Haematology Tumour Site Specific Group meeting
Wednesday 19th May 2021
Microsoft Teams
09:30 – 13:00
Final Meeting Notes

Present	Initials	Title	Organisation
Lalita Banerjee (Chair)	**LB**	Consultant Haematologist	MTW
Rosie Barker	**RB**	F2	MTW
Adrian Choy	**AC**	F2	MTW
Emma Richardson-Smith	**ERS**	Research Nurse	MTW
Carolyn Gupwell	**CG**	Haematology CNS	MTW
Deborah Willcox	**DW**	Research Nurse	MTW
Kavi Robinson	**KR**	Haematology CNS	MTW
Claire Williams	**CWi**		MTW
Annabel Page	**AP**	Clinical Trials Coordinator – Haematology/Lymphoma	MTW
Karen McDonald	**KMc**	Haematology Matron	MTW
Evangelia Dimitriadou	**ED**	Consultant Haematologist	MTW
Skye Yip	**SY**	Consultant Haematologist	DVH
Olumide Olufuwa	**OO**	Lead Research Nurse	DVH
Joyce van den Camp	**JVDC**	Senior Sister – Pine Therapy Unit	DVH
Jayne-Marie Osborne	**JMO**	Haematology Registrar	DVH
Natalie Heeney	**NH**	Consultant Haematologist	DVH
Faye Barrow	**FB**	Haematology MDT Coordinator	DVH
Clayton Wong	**CWo**	Lead Clinical Pharmacist - Cancer and Planned Care	DVH
Joy Zacharoula Galani	**JZG**	Consultant Haematologist	DVH
Michelle McCann	**MM**	Operational Manager for Cancer & Haematology	DVH
Lavinia Davey	**LD**	Research Nurse	EKHUFT
Jin Lindsay	**JL**	Consultant Haematologist	EKHUFT
Sree Munisamy	**SM**	Consultant Haematologist	EKHUFT
Pippa Miles	**PM**	Senior Service Manager	EKHUFT
Miguel Capomir	**MC**	Haematology Pharmacist	EKHUFT
Moya Young	**MY**	Consultant Haematologist	EKHUFT
Stephanie Goodchild	**SGo**	Macmillan Lead CNS - Haemato-oncology and Lymphadenopathy	EKHUFT
Sarah Howland	**SH**	Senior Operations Manager – Haematology & Haemophilia	EKHUFT
Robin Sanderson	**RS**	Consultant Haematologist	King's College Hospital
Chibuzo Mowete	**CMo**	Specialist Trainee (Haematology)	King's College Hospital
Claire Mallett	**CMal**	Programme Lead – Living With and Beyond Cancer	KMCA

Irene Nhandara	**IN**	Programme Lead – Early Diagnosis	KMCA
Karen Glass	**KG**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Facilitator	KMCC
Colin Chamberlain (Notes)	**CC**	Administration & Support Officer	KMCC
Hayley Paddock	**HP**	E-Prescribing Pharmacist	KMCC
Michelle Archer	**MAr**	Pharmacy Technician	KMCC
Maadh Aldouri	**MAl**	Consultant Haematologist	MFT
Cynthia Matarutse	**CMat**	Macmillan Lead Cancer Nurse	MFT
Nahla Osman	**NO**	Consultant Haematologist	MFT
Zubeir Nurgat	**ZN**	Lead Pharmacist - Haematology, Oncology, Clinical Trials and Research	MFT
Kerry Michelsen	**KMi**	Haemato-oncology CNS	MFT
Sue Green	**SGr**	Macmillan Recovery Package Facilitator	MFT
Agne Sadauskaite	**AS**	Pharmacist Manager	MFT
Margaret Williams	**MW**	Haematology MDT Coordinator	MFT
Elizabet Sanchez	**ES**	Service Manager for Oncology & Haematology	MFT
Jodie Seymour	**JS**	Clinical Research Officer	MFT
Handunneththi Mendis	**HM**	Consultant Haematologist	MFT
Jack Jacobs	**JJ**	Macmillan GP & Cancer Lead	NHS Kent & Medway CCG
Chris Singleton	**CS**	Senior Programme Manager – KMCA	NHS Kent & Medway CCG
Bana Haddad	**BHa**	Macmillan GP / Clinical Lead – Living With and Beyond Cancer	NHS Kent & Medway CCG
Brian Howson	**BHo**	NHS Partnership Manager	Novartis Pharmaceuticals UK
Apologies			
Marie Payne	**MP**	Macmillan Lead Cancer Nurse / Clinical Services Manager	DVH
Pramila Krishnamurthy	**PK**	Consultant Haematologist	King's College Hospital
Serena Gilbert	**SGi**	Cancer Performance Manager	KMCA
Helen Downs	**HD**	Aria System Administrator	KMCC
Tracey Ryan	**TR**	Macmillan User Involvement Manager	KMCC
Musab Omer	**MO**	Haematology Registrar	MFT
Natasha Wilson	**NW**	Macmillan Haemato-oncology CNS	MFT
Vicky Stables	**VS**	Consultant Haematologist	MTW
Sona Gupta	**SGu**	Macmillan GP & Cancer Lead	NHS Kent & Medway CCG

Item		Discussion	Action
