Kent & Medway Cancer Collaborative

Haematology Tumour Site Specific Group meeting
Monday 18th November 2024
Park View Meeting Room, Mercure Great Danes Hotel, Ashford Road, Maidstone. ME17 1RE
09:00-12:30
Final Meeting Minutes

Present	Initials	Title	Organisation
Lolly Banerjee (Chair)	**LB**	Consultant Haematologist	MTW
Deborah Willcox	**DW**	Senior Research Nurse	MTW
Michelle Janney	**MJ**	Research Nurse	MTW
Victoria Harris	**VH**	Clinical Trials Co-ordinator	MTW
Mirela Velicu	**MV**	Clinical Research Practitioner	MTW
Simeon Blackbourn	**SB**	MDT Co-ordinator	MTW
Miles Pope	**MP**	MDT Support Co-ordinator	MTW
Kanwal-Zia Robinson	**KZR**	Haematology CNS	MTW
Sarah Updyke	**SU**	Haematology CNS	MTW
Carolyn Gupwell	**CG**	Haematology CNS	MTW
Emma Richardson-Smith	**ERS**	Haematology CNS	MTW
Evangelia Dimitriadou	**ED**	Consultant Haematologist	MTW
Samantha Williams (Minutes)	**SW**	Administration & Support Officer	KMCC
Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Lead	KMCC
Hayley Paddock	**HP**	Chemotherapy Electronic Prescribing Pharmacist	KMCC
Michelle Archer	**MA**	Pharmacy Technician	KMCC
Karen Glass	**KG**	PA/Business Support Manager	KMCA/KMCC
Joanne Jackson	**JJ**	Early Diagnosis Project Manager	KMCA
Joanne Bailey	**JB**	Early Diagnosis Programme Manager	KMCA
Sharon Middleton	**SM**	Workforce Programme Lead	KMCA
Tracey Ryan	**TR**	Macmillan User Involvement Manager	KMCA
Thais Ferrari	**TF**	Clinical Scientist – HSST Trainee	DVH
Vijayvalli Dhanapal	**VD**	Consultant Haematologist	DVH
Natalie Heeney	**NH**	Consultant Haematologist	DVH
Charan Basra	**CB**	Haematology CNS	DVH

Joyce van den Camp	**JC**	Haematology CNS	DVH
Lemun Mutlu	**LM**	Consultant Immunologist & Allergist	EKHUFT
Jayne-Marie Osborne	**JO**	Consultant Haematologist	EKHUFT
Stefanie Goodchild	**SG**	Haematology CNS	EKHUFT
Colleen Jones	**CJ**	Haematology CNS	MFT
Kerry Michelsen	**KM**	Lead Haematology-Oncology CNS	MFT
Sudarshan Gurung	**SGu**	Consultant Haematologist	MFT
Joy Ezekwesili	**JE**	Advanced Specialist Pharmacist	MFT
Mehrukh Arshad	**MAr**	IMT1	MFT
Sarah Arnott	**SA**	Consultant Haematologist	MFT
Ashleigh Parvatan-Plunkett	**APP**	IMT3	MFT
Amanda Harris	**AH**	Patient Partner	
Apologies			
Pippa Enticknap	**PE**	Deputy General Manager	EKHUFT
Sreetharan Munisamy	**SMu**	Consultant Haematologist	EKHUFT
Melene Locke	**ML**	Senior Research Nurse	EKHUFT
Iresha Dharmasena	**ID**	Consultant Haematology	EKHUFT
Danielle MacKenzie	**DN**	Macmillan Nurse for Personalised Care	EKHUFT
Nipin Bagla	**NB**	Consultant Histopathologist	EKHUFT
Tracey Spencer-Brown	**TSB**	Head of Nursing for Oncology & Haematology	MTW
Clare Oni	**CO**	Haematology Registrar	MTW
Alexis Corrigan	**AC**	Consultant Radiologist	MTW
John Schofield	**JS**	Consultant Pathologist	MTW
Ola Okuwa	**OO**	Haematology Pharmacist	MTW
Dhalvir Midda	**DM**	Deputy Chief Pharmacist	MTW
Ritchie Chalmers	**RC**	Medical Director	KMCA
Ann Courtness	**AC**	Macmillan Primary Care Nurse Facilitator	KMCA
Chris Singleton	**CS**	Senior Programme Manager	KMCA
Laura Alton	**LA**	Senior Programme Manager	KMCA
Kirsty Hearn	**KH**	Service Manager	MFT

