Kent and Medway Cancer Collaborative

Acute Oncology & CUP Forum Tumour Site Specific Group meeting
Monday 26th April 2021
Microsoft Teams
09:00 – 12:30

Final Meeting Notes

Present	Initials	Title	Organisation
Afroditi Karathanasi (Chair)	**AK**	Consultant Medical Oncologist	MFT
Cynthia Matarutse	**CM**	Lead Cancer Nurse	MFT
Vicky Kidner	**VK**	Lead Nurse/Matron for Chemotherapy	MFT
Elizabet Sanchez	**ES**	Service Manager for Oncology & Haematology	MFT
Cherie Neill	**CN**	AOS CNS	MFT
Stergios Boussios	**SB**	Consultant Medical Oncologist	MFT
Deirdre Cooke	**DC**	AO & CUP CNS	DVH
Donna Watson	**DW**	Development Analyst	DVH
Nicola Bonthron	**NB**	Macmillan Lead Nurse for Palliative Care and Acute Oncology	DVH
Tracey Spencer-Brown	**TSB**	AO Matron	EKHUFT
Claire Whiteley	**CWh**	AO Nurse Practitoner	EKHUFT
Irene Nhandra	**IN**	Programme Lead – Early Diagnosis	KMCA
Colin Chamberlain (Notes)	**CC**	Administration & Support Officer	KMCC
Karen Glass	**KG**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Facilitator	KMCC
Sharon Middleton	**SM**	Partnership Manager for Kent & Medway	Macmillan
Jo Carrim	**JC**	Palliative Care Doctor	Medway Community Healthcare
Sola Adeleke	**SA**	ST3 in Clinical Oncology	MTW
Jeanette Smith	**JS**	Metastatic CNS	MTW
Rosalyn Yates	**RY**	Cancer Matron	MTW
Andrew Brown	**ABr**	AO CNS	MTW
Amit Goel	**AG**	Consultant Histopathologist	MTW
Stacy White	**SW**	AO CNS	MTW
Andrea Blurton	**ABl**	AO CNS	MTW
Lewis Taylor	**LT**	AO Support Worker	MTW
Erika Wade	**EW**	AO CNS	MTW
Saba Imtiaz	**SI**	Consultant Medical Oncologist	MTW

Kathryn Lees	**KL**	Consultant Clinical Oncologist	MTW
Bana Haddad	**BH**	Macmillan GP & Cancer Lead/Programme Lead – Living With and Beyond Cancer/Personalised Care & Support	NHS Kent & Medway CCG
Jack Jacobs	**JJ**	Macmillan GP & Cancer Lead	NHS Kent & Medway CCG
Apologies			
Jacqueline Motta	**JM**	Macmillan Lung CNS	EKHUFT
Jindriska Lindsay	**JL**	Consultant Haematologist	EKHUFT
Lavinia Davey	**LD**	Research Nurse	EKHUFT
Tracey Ryan	**TR**	Macmillan User Involvement Manager	KMCC
Andrew Stradling	**AS**	Consultant and Lead Clinician - Emergency Medicine	MFT
Charlotte Wadey	**CWa**	Director of Nursing and Quality for Cancer Services	MTW
Maher Hadaki	**MH**	Consultant Clinical Oncologist	MTW
Mathilda Cominos	**MC**	Consultant Clinical Oncologist	MTW
Ola Okuwa	**OO**	Haematology Pharmacist	MTW
Paulette Basham	**PB**	Clinical Trials Administrator	MTW
Ravish Mankragod	**RM**	Consultant in Respiratory and General Medicine	MTW
Chris Singleton	**CS**	Senior Programme Manager - KMCA	NHS Kent & Medway CCG
Laura Alton	**LA**	Senior Programme Manager - KMCA	NHS Kent & Medway CCG
Sona Gupta	**SG**	Macmillan GP & Cancer Lead	NHS Kent & Medway CCG

Item		**Discussion**	**Agreed**	**Action**
1	**TSSG Meeting**	**Apologies** • The apologies are listed above. **Introductions** • AK welcomed the members to the meeting and asked them to introduce themselves. **Review previous minutes** • The minutes from the previous meeting were reviewed and agreed as a true and accurate record. **Action log Review** • The action log was reviewed, updated and will be circulated along with the minutes from today's meeting.		

