

**Breast Tumour Site Specific Group meeting**  
**Thursday 7<sup>th</sup> May 2026**  
**Lecture Theatre, Postgraduate Centre, WHH**  
**09:00-12:30**

**Final Meeting Minutes**

| <b>Present</b>                  | <b>Initials</b> | <b>Title</b>                                                  | <b>Organisation</b>             |
|---------------------------------|-----------------|---------------------------------------------------------------|---------------------------------|
| Deepika Akolekar <b>(Chair)</b> | <b>DA</b>       | Consultant Oncoplastic Breast Surgeon                         | MTW                             |
| Nirupa Murugasesu               | <b>NM</b>       | <b>Guest speaker – Consultant in Medical Oncology</b>         | GSTT - via Teams                |
| Nicky Scott                     | <b>NS</b>       | <b>Guest speaker – Communications and Involvement Manager</b> | South East Genomics - via Teams |
| Ceepea Vijayamohan              | <b>CV</b>       | Endocrine Lead Breast CNS                                     | DVH                             |
| Claudiu Simonca                 | <b>CS</b>       | Consultant Surgeon                                            | DVH                             |
| Marie Payne                     | <b>MP</b>       | Macmillan Lead Cancer Nurse                                   | DVH                             |
| Sylvia Hurley                   | <b>SH</b>       | Macmillan Lead Breast CNS                                     | DVH                             |
| Nicholas Williams               | <b>NW</b>       | Consultant General Surgeon                                    | EKHUFT                          |
| Vicky Stevenson                 | <b>VS</b>       | Breast Cancer Support Worker                                  | EKHUFT                          |
| Abigail Watson                  | <b>AW</b>       | Breast CNS                                                    | EKHUFT                          |
| Catherine Gawler                | <b>CG</b>       | Operations Manager - Breast Surgery                           | EKHUFT                          |
| Krishnamurthy Murthy            | <b>KM</b>       | Consultant Surgeon                                            | EKHUFT                          |
| Jane Shephard                   | <b>JS</b>       | Breast CNS                                                    | EKHUFT                          |
| Michalis Charalambous           | <b>MCh</b>      | Consultant Breast Surgeon                                     | EKHUFT                          |
| Pamela Machidza                 | <b>PM</b>       | Breast Nurse Consultant                                       | EKHUFT                          |
| Veronika Pronisceva             | <b>VP</b>       | Locum Consultant Breast/Skin cancer surgeon                   | EKHUFT                          |
| Vanessa Potter                  | <b>VP</b>       | Lead Breast Care CNS                                          | EKHUFT                          |
| Mehvish Nazeer                  | <b>MN</b>       | Specialty Doctor                                              | EKHUFT                          |
| Wendy Cunningham                | <b>WC</b>       | Breast CNS                                                    | EKHUFT                          |
| Fiona Mahon                     | <b>FM</b>       | Breast CNS                                                    | EKHUFT                          |
| Kirstie Wiltshire               | <b>KW</b>       | Consultant Radiographer                                       | EKHUFT                          |
| Anil Poddar                     | <b>AP</b>       | Consultant General Surgeon                                    | EKHUFT                          |
| Lois Aikins                     | <b>LA</b>       | Radiology Registrar                                           | EKHUFT                          |
| Louise De Pledge                | <b>LDP</b>      | Metastatic Breast Clinical Nurse Specialist                   | EKHUFT                          |