1	**TSSG Meeting**	**<u>Apologies</u>** • The apologies are listed above. **<u>Introductions</u>** • LB welcomed the members to the meeting.	

		Action log Review • The action log was reviewed, updated and will be circulated along with the final minutes from today's meeting. **Review previous minutes** • The minutes from the last meeting were reviewed and agreed as a true and accurate record.	
2	**HOG**	**Update provided by Hayley Paddock** • **Action: HP to send CC a written update of today's discussions.**	**HP**
3	**PSFU for CLL**	**Update provided by Skye Yip and Brian Howson** • Following conversations at previous Haematology TSSG meetings and subsequently with SY and MY, the KMCA wished to explore the mapping of a new potential CLL stratified follow-up remote monitoring service. CMal and Consultant colleagues asked Novartis Pharmaceuticals UK to facilitate a Kent CLL stratified follow-up remote monitoring service pathway-mapping workshop which took place on 05.05.2021 from 14:00-16:00. Novartis acted as a facilitator of the workshop, but the outputs of the meeting belong entirely to the NHS and do not necessarily represent the views of Novartis. There was no proactive discussion of Novartis products. • The proposed pathway would aim to improve CLL patients' experience of their follow-up care by providing blood tests closer to home and reducing unnecessary hospital appointments whilst freeing up clinical capacity. • KMCA management, Consultant Haematologists, GP's, CNS', Cancer Support Workers and Hospital Operational/ Service/Business managers attended the workshop. • The proposed pathway, which BHo presented to the group, displayed the potential options which could be implemented straight from *'GP urgent referral via the 2ww pathway or routine referral via 'Book and Choose' system to hospital haematology Outpatient Clinic Consultation (OPC)'* all the way through to the *'Continuous 4-6 months follow-up'*. In order to view a detailed breakdown of the proposed pathway, please refer to the presentation CC circulated on 20.05.2021. • CMal highlighted the importance of standardising care, inclusive of protocols. The KMCA are willing to help coordinate this piece of work, send invites and set up Task & Finish groups if required. • In order to progress with this piece of work (which will include the standardisation of protocols and PROMS), the following Trust colleagues will provide support to it: MY from EKHUFT, SY from DVH, MAl from MFT and LB or one of her colleagues from MTW. SGr suggested Consultants, CNS' and Support Workers be invited too. • BHo attended this meeting in a neutral capacity and there was no product promotion or endorsement. **Update provided by Skye Yip** • SY stated the consent form presented on the screen at today's meeting (FLAG-IDA) is based on the King's College Hospital and GSTT documents. He would like someone, possibly in an administrative role, to apply the same layout situated on the FLAG-IDA document to the other consent forms. • LB specified she was happy with the layout and clarity of the form. • SY confirmed the forms would need to be approved by the individual Trusts before they can be utilised. • NH stated K&M should use standardised consent forms as they are easier and quicker. MAl added oncology colleagues are in the process of moving to regimen-specific consent forms. • CMal suggested the forms could be implemented in to InfoFlex where much of the information could be pre-populated	
	Pan Kent specific chemo consent forms		

