Kent and Medway Cancer Collaborative

Gynaecology Tumour Site Specific Group meeting
Wednesday 13th November 2024
Ashford International Hotel, Simone Weil Ave, Ashford, TN24 8UX
13:30 – 16:30
Final Meeting Notes

Present	Initials	Title	Organisation
Hany Habeeb **(Chair)**	**HH**	Consultant Gynaecologist	MFT
Hasib Ahmed	**HA**	Consultant Obstetrician and Gynaecologist	MFT
Karen Flannery	**KF**	Macmillan Gynae Oncology CNS	MFT
Zoe Plumb	**ZP**	Cancer Support Worker	MFT
Sharon Griffin	**SG**	Consultant Gynaecologist	MFT
Jeyanithy Nicholas	**JN**	General Manager	DVH
Charmaine Walker	**CW**	Performance Manager	DVH
Sam Daniels	**SD**	Gynae Oncology Lead CNS	DVH
Emma Martin	**EM**	Clinical Governance Sister Gynaecology	EKHUFT
Rhiannon Frame	**RF**	Research Nurse Gynae Oncology	EKHUFT
Rema Iyer	**RI**	Consultant Gynaecological Oncologist	EKHUFT
Danko Perovic	**DP**	Gynae Specialist	EKHUFT
Justine Elliot	**JE**	Gynae Oncology Nurse	EKHUFT
Vicky Morgan	**VM**	Gynae Oncology Clinical Lead	EKHUFT
Nicky Chalmers	**NC**	Gynae-Oncology Family History Associate Practitioner	EKHUFT
Mohamed Ismail	**MI**	Gynae Consultant	EKHUFT
Gemma Connaughton	**GC**	Gynae Oncology Support Worker	EKHUFT
Laura Lawrence	**LL**	Gynae Oncology Support Nurse	EKHUFT
Claire Mallett	**CM**	Programme Lead – Personalised Care & Support	KMCA
Ann Courtness	**AC**	Macmillan Primary Care Nurse Facilitator	KMCA
Sharon Middleton	**SM**	Workforce Programme Lead	KMCA
Jo Bailey	**JB**	Programme Manager – Early Diagnosis	KMCA
Jo Jackson	**JJ**	Project Manager – Early Diagnosis	KMCA
Karen Glass **(Minutes)**	**KG**	PA / Business Support Manager	KMCA & KMCC
Annette Wiltshire	**AWi**	Service Improvement Lead	KMCC

Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Sam Williams	**SW**	Administration & Support Officer	KMCC
Justin Waters	**JW**	Consultant Medical Oncologist	MTW / EKHUFT
Gaynor Reeve	**GR**	Macmillan Gynae Oncology Support Nurse	MTW
Karolina Salamaga	**KS**	Gynae Oncology CNS	MTW
Charlotte Wyeth	**CW**	ST7	MTW
Lorna Kviat	**LK**	Consultant Oncologist	MTW
Ravneet Oberai	**RO**	Programme Manager	NHS Kent & Medway ICB
Aparna Belapurkar	**AB**	Senior Delivery and Improvement Manager	NHS Kent & Medway ICB
Dawn Langdon	**DL**	Advanced Nurse Practitioner	Thanet Health CIC
Apologies			
Jody-Ann Taylor	**JAT**	Consultant Obstetrician & Gynaecologist	DVH
Andy Nordin	**AN**	Consultant Gynaecological Oncologist	EKHUFT
Carly Price	**CP**	Gynae Oncology / Family History & Genetics CNS	EKHUFT
Ritchie Chalmers	**RC**	Medical Director	KMCA
Bana Haddad	**BH**	Clinical Lead – Personalised Care & Support	KMCA
Robin Edwards	**RE**	Consultant Obstetrician and Gynaecologist	MFT
Alecia Bell	**AB**	Clinical Trial Coordinator for Urology & Gynaecology	MTW
Alison Richards	**AR**	Lead Uro-Oncology Research Nurse	MTW
Rema Jyothirmayi	**RJ**	Consultant Clinical Oncologist	MTW
Vickie Gadd	**VG**	CNS Lead – Gynae Oncology Genetics & Family History Macmillan Clinical Nurse Specialist, Trust Lynch Champion - Endometrial	MTW
Stephen Attard-Montalto	**SAM**	Consultant Gynaecologist and Gynae-oncology Surgeon	MTW
Andreas Papadopoulos	**AP**	Consultant Gynaecologist & Gynae-oncology Surgeon	MTW
Michelle Godfrey	**MG**	Consultant Gynae Oncologist	MTW
Ying Yiing Lou	**YYL**	Consultant Obstetrician & Gynaecologist	MTW
Omer Devaja	**OD**	Consultant Gynaecologist & Consultant Gynae-oncology Surgeon	MTW
Dawn Willis	**DW**	Patient Partner	