## Kent and Medway Cancer Collaborative

|                                |             |                                                              |             |
|--------------------------------|-------------|--------------------------------------------------------------|-------------|
| Bana Haddad                    | <b>BH</b>   | Clinical Lead / GP                                           | KMCA        |
| Claire Mallett                 | <b>CM</b>   | Programme Lead – Personalised Care and Support               | KMCA        |
| Karen Glass ( <b>Minutes</b> ) | <b>KG</b>   | PA / Business Support Manager                                | KMCA & KMCC |
| Conchi Blanco                  | <b>CB</b>   | Cancer Alliance Pharmacist and SACT Senior Clinical Advisor- | KMCA / MTW  |
| Anthea Randell                 | <b>AR</b>   | SACT Clinical Improvement Manager                            | KMCA / MTW  |
| Colin Chamberlain              | <b>CCha</b> | Administration & Support Officer                             | KMCC        |
| Sam Williams                   | <b>SW</b>   | Administration & Support Officer                             | KMCC        |
| Melissa Williams               | <b>MW</b>   | Faster Diagnosis Breast Service CNS                          | MFT         |
| Samantha Tomlin                | <b>ST</b>   | Breast CNS                                                   | MFT         |
| Delilah Hassanally             | <b>DH</b>   | Consultant Oncoplastic Breast Surgeon                        | MFT         |
| Nuriyat Abdulrasheed           | <b>NA</b>   | Clinical Nurse Specialist (Breast OAFU)                      | MFT         |
| Elizabeth Whitehouse           | <b>EW</b>   | Breast CNS                                                   | MTW         |
| Carys Thomas                   | <b>CT</b>   | Consultant Oncologist                                        | MTW         |
| Justina Hissett                | <b>JH</b>   | Breast CNS                                                   | MTW         |
| Justine Milton                 | <b>JM</b>   | Breast CNS                                                   | MTW         |
| Juanita Caseley                | <b>JC</b>   | Breast ANP                                                   | MTW         |
| Noor Obeid                     | <b>NO</b>   | Consultant Oncoplastic Breast Surgeon                        | MTW         |
| Jennifer Glendenning           | <b>JG</b>   | Consultant Clinical Oncologist                               | MTW         |
| Catherine Harper-Wynne         | <b>CHW</b>  | Consultant Medical Oncologist                                | MTW         |
| Savita Honakeri                | <b>SH</b>   | Consultant Histopathologist                                  | MTW         |
| Sarah Qureshi                  | <b>SQ</b>   | Consultant Medical Oncologist                                | MTW         |
| Kimberley Wynter-Davies        | <b>KWD</b>  | Radiology Registrar                                          | MTW         |
| Lesley Boast                   | <b>LB</b>   | Breast CNS                                                   | MTW         |
| Nicky Dineen                   | <b>ND</b>   | Consultant Radiologist                                       | MTW         |
| <b>Apologies</b>               |             |                                                              |             |
| Doraline Phillips              | <b>DP</b>   | Consultant Cellular Pathologist                              | EKHUFT      |
| Louise Barker                  | <b>LB</b>   | Breast Cancer Clinical Nurse Specialist                      | EKHUFT      |
| Jonathan Bryant                | <b>JBry</b> | Clinical Lead / GP                                           | KMCA        |
| Russell Burcombe               | <b>RB</b>   | Consultant Clinical Oncologist                               | MTW         |
| Gemma McCormick                | <b>GMC</b>  | Consultant Clinical Oncologist                               | MTW         |
| Shona Sinha                    | <b>SS</b>   | Consultant Histopathologist                                  | MTW         |
| Olena Dotsenko                 | <b>OD</b>   | Consultant Histopathologist                                  | MTW         |
| Dhalvir Midda                  | <b>DM</b>   | Deputy Chief Pharmacist                                      | MTW         |

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| Liz Simmons       | LS | Patient Partner |  |
| Christine Howarth | CH | Patient Partner |  |
| Christine Lee     | CL | Patient Partner |  |
| Janice Strevens   | JS | Patient Partner |  |

| Item |              | Discussion                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Agreed | Action |
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| 1.   | TSSG Meeting | <p><b><u>Apologies</u></b></p> <ul style="list-style-type: none"> <li>The formal apologies are listed above including the Patient Reps. They sent their apologies explaining this will be the first time in a number of years that there has been no patient representation at this meeting.</li> </ul> <p><b><u>Introductions</u></b></p> <ul style="list-style-type: none"> <li>If anyone attended the meeting and has not been captured within the attendee list above please email <a href="mailto:karen.glass3@nhs.net">karen.glass3@nhs.net</a> directly. There were no formal introductions other than CB and AR who introduced themselves as new to this meeting.</li> </ul> <p><b><u>Action log Review</u></b></p> <ul style="list-style-type: none"> <li>The action log was reviewed and the updated version will be circulated together with the final minutes from today's meeting.</li> </ul> <p><b><u>Review previous minutes</u></b></p> <ul style="list-style-type: none"> <li>There were no objections to the accuracy of the previous meeting minutes which took place on the 11<sup>th</sup> November 2025 and were signed off as a true and accurate account of the meeting.</li> </ul> |        |        |