2	**MSCC Audit Presentation**	**Presentation provided by Sola Adeleke** • SA stated the true incidence of spinal cord compression is unknown. However, postmortem data indicates it affects 5-10% of patients with advanced cancer. • According to NICE guidance, there are on average 4000 cases each year in England and Wales, equating to approximately 100 cases per cancer network. • The presentation provided data on MSCC referrals between January 2015 and December 2020. It showed: - A variation in decisions made on different weekdays (including at the Kent Oncology Centre) - A variation in decisions made in different months - A variation in radiotherapy protocol choice with time - Referral breakdowns by consultant - A variation in weekday referrals - A variation in decisions made in different Trusts - COVID-19 and MSCC patterns in K&M (including during lockdowns 1 and 2). • SA referred to the 2021 ASCO meeting which the audit will be presented at as well as the Quality Improvement Project. She emphasized the importance of closer collaboration with the multi-specialist team, which includes: - King's College Hospital surgeons - Physiotherapy - Occupational therapy - Community care providers - Palliative care - Oncology trainees. • NICE guidance recommends a diagnosis be made within 24 hours of presentation. Ideally an MRI scan should be performed within 24 hours of presentation, RT within 24 hours of MSCC confirmation and surgery by day 5 if neurologically stable. • Further data will be published in June 2021. • It was felt a radiotherapy MSCC pathway coordinator role at the Kent Oncology Centre was needed with a dedicated mobile telephone number in order to help coordinate radiotherapy once MSCC has been identified. The telephone will be held by Katy Taylor at the KOC as a pilot to see if this smooths the pathway for patients having urgent palliative radiotherapy for MSCC. • The problems/delays they have found with the pathway were usually where patients were on outlying wards and AO had not been contacted. It was recommended that radiology departments alert AO when they report a scan with (impending) MSCC to avoid the situation of patients being on the ward without AO being aware of this.		
3	**MSCC Pathway**	**Update provided by Kathryn Lees** • KL stated the 'Kent and Medway Metastatic Spinal Cord Compression (MSCC) Guidelines and		

		Referral Pathways' document is an adaptation of all pathways across the patch. • KL emphasised the importance of encouraging early referrals to AO. • Pathway 1 relates to patients who present with symptoms suggestive of spinal metastases with neurological symptoms or signs suggestive of MSCC. On suspicion, the patient should have a fully documented neurological assessment and commence steroid and pain relief treatment. An MRI scan of the whole spine should be performed as soon as possible or at the latest within 24 hours from presentation and ideally a treatment plan should be agreed and commence within the following 24 hours. • Pathway 2 relates to patients who present with symptoms suggestive of spinal metastases without new neurological symptoms. These patients must undergo an MRI scan within 7 days. Contact must be made with the MSCC coordinators as soon as MSCC is confirmed on the MRI scan. KL stated the MSCC coordinator at King's College Hospital has been particularly helpful. • If an oncologist feels surgery would not be appropriate then radiotherapy can be provided in order to avoid delays but patients should still be referred via the MSCC coordinator/online portal for a subsequent neuro-oncology MDM review. • The document provided an overview of MSCC symptoms. • The document also referred to the Spinal Instability Neoplastic Score (SINS), which assesses spinal stability. A score of 1-6 is deemed stable, 7-12 potentially unstable and 13-18 unstable. A score of 7-18 warrants surgical consultation (if appropriate) to assess for instability prior to proceeding with any planned radiation treatment. • KL highlighted the importance of having the appropriate staff in place throughout the pathway. • KL, in discussion with the GSTT spinal team, has developed new MSCC guidelines which she will present at the next Kent Oncology Centre governance meeting on 04.05.2021. • The radiotherapy MSCC pathway coordinator mobile number and guidelines have been circulated by SA and her colleague Ruby to both EKHUFT and DVH for their initial feedback.		
4	**COVID 19 pandemic second wave - impact on AO Teams** **COVID 19 pandemic second wave impact on AO patients**	**DVH – update provided by Nicola Bonthron** • Advanced cancers and late presentations (including in young people) has been an issue at DVH. • The team supported palliative care during the first wave due to how busy the service was. • The number of cases in November 2020 were particularly high which proved to be very challenging. **EKHUFT – update provided by Tracey Spencer-Brown** • The team worked together in order to undertake risk assessments for oncology patients during the first wave, with COVID cases predominantly contained within wards. Their workload during the second wave increased and this placed an emotional strain on the team, especially as 3 of their 8 staff members contracted COVID and therefore had to self-isolate. • They did not have many complicated SACT cases during the first wave.		