Item		Discussion	Action
1.	TSSG Meeting	**Apologies** • The apologies are listed above. **Introductions** • LB welcomed the members to today's face to face meeting and the group introduced themselves. • If you attended this meeting and are not captured on the attendance list above please contact Samantha.williams23@nhs.net directly and the distribution list will be amended accordingly. **Action Log Review** • The action log was reviewed, updated and will be circulated to the members along with the final minutes from today's meeting. **Review Previous Minutes** • The final minutes from the previous meeting which took place on the 15th April 2024 were reviewed and agreed as a true and accurate account of the meeting. • LB asked everyone to provide an update regarding the previous minutes. • A Spinal Service is needed for Kent & Medway, Managers at MTW to contact Stephen Lowe at EKHUFT, it is difficult to contact Stanmore directly, which is an ongoing issue. There is a need to have a cost-effective way to have a better service for their patients. The Kings Pathway seems to be a quicker service. **Action – AW to liaise/help set up a group to discuss a Spinal Service, but it requires a short-term solution in the meantime.**	**AW**

		• Backbone National Study - starting to recruit patients in 2027, an update will be provided at the next meeting. • National Lymphoma Audit is ongoing. • TR advised that a monthly engagement meeting (on Teams) has now been set up with patients. The Cancer Alliance film regarding 'Being in Limbo Land' is going through agreement and this film shows how it feels for patients going through different stages of their cancer journey. There are also top tips for chemo patients described by chemo patients eg association with clothing and perfume when having treatment. • **Action – TR to email the CNS's across the Trusts regarding the Patient Survey and how the trusts can be supported with the results.**	**TR**
2.	**EOI TSSG Chair** **CRG Roles & Update**	**<u>Update provided by Lolly Banerjee</u>** • LB advised that the Expression of Interest and Job Description for the TSSG Chair has been sent out twice to Haematology TSSG Members. **Action – AW to re-send out the TSSG Chair Job Description and EOI to all Trusts (with responses required by the end of this week).** **<u>Update provided by Lolly Banerjee</u>** • LB stated the CRG will be a sub-group from the TSSG and will consist of Haematology, Nursing, Radiology, Surgery, Oncology and Primary Care roles. The aim of the group is to be the interface between the TSSG and the Alliance. The CRG will meet once a month for 1hr and 30minutes and attracts 0.5PA. **Action – AW to re-send out the CRG Job Description and EOI to all Trusts.**	**AW** **AW**
3.	**HOG**	**<u>Update provided by Hayley Paddock & Michelle Archer</u>** No items received for discussion.	

		1. QUIZARTINIB: Protocol in progress. Still awaiting response from Kings, who are sharing their protocol. HP asked the group if they were happy for the protocol/regimen to be built similarly to the KMCC midostaurin protocol/regimen. Group confirmed they are happy for it to be built as a support regimen to be prescribed alongside the chemotherapy regimen. HP highlighted that the SPC recommendation for the DA component of the treatment is not in line with our standard DA regimen and asked the group how they wished to proceed. The group agreed to give as per standard KMCC DA protocol/regimen. ACTION: King's to be chased for a copy of their protocol. MA to finish draft protocol and circulate for approval. **2. TECLISTAMB/ ELRANATAMAB:** HP informed the group that the indication for both of these newly commissioned treatments is the same and enquired if there would be a preference of therapy within the KMCC. HP also raised concerns of the potential safety issue with teclistamab due to there being 2 vials of different strengths available, 10mg/ml and 90mg/ml. Following discussion, the following points were noted: • Administration of Elranatamab is easier and there is less waste. • Inpatient stay for Elranatamab is 6 days where as for Teclistamab it is 7 to 8 days. • Medway have treated some patients with elranatamab in the ambulatory setting with steroid cover and had no complications. • MTW have treated patients with Elranatamab with no complications, post treatment infection has been observed. • EKHUFT are currently running a clinical trial for teclistamab. Following the results of the trial they may lean towards using teclistamab over elranatamab. • DVH expressed a preference for elranatamab. ACTION: LB will contact King's myeloma to obtain further guidance and report back. MA / HP to continue progressing protocols and ARIA regimens.	