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| 2. | ctDNA & Breast cancer | <p><b><u>Update provided by Nirupa Murugasesu</u></b></p> <ul style="list-style-type: none"> <li>• NM provided the following link related to her presentation - <a href="#">Circulating tumour DNA testing - South East Genomics : South East Genomics</a></li> <li>• Circulating tumour DNA (ctDNA) is a promising biomarker for detecting minimal residual disease, monitoring treatment response and predicting recurrence in breast cancer, though its routine clinical use is still under investigation.</li> <li>• The South East Genomic Medicine Service is one of three Centre's providing ctDNA testing for the NHS and is currently available for non-small cell lung cancer and breast cancer.</li> </ul> <p><b>Role in Early-Stage Breast Cancer</b></p> <ul style="list-style-type: none"> <li>• ctDNA can detect <b>molecular residual disease (MRD)</b> before macroscopic recurrence is visible on imaging, offering a potential tool for <b>personalized therapy</b> and risk stratification. Next-generation ctDNA assays are more sensitive than traditional blood-based biomarkers like CA 27-29 or circulating tumor cells.</li> <li>• NM referred to the Genomic Tumour Advisory Board (GTAB) – see further details - <a href="#">GTAB_Infographic_final_10_04_26.pdf</a></li> <li>• NM encouraged the group to refer patients to GTAB. NM added there are ongoing national discussions to have a more consistent and standardised approach.</li> <li>• CHW mentioned the Hub's carry out tissue testing for mutations.</li> <li>• JG referenced an issue with storing the results which the CA are aware of. Further reference of ctDNA governance and the detail being stored accurately on KOMS. Further discussion is needed between Pathology and the CA.</li> </ul> |  | <p><b>Presentation link was circulated to the group on the 14<sup>th</sup> May 2026.</b></p> |
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| 3. | Metastatic Recurrence | <p><b><u>Update provided by Catherine Harper-Wynne</u></b></p> <ul style="list-style-type: none"> <li>CHW highlighted the issue of metastatic breast cancer data not being captured accurately and therefore not being correctly funded for K&amp;M. There is also no way of collating previous K&amp;M metastatic breast cancer data.</li> </ul> <p><b>Action – CHW, JG, DA to pick this up separately with Ritchie and Ian outside of this meeting.</b></p> <ul style="list-style-type: none"> <li>According to NHSE Hospital Episode Statistics (HES) data metastatic breast cancer prevalence has seen a 90% increase in England since 2016. There has been a 76% increase for patients living with metastatic breast cancer at MTW from 2019 – 2026 including their follow up which accounts for 50% of Oncologists workload.</li> <li>In 2015, there were 4 NICE approved SACT regimens for Advanced Breast Cancer increasing to 14 by 2026.</li> <li>Treatments are centrally funded but there is no funding for the increase in resource and capacity to utilise the new regimens.</li> <li>Treatment selection often requires repeat biopsies and testing for specific molecular targets.</li> <li>Most patients have at least 3 lines of treatment (successive SACT treatments) which require treatment reviews for increasing complex toxicities and radiological response.</li> <li>Improved survival means many patients live &gt;3 years with metastatic disease and as such requires long-term active management.</li> <li>The current NHS reimbursement models do not adequately fund complex metastatic follow-up activity and there is an imbalance in new patient / follow up activity. This activity is inappropriate for the modern oncology care of patients.</li> <li>National groups have been set up including:</li> </ul> |  | <p><b>Presentation slides were circulated to the group on the 14<sup>th</sup> May 2026.</b></p> <p><b>KG - actioned</b></p> |
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|    |                     | <ul style="list-style-type: none"> <li>○ <b>Breast Pan-Alliance – to address increasing capacity and resource issues related to:</b> <ul style="list-style-type: none"> <li>i) Rising prevalence of metastatic disease and demand on oncologists for treatment – unseen, not counted and not reimbursed.</li> <li>ii) Large increase in early breast cancer treatments from CDK 4/6</li> </ul> </li> <li>○ <b>National Audit of Metastatic Breast Cancer (NAoMe):</b> <ul style="list-style-type: none"> <li>i) Collect prescription at MDM, CNS contact</li> <li>ii) De-Novo and other</li> <li>iii) Death rates</li> <li>iv) CDK 4/6 use</li> <li>v) Other qualitative data</li> </ul> </li> <li>• NAoME highlighted that newly relapsed data being collected by HES was inaccurate. There has been some improvement in 2025 but data showed that specific patients were not being discussed in the MDT when they relapsed /or were metastatic. They were encouraged to use the new guidance to collect COSD data for breast cancer recurrence within the MDT. All new metastatic / relapsed cases should be put onto the MDM.</li> <li>• CHW highlighted the results of the MTW audit carried out from July – September 2025 – for 30 patients with relapsed / metastatic disease. In summary the main issue was delay and catching up due to previous incorrect forms being used. CHW encouraged the other trusts to carry out the same audit.</li> <li>• In conclusion: <ul style="list-style-type: none"> <li>i) The Data lead is now in place at MTW.</li> <li>ii) Early and advanced breast cancer clinics are in place.</li> </ul> </li> </ul> |  |                     |
| 4. | Pan-Alliance Breast | <ul style="list-style-type: none"> <li>• CHW provided an update on the recent Pan-Alliance Meeting which focussed on:</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | Presentation slides |