		• Advanced cancers and late presentations has been an issue at the Trust. • Of the 120 cancer patients they had, 75 died. • A number of their staff members supported the chemotherapy team during the first wave. • They are monitoring the number of cancer patients which either had COVID upon admission to hospital or contracted it following admission. • They have provided a lot of support to patients' relatives who could not visit the hospital (due to COVID restrictions) or were struggling to get through to the wards by telephone. The 7 day cancer careline has been instrumental in facilitating this but it has placed a lot of pressure on the service. • **<u>Action:</u> TSB agreed to send CC the link for a compassionate webinar she attended recently.** **<u>MFT – update provided by Afroditi Karathanasi</u>** • AK stated the second wave was more challenging than the first. • Advanced cancers and late presentations has been an issue at the Trust. • None of the team at MFT contracted COVID. • Between March 2020 and March 2021, they saw 1019 patients. 123 of their cancer patients were diagnosed with COVID, 64 of which died and 52 were discharged. • 30 patients were on a diagnostic pathway, 22 of which died. • 46 patients under SACT had treatment within 3-6 months, 30 of which died. • 30 patients were on a treatment break, 11 of which died. • 1 patient admitted with COVID while waiting to start SACT also died. • 123 patients were diagnosed with COVID at the time, or within 48 hours, of presentation. 31 patients had 2 negative swabs and became positive 10 days following admission. • BH stated she has seen a number of patients presenting late to primary care. • JC mentioned there had been difficulties during the first wave and she is now the only palliative care consultant at MFT. They saw a number of admissions to the Wisdom Hospice by oncology and COVID patients. • During the second wave, there were more staff on the hospital palliative care team and 2 advanced care practitioners are now working alongside the CNS'. JC felt palliative support is now more visible and they are in a better position to support AO patients. • JC mentioned more patients are dying in hospital before they can be admitted to the Hospice. **<u>MTW – update provided by Erika Wade</u>** • During the first wave, EW and SW were redeployed to ITU. They did, however, remain with the AO team during the second wave. • Following the first wave, they noticed an increase in the number of unwell patients and advanced cancers (many of which had to be referred straight to palliative care).		**TSB**