		from existing data entry. They are implementing treatment summaries in this way. MAl believes most clinicians are not familiar with using InfoFlex and generic consent forms will still be needed for regimens not yet included. He added it took 3 years for the legal office at MFT to approve the current network consent forms. • SM mentioned having 2 separate consent forms could cause confusion but suggested DVH trial this and feed back to the group at the next meeting. • **<u>Action:</u> SY confirmed DVH will trial, in consultation with relevant Trust colleagues, the use of the forms and report the findings at the next meeting.**	**SY**
4	**CAR-T update**	**<u>Update provided by Robin Sanderson</u>** RS' slides provided an overview of: • The model of progression of mantle cell lymphoma, including its morphological variants. • The eligibility for CAR-T therapy as well as the NHS eligibility criteria for CAR-T. • Mantle cell lymphoma outcomes after BTKi failure (the median overall survival post-BTKi failure is 6-10 months) and alternative treatments available. • The efficacy of the ZUMA-2 study. • The current landscape for CAR-T in the NHS. • The mantle cell lymphoma programme at King's College Hospital, including outcomes. • The mantle cell lymphoma NCCP learning points. • Future developments for CAR-T in mantle cell lymphoma. • The first 4 patients given CAR-T for mantle cell lymphoma were infused at King's College Hospital, 3 of which are now in remission and 1 is in recovery. • RS stated it is best to refer patients to King's College Hospital early whilst they are on a BTKi.	
5	**Our experience of the Ninlaro patient support programme**	**<u>Update provided by Skye Yip</u>** • The programme is delivered by experienced Ninlaro Specialist Nurses (NSN's) who provide incremental and integrated capacity to NHS units whilst delivering high levels of quality patient interactions. These interactions can take place in the patient's home, by telephone, in clinic or any combination of these options. • At participating hospitals, every Ninlaro patient has a named NSN along with a tailored support plan in alignment with their preferences. This drives continuity of care, the best possible experiences and outcomes and helps them, and their healthcare professionals, to identify and manage toxicities early, therefore helping them to determine when therapy should be started and how long the patient is likely to remain on it. • DVH signed an SLA in November 2019 and the first patient enrolled to the Patient Support Programme (PSP) in January 2020, the first Trust to adopt it in Kent. • At present, there are 2 NSN's who cover each other to ensure continuity of care. • The PSP is supported by educational documentation for both patients and healthcare professionals and is designed to drive knowledge and confidence in treatment and management. • Helpful tools and resources for patients include: a laboratory test tracker, treatment calendars and Ninlaro treatment guidance. • Since January 2020: 15 patients have enrolled, 9 were already receiving Ninlaro therapy, 6 joined at the same time as starting treatment, 12 are active on the PSP, the longest patient was on treatment for 16 months and 3 patients who	

		enrolled subsequently left the PSP (they had all been on treatment for over 12 months before joining, and their average time on the programme was 11 months). • Feedback from both patients and healthcare professionals demonstrates the programme is having a positive impact on treatment outcomes and is valued highly. • To ensure high levels of performance and a culture of continuous improvement, the Programme at each Trust is reviewed regularly by their senior managers, Apodi (an outsourcing organisation which works in partnership with clients to identify and implement innovative access strategies) and Takeda (a pharmaceutical company). • SY stated the PSP has been planned with good insight, clear objectives and has resulted in positive outcomes which they hope can be adopted throughout K&M. Patient feedback has also been very positive.	
