Acute Oncology & Palliative Care Tumour Site Specific Group meeting
Thursday 9th October 2025
Microsoft Teams
09:00-12:30

Final Meeting Notes

Present	Initials	Title	Organisation
Tracey Spencer-Brown (Chair)	**TSB**	Head of Nursing for Oncology & Cancer Performance	MTW
Sarah Eastwood	**SE**	Macmillan Personalised Care Project Manager	MTW
Jennifer Pang	**JP**	Consultant Clinical Oncologist	MTW
Claire Ryan	**CR**	Macmillan Consultant Nurse - Metastatic Breast Cancer	MTW
Tom Allum	**TA**	Macmillan Information and Support Lead - Kent and Medway	MTW
Amy Daniels	**AD**	Head of Mental Health	MTW
Natasha Woodrow	**NW**	AO Triage Nurse	MTW
Kelly Morphew	**KM**	Metastatic Breast CNS	MTW
Marie Payne	**MP**	Macmillan Lead Cancer Nurse	DGT
Billie-Jo Beacroft	**BJB**	Macmillan AO CNS	DGT
Tracy Wooldridge	**TW**	Palliative Care CNS	DGT
Carrie Barton	**CB**	NSS CNS	DGT
Jennifer Jewell	**JJ**	Macmillan Lead AONP	EKHUFT
Lucie Rudd	**LR**	Joint Clinical Lead for End of Life Care	EKHUFT
Claire Whiteley	**CWhi**	Macmillan Lead NSS/AONP	EKHUFT
Denise O'Malley	**DOM**	Head of Hospice Outreach Service	Hospice in the Weald
Clare Wilkins	**CWi**	Consultant for Palliative Medicine and AO	Hospice in the Weald
Chris Wheal	**CWhe**	Patient Partner	KMCA
Emma Lloyd	**EL**	Cancer Pathways Improvement Project Manager	KMCA
Tracey Squire	**TS**	Macmillan User Involvement Manager	KMCA
Chris Singleton	**CS**	Senior Programme Manager for KMCA Commissioning	KMCA
Karen Glass	**KG**	PA/Business Support Manager	KMCA/KMCC
Colin Chamberlain (Notes)	**CC**	Administration & Support Officer	KMCC
Samantha Williams	**SW**	Administration & Support Officer	KMCC
Erica Simpson	**ES**	Community Palliative Care Team Lead	Medway Community Healthcare
Rosalyn Yates	**RY**	Clinical Lead for Palliative Care Services	Medway Community Healthcare
Rosemary Chester	**RC**	Consultant in Palliative Medicine	Medway Community Healthcare
Suzanne Bodkin	**SB**	Cancer Service Manager	MFT
Afroditi Karathanasi	**AK**	Consultant Medical Oncologist	MFT
Rachael Butcher	**RB**		MFT
Bobbie Matthews	**BM**	Macmillan Lead AONP	MFT
Louise Farrow	**LF**	Macmillan Lead Cancer Nurse	MFT

Apologies			
Stacie Main	**SM**	AO Lead Nurse	DGT
Hannah Weston-Simons	**HWS**	NSS GP Lead	DGT
Danielle Mackenzie	**DM**	Macmillan Lead Nurse for Personalised Care	EKHUFT
Jin Lindsay	**JL**	Consultant Haematologist	EKHUFT
Ann Courtness	**AC**	Macmillan Primary Care Nurse Facilitator	KMCA
Jonathan Bryant	**JB**	Primary Care Cancer Clinical Lead	KMCA
Sarah Slater	**SS**	Community Palliative Care Team Manager	Medway Community Healthcare
Charlotte Moss	**CM**	Consultant Medical Oncologist	MTW
Jenny Weaver	**JW**	Macmillan Immunotherapy CNS in AO	MTW
John Schofield	**JS**	Consultant Pathologist	MTW
Maher Hadaki	**MH**	Consultant Clinical Oncologist	MTW
Mathilda Cominos	**MC**	Consultant Clinical Oncologist	MTW
Megan Lumley	**ML**	CUP CNS	MTW
Ruth Palfrey	**RP**	FDS NSS Nurse Specialist	MTW
Riyaz Shah	**RS**	Consultant Medical Oncologist	MTW
Stefano Santini	**SS**	NSS GP Lead	MTW