		• They have noticed an increase in the number of very unwell MUO patients, especially in the last 2 months. • A number of oncology patients admitted to hospital contracted COVID, some of which later died from it. AK stated she would be interested to see the figures for this. • SW contracted COVID and had to self-isolate for 2 weeks.		
5	**CNS Updates (Staffing, 7 day service, challenges and subgroup meetings)**	**DVH – update provided by Nicola Bonthron** • The service is currently stable. NB stated there is a need to look at the CNS staff ratios, which she has spoken to a senior colleague about. They often have to backfill in order to provide the 7 day service. • They are looking at their unwell patient pathway in order to determine whether it needs to be developed. • They hope to recruit an AO consultant oncologist this year. • NB felt the workforce needs to be reviewed, to identify whether additional staff are needed. **EKHUFT – update provided by Tracey Spencer-Brown** • Their team comprises of 2 WTE Band 8A's, 5 Band 7's and a Band 4 AO navigator. • They have been successful in their business case for 2 Band 4 nurse support roles, one of which has been recruited to and the other is out to advert. • They have sustained a 7 day service since February 2021. KCH are offered remote support. There is currently only 1 nurse in place for the service at weekends but this will hopefully be increased in due course. • TSB has been involved in a business planning project, which includes the need for an increase in workforce and a dedicated ambulatory unit/protected chairs and trolleys in the emergency department. • They have a good relationship with the hospital at home team. • Clinical support is provided to the cancer careline when required. The Trust feel a clinician needs to be in place for the careline and this is reflected in the business case being written. **MFT – update provided by Deirdre Cooke & Cherie Neill** • They have successfully recruited a third CNS, who will start in late June 2021. They will provide a 7 day service (5 hours on Saturdays and 4.5 hours on Sundays). • None of the team has had COVID. • They are currently a team of 5 (2 consultants, 2 CNS' and 1 administrator). • They saw a significant increase in referrals for 2020, MUO and MSCC in particular, when compared to the data from 2019. • The sepsis pathway at MFT is in the process of being reviewed.		

		MTW – update provided by Andrew Brown • They have recruited a 4th CNS, ABl, who works full time and is on a 1 year secondment. They have also recruited LT (AO support worker). • RY has returned from her secondment and will be working on developing the service. • They hope to develop a 6 day service once their new staff have assimilated into their roles. • They have committed to a regular presence at both sites 5 days a week (Tunbridge Wells Hospital and Maidstone Hospital). • The AO team have accepted an additional role as a pilot for holding the chemotherapy day unit triage phone (which will hopefully reduce admissions to the emergency departments). RY believes this is a full time job and a dedicated triage practitioner should be put in place. They are looking to audit this when the pilot is over. Should the service remain with them post-pilot, they will need additional staff. • They are trying to develop the skills of their current CNS team, with prescriber/clinical assessment/radiology courses being offered. • They are writing a business case in order to recruit 2 new consultants to provide more AO support and are looking to develop more trainee involvement in AO. • RY has written a business case for a new CNS role who would cover MUO, CUP, sarcoma and rare tumours at MTW.		
6	**Horizon scoping**	**AOS models and Development plan across K&M – update provided by Tracey Spencer-Brown** • RCP, ACP & RCR (2020) published national recommendations to support AO services. The key priorities include increasing engagement and viability in acute settings with clinical leadership from oncologists. • TSB stated this is pivotal in delivering an equitable, high quality, safe and effective specialist service and she is looking forward to leading on this piece of work from April to November 2021. • TSB stated AO teams work hard to deliver a patient-centred responsive service with increasing demands and challenges nationally, which include: the COVID pandemic and its significant impact on services, ageing populations, comorbidities and the complexities this brings for AO services to support and manage. • TSB stated there may be opportunities for the KMCA and Macmillan to support with extra workforce. • TSB mentioned the project needs to be patient-focused, have strong working relations and comprehensive data collection. • Currently, AO services are not equitable across the patch due to: - Variations in models of care and accessibility of services - Not all Trusts have designated AO clinical leads - There is no standardised audit dataset reporting process - There is an increase in demand and complexity which is unsustainable		