		3. Dexamethasone dose on DRD protocol: Discussion raised concerning the current dexamethasone dose on the DRD protocol. Myeloma patients are generally not fit for intensive treatment. It is of concern that this dose reduction may not be applied. Current dose is 40mg OM on days 1,8,15 and 22, with an advisory note in the monitoring parameters "*Dose reduction should be considered in patients who are >75 years, patients who have a BMI <18.5, patients with poorly controlled diabetes mellitus or who have had prior intolerance/adverse event (AE) to steroid therapy"* The group agreed that the dose should be amended to 20mg as standard of care on the KMCC protocol and on ARIA, with an option to reduce further and also the option to increase at clinician's discretion on ARIA. ACTION: MA to change dexamethasone dose: HAEM-MYEL-048 Daratumumab SC with lenalidomide an dexamethasone. ARIA to be updated to reflect protocol change. HP to ask HD if there is the facility on ARIA that if a dose change is made it can cascade to all cycles. **4. LEVOFLOXACIN:** SG raised the use of levofloxacin in the first 3 months of treatment for myeloma patients. HP expressed that this has been an ongoing discussion topic for many years and that the last consensus of opinion at the HOG and TSSG HOG were: "Levofloxacin to remain as a favourite and prescribed on a patient by patient basis." (TSSG HOG October 2023) *All regimens used for newly diagnosed myeloma treatment has a reminder for the first cycle, "consider prescribing 12 weeks of Levofloxacin from the favourites menu".* *HP asked the group of they wish for this to stay on as a reminder after the drug safety alert. The NOG agree for the reminder to stay on. HP reminded the group to make a conscious decision on whether or not to give levofloxacin and that if given the patient is aware of side effects.* (HOG March 2024) VJ commented that most protocols have co-trimoxazole as standard and that this adds adequate cover for most patients.	

		The HOG acknowledged that the data for the use of levofloxacin came from a single trial, this does not necessarily give clear data of its benefit for use. NH informed the HOG that levofloxacin has now been removed from the formulary at DVH and that if prescribed the patient has to be consented. The final decision made at the TSSG HOG is that levofloxacin to remain as favourite to be prescribed at clinicians' discretion on a patient by patient basis. Not to be added as standard prophylactic TTO. ACTION: For information only. MA/HP contact DVH to establish why levofloxacin has been removed. **5. ARIA / PROTOCOLS** HP expressed that there is a significant delay in the approval/validation of protocols/regimens and that it is appreciated that everyone is working to full capacity. However, if you are asked to review something that is not your speciality or you will not have capacity to review in the near future can individuals please respond to emails so work can be re allocated, we need to avoid treatment delays and the use of paper prescriptions. **6. CRS protocols and SOP** HP asked if everyone could forward their local policy for CRS. Previous request for these has not been actioned by all. It was previously discussed if the KMCC should have a collaborative document for CRS but a comparison of local trust policy will need to be performed to asses if this is an option. LB noted that the treatment for CRS will be similar across the KMCC however local administration and policy may differ. It may be that a CRS document could be written for guidance with signposting to individual trusts policies. ACTION: Trusts to send MA and HP a copy of their local CRS policy/SOP. MA to review and discuss with HP. Add to next HOG agenda.	
4.	**Dashboard**	**<u>Update provided by Lolly Banerjee</u>** • LB went through the Data Pack sent by David Osborne.	**Data Pack circulated to the group on Thursday 4th November.**

