment – backlog due to resources iii) Endocrine Review delivery – confirmation needed on how this is undertaken iv) CNS ability to cover CSW. **MTW – update provided by Juanita Caseley & Elizabeth Whitehouse** • JC outlined the roles and responsibilities of the team. • MTW OAFU in numbers: i) Approximately 3,196 patients on active breast follow up at MTW. ii) 192 patients on non-malignant surveillance pathway. iii) 40+ symptomatic clinic reviews per month. iv) 30 – 40 discharge reviews per month. v) Average 250 – 300 mammogram result letters per month. • The follow up groups are classified into 3 categories: i) Red – all need clinical follow up ii) Amber – non-malignant pathway		

iii) Green – all other groups and tracked through OAFU

- Rapid Access Clinics are run 3 times per week with 5-6 patients seen per clinic.
- Future plans are to set up a dedicated menopause MDM for complex patients and CBT training for the CNS team.
- The Virtual Endocrine fortnightly MDM was set up in February 2021 to better facilitate endocrine reviews at end of treatment.
- Discharge pathway - a letter is sent to the patient and GP following the discharge review – to confirm the endocrine plan and review of EOT DEXA.
- There are currently 172 patients receiving primary endocrine treatment and under the care of 10 consultants based across two sites. There is no standardized pathway for this group of patients and no single agency having overall responsibility for managing care.
- Plans proposed for the new Primary Endocrine pathway is for OAFU to take over the management of these patients and ensure there is standardised care and safety netting in place.
- Benefits of having nurse-led follow-up includes saving 831 surgical clinical slots and 309 Oncology slots (2023.)
- In conclusion – nurse led follow-up resulted in:

  i) Significantly improved breast cancer-specific HRQoL, reduced fear of recurrence, anxiety and depression.
  ii) Less outpatient visits with physician and more telephone consultation with the nurse.
  iii) No increase in the number of diagnostic imaging examinations.

- Plan is to set up an End of Treatment support session in the future.

EKHUFT – update provided by Vanessa Potter & Vicky Stevenson

- VP and VS run the OAFU service together – total of 22 hours per week. VS spends approximately half of her 33 hours per week on OAFU.
- Patients are allocated OAFU at the MDM or post MDM by VS, using the strict inclusion and exclusion criteria put in place.
- The OAFU review is carried out by VP. HNA's are discussed detailing any concerns and side effects.
- HNA's and End of Treatment summaries are offered initially at diagnosis and once treatment is completed.
- Issues highlighted include:

  i) Need more staff as OAFU is offered at both WHH and QEQM – not all patients are captured.
  ii) Mammograms are being undertaken by an outside agency and they are not classifying both breasts – only the treated breast. This is hard to document on InfoFlex.
  iii) GP's have to be reminded to order repeat DEXA scans when required. Time consuming process for VS. The scans are not managed in a PC setting so is hard to track.

Extended Endocrine Service – Breast Patient Pathway Flowchart – update provided by Ceepa Vijayamohan

- CV confirmed this service started at DVH in 2023. The aim is to track patients from the InfoFlex database who have completed 5-years of endocrine treatment.
- CV outlined the exclusion criteria including:

  i) Triple negative breast cancer

		ii) DCIS iii) Metastatic cancer iv) Patients with poor tolerance. • Eligible patients will be discussed by the Oncologist and Endocrine CNS at the MDM. • Question of patients with varying comorbidities – to include patients who are unable to self-examine reliably – such as those with dementia / stroke. JG suggested the terminology 'comorbidities' should be changed to 'physical / cognitive conditions.' • JG emphasised the importance of equity across the patch, to work closely with the Cancer Alliance as this will be more cost effective once in place.		
5.	**EROS**	**<u>EROS referral system – presentation provided by Nicki Perry</u>** • NP explained the advantages of the new EROS system (Electronic Referral Optimisation System) including: i) Reduce referral rejections and optimize referrals into Secondary Care ii) Right place first time (better patient experience) iii) Reduce the myriad of referral forms iv) Up to date guidelines v) Easy access to patient information – relevant to the referral vi) Improve Primary / Secondary Care interface vii) Dashboard allows pinch points to be identified for funding viii) Fair distribution of 'load' waiting times ix) Fewer DNA's • Started with MSK and ENT who have the largest waiting lists - 900 referrals so far. They are now working with Gynae, Urology, General Surgery, Dermatology and Gastroenterology. • NP referred to some software glitches but staff within the digital group meet regularly to resolve these issues.		**Presentation circulated to the group on the 7th May 2024**