		- Patient experience in emergency departments is variable. There is a clear need to try and reduce emergency department admissions. • The KMCA will be supporting the review of the current service in order to promote an equitable and effective AO service across the patch, in line with national recommendations and regional and patient need. • The minimum requirements include a need for an equitable patch-wide 7 day service with sufficient staff to support it, AO consultant clinical leads, a K&M standardised dataset, administrative support, a robust K&M AOS data system (inclusive of HNA's), improved patient and service user experience, development of oncology emergency and elective pathways and investment in AOS staff training to enhance skills and improve service delivery. All of these are integral to recovery and restoration post-COVID. • The KMCA will be completing a report detailing recommendations for change. • TSB stated an audit and report of the baseline situation across K&M is required as are engagement events and focus groups. **Action: A representative from each Trust is required to work with TSB in order to provide her with the baseline information needed for the audit.** • TSB feels investment in training is required. She also feels better investment in wellbeing services would help to enhance skills and improve service delivery. • TSB agreed to travel to each Trust at some point, but will liaise with them virtually for now. She has been communicating with other hospital Trusts across the country and has access to webinars which she would be happy to share with the teams. • TSB mentioned she is open to all suggestions/feedback from the members. • The pandemic has raised the profile of AO and Macmillan will be happy to support them from a comms perspective. • BH specified she is keen to see how the HNA's will evolve and to identify what the patient needs are. She suggested training be put in place for primary and secondary care staff and they should work together to engage in this. • SM stated Macmillan Cancer Support also have AO as a strategic grant funding priority for 2021 and beyond. She has raised this and discussed joint funding the future models with the KMCA. Macmillan are also keen to support work around patient experience. • Macmillan are joint funding and working in partnership with the STP/CCG workforce team on some simulation training in primary care/the community. She has discussed this with TSB and feels there could be some AO sessions developed and red flag training with the Macmillan primary care nurse facilitators. • Macmillan have resources to support emotional health and wellbeing (especially during the pandemic). The links are: - https://www.macmillan.org.uk/healthcare-professionals - https://www.macmillan.org.uk/coronavirus/healthcare-		**All Trusts**

		professionals/wellbeing/resilience#vicarious_traumatisation **MUO and CUP** • AK stated TSB will be collating MUO and CUP figures in a more efficient way going forward.		
7	**Performance All Trusts to present** **Annual reports**	**DVH** • NB stated DVH did not have performance data or an annual report to share with the group. She will liaise with DW to ensure this is in place for future meetings. The data team have spent most of their time on cancer waiting times. **EKHUFT – update provided by Claire Whiteley** • 195 referrals were made to the CUP AO team between April 2020 and March 2021. • The referrals came from different avenues including: MDM referrals, through the inpatient/ambulatory services, other MDM teams, other CNS' (once an initial assessment has been carried out) and King's College Hospital MSCC alerts. • There was a variation in diagnostic outcomes as well as primaries identified. • 65% of patients had adenocarcinomas and 35% had carcinomas. • In terms of MUO/CUP interventions, contact has been made remotely via telephone (due to COVID), unless the patient has been in hospital. • There have been variations in how patients present. **MFT – update provided by Deirdre Cooke & Cherie Neill** • Between April 2020 and March 2021 there were: - 966 new inpatients managed by the AO team - 4502 inpatient reviews - 17.5 face-to-face reviews each day on average. • 99 outpatients were managed by the AO team on diagnostic pathways or complex cancer needs. • There were approximately 200 telephone clinics for outpatients. • 120 inpatients/outpatients have been on the MUO pathway. 48 of them were discussed in the MUO/CUP MDT and the other 72 were diagnosed with a primary (with AOS leading the diagnostic pathway and referring to the site specific MDT meetings). • 1 patient breached the 62d target as they were referred after the breach had occurred. • 67% of cases were discussed once and 33% required more than one discussion. **MTW – update provided by Erika Wade** • MTW provided an overview of activity between October 2020 and March 2021 (minus 2 weeks in October 2020 due to IT issues). • There were 511 new inpatients managed by the AO team, 66 AO telephone assessments and 12		