		• FDS has improved at Kent & Medway from 55.9% to 68.5% in the last 6 months. 62 day performance is at 82.0% compared with 83.5% six months ago. • FDS Performance at MFT is at 80.8%, MTW at 64.9%, DGT at 53.2% and EKHUFT at 48.4%. • 62 day Performance at DGT is at 93.7%, MTW at 89.0%, MFT at 75.9% and EKHUFT at 73.0%. • SGu stated that they require FDS nurse provision at MFT. LB believes it would be helpful if Pauline Wood could contact MFT and DVH colleagues to let them know more about the business case MTW used to recruit an FDS Nurse. **ACTION – LB will enquire with Management regarding a Business Case for an FDS Nurse. SU from MTW will share their Business Case as it improves patient experience.** **ACTION - LB to contact David Osborne regarding incorporating biopsy parameters in to the Dashboard – e.g. how long is it taking for a patient to have a biopsy, turnaround times and the quality of the biopsy.** • LB highlighted that there is often inadequate information on the referral forms and there needs to be a meeting with ICB/KMCA colleagues to discuss this further. It would also be helpful to know more about turnaround times for ultrasound scans. • MTW do not use Infoflex. • 2ww Referral Proforma needs to be improved as there is a lot of inappropriate referrals. DVH currently have 3 different proformas sent to them and the K&M proforma is the worst one. **ACTION – LB to discuss 2ww referral with David Osborne as more data is required. Further discussion is also required with Jonathan Bryant regarding the 2ww referral proforma and how to improve/update.** • LB asked everyone to send any questions to her that they would like to raise/discuss with Jonathan Bryant and David Osbourne.	**LB & SU** **LB** **LB**

5.	**MDT Streamlining – update**	**<u>Update provided by Sarah Arnott</u>** • SA has tried to initiate improvements in West Kent & Medway and engage all sites to move forwards to improve the Friday MDT. There is a high volume of patients to discuss and there is frustration with patients being deferred. There has been useful discussion lately but there are staff who are not able to attend every week with some staff only attending every other week. There needs to be a focus on Pre-MDM, have individual sites triage their patients and work with their MDT Co-Ordinator to ensure patients are ready for discussion at the full MDM. • SA would like all sites to be motivated and engaged to join on Friday afternoons. They are also struggling on all sites to have a Radiology meeting outside of the MDT. All members should be job planned. There is a need for someone on each of the sites to triage, look at the priority of the list being circulated and ensure the Consultant is not on annual leave. Standards of Care for patients should also be noted. • The burden is falling on one team for Chairmanship and SA suggested chairing of these meetings should be rotated fairly and appropriate patients put on the list for discussion. • SA stressed that the efficiency of their MDT meeting is not good enough.	
6.	**Myeloma Pathway Update**	**<u>Presentation provided by Leman Mutlu</u>** • The Myeloma Early Diagnosis Pathway Update Presentation (Role of the Lab) provided an overview of the following :- • Minutes from TSSG April 2024 and Summary • Proportion of People Presenting as an Emergency • Survival from Myeloma • Clinical Haematology Clinics	**Presentation circulated to the group on Tuesday 19th November.**

		• Early Diagnosis Flow Chart – Teamwork "Kent & Medway Myeloma Diagnostics Working Group" Recommendations • K&M Myeloma UK Lab Tool Compliance Audit • Introduction & Methodology • Pre-Analytical Phase • Analytical Phase • Post Analytical Phase • Results – Overall Compliance • Audit Recommendations – Requesting Guidance & Testing • Possible Actions – Paraprotein Management Algorithm – The MDWG Guidance • K&M Paraprotein Management Algorithm – Requesting & Testing • Laboratory Reporting of New Paraproteins • In terms of Bringing SFLC Testing into Kent & Medway :- i) A two-site solution for resilience is needed. ii) Optilite technology needs to align with the majority of users. iii) There needs to be a Kent & Medway-wide business case to support this piece of work and a decision made on when this should be instigated and what the interim solution will need to be. iv) Expertise in place to set up and maintain the SFLC service. v) Other immunological tests are possible on the SFLC testing platform and this needs to be discussed around how best to use it. vi) It would be helpful to have discussions around immunology staff rotations and SLAs between Trusts with Optilite. • LM highlighted that there had been a Kent & Medway Myeloma Diagnostics Working Group meeting in June 2024 and there was a discussion around integrative reporting for paraproteins. There are three laboratories in the region - Ashford, Dartford and Tunbridge Wells. • The aim for the Working Group in 2025 will be to harmonise laboratory practices. • A discussion needs to be held regarding whether oversight is needed from the Immunology Consultant at EKHUFT.	