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|    | Meeting feedback – 17 <sup>th</sup> April event | <ul style="list-style-type: none"> <li>○ <b>Cancer Plan</b> <ul style="list-style-type: none"> <li>i) Sickness to prevention</li> <li>ii) Analogue to digital</li> <li>iii) Hospital to Community – this can work in some areas. However, complex SACT treatment can not be delivered in the Community. Dedicated Chemo Centres are the best place but has to be done within budget as there is no extra finance.</li> </ul> </li> <li>○ <b>TDXD- lung toxicity</b> <ul style="list-style-type: none"> <li>i) National Guidelines</li> <li>ii) 1 min sit to stand test and oximetry – good baseline test – 95% &lt; sat TDXD</li> </ul> </li> <li>○ <b>NDRS /SACT Data set analysis</b> <ul style="list-style-type: none"> <li>i) Time post first definitive treatment to next treatment</li> <li>ii) Analysed 42000 patients</li> <li>iii) NACT to surgery – delays due to histopathology TAT in K&amp;M</li> <li>iv) Surgery to SACT or RT – do well in K&amp;M</li> </ul> </li> </ul> |  | were circulated to the group on the 14 <sup>th</sup> May 2026. |
| 5. | Research / AUDIT                                | <p><u>Update provided by Catherine Harper-Wynne</u></p> <ul style="list-style-type: none"> <li>• CHW explained the delivery of research across K&amp;M has gone down due to number of reasons including workforce shortages.</li> <li>• The HER2-RADiCAL trial is a clinical study aimed at recruiting around 720 patients with HER2-positive breast cancer. The study focuses on personalised treatment plans for individuals with early HER2-positive breast cancer. EKHUFT has been a good recruiter for this trial and also OPTIMA. The OPTIMA trial is a significant initiative aimed at improving the treatment of HER2-positive breast cancer in premenopausal women.</li> </ul>                                                                                                                                                                                                                                                                                                  |  |                                                                |

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|    |                       | <ul style="list-style-type: none"> <li>CHW stated they are keen to start Commercial Trials at MTW as it provides good income but this has not been successful to date. They are encouraging surgical staff to also run clinical trials.</li> <li>They have temporary cover at MTW to set up a metastatic advanced breast cancer clinic – Pan Kent – whereby Clinicians will still have ownership of their patients.</li> <li>JG explained the radiotherapy trial they are keen to open for patients across Kent requiring boost is Fast Forward Boost.</li> <li>JG referred to Tadpole a surgical trial. Capacity within the significantly reduced radiotherapy research team cannot support this at present (not a RT research trial but requires input from RT research team and a breast RT trial to be open). We would like to support the Kent surgical teams opening this once radiotherapy research is on a more secure footing.</li> </ul> |  |                                                                                    |
| 6. | Data Dashboard update | <p><u>Update provided by Deepika Akolekar</u></p> <ul style="list-style-type: none"> <li>DA provided an update on the data dashboard, even though this was not a set item on today's agenda.</li> <li>The Breast FDS – 28-day performance target has improved (87%) however, the 62-day performance target has deteriorated in the last 6-months to 59.5%.</li> <li>Diagnosing patients with or without a cancer within 28-days K&amp;M are above the national target – MFT are performing at 91.8%, DGT – 89.6%, MTW – 86.3% and EKHUFT – 83.1%. DA added the proportion of patients diagnosed with cancer within 28-days has been low at MFT for the last two years.</li> <li>The percentage of first treatments started within 62-days of referral – MFT – 75%,</li> </ul>                                                                                                                                                                      |  | Presentation slides were circulated to the group on the 14 <sup>th</sup> May 2026. |