		face-to-face outpatient assessments. They have had difficulty securing an assessment area due to COVID. • 91 new MUO cases were referred to AO between October 2020 and March 2021. 59 of these were managed by AO on an outpatient basis from diagnostic work up until they were taken over by a site specific team following histology and MDT discussion. • Of the 91 MUO patients referred to AO, 20 were not fit for a biopsy and therefore not discussed in MDT. Reasons for this include: patients dying as an inpatient, referrals being sent to community palliative care teams for ongoing support and hospice admissions. 71 patients were fit for a biopsy and therefore referred for MDT discussion, 23 of which were referred to the lung team. • There were 18 neutropenic sepsis cases in total, which were managed well by medical practitioners. • MUO is the most consistent referral presenting currently. • MUO cases are managed by the team as there is no specific MDT for this. • The CUP MDT lead is Charlotte Moss. • Referral sources included: Allscripts, verbal (telephone/face-to-face), email, triage call and GP. • With regards to the reasons for the 511 referrals, these include: 91 due to a new cancer diagnosis, 235 due to complication(s) of known cancer, 111 due to toxicity of SACT/radiotherapy, 48 were inappropriate referrals and 11 remain unknown.		
8	**Research**	**<u>Update provided by Stergios Boussios</u>** • CUP constitutes 3–5% of all cancers, with a median survival of 6–9 months. • SB referred to the CUPISCO study, which compares the efficacy and safety of targeted therapy of cancer immunotherapy guided by genomic profiling versus platinum-based chemotherapy in patients with CUP who have received three cycles of platinum doublet chemotherapy. • The CUPISCO study design is currently awaiting final UK approvals. • SB referred to NivoCUP, an open-label phase II study on the efficacy of nivolumab in cancer of unknown primary.		
9	**Primary Care & Commissioning**	**<u>Email update provided by Chris Singleton & Laura Alton</u>** • CS and LA are the new Senior Programme Managers for cancer commissioning in K&M and are working as part of an integrated CCG and KMCA team. They believe this is a positive change from the previous locality-based commissioning approach, and is in line with the development of the Integrated Care System. It will support delivery of local and national cancer priorities, and brings together the expertise of the KMCA with commissioners under the leadership of Ian Vousden (Programme Director). • LA and CS are keen to help support development of clinical pathways which improve access to cancer services for the K&M population, navigating through the new CCG governance processes. As a new organization, the CCG will have to ensure they work at scale across the patch, whilst		

		also ensuring all voices are heard. • They are working closely with their planned care commissioning colleagues in each of the 4 Kent & Medway Integrated Care Partnerships, given the overlap between cancer and planned care pathways. • Cancer is a clear priority in the recently published NHS Planning Guidance, and they will be working with all relevant colleagues to help deliver the priorities, particularly in terms of returning to pre-pandemic levels of cancer treatment. • They are currently focusing on a number of commissioning priorities for cancer, including pilots of a number of rapid diagnostic services including the Vague and Indeterminate Symptoms Service at DVH (which they looking to make a substantive commissioned service there due to the success of the pilot) and the rapid lymphadenopathy service and low dose CT piece at EKHUFT. Discussions are also underway to extend the VISS model more widely across the patch. • CS and LA have also been working with the provider of the K&M prehabiliation program, which has been presented and discussed at a number of TSSG meetings, in order to extend the pilot of the service for patients and to help them prepare for surgery. • CS encouraged the members to contact him/LA if they require commissioning support with any cancer pathway developments.		
10	**Cancer Alliance update**	The predominant aims of cancer services across the patch are to: • Restore urgent cancer referrals at least to pre-pandemic levels. Between March 2020 and February 2021, 85% of the normal amount of treatments were provided. • Reduce the backlog at least to pre-pandemic levels on 62 day (urgent referral and referral from screening) and 31 day pathways. • Ensure sufficient capacity is in place to manage increased demand moving forward, including follow-up care. • Reduce health inequalities. • Support the 28d FDS piece. • Ensure patients and staff are confident services are COVID-protected. • Ensure the right workforce is in place. • Restart Long Term Plan activity.		
11	**AOB**	• No-one had anything to raise under any other business.		
	Next Meeting Date	• To be confirmed.		