		• K&M Myeloma Diagnostics Working Group Meeting is taking place next week (26th November 2024) to discuss the flowchart and agree the pathway.	
7.	**Clinical Audits**	**<u>Local Antifungal Practice Audit – Haematology Patients at risk of Invasive Fungal Disease - Presentation provided by Mehrukh Arshad</u>** • The presentation provided an overview of the following :- • Primary Antifungal Prophylaxis • Definitions • IFD Examples • Significance • Classification • Proven • Probable • Possible • Risk Factors • Prolonged Neutropenia • Graft-versus-host disease (GVHD) • Underlying Conditions • Immunosuppression • Patients at risk of IFD can be categorised as - High Risk, Intermediate Risk, Low Risk & Very Low Risk • Treatment of Early/Suspected Invasive Fungal Infections • Suspect IFD	**Presentations circulated to the group on Tuesday 19th November.**

		• Mycology Tests • The Aim was to find out if MFT's local antifungal practice for those at risk of invasive fungal disease is compliant with King's College Hospital NHS Foundation Trust (KCH) Adult Haemato-oncology Antifungal Guidelines. • Outcome of 1st Cycle of Audit which commenced in February 2024. • Audit Details – 2nd Cycle - 9 patients – 8 high risk and 1 low risk. • Age at Presentation & Gender • Compliance with Antifungal Prophylaxis Guidelines • Fungal Serology Testing - Seven out of nine patients with AML had their Fungal Serology carried out - one was tested positive for Aspergillus and six were negative. • Frequency of testing Fungal Markers • Turnaround Time of Test Result – This should be 48 hours. Samples go to Bristol and they take 9-17 days which is very poor. • Conclusion - MFT are 78% compliant with giving the right prophylaxis in the AML high-risk group with suspected IFD. Seven out of nine patients with AML had their fungal serology carried out in the two week period but MFT are not consistent with testing it twice weekly or even once weekly for every patient with suspected IFD. MFT's turnaround time of fungal serology is quite poor. • <u>Recommendations</u> • To print and display the King's College Hospital fungal serology testing guidelines poster in the Lawrence Ward. • At the time of clerking, to mention in notes if a patient has probable/possible IFD. • For doctors to mention fungal serology in every Monday and Thursday Management Plan for suspected IFD patients. • To consider changing the testing centre to where turnaround time is quick. • For awareness/teaching to be given quarterly to new sets of doctors in Lawrence Ward.	

- To re-audit in three months' time.

Re-Audit - Does Medway NHS Foundation Trust follow NICE Guidelines for Investigating Occult Malignancy in Unprovoked Pulmonary Embolism? – Presentation provided by Ashleigh Parvatan-Plunkett

- The presentation provided an overview of the following :-

- Venous Thromboembolism (VTE), VTE is a blood clot that forms in a vein that partially or completely occludes blood flow.
- Venous Thromboembolism – Risk Factors
- Provoked or Unprovoked VTE. VTE risk is increased in people with cancer. Unprovoked VTE may be the first sign of an occult malignancy.

- NICE Guidelines: Changed in 2020.

- Why NICE Committee changed Recommendations? Evidence showed no benefit from further investigations for cancer in people without relevant signs or symptoms.

- The aim was to determine if MFT follow NICE guidelines for investigating occult malignancy in unprovoked pulmonary embolism.

- Method of the Audit
- Results of the Audit
- Limitations of the Audit

- Discussions - History documentation has started to improve (not statistically significantly and not extensive). Documentation of relevant clinical examination remains sparce (negative findings).
  A similar number of inappropriate CTAPs are being done. 10 mSv of radiation per CTAP is equivalent to a 4.5 year period of natural background radiation (there is a lifetime additional risk of fatal cancer per examination of 1 in 2000). There is a slight improvement in clinical practice following NICE guidelines (not statistically significant).

- Conclusion - MMH are not in line with NICE guidelines for investigating occult cancer. They are over investigating and this increases pressure on radiological resources and unnecessary financial expenditure. It is also time-consuming, provokes anxiety for patient and causes avoidable radiation exposure. There is a need to improve documentation of history and examination – positive and negative findings. It is important to review previous imaging. The results of the re-audit will be presented at the MFT Grand Round.

- Acknowledgements
- References

Every Consultant should be responsible for examining the patient and finding out the red flag symptoms.

NH stated that at DVH they have a VTE Nurse and VTE Proforma's are in their Emergency Department.

