Kent and Medway Cancer Collaborative

Gynaecology Tumour Site Specific Group meeting
Thursday 16th May 2024
Bridgewood Manor Hotel, Chatham, ME5 9AX
09:00 – 12:30
Final Meeting Notes

Present	Initials	Title	Organisation
Hany Habeeb **(Chair)**	**HH**	Consultant Gynaecologist	MFT
Hasib Ahmed	**HA**	Consultant Obstetrician and Gynaecologist	MFT
Louise Black	**LB**	Macmillan Deputy Lead Cancer Nurse	MFT
Karen Flannery	**KF**	Macmillan Gynae Oncology CNS	MFT
Sharon Griffin	**SG**	Consultant Gynaecologist	MFT
Chloe Welfare	**CW**	MDT Coordinator	MFT
Denise Thompson	**DT**	Cancer Team Lead	MFT
Leeja John	**LJ**	Gynae FDS CNS	MFT
Annaselvi Nadar	**AN**	Matron FDS	MFT
Olivia Baffoe	**OB**	Gynae Oncology CNS	MFT
Michelle McCann	**MMC**	Interim General Manager for Cancer	DVH
Charmaine Walker	**CW**	Performance Manager	DVH
Ana Zakaryan	**AZ**	Consultant Gynaecologist	DVH
Emily Farrell	**EF**	Gynae MDT Co-ordinator	DVH
Leanne Warren	**LW**	Gynae Oncology CNS	DVH
Jody Taylor	**JT**	Consultant Gynaecologist	DVH
Sam Daniels	**SD**	Gynae Oncology CNS	DVH
Andy Nordin	**AN**	Consultant Gynaecological Oncologist	EKHUFT
Rema Iyer	**RI**	Consultant Gynaecological Oncologist	EKHUFT
Fani Kokka	**FK**	Consultant Gynaecologist/Subspecialist in Gynaecological Oncology	EKHUFT
Eliza Davies	**ED**	Gynae Oncology Nurse	EKHUFT
Justine Elliot	**JE**	Gynae Oncology Nurse	EKHUFT
Vicki Hatcher	**VH**	FDS Clinical Lead	EKHUFT
Charlotte Wyeth	**CW**	ST6	EKHUFT
Vicky Morgan	**VM**	Gynae Oncology Clinical Lead	EKHUFT

Edmund Inetianbor	**EI**	Consultant Gynae Oncologist	EKHUFT
Mohamed Ismail	**MI**	Gynae Consultant	EKHUFT
Gemma Connaughton	**GC**	Gynae Oncology Support Worker	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
Ann Courtness	**AC**	Macmillan Primary Care Nurse Facilitator	KMCA
Karen Glass **(Minutes)**	**KG**	PA / Business Support Manager	KMCA & KMCC
Jonathan Bryant	**JB**	PC Clinical Lead	KMCA & NHS Kent & Medway ICB
Annette Wiltshire	**AWi**	Service Improvement Lead	KMCC
Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Sam Williams	**SW**	Administration & Support Officer	KMCC
Roxani Dampali	**RD**	Gynae-oncology – Senior Clinical Fellow	MTW
Vickie Gadd	**VG**	Macmillan Gynae-oncology CNS / Genetics / Family History	MTW
Michelle Godfrey	**MG**	Consultant Gynae Oncologist	MTW
Deborah Smith	**DS**	Macmillan Gynae-oncology CNS	MTW
Ying Yiing Lou	**YYL**	Consultant Obstetrician & Gynaecologist	MTW
Kelly Bonner	**KB**	FDS Team Lead	MTW
Lorna Kviat	**LK**	Consultant Oncologist	MTW
Gemma Hegarty	**GH**	Clinical Oncology SpR	MTW
Izabela Boniecki	**IB**	MDT Coordinator	MTW
Maxine Ogunrombi	**MO**	MDT Navigator	MTW
Susan Tanton	**ST**	Gynae MDT Coordinator	MTW
Linda Cain	**LC**	Associate Director	NHS Kent & Medway ICB
Nicola Perry	**NP**	Clinical Lead / GP – West Kent	NHS Kent & Medway ICB
Sandra Houghton	**SH**	Director of Primary Care	Thanet Health CIC
Dawn Langdon	**DL**	Advanced Nurse Practitioner	Thanet Health CIC
Ged Timson	**GT**	Quality and Governance Officer	Thanet Health CIC
Dawn Willis	**DW**	Patient Partner	
Apologies			
Robert MacDermott	**RMD**	Consultant Obstetrician, Gynaecologist and Uro-gynaecologist	DVH
Marie Payne	**MP**	Macmillan Lead Cancer Nurse/ Clinical Services Manager	DVH
Nicola Chalmers	**NC**	Gynae CNS Support Worker	EKHUFT