6	**Lymph node Biopsy at EKHUFT: A 5 year review**	**Update provided by Sree Munisamy and Chibuzo Mowete** • The data was collected from lymph node biopsies carried out across the service at EKHUFT from January 2015 to March 2020. The figures were then categorised in to either excision or core needle biopsies as well as diagnosis. Further subgroup analysis of non-diagnostic samples was carried out from electronic patient records to determine the final outcome for the patient. • A total of 2499 biopsies were carried out between January 2015 and March 2020. 41% were core needle biopsies and 59% were excision biopsies. The diagnoses for all biopsies regardless of modality include: non-malignant (49%), haematological malignancy (24%), non-haematological malignancy (23%) and non-diagnostic (4%). • There were significantly more non-diagnostic samples with core needle biopsies (8%) compared to excision biopsies (1%). • The audit also looked at outcomes of patients undergoing their initial biopsy by modality and diagnosis and outcomes of patients following their repeat biopsy. • The average time taken from the initial biopsy to a repeat biopsy of any modality was 45 days (which they hope to reduce). There was no statistically significant difference between a repeat core needle biopsy (which had a mean of 38 days) and a repeat excision biopsy (which had a mean of 49 days). • They found excision biopsies more accurate, although it consumed more resources and carries additional risks compared to core needle biopsies. • There was a personalised approach to each patient (inclusive of fitness, disease and external factors). • They feel it would be reasonable to adopt a strategy for the initial core biopsy to be used in most cases, but an excision biopsy should be adopted for repeat biopsies. • SM stated the audit helped them to plan for the lumps and bumps clinic. He added the clinic is to be rolled out regionally and would be happy to discuss this further should anyone wish to contact him. • **Action: Microsoft Teams meeting to be set up in order to harmonise the lymphadenopathy pathway. The meeting will include JJ, SGo, SH, SM, LB, CS and other relevant Trust colleagues. This item replaces action number 6 on the action log (which is now closed).** • JJ stated the rapid lymphadenopathy service has been well received. CS confirmed there is some work going on at the CCG to ensure there is just 1 referral form. He highlighted the importance of GP's knowing where to find the form, utilising it and agreed to keep the TSSG up to date on any developments in this direction.	**LB**

7	**Performance**	**DVH – update provided by Michelle McCann** • The Trust achieved the 2ww target in February, failed it in March and are likely to fail it again in April 2021. Of the 7 cases they had in April 2021, 1 breach resulted in them failing the standard. They have seen an increase in 2ww referrals. • They met the 31d standard in February and March and are likely to do so again in April 2021. • DVH failed to reach the 62d target in February (due to 1 patient having a complex pathway), achieved it in March and are likely to achieve it in April 2021 too. • The Trust have 1 104d+ patient, a complex case which has had to undergo multiple investigations and is also being reviewed by the lung MDM team. • DVH failed to achieve the 28d data compliance standard in February and March but are likely to meet it in April 2021. In terms of the 28d data completeness target, they are currently at 80% and are therefore meeting the standard. • A reduction in Consultants and an increase in workload has had an impact on their ability to manage the service as efficiently as they would like. In order to expedite this, the Trust have appointed 2 additional Consultant Haematologists, 1 CNS and 1 full-time secretary. • SY has amended clinic templates and specialised clinics have been introduced. • The Trust have no theatre capacity issues. **EKHUFT – update provided by Pippa Miles** • The Trust achieved the 2ww standard in February and March and are likely to do so in April 2021 also. Daily calls with the team ensure capacity is managed to ensure compliance. • EKHUFT met the 31d standard in February and March and are likely to meet it in April 2021 too. Daily calls with the team ensure capacity is managed and engagement with the team ensures compliance as any issues can be addressed quickly. • They failed to reach the 62d standard in February, met it in March and are predicted to also achieve it in April 2021. They failed to achieve the target in February due to 1 complex diagnostic pathway case which was referred to them late in the pathway by another tumour site. There was also a delay with the ultrasound-guided biopsy. • The Trust had no 104d+ cases in February, 1 in March and are likely to have none in April 2021. Weekly PTL calls ensure patients are managed and any with a potential to breach are discussed and solutions put in place. • In terms of 62d+ backlogs, they had 2 in February, 2 in March and are likely to have 1 in April 2021. • In relation to the 28d data compliance piece, they average around 65% for this (the expected standard is 75%) and have only met the target twice in the last year. • With regard to 28d data completeness, they average 90%+ for this (the expected standard is 80%). Dedicated administrative support is in place to improve 28d data collection and accuracy. The Pathway Navigators also support with data entry. • There are no COVID-related barriers to service delivery. • Delays in diagnostics are related to complex pathways and patients referred in from other tumour site teams. • All rapid access lymphadenopathy patients are compliant with the 28d targets. • They have no theatre or outpatient capacity issues. • They have had some radiological issues but are working with colleagues to resolve these.	