Item		Discussion	Agreed	Action
1.	TSSG Meeting	**Apologies** • The formal apologies are listed above. **Introductions** • HH welcomed the members to today's face to face meeting and the group introduced themselves. • If you attended the meeting and have not been captured within the attendance log above please contact karen.glass3@nhs.net directly. **Action log Review** • The action log was reviewed, updated and 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 16th May 2024 were agreed and signed off as a true and accurate record.		
2.	CRG update	• HH explained the CRG is the Clinical Reference Group and will be the interface between the Cancer Alliance and the Gynae TSSG with the aim to move actions forward. • There will be a monthly meeting for 60 – 90 minutes and will include representatives from Nursing, Radiology, Pathology, Oncology and Primary Care. The set up of this group will be reviewed on an annual basis and each role will attract 0.5PA. • HH confirmed they have had expressions of interest from Surgery, Radiology, Oncology and		

		Primary Care but are yet to fill the roles of Nursing and Pathology.		
3.	**Dashboard**	**<u>Update provided by Hany Habeeb</u>** • HH explained K&M FDS performance has improved from 65.8% to 69.2% over the last six months and K&M is the highest performing Alliance for 62-day performance. • FDS performance has improved over the last six months at MFT from 67.4% to 73.4%, and at EKHUFT from 51.3% to 60.8%. However, performance has fallen at DGT from 82.6% to 73.4%. It was noted that most of these patients will not have a cancer. • In terms of 62-day performance – EKHUFT are seeing 90.6% of their patients within the agreed timeline compared to 67.3% at MFT. • RI highlighted Imaging / Histology reporting delays at EKHUFT which is having an impact on the MDT deadline and also the 28-day FDS target. Pathology results can take 3-weeks to come back. If hysteroscopy results are normal they should be able to take these patients off of the USC pathway as this is also having an impact on their 28-day FDS target. • JW noted that 71.4% of ovarian cancers at MFT are stage 1 or 2 compared to the other 3 trusts which was considerably less. He wondered whether these figures were accurate. • HH suggested if the group did not agree with the data presented they should talk to their BI teams or raise any concerns directly with David Osborne (KMCA data analyst) - david.osborne11@nhs.net • HH provided the group with an overview of the investigation & treatment indicators plus the waiting time from referral to specific milestones (in median days) for each of the Trusts. • DO asked which parts of the pathway the Trusts would want to target for improvement and what additional data they need.		**Presentation was circulated on the 19th November 2024**

		• The group agreed they could improve their 28-day performance if they had better quality referrals coming in from GP's and a better triage system in place. There are 30% locum GP's in the Medway and Swale area which results in more referrals into SC. It was noted that PC is broken due to the lack of GP's. • DVH did not feel the dashboard data reflected their referral numbers coming in accurately.		
4.	**NG12 – proforma discussions** **Proposed changes to proforma**	**<u>2ww proforma, current and future - update provided by Hany Habeeb</u>** • HH navigated through the Gynaecological Urgent Suspected Cancer e-Referral form which was agreed needed updating. **Action – Hany asked for an audit to be carried out by DGT for suspected Cervical Cancer screening tests as there is a high chance these patients will not have cancer.** • HH mentioned he had done a previous audit at MFT with 30 - 40 referrals and none of the women had cancer. • In terms of the current proforma: **i)** **No mention of referral criteria for women on HRT.** ii) **Concerned the patient has cancer but does not meet the NICE NG12 criteria –** this statement is too broad. iii) **Suspected ovarian cancer CA125 first or an ultrasound**. • Technically all 3 points above could denote a cancer. There are lots of women up to the age of 60 who are now on HRT. These patients would benefit from having an HRT review however the wait for an HRT clinic is 18-months at EKHUFT which is not feasible. • According to BMS Guidance patients showing an endometrial thickness of <7mm or >4mm should not be coming into a Rapid Access Clinic and there is clear guidance in place for Primary Care.		**Presentation was circulated on the 19th November 2024** **DVH**