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|  |  | <p>MTW – 71.7%, EKHUFT – 51.4% and DGT – 38.6%.</p> <ul style="list-style-type: none"> <li>The recording of stage on InfoFlex has been low for the breast pathway at DGT and MFT in recent months.</li> <li>The Cancer Alliance planning guidance recommends that 25% of primary breast cancer patients receive immediate reconstruction following a mastectomy.</li> <li>Survival from breast cancer in K&amp;M is close to the England average.</li> <li>SS highlighted no issue in terms of surgical capacity at DGT. Their delays are multi-factorial including diagnostic delays, histopathology TAT, complex surgery / investigations and multiple MDM discussions.</li> </ul> <p><b>Action - SS suggested conducting an audit of random - One Stop patients over a 3-month period to see where the delays are taking place. She hoped to have this data by the next TSSG meeting.</b></p> <ul style="list-style-type: none"> <li>MTW have a one stop Radiology Clinic in place. SS referred to the recruitment freeze which means they are unable to recruit to any radiology posts.</li> <li>CHW suggested having a more detailed pathway review in light of the financial cuts – with more granularity on the data presented by the Cancer Leads. JG would like to see more data on first line oncology treatment.</li> </ul> <p><b>Action – Deepika agreed to ask David Osborne for a breakdown of the FDS data for breast cancer patients.</b></p> <ul style="list-style-type: none"> <li>DA confirmed the histopathology TAT being 10-days and losing 2-days with samples coming from DGT and MFT onto MTW.</li> <li>SS questioned the data as DGT do more oncoplastic breast excision than presented and presumed this was a coding issue. The data goes to the National GIRFT team. SS</li> </ul> |  | <p>SS</p> <p>DA</p> |
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|    |                                    | <p>stated she will not do a One Stop Clinic without radiology being present.</p> <ul style="list-style-type: none"> <li>• CHW emphasised they will be unable to improve the data unless they put in writing what is needed – FDS cancer ruled out and FDS data cancer diagnosed.</li> <li>• The MDT Co-ordinators collaboration meetings are ongoing – in order to improve the data which is recorded on InfoFlex.</li> </ul> <p><b><u>How to sign up to the Cancer Pathways and Cancer in Primary Care Dashboards</u></b></p> <ul style="list-style-type: none"> <li>• Register for access to Kent and Medway ICB Power BI reports by completing the form at <a href="https://forms.office.com/r/svyPSvktHw">https://forms.office.com/r/svyPSvktHw</a>.</li> <li>• Email <a href="mailto:David.Osborne11@nhs.net">David.Osborne11@nhs.net</a> to inform him that you have completed the form for access to the dashboard. It can take up to a week for the ICB to grant access.</li> <li>• Once access has been granted, you can access the dashboard at <a href="https://app.powerbi.com/home?ctid=4cfbd3c4-a42e-48a1-b841-31ff989d016e">https://app.powerbi.com/home?ctid=4cfbd3c4-a42e-48a1-b841-31ff989d016e</a>. Click on the <b>KM ICB Main</b> app and you will see <b>Cancer in Primary Care</b> and <b>Cancer Pathways</b> listed on the left-hand menu.</li> </ul> |  |                                                                                                 |
| 7. | K&M SACT Demand & Capacity project | <p><b><u>Update provided by Conchi Blanco and Anthea Randell</u></b></p> <ul style="list-style-type: none"> <li>• CB explained as part of the Treatment Variation Work Programme 2024/25 the CA undertook a detailed assessment of the demand and capacity for SACT services across K&amp;M from March to June 2025. There are 10 SACT units in place across K&amp;M with 2 out-reach at EKHUFT and DGT - bus (none at MFT or MTW)</li> <li>• The CA carried out this work in partnership with MSD and collected data across a 2-week period which was analysed using their demand and capacity tool.</li> <li>• Both scheduling and nursing staff were asked to complete a detailed time in motion</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | <p><b>Presentation slides were circulated to the group on the 14<sup>th</sup> May 2026.</b></p> |