Retrospective, Real-Life Data of Venetoclax plus Azacitidine in patients with AML ineligible for Intensive Chemotherapy at a DGH and Impact on Transfusion Requirements – Presentation provided by Thais Ferrari & Vijayvalli Dhanapal

- The purpose was to look into the impact that Ven/Aza have in the requirement of RBC and PLT transfusion on patients with AML. The overall outcome of AML patients treated with Ven/Aza.

- Introduction - Intensive chemotherapy remains standard-of-care for induction–eligible patients with newly diagnosed AML. Options for older, less fit AML patients remains challenging due to toxicities and limited efficacy. Ven/Aza is NICE-approved in newly diagnosed AML patients ≥ 75 years and younger – they are ineligible for intensive chemotherapy.

- Methods - There was a review of retrospective data. Eligible patients were those with AML that were ineligible for intensive chemotherapy (on Ven+Aza between June 2020 to January 2024). The primary endpoint was to look at transfusion requirements. The secondary endpoint was OS.
- The presentation provided an overview of the following :-

- Patient Characteristics
- Results – RBC Requirements

		• Results – PLT Requirements • Kaplan-Meier Survival Curve • Conclusion i) There are fewer transfusions with a trend towards achieving transfusion independence more frequently. ii) It was also noticed a mild increase in PLT requirement could be related to cytopenias associated with Venetoclax. iii) The combination of chemotherapy (Ven+Aza) showed OS of 10.3 months. iv) Limitations include the date being retrospective (patient selected bias) and there being a small number of patients. v) A follow-up audit could be done for Kent and it would be advisable to collect data on toxicity. • References **Action - MTW and EKHUFT to provide an audit at the next TSSG meeting.**	**MTW & EKHUFT**
8.	**Validation of Digital Pathology across KMPN**	• Presentation to be circulated as Dominic Chambers was unable to attend today's meeting.	**Presentation circulated to the group on Tuesday 19th November**
9.	**CNS Updates**	**DVH** • The DVH team have 3 CNS's and a Cancer Support Worker. HNA's are carried out for Watch and Wait patients. A Sickle Nurse has been appointed and will commence in January 2025. A Business Case for a Band 7 Nurse has been completed. The Sickle Support Group is held monthly. An Oral Chemotherapy Clinic is held	

		weekly every Wednesday and Thursday and is full to capacity. There is an Outreach Service and they are taking Oncology Patients to Queen Mary's Hospital. The team are waiting for an SLA for King's College patients that come through. **EKHUFT** • The EKHUFT team have appointed a full-time CNS to work mainly with myeloma patients. Their model is slightly different to other Trusts with patients calling a Cancer Care Line who are triaged before being routed to Haematology. Work is currently taking place auditing MPM patients. Nurse Led Clinics are currently in place for CLL/LPD, SFU and MGUS. EKHUFT are carrying out Stratified Pathways and carry out a Nurse Led Service for those that need support. CML is for patients who are stable on KPI's. They are carrying out End of Treatment Summaries for patients but there are challenges with space, there is nowhere to see patients and CNS's are begging for Clinic Rooms. **MFT** • MFT have 1 Band 8a CNS which is Alliance funded, however there now needs to be discussion around how to make this post substantive with Trust funding. There are four Band 7's and 2 Support Workers. 4 CNS's run a Post Bone Marrow Transplant Clinic twice a week. There is an MPN Clinic which is 2 Nurse Led. Office Space is a challenge and there has been an increase in workload and getting posts made substantive. **MTW** • MTW have 5 Part-Time CNS's and 1 Fast Track Diagnosis Nurse. Myeloma Service is up and running one day a week. There is a Band 4 CSW and Band 4 Administrator. Lead Haematology CNS post is now out to advert and MTW are developing a SOP for a Nurse Led Myeloma Clinic. There is a requirement for another CNS.	
10.	**Research Update**	• Presentation to be circulated as Melene Locke was unable to attend today's meeting.	**Presentation circulated to the group on Tuesday 19th November**

11.	**AOB**	• No issues raised.	
	Next Meeting	• TBC - Mid May 2025. **Action - SW to circulate the meeting invite to the group once the date/venue has been confirmed.**	**SW**