		MFT – update provided by Margaret Williams • They achieved the 2ww standard in February and March and are likely to meet it in April 2021 too. • MFT met the 31d target in February and March and are predicted to do so again in April 2021. • The Trust did not meet the 62d standard in February and March but are likely to achieve it in April 2021. • They had no 104d+ cases in February and March and are predicted to have none in April 2021 too. • In relation to 62d+ backlogs, they had 1 in February, 1 in March (a patient was transferred to them by the upper GI team on day 58) and are likely to have none in April 2021. • With regard to the 28d data compliance target, they failed to achieved this in February and March and will likely fail it in April 2021 too. • MFT did not provide any 28d data completeness figures in their presentation. • Upon lockdown, they relinquished their permanent Wednesday afternoon clinic room. However, they now need this room in order to accommodate further demand. Unfortunately, there is not sufficient capacity to have the room on a permanent basis but they are now trying to work around this as they are overbooking across all clinics. • MW stated she believes some of the data presented on the MFT slides is inaccurate. • MAl specified most of MFT's breaches tend to be due to cases being referred to them from other tumour sites late in patients' pathways. • MW mentioned MFT have a 31d subsequent treatment breach due to a patient having their second vaccine and not being able to be treated for 2 weeks. **MTW** • No update provided despite AW emailing cancer management on several occasions.	
8	**Clinical Pathway Discussion**	**HOP** • **Action: LB to update and finalise this document by 14.07.2021.** **Leukaemia PoC** • **Action: AW to email ED to confirm whether she will still be updating this document, which will need to be finalised by 14.07.2021.** **Myeloma PoC** • **Action: LB and JL to update this document which will need to be finalised by 14.07.2021.** **Haemato-oncological PoC** • **Action: AW to email Sarah Arnott to confirm whether she will still be updating this document, which will need to be finalised by 14.07.2021.** **Draft Lymphoma POC** • LB thanked SY for updating the high grade section of the lymphoma PoC document. **Action: AW to email Clare Wykes to confirm whether she will still be updating the low grade section of the lymphoma PoC document. AW to also email Vijay Dhanapal to confirm whether she will still be updating the**	**LB** **AW** **LB/JL** **AW** **AW**

		Hodgkin's section of the lymphoma PoC document. Both of these sections will need to be finalised by 14.07.2021. • AW confirmed pan-London pathway links would be included in the relevant documents.	