Suzanne Bodkin	**SB**	Cancer Service Manager	MFT
Kannon Nathan	**KN**	Consultant Clinical Oncologist	MTW
Rema Jyothirmayi	**RJ**	Consultant Clinical Oncologist	MTW
Stephen Attard-Montalto	**SAM**	Consultant Gynaecologist and Gynae-oncology Surgeon	MTW
Andreas Papadopoulos	**AP**	Consultant Gynaecologist & Gynae-oncological Surgeon	MTW
Alison Watkins	**AWa**	FDS Team Lead	MTW
Omer Devaja	**OD**	Consultant Gynaecologist & Consultant Gynae-oncology Surgeon	MTW
Linda Turner	**LT**	Consultant Radiologist	MTW

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 introduced himself as the new Chair of the Gynae TSSG meeting. • 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 1st November 2023 were agreed and signed off as a true and accurate record.		
2.	**Ovarian audit** **Endometrial audit pilot**	**<u>Ovarian Cancer Audit – update provided by Andy Nordin</u>** • National Cancer Audit Programme – there have been a number of different audits running including Breast, Lung and Prostate – trusts submit their data for these audits. • In 2011 – 31% of ovarian cancer patients would die within a year of diagnosis. Thanks to diagnosing ovarian cancer earlier these statistics are now improving. • The Ovarian Cancer Audit Feasibility Pilot (OCAFP) is a jointly funded partnership project with the British Gynaecological Cancer Society, Ovarian Cancer Action and Target Ovarian Cancer. • AN alluded to variation in treatment across the country in terms of debulking surgery. Patients referred to a Specialist Gynae Centre – at EKHUFT and MTW tend to receive better treatment. • The Ovarian Audit is a 3-year nationally funded project and is now part of the National Ovarian Cancer Audit. They hope to see outputs from this audit soon with the first profile report to be published in August / September. • AN is unable to present any new data at today's meeting. AN highlighted the importance of performance status data. Pathology data automatically feeds into NCRAS. **<u>Endometrial Cancer Audit Pilot (ECAP) – update provided by Andy Nordin</u>** • The Endometrial Cancer Audit pilot is a duplicate of the Ovarian Cancer Audit. • The work programme started in April 2024 and there have been 2 meetings to date. Funding the 2-year pilot has been provided by BGCS, charities and Pharmaceutical Companies at a cost of £160K.		**No slides were circulated.**

		• There is potential analysis of treatment modalities for advanced stage disease presentation (chemo, interval debulking surgery, radiotherapy, immunotherapy, hormone therapy if captured by COSD). • Access to Immunotherapy and Pathology data will be available in due course. • The first project as part of this audit will be to develop a profile report on regional variation in practice. Access to local data can be located on CancerStats2. Draft data should be available from the Autumn (2024). • Only primary treatment data is captured and therefore does not currently capture recurrence of cancer.		
3.	**HRT bleeding**	**<u>Update provided by Hany Habeeb</u>** • HH highlighted the huge increase in NG12 referrals due to women bleeding on HRT. HH mentioned out of 16 patients in his clinic at least 7/8 of these were on HRT. HA added the diagnosis of cancer for these patients is very rare. • HH mentioned the NG12 referral form was last updated in 2023. There is still no consideration given to whether women are on HRT. HH stated the importance of GP's taking the history of the patient and conducting an abdominal examination before referring in on an urgent suspected cancer pathway. • HH outlined the major and minor risk factors for endometrial cancer. • Implications include: i) Continue to support GP colleagues ii) Ensure patients are triaged adequately iii) Take patients off of the cancer pathway if they do not have cancer iv) Update the current proforma to reflect bleeding on HRT v) Is regional guidance required for HRT bleeding		**Presentation circulated to the group on the 16th May 2024**