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|  |  | <p>study and the trusts were invited to suggest up to 3 scenarios for future modelling.</p> <ul style="list-style-type: none"> <li>The SACT D&amp;C priority transformation areas included: <ul style="list-style-type: none"> <li>i) Chair capacity – 105 across K&amp;M</li> <li>ii) Workforce – 101 SACT trained nurses</li> <li>iii) Deferrals – can be quite high due to a number of reasons including patients not being well or delayed bloods. Not enough time to then reallocate the chair.</li> <li>iv) Delays – patients / drugs / nurses delayed, overbooking – particularly at MTW.</li> <li>v) Clinic activity – MFT and DGT there is not much room for growth</li> </ul> </li> <li>From a CA perspective they are operating at 89% of their available capacity and in 12 months' time this would be 97%. In 5 years', the demand for chair capacity would be an additional 42 chairs.</li> <li>Recommended next steps: <ul style="list-style-type: none"> <li>i) Review of workforce to align roles and responsibilities</li> <li>ii) Review processes impacting deferrals and delays to optimize chair capacity</li> <li>iii) Consider alternative models of service delivery such as closer to home for sub cut treatments</li> <li>iv) Scoping the impact of new SACT treatments at service level, inclusive of core clinical services. Impact on radiology, pharmacy and nursing teams.</li> <li>v) Appraisal of new models to deliver patient information sessions (E-PROMS / digitalization) and undertake pre-treatment reviews. Role of the TSSG is critical to this work.</li> </ul> </li> <li>CB outlined the CA SACT workplan for 2026: <ul style="list-style-type: none"> <li>i) Review processes impacting deferrals and delays to optimize chair capacity and improving patient flow with individual trusts</li> <li>ii) Working collaboratively across all 4 trusts to review and standardize protocol timings in KOMS, ensuring a consistent and equitable approach to SACT</li> </ul> </li> </ul> |  |  |
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|    |                                         | <p>delivery</p> <p>iii) In line with the 10-year Cancer Plan – explore and evaluate alternative models of care delivery, including options for administering sub cut treatments closer to patient’s homes where clinically appropriate</p> <p>iv) Option for breast cancer patients on maintenance to receive Phesgo and Trastuzumab SC closer to home (well established patients – no need to deliver at an acute trust / either close to home or at the patient’s home)</p> <p>v) Assess the service impact of new SACT treatments as service level – scoping the introduction of a “super clinic” for Abemaciclib and Ribociclib. Likely to be Pharmacy NMP led clinics – K&amp;M Pan initiative.</p> <ul style="list-style-type: none"> <li>• There are Radiotherapy Super clinics in place. A non-medical Pharmacist prescriber helps support this clinic at EKHUFT.</li> <li>• MTW have introduced a daily huddle with pharmacy, scheduling and the nursing team to discuss their SACT delays.</li> </ul>      |  |                                                                                                 |
| 8. | Breast pain pathway – MTW pilot results | <p><u>Update provided by Noor Obeid</u></p> <ul style="list-style-type: none"> <li>• NO highlighted that breast pain affects 70% of women at some point in their lifetime and it is not a common symptom of breast cancer. It is estimated there are 700,000 breast pain referrals made each year which accounts for 20-40% of cases. Occurrence of breast cancer for this cohort of patients is 0.4%.</li> <li>• Cyclical breast pain is the most common cause of the condition.</li> <li>• Breast pain patients are still referred though the USC (2ww) pathway which is adding additional pressure to the One Stop Clinics and increasing patient anxiety.</li> <li>• The Association of Breast Surgery Aspire Breast Pain Pathway project identified <b>significant variation in care pathways</b> across NHS Trusts (ABS, 2021). They initiated the breast pain pathway rapid evaluation project (ASPIRE) to establish a standardised method for evaluating novel breast pain pathways across sites.</li> </ul> |  | <p><b>Presentation slides were circulated to the group on the 14<sup>th</sup> May 2026.</b></p> |