		• HH suggested an ultrasound should be the first primary treatment for suspected ovarian cancer followed by the CA125 investigation. RI stated there needs to be a combination of both CA125 and ultrasound. AC mentioned that GP's tend to do both tests. • It was noted that 80% of their referrals are endometrial and if they are able to reduce the number of these referrals this would significantly improve their performance. **Action - In terms of unscheduled bleeding on HRT, HH is keen for this to be discussed further at the CRG meeting.** • RI recommended the examination box plus other mandatory fields should be completed on the NG12 Referral Form. If these mandatory fields are not fully completed the proforma should be declined.		**CRG**
5.	**PIFU**	**<u>Endometrial PIFU and PCSP Education Opportunities - update provided by Claire Mallett</u>** • CM apologised for not being able to attend the face to face meeting today but was keen to provide an update on the Endometrial PSFU pathway. This has been running across K&M for just over 2 years. • CM outlined the number of patients who are currently on the Endometrial PSFU pathway across the 4 trusts. The details are broken down further into the number of patients who are on a PSFU pathway as a % of their first treatments. • NHSE have an expected guideline for the number of patients expected to be on a self-management pathway for the following tumour groups: i) Breast – 75% ii) Prostate – 30% iii) Colorectal - 45% • Once all elements of the pathway are together these figures are likely to increase. There is		**Presentation was circulated on the 19th November 2024**

		currently no NHSE expectation for endometrial cancer patients, however, this group may have other ideas of what this should be. CM alluded to the exclusion criteria for patients not included which could highlight clinical variation. This could be due to the way the pathway works, clinical preference / choice or due to available resources. • EKHUFT were identified as putting patients on the PSFU pathway from 2019 compared to the other trusts being 2021 (MFT / DGT) and MTW from 2022. This data is provided by DO on a quarterly basis and details the number of active patients on the pathway from diagnosis. • CM referred to the new BGCS recommendations and guidance on PIFU. CM believes it would be helpful to review the eligibility criteria and the reasons why some patients have been excluded. Additionally, what else needs to happen around the five-year discharge process and if this process can be standardised. • JW asked if there was any data on the detection of recurrence in this group of patients. CM confirmed they do not have that data but she would be interested to know how they could feasibly capture it. RI confirmed the detail would be recorded on InfoFlex and the patient would then come off of PIFU. HH recommended doing an ongoing prospective audit to obtain this detail. • DVH highlighted that 4 patients have gone back to their GP and not via the PIFU route which has caused a new 2ww referral. • AW highlighted the outstanding action on the action plan – CM to set up a Task & Finish group to explore PIFU pathways for low risk ovarian cancer, including options for a patient portal with PROMS monitoring. • DVH stated it needs to be recognised as an Oncology PIFU as there has been confusion. There were discussions regarding patients being given a contact card. CM asked about patients receiving a treatment summary - which should include a SC management plan, GP actions, red flags for patients and how to contact the service if they have any concerns. This would be another way for patients to be aware of a route back in to SC rather than going back to their GP. This work is still ongoing.		

		• CM asked the group if there was a consensus to take forward another pathway as ovarian had been discussed previously. They could help set up the remote tracking system via InfoFlex utilising CA funding. This would require representatives from each trust to confirm the protocol and then work with the InfoFlex team to design the pathway. • The Gynae TSSG agreed no further pathway was required at this time. CM reiterated the offer is there if they change their mind. • CM mentioned NHSE have asked for a snap shot audit regarding the number of patients who were on various PSFU pathways around the 30th September and to be able to evaluate these pathways. The ask is to have this data back to DO by the end of this week. If there are any outstanding questions to direct them back to CM - claire.mallett3@nhs.net. • CM outlined some training opportunities which are currently on offer: i) **Menopause training** – 13th and 27th January 2025 – 2-day course – open to CNS's and CSW's funded by NHSE. ii) **KMCA Menopause and Cancer Workshop** – 14th November 2024 – open to CNS's at the Ashford International Hotel. iii) **Menopause and Cancer** – dates TBC – open to CSW. iv) **Physical Activity Workshop** – 28th November 2024 – open to CSW. Open to CNS's in 2025 – dates TBC. v) **Range of communication skills training on offer:** ○ Advanced communications skills training – mandatory for CNS's ○ Enhanced communication skills – 1-day course available for CSW's ○ Sage and Thyme ○ Motivational Interviewing – 1-day online course on the 20th November available to all healthcare professionals.		
6.	**Rocket Drain Pathway**	• There is a requirement as a system to discuss the Rocket Drain pathway in order to improve this pathway and avoid patients going to A&E.		