		• AN highlighted that referrals have increased three-fold at EKHUFT from 1818 in 2013/14 to 4973 in 2023/24. Most of these referrals are due to bleeding on HRT and as a consequence they are not meeting the 28-day FDS. GP's are not referring to the guidance and continue to refer into Secondary Care. • Propose – how to deal with patients bleeding on HRT so they do not clog up the diagnostic pathways. Very small numbers - 1-2% of patients will be diagnosed with cancer. AN suggested HRT is stopped for 6-8 weeks, ultrasound scan after 6-weeks with a follow up telephone call by the Consultant / CNS. • Radiology capacity is a struggle due to the increased number of hysteroscopies and MRI scans. • MMC mentioned DGT now use alternative pathways, they have weekly PTL's so no patient is missed. If the patient is diagnosed with cancer they will go back onto the cancer pathway. • LC referred to some ongoing funding allocated to set up Women's Health Hubs for Gynae patients. • BH mentioned EROS will take some time to embed and alluded to other health professionals within PC who refer into SC. BH and LC agreed GP education is vital. DL explained she has set up education sessions for GP's and Nurses in the Thanet area where she is based. DL added the importance of breaking down the barriers which are still in place between Primary and Secondary Care. • AC confirmed the wording on the NG12 referral forms are being reviewed for all tumour sites – in order to rule out cancer and not that you may have cancer. • HH stated the importance of also considering their patients anxiety that they may have cancer.		
4.	**NG12**	**<u>Update provided by Jonathan Bryant</u>**		

		• JB confirmed the name of 2ww referral form has been changed to Urgent Suspected Cancer (USC) referral form – which will make it clearer and more transparent for the patient. Cancer pick up rates have not changed even though there has been an increase in patient numbers in clinics. • RMD looks at all the 2ww referrals and if not appropriate will downgrade and direct the patient to a more appropriate pathway (via the general Gynae Clinic). RMD also provides advice and guidance. This means their STT clinics are not clogged up with inappropriate referrals. • The group agreed the NG12 Gynae referral form needed updating. **Action – DGT agreed to provide an audit of their USC data at the next TSSG meeting.**		**DGT**
5.	**Performance data**	**<u>Update provided by Hany Habeeb</u>** • HH explained the performance data has been provided by David Osborne (KMCA data analyst) and will be presented in a different way for today's meeting. • K&M 62-day performance target is the best in England at 85.4%. However, their FDS performance is close to the England average at 65.8%. This target informs patients if they have a cancer diagnosis or not. The group wondered what the Northern CA is doing differently as their FDS performance is 77.4%. • In terms of FDS performance MTW (82.7%) and DGT (82.6%) are performing well with MFT close to the England average at 67.4%. However, EKHUFT are struggling to reach this target at 51.3% but are however achieving the 62-day target at 87.8%. • AN mentioned they have 250 new cancer cases at EKHUFT per year. Rapid Access referrals have gone up in the past decade from 1800 to 5000. Most cancers are diagnosed through the emergency department and not through rapid access. • There are differences in waiting times for patients with a cancer diagnosis and those with		**Performance data circulated to the group on the 16th May 2024.**

		cancer ruled out. The median number of days for patients to be told they have not got cancer is quicker compared to the diagnostic tests required to confirm cancer. • AN mentioned they cannot compare trusts with Gynae Centres due to the difference in performance carried out within each area. AN added there are 5 different types of Gynae Cancer – Endometrial, Ovarian, Cervical, Vulval and Vaginal so is harder to collate the data effectively. • The group discussed and disputed some of the hysterectomy data produced by David Osborne. There appeared to be an issue with the internal data which is being pulled into Model Hospital. **Action – Hany agreed to contact David (Osborne) directly to ask for an explanation regarding the data produced. Hany asked that every trust contacted David directly - david.osborne11@nhs.net so they are able to understand the data for their individual trusts.**		**Hany Habeeb / Trusts**
6.	**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 • They started with MSK and ENT who have the largest waiting lists – with 6000 referrals so far. They are now working with Gynae, Urology, General Surgery, Dermatology and		**Presentation circulate to the group on the 16th May 2024**

		Gastroenterology. Gynae is due to come out in the next 2-3 weeks. NP referred to a menopause bible which GP's have access to – there are simple pathways in place for GP's which link back to the comprehensive bible. • NP referred to some software glitches but staff within the digital group meet regularly to resolve these issues. • There is a helpline email - kmicb.eros@nhs.net which is manned 5 days a week. • There is no timeline in place to incorporate the 2ww referral forms, but they are working closely with RC and the Cancer Alliance.		
7.	**CNS update**	**DVH update** • Leanne (Warren) is now in post. • 1.5 FTE CNS in post. **EKHUFT update** • Family History / Genetics clinics are now set up. • 4 CNS in post. **MTW update** • HNA's are being carried out by 2 members of the team. • Family History / Genetics clinics are now set up. • More CNS's are required to support the team. **MFT update** • The patient satisfaction audit came back with mixed results – due to Covid. • The team are looking at the volume of complex metastatic patients – presenting at a late stage.		