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|  |  | <ul style="list-style-type: none"> <li>• RCR guidance has changed and recommended that patients presenting with breast pain only should not be routinely offered imaging unless they found something worrying.</li> <li>• The aim of the breast pain clinic at MTW: <ul style="list-style-type: none"> <li>i) Align / compliance with RCR guidance</li> <li>ii) Identify opportunities to reduce unnecessary imaging – which is often driven by patient anxiety rather than clinical need</li> <li>iii) Enhance workflow efficiency and deliver safe, high quality patient care</li> </ul> </li> <li>• NO outlined the details of the retrospective review carried out from Jan – May 2026 including: <ul style="list-style-type: none"> <li>• <ul style="list-style-type: none"> <li>i) Referrals – patients above the age of 16 presenting with breast pain without any other breast symptoms – referred by the GP and triaged to the breast pain clinic</li> <li>ii) Inclusion criteria</li> <li>iii) Exclusion criteria</li> <li>iv) Friday morning clinic – 8 patients seen with 30-minute appointment slots</li> <li>v) Imaging – if urgent will be carried out within 2-weeks and if non-urgent 6-8 weeks</li> <li>vi) Results - 91 patients seen in total – aged 23-88 – 72 (79%) discharged, 17 (19%) had routine imaging and 2 (2%) urgent imaging.</li> <li>vii) No malignancies were detected.</li> <li>viii) No patients were referred back in.</li> </ul> </li> </ul> </li> <li>• In conclusion: <ul style="list-style-type: none"> <li>i) Breast pain clinic safely discharges the majority of patients</li> <li>ii) Routine imaging has low clinical value</li> <li>iii) Opportunity to further optimise practice</li> </ul> </li> </ul> |  |  |
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|    |                       | <ul style="list-style-type: none"> <li>There was further discussion regarding managing breast pain patients within a community setting. Patients are keen to see a breast specialist and are often advised by the GP that they will have a scan to reassure them.</li> <li>SS mentioned at DGT the Advanced Nurse Practitioners previously ran their mastalgia clinics.</li> <li>This audit has taken these patients out of the One Stop Clinic. It was felt inappropriate to have a specialist Consultant running a breast pain clinic. However, this allowed the One Stop Clinic capacity to focus on the higher risk patients.</li> <li>AR emphasised that it was not appropriate to send a patient straight for a mammogram without being examined first.</li> </ul>                                                                                                                                                                                                                                                                                                                               |  |                                                                                                 |
| 9. | Histopathology update | <p><b><u>Update provided by Savita Honakeri</u></b></p> <ul style="list-style-type: none"> <li>SH highlighted the increase in histopathology breast cases at MTW from 2015 being 4,598 cases to currently 7,077 cases.</li> <li>Breast TAT have increased due to multiple factors but these are now improving. Currently they have 8 breast resections and 18 breast core biopsies outstanding.</li> <li>SH mentioned that most Histopathologists report to more than one specialty and she reports for GI, Breast and Urology.</li> <li>There have been a number of staffing changes within the lab which requires additional training and supervision. There is also a national shortage of pathologists and radiologists.</li> <li>There are delays in samples arriving in the lab particularly from MFT and DGT. The lab closes at 16:30 on a Friday so samples will be delayed until Monday morning.</li> <li>Histopathology TAT have dipped due to school holidays, bank holidays and also digital pathology training which can take up to 6-months to become fully trained. They may</li> </ul> |  | <p><b>Presentation slides were circulated to the group on the 14<sup>th</sup> May 2026.</b></p> |

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|     |                                 | <p>need to outsource again to Diagnexia during reduced inhouse reporting capacity times.</p> <ul style="list-style-type: none"> <li>As part of the MDM streamlining they will be changing their MDM review processes – paper review for cases reported by substantive sub-specialist consultants; and only review cases reported by locums / outsourced / specialist histopathologists. The RCP have advised against double reporting for sub-specialists.</li> <li>SH highlighted that some mastectomy specimens are being forced into smaller sample pots which is not good for fixation and could potentially affect the tumour morphology and margin measurement. SH asked the group to ensure the specimens were put in larger pots with formalin.</li> </ul> <p><b>Action – Savita agreed to provide a further update at the next TSSG meeting on the specimen TAT and highlighting the transport issues affecting MFT and DVH.</b></p> |  | SH                                   |
| 10. | GIRFT surgery follow up and FDS | <ul style="list-style-type: none"> <li>This agenda item was not discussed due to time constraints.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                      |
| 11. | AOB                             | <ul style="list-style-type: none"> <li>NW raised serious ongoing concerns from EKHUFT's perspective regarding their patients seeing a number of locum oncologists which needs addressing as a matter of urgency. LDP agreed this is impacting their patient's continuity of care.</li> </ul> <p><b>Action – Deepika agreed to follow up this issue.</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | DA                                   |
| 12. | Next Meeting Date               | <ul style="list-style-type: none"> <li><b>Thursday 12<sup>th</sup> November 2026 – 09:00 – 12:30 - Auditorium, Academic Centre, Maidstone Hospital, Hermitage Lane, Maidstone, ME16 9QQ.</b></li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | KG has circulated the meeting invite |