7.	**Women's Health Hub**	**<u>Update provided by Aparna Belapurkar</u>** • AB kindly agreed to provide an update on the Women's Health Hubs for today's TSSG meeting. AB is the SRO for this programme of work. • The Women's Health Strategy for England was published in 2022 and details the government's 10-year ambition and actions to improve the health and wellbeing of women and girls. • NHSE expect at least one hub to be established in every ICB by the end of July 2024. The hub should be operational and provide clinical support including consultations / triaging for at least 2 out of the 8 core services. 8 core services should be in place by December 2024. • The benefits of the WHH outweighs the cost and aims to improve women's experience, increased access to treatment / services and improve outcomes. • The WHH brings together healthcare professionals and existing services to provide integrated women's health services in the community, centered on meeting women's needs across the life course. Hub models aim to improve access to and experiences of care, improve health outcomes for women and reduce health inequalities. • £595K was awarded to each ICB in order to set up the WHH. There were 5 proposals from the PCN's in K&M from areas of deprivation. • The following 4 hubs have been set up in K&M: i) **Thanet Health CIC** – July 2024 ii) **DGS** – to go live in August iii) **Mid-Kent** – beginning of September iv) **MFT** – October • The 4 hubs have now gone live and the team are working closely with the ICB Communication & Engagement Team.		**Presentation was circulated on the 19th November 2024**

		• The Delivery Group meets on a monthly basis with PCN Leads and Public Health Leads. They are looking at a digital solutions pilot to find sustainable ways to reduce Secondary Care referrals and the funding required. • HH felt the funding for the WHH was minimal and recommended an audit detailing the reduction in referrals and a request for additional funding in the future.		
8.	**CNS updates**	**<u>DVH update</u>** • Jody-Ann Taylor has replaced Rob McDermott as the new Cancer Lead. However, she is due to go on maternity shortly so a replacement will be required. • SD is now doing STT and histology results. She has also completed a 2-day BMS menopause accredited course and is able to provide advice and guidance at referrals. **<u>EKHUFT update</u>** • The PIFU workstream continues to evolve well. • The team are doing well with HNA offers. • Trying to improve their 28-day compliance. • The Family History clinic is progressing well, although the nurse for this service is currently off sick. There is one clinic a month at WHH and one at QEQM. • Germline testing is being offered to all Ovarian cancer patients. • All endometrial MMR-deficient patients have Lynch Syndrome testing. **<u>MTW update</u>** • The Genetics Family History service continues. • Vickie Gadd is doing the Lynch Syndrome mainstreaming clinic for endometrial patients in West Kent. • Continue with PIFU / HNA's – face to face for their patients. • MTW are struggling with the lymphoedema service after surgery – there is no service in place in North Kent. Patients are being referred to Essex or London. **Action – to follow this up with Claire Mallett.** **<u>MFT update</u>**		

		• The team are looking at the volume of complex metastatic patients – presenting at a late stage. • The Paracentesis - Rocket Drain pathway is being reviewed. • MFT are utilising the HNA at Home functionality – using an email link. • PIFU continues to work well at MFT. • ZP is the new Gynae CSW band 4. • Olivia (Serwaa Baffoeis) – CNS is due to go on maternity leave in 2-3 weeks' time. • Leeja (John) is in post as the FD nurse and also triages the referrals coming in.		
9.	**Research update**	• There were no research updates provided by DVH, MFT or MTW. **<u>EKHUFT update</u>** • RF is the new research nurse and started in post in October (2024). • **PROTECTOR Study** – phase 1 not yet complete but due to start phase 2 imminently. This is a research study for women who are at an increased risk of developing ovarian cancer due to an altered gene or a strong family history of cancer. • **DETECT-2** study to start soon. • **Drug Therapy Trial** – to be led by the Community Pharmacy team.		
10.	**AOB**	• There were no further points raised under this agenda item. • HH thanked the members for their attendance at today's meeting.		
13.	**Next Meeting Date**	• **Wednesday 7th May 2025 – AM – Venue TBC in Maidstone.**		**KG to circulate the meeting date and**

				venue once agreed.