		• The Paracentesis - Rocket Drain pathway is being reviewed. • The Band 4 CSW has now left but the service is hoping to recruit to the post in June or July. • There are some concerns regarding imaging reporting – which has been reported. • RC suggested the Rocket Drain pathway needed to be discussed as a system in order to improve this pathway so patients avoid going to A&E. **Action – Ritchie, Dave (Merrett), CNS's and Interventional Radiologists from all 4 trusts to discuss the improvement of the Rocket Drain pathway for K&M patients.**		**RC, DM, CNS and IR**
8.	**MDT Streamlining**	**<u>Update provided by Hany Habeeb</u>** • HH explained the benefits and importance of MDT Streamlining including: i) Significant pressure on MDT time ii) Limited time to review imaging iii) More focus is required to discuss complex patient cases iv) Delay in local reporting v) Job plans not including enough time for MDT preparation vi) Adequate admin support is required • AN mentioned they regularly had 60 patients to discuss at their weekly MDM. However, in order to reduce these numbers, they took out the benign surgery cases. Every referral for the MDM is triaged before the meeting by the consultant. The MDM Coordinator will email all of the referrals to the consultants, who will then reply to all which has saved a lot of time and made a huge difference. This has halved the numbers of patients discussed and overall length of time for the MDM. • HH mentioned he has written a document detailing the roles and responsibilities of the Cancer Lead for MFT which has been sent to their Clinical Director.		**Presentation circulated to the group on the 16th May 2024**

9.	**Oral thromboprophylaxis following gynae oncology surgery**	**<u>Presentation provided by Charlotte Wyeth</u>** • CW explained Venous thromboembolism (VTE) is a major cause of morbidity and mortality in patients post-operatively. The risk of developing VTE is 4 times higher in gynae-oncology patients compared to those having surgery for benign disease. • Rates of post-operative VTE in gynae-oncology patients without prophylaxis range from 15-40%. Despite prophylaxis, VTE still occurs in approximately 6-7% of gynae-oncology patients. • The incidence of VTE varies depending on the type of cancer, type of surgery and patient-specific risk factors such as obesity and age. • Minimally invasive surgery reduces the risk of VTE by approximately one-third compared with laparotomy. • VTE is the second leading cause of death in cancer patients, after disease progression, and post-operatively it is the most common cause of death in the first 30 days after surgery. • CW highlighted the pros and cons of the use of DOAC's (Direct Oral Anticoagulants) compared to LMWH (Low Molecular Weight Heparins). Fondaparinux and Warfarin tend to be used less now. There is poor evidence for the use of DOAC for gynae patients. • The plan moving forwards is to create a SoP comparing DOAC's to LMWH with the support of the Cancer Alliance. • Patient compliance was better with oral medication compared to injections.		**Presentation circulated to the group on the 16th May 2024**
10.	**Research update**	• There was no update on research at today's meeting.		

11.	**Same day discharge hysterectomy in gynaecology / gynaecological oncology**	**<u>Update provided by Fani Kokka</u>** • FK highlighted the advantages of same day discharge for hysterectomies. These include: i) Reduced hospital infections and VTE ii) Improved patient recovery / patient experience iii) Surgery is minimally invasive – avoids spinal anaesthesia – catheter can be removed in theatre iv) Release of inpatient bed and theatre capacity for more complex cases v) Increased capacity to treat patients quicker who are on the waiting list (23,000 bed days) vi) Annual financial benefits - £5,000,000 • FK presented some preliminary results based on 12 cases from November 2023 to date. The age range of these women were 35-64 with the highest BMI being 47. There was a high patient satisfaction rate, with no readmissions. • Patients are discharged 4-6 hours after surgery with a Gynae Assessment Unit contact number for further advice as required. • In conclusion, FK planned to continue with day-case hysterectomies at EKHUFT for eligible patients.		**Presentation circulated to the group on the 16th May 2024**
12.	**AOB** **CA 125 in non-ovarian cancers**	• CA-125 is the test that measures the amount of protein in blood. This test can be used to monitor certain cancers during and after treatment. In some situations, the test may be used to look for early signs of ovarian cancer in people with a very high risk of the disease. A high CA-125 level does not always mean cancer is present. For this reason, this test is not an effective screening for ovarian cancer and could indicate another cancer such as pancreatic. • There were no further discussions under AOB. • HH thanked the group for their attendance and contribution at today's meeting.		

13.	**Next Meeting Date**	• **Wednesday 13th November 2024 – PM – Venue TBC in Ashford.**		**KG to circulate the meeting date and venue once agreed.**