9	**Research**	**Update provided by Olumide Olufuwa** **Maple** • Recruitment for this trial is currently on hold at DVH. **ITP Registry** • This trial is now open at DVH. **PIMMS** • This trial is about to open at DVH. • OO stated the CCP Cancer UK Companion study is about to open at DVH and PREPARE is being set up. With regard to MYELOMA XIV, OO is not sure if this trial is still recruiting but if it is, DVH would like to take it on. • LB highlighted the importance of being aware of the trials other Trusts are participating in and of cross-referring. • **Action: All Trusts to send LB and CC/AW a summary of open, upcoming or potential trials.** • **Action: LD to arrange a meeting with Trust colleagues to further discuss research and commercial trials.**	**All Trusts** **LD**
10	**NG12**	**Update provided by Jack Jacobs** • JJ stated he appreciates the forms are lengthy but they have to adhere to NICE NG12 guidance. In view of this, it can take some time to change them. They try to encourage GP's to provide supporting information when making a referral. • JL stated she assumes when a referral is made to secondary care, the patient has a good performance status and is not bedbound. She added it is helpful to know their comorbidities and relevant medications (including if they are on anticoagulants). • JL mentioned the referral is often accompanied with a lengthy overview of information, some of which is not related to the case at hand. In view of this, she is concerned clinicians may miss some important information as they often do not have the time to read it all. JJ stated it is currently not possible to change this process due to ERS having a system in place whereby the information is automatically attached to the referral when it is made. • CS specified the CCG are working on implementing a process whereby a single system will hold all 2ww forms for GP practices to refer to. Some GP's are using outdated 2ww forms, often saved on their computer desktops, instead of the current ones (which JJ specified can be found on the KMCC website). • CS stated the forms have been through a very extensive and clinically-resourced process and the CCG are trying to put measures in place to improve their utilisation. • JZG mentioned GP's sometimes refer patients to secondary care without conducting a clinical examination, especially during the pandemic, with the assumption that haematology are the team likely to treat any confirmed malignancy. • **Action: JJ stated there needs to be an IT platform which will enable clinical systems to have the forms embedded within them. Following this, they may then be in a better position to look at a reiteration of cancer**	**JJ**

		referral forms. JJ to keep the TSSG up to date with any developments in this direction. • JJ specified the embedding of the Kent & Medway Care Record (KMCR), which will enable data sharing between organisations, would be most helpful. When implemented, organisations will no longer need to send letters and problem lists to each other as the information will be located on the system. The governance piece for this system is in the process of being reviewed. CMal stated there is a piece of work underway on integrating InfoFlex data to the KMCR.	
11	**Clinical Audit**	**<u>Neutropenic Sepsis Audit – update provided by Adrian Choy & Rosie Barker</u>** AC and RB presented an audit on door-to-antibiotic times for suspected neutropenic sepsis. Their slides provided an overview of: • The background to the audit. • 2012 NICE guidelines. • Trust guidelines (which states patients should be treated on suspicion of neutropenic sepsis through the red flag process). • The standards, objectives, methodology and results (including demographics) of the audit. • The proportion of cases with door-to-antibiotics within 1 hour (between July and October 2020) and the proportion of cases with Trust-approved antibiotics given. AC and RB confirmed patients are not being given the antibiotics as promptly as they would like. • Patient outcomes. • Limitations. • Next steps and recommendations. • The MTW 'Patient at risk of neutropenic sepsis' form. Some colleagues at MTW initially confused this form with a DNAR one. In view of this, they are considering changing the colour of the form (LB suggested blue). • They plan to send out what they described as a red letter, essentially a checklist for the measures which need to be taken if neutropenic sepsis is suspected. The patients are to take this home with them and bring in to A&E so the doctors there are aware of what course of action is needed. Ideally, they would like this to be uploaded to AllScripts and have tried to give it out in their chemotherapy unit and on the wards over the last month and disseminate information to the nurses and