		• There is a helpline email - kmicb.eros@nhs.net which is manned 5 days a week. • The Breast pathway development work has not started yet. NP asked for the TSSG's support to develop this pathway across K&M in line with National Guidelines. If anyone is interested in being part of this work please could they email NP directly nperry@nhs.net or speak to Ritchie Chalmers. • There is no timeline in place to incorporate the 2ww referral forms, but they are working closely with Ritchie Chalmers and the Cancer Alliance.		
6.	**MDT Streamlining**	**Update by Serena Gilbert** • SGi explained the process of MDT Streamlining which is to stratify patients for discussion at the MDT. This is a valuable use of both diagnostic and clinician's time in order to focus the discussion on the more complex patients. • The aim is to develop a Standard of Care (SoC) to allow teams to triage patients more appropriately. • SGi highlighted the success of the Urology MDT Streamlining pilot at DVH. This has made a big difference to the length and quality of their MDT meetings. • SGi referred to the NHSE MDT Streamlining guidance document - Streamlining (england.nhs.uk) • KMCA are keen for MDT Streamlining to be implemented across as many Tumour pathways as possible this year. **Action – DA suggested setting up a Breast MDT Streamlining Working group. SGi agreed to send out an email to all Breast MDT leads across the 4 trusts.**		**DA / SGi**

7.	**Breast pain pathways**	**<u>Nurse led Breast Pain Clinic - update provided by Fiona Andersen</u>** • FA confirmed the nurse-led breast pain clinic at MTW has been established since 1999. FA outlined the process by which female 'only' patients come into her clinic via a 2ww referral. FA sees on average 8 patients per week / 32 slots per month which has saved clinic slots. The return rate has been very low since the breast pain clinic has been set up. There is a 0.4% chance of patients with breast pain having breast cancer. • Patients are offered a 20-minute comprehensive and holistic consultation. • FA will carry out a clinical examination and imaging is provided. • FA explained she will discuss with the patient the internal structure of the breast; mammograms, hormonal influences including HRT in order to stem any anxieties the patient may have about cancer. FA has also produced a breast pain leaflet which has been really beneficial. Patient satisfaction has been overwhelmingly positive. • FA has audited her practice to ensure she is doing the right thing for her patients and practice. • IA mentioned 90% of referrals come in via the NG12 referral – suspected risk of cancer which makes it very hard to triage within Secondary Care and the patient will be seen in the One Stop Clinic. There needs to be a discussion with Primary Care to set up a separate breast-pain pathway so these patients do not come in via a 2ww referral. • Primary Care currently only have 1 proforma for referring in and there needs to be a separate proforma for breast pain. • IA mentioned it is extremely difficult to triage at MFT and they are not able to set up a Breast Pain Clinic in Secondary care. • DA suggested setting up a pilot breast pain pathway for K&M patients. This could be ANP led to provide advice over the telephone. FA added that listening to the patient and the quality of the call would be extremely important.		**Presentation circulated to the group on the 7th May 2024**

		Action – DA asked for volunteers so that she can feedback to NHS England as the service is currently a One Stop service and they are struggling to triage the breast pain patients.		**Group**
8.	**Data performance**	• K&M is close to the England average for their FDS performance (89.4%) and above the England average for 62-day performance (75.1%). • Breaking down the performance data - EKHUFT (85.4%) and DGT (87.6%) are below the England average for FDS performance, with MTW (91.6%) and MFT (94.3%) above. In terms of 62-day performance DGT (61.3%) is below the England average with MFT (71.3%), EKHUFT (73.7%) and MTW (85.7%) above. **MTW - update by Naomi Butcher** • Over the last 12-month period MTW has not achieved the 62-day standard for 9-months, 2ww standard was not achieved for 3-months, but they have achieved the FDS performance target for 90% of that period. **MFT – update by Suzanne Bodkin** • MFT are struggling with OPA and will continue to insource until the end of June 2024. They are not meeting the FDS – 28-day performance target for Breast. **DVH – update by Michelle McCann** • DVH are meeting the 2ww and 28-day FDS performance targets. The 62-day standard is currently at 70%. **EKHUFT – no update provided at today's meeting**		**Performance data circulated to the group on the 7th May 2024**
9.	**AOB**	**Oncology update – provided by Jennifer Glendenning** 1. Need to develop breast radiotherapy planning to include VMAT technique in the NHS		

		setting and reduce outsourcing to private sector where this is required. NHSE educational grant secured to fund joint physics and oncologist fellow supervised by JLG to address this need (commences October 2024). Pending procurement approval Breast Cancer Kent will fund purchase of radiotherapy auto-contouring software which will facilitate a more efficient radiotherapy planning pathway. 2. NICE approval of new agents for BRCA specific breast cancer in higher risk adjuvant setting and metastatic setting. This approval significantly broadens the cohort of women now eligible for germline BRCA testing. Oncology are working to identify the population in the metastatic setting to whom testing can now be offered. Recognising this may be several hundred women across the county we will be looking to offer some dedicated WLI clinics to address this need. • MFT - have no staff, but the plan is to move moving slowly forward and for MTW to assess the first 50-patients who have been on the waiting list the longest. • EKHUFT – plan is to also be offered mutual aid but this is yet to materialise. EKHUFT have 114 eligible metastatic patients and if they are target these over the next 3-4 months they will get back on track. • It was agreed to discuss further offline as there needs to be a county wide solution in place.		
10.	**Next Meeting Date**	• **November 2024 (date, time and venue to be confirmed)**		**KG to circulate meeting invite details**