other relevant healthcare professionals on the ward. AC confirmed he had taken a stack of the printed letters to the Chartwell Unit and colleagues there confirmed it is being given to patients. MAl stated they have red cards at MFT and MY mentioned EKHUFT have a pre-filled prescription document (put together by a matron) informing clinicians which drugs to administer to the patient upon suspicion/confirmation of neutropenic sepsis. JZG advised that DVH do not have a proforma for neutropenic sepsis. • ERS stated the red letter would be of great help and she believes the best time for patients to be given this is when they have their initial consultation, along with information such as emergency contact numbers. NH added the letter was emailed out to all staff requesting they post it to patients along with the other new patient information documentation. • LB specified MTW need to determine when it would be most suitable for the letters to be given to patients. • LB stated it would be helpful to have a neutropenic sepsis proforma and suggested they utilise what is already in place in the Lord North Ward at Maidstone Hospital. She is happy to help AC and RB with this if required. She also	

		suggested they speak to simulation team colleagues to determine whether they would be able to include neutropenic sepsis as part of their programme. • SM suggested an electronic document be put in place. An EPR alert could be flagged up when the A&E doctor opens the record stating the patient is having chemotherapy and could have neutropenic sepsis. • **<u>Action:</u> The group agreed there should be an electronic form in place with flags highlighted for patients who are at risk of neutropenic sepsis and to use an agreed proforma in the interim. LB to coordinate this.** • LB stated she would contact AC and RB later today to discuss further with them the proforma piece in addition to the simulation suggestion.	**LB**
12	**CNS Updates**	**<u>DVH</u>** • No update provided. **<u>EKHUFT – update provided by Stephanie Goodchild</u>** • There have been no personnel changes since the last meeting. • Their lumps and bumps clinic is functioning well. • There are currently 2 CNS' in place. • They do not currently have a Support Worker in place. They will, however, require one in order to deal with the workload associated with the CLL stratified follow-up remote monitoring service piece discussed earlier in the meeting. • They have yet to meet with the other CNS teams across the patch but plan to do so soon over Microsoft Teams. • During the pandemic, most CNS work was done by telephone. • Patient feedback has been positive in relation to the remote follow-up piece. • They send out blood test forms to patients and encourage them to have this done 2 weeks prior to their telephone appointment. **<u>MFT – update provided by Kerry Michelsen</u>** • They are currently 1 WTE CNS down, leaving just 1 CNS (KM) in place at the Trust. • They have a part-time Support Worker but would need a full-time one in place in order to deal with the workload associated with the CLL stratified follow-up remote monitoring service piece discussed earlier in the meeting. **<u>MTW – update provided by Emma Richardson-Smith</u>** • They have 6 CNS' in place, most of which work part-time. In view of this, they have a total of 3.9 WTE CNS'. They also have a full-time administrator. • There are 3 chemotherapy clinics, 3 MPN clinics, 2 IT clinics and a bone marrow list each week. They also support Consultants with their clinics when and where possible. • They are looking to set up a new ITP clinic but this is unlikely to be implemented for some time as they are extremely busy at present. • From next week, they will have a new unit to work out of which will enable them to have more clinic and treatment rooms. • During the pandemic, separate blood clinics were set up and they continued to treat COVID-positive patients in designated areas.	

		• They are struggling with chemotherapy patient workload. • Most clinics take place by telephone. • Patients are required to have a blood test 1 week prior to needing medications for chemotherapy clinics. • A number of patients who have struggled to book a GP appointment throughout the pandemic have called the haematology clinics for advice and guidance. They then had to divert these patients back to their GP practices. JJ stated primary care have received a significant number of eConsults which has placed pressures on practices across the patch. Both primary care and secondary care have received an increase in telephone calls, especially in relation to vaccination queries. • SH stated EKHUFT were vaccinating patients but the in-house service has now ended so they are redirecting patients to the national vaccination centres.	
13	**Palliative Care update**	**<u>Written updated provided by Georgina Parker (Lead Consultant in Palliative Medicine – Heart of Kent Hospice)</u>** • COVID has changed the way their services have been provided over the last year but they have continued to deliver a service in both the inpatient unit and in the community. • They are still admitting patients for symptom control and end of life care. • Visiting restrictions continue and are likely to do so for the next few months at least. Their website is regularly updated with information about this. - • They continue to visit patients in their homes as well as in care homes but are also doing more telephone and video call consultations. • Their Living Well services were transferred online for a while but some are slowly going to start coming back to face-to-face over the next few weeks. Some may stay online for ease of access and they continue to liaise with patients/clients to see what their preferences are. • Counselling sessions have taken place by telephone or video call, although some are now starting to come back to face-to-face. • Compassionate Neighbours have continued to support their community members and there have been some valuable stories of support throughout the last year. • Their fundraising activities had to move to remote activities but they have continued to engage with all of their partners despite the pandemic and had an amazing response to their appeal. Their shops were shut for long periods. • Georgina Parker would like to draw the members' attention to their Elmer's Big Heart of Kent Parade Sculpture Trail which is coming to Maidstone over the summer. They have over 50 elephants (sponsored by local companies and individuals) which have been designed by artists from all over the UK and these will be arranged into 3 trails over approximately 7 miles around Maidstone where people can walk and visit them all. They will then be auctioned off when the trail finishes and head off to their forever home. If anyone is interested in volunteering as a Trailmaker, they are asked to visit https://elmermaidstone.co.uk/ for more details. • Georgina Parker and Kumi Wilkinson believe it would be helpful to arrange a meeting with LB at some point in the autumn (all being well COVID-wise) to discuss where the hospice might sit with regard to offering blood transfusions for symptomatic benefit for their mutual patients. Their plans for getting this service off the ground were slowed down by the pandemic as they have not been able to complete the training and competency programme for nursing staff. They are, however, hopeful they can progress with this.	

14	**Cancer Alliance update**	**<u>Update provided by Irene Nhandara</u>** The predominant aims of cancer services across the patch are to: • Restore urgent cancer referrals at least to pre-pandemic levels. • Reduce the backlog at least to pre-pandemic levels on 62d (urgent referral and referral from screening) and 31d 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.	
15	**CCG Update**	**<u>Update provided by Chris Singleton</u>** • CS and Laura Alton are the new Senior Programme Managers for cancer commissioning in Kent & Medway 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). • CS and Laura Alton are keen to help support the development of clinical pathways which improve access to cancer services for the K&M population, navigating through the new CCG governance processes. The CCG will ensure they work at scale across the patch, whilst also making sure 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 (VISS) at DVH, which they are looking to make a substantive commissioned service there due to the success of the pilot. Discussions are underway to extend the VISS model more widely across the patch. MY stated the team at EKHUFT are currently not in a position to take this piece of work forward due to their large workload (which includes the rapid lymphadenopathy service piece). JJ stated he would be happy to link in with LB to discuss the VISS piece and how MTW could potentially support this piece of work. - The rapid lymphadenopathy service at EKHUFT. MTW have expressed an interest in having this service in place by the end of 2021. - The low dose CT piece at EKHUFT. • CS and Laura Alton have also been working with the provider of the K&M prehabiliation programme, 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/Laura Alton if they require commissioning support with any cancer pathway developments.	

16	**AOB**	• LB mentioned a support group in West Kent, initially known as the myeloma support group, are looking to expand it to a pan-Kent cancer support group. They have yet to decide on the name of the group. LB stated if anyone feels they should be invited to this group or would like to help set it up then they are encouraged to email her and she will then pass the details on to the group organisers. The idea would be to have the meetings by Microsoft Teams initially before meeting face-to-face. The meetings will discuss items such as side effects of cancer and guest speakers will be invited to present. Discussions around lymphoma, myeloma, leukaemia and other topics can be discussed and patients will have an opportunity to link in with each other should they wish. Macmillan have previously been part of the myeloma meetings and would be keen to continue participating in the newly-formed group.	
	Next meeting	• Wednesday 17th November 2021 (09:30–13:00) – Microsoft Teams	