Item		Discussion	Action
1	**TSSG Meeting**	**<u>Apologies</u>** • The apologies are listed above. **<u>Introductions</u>** • TSB welcomed the members to the meeting and asked them to introduce themselves.	
2	**Review of action log and previous minutes**	**<u>Action log review</u>** • The action log was reviewed, updated and will be circulated to the group along with the final minutes from today's meeting. **<u>Review previous minutes</u>** • The minutes from the previous meeting were not reviewed but had previously been agreed to be a true and accurate record.	
3	**Palliative Care Service Presentation**	**<u>Medway Community Healthcare – update provided by Rosalyn Yates</u>** • The service covers Medway and Swale and is an unusual model in that it is a community service that also manages inpatient care. • There are interfaces with multiple local authorities and health providers and this can sometimes result in system and communication challenges. • The Wisdom Hospice (Rochester) has 15 beds (three bays and three side rooms) and there is often a waiting list. • The Wisdom Hospice provides a 24 hour service providing advice to the community and MFT.	

		• At Wisdom Hospice, there is a multidisciplinary approach to working together which includes medical staff, family care and bereavement teams, therapy staff, and a specialist MND service. • The Wisdom Hospice service is supported by the Wisdom Hospice Charity (while NHS-funded). • The MFT in-reach team comprises of one ACP, six CNSs, a Band 3 role and one specialist doctor. • The team supports patients from ED onwards through crisis, completes all fast-track referrals at MFT (roles now integrated into CNS duties) and works closely with the End of Life Care team and Namaste Practitioner. • The community team comprises of one ACP, eight CNSs and a Band 3 role covering Medway and Swale. The team includes a dedicated End of Life Care CNS for nursing/care homes. • There are daily multidisciplinary huddles across the hospital, community and inpatient teams to coordinate care. • Initiatives and partnerships include: - Collaborating with Oxleas NHS Foundation Trust to improve palliative care in the five prisons Medway & Swale cover. - A homelessness project and support for 'unbefriended' patients. - Multi-faith engagement. An evening was held for faith leaders in order to work towards improving community links and patient support. - Marching at Pride (ensuring LGBTQ+ inclusion). - Transition care. The service is working with Demelza and TYA Nurse (Sarah Trollope) to support younger patients and transitional pathways. - Namaste Care which focuses on expanding a holistic approach beyond the inpatient unit. - The Wellbeing & Therapy Centre. The re-opening of this is planned for the new year to engage patients earlier in their journey. - Facilitating living wakes, weddings and outdoor end-of-life space development. - The Blackbird Project which has been adopted from Pilgrims Hospice and allows patients to record messages for loved ones as lasting audio memories. • TSB praised the service as unique, inspiring and aligned with the 10-year strategy of integrating primary, secondary and community care. • DOM commended the breadth of work and asked about the prison service link. In response to this, RY explained the educational and advisory role with five prisons and the focus on ensuring compassion is balanced with security.	
4	**Acute Oncology: Trust Service Updates**	**EKHUFT** • AOS covers two acute sites (William Harvey Hospital and QEQM Hospital). There is no current staffing to support the Canterbury site, though service demand exists. • The team includes AO/Palliative Care Consultant Declan Cawley (DC), eight Nurse Practitioners, and four Navigators. • From April to September 2025, the service engaged with 782 new patients, did ~1000 follow-ups and avoided admission for 66 patients across the two acute sites.	

		• Sustaining a seven-day service with limited workforce and increased sickness absence has required prioritisation of oncological emergencies and new diagnoses. • There is a rising number of complex presentations, particularly immunotherapy-related complications. • There is a reliance on CNS teams for additional inpatient support during periods of reduced staffing. • With regard to developments and achievements, the service has: - Four Non-Medical Prescribers (NMP), with a fifth in training. - Worked on developing an AOS live dashboard to analyse cancer presentations at ED (distinguishing cancer-related vs. treatment-related attendances). - A continuation of education programmes covering immunotherapy toxicity, radiotherapy, MSCC, and neutropenic sepsis. - Managed to sustain a seven-day service for five years – noted as a major achievement. • There is ongoing work with ED and SDEC teams to strengthen ambulatory and rapid-assessment pathways. • There is collaboration with the EKHUFT Skin Nurse Consultant (Kim Peate) to deliver targeted education on neutropenic sepsis and immunotherapy complications. • Band 4 Navigator Lucy Page has commenced nurse training. • The handheld antibiotic prescription pathway is performing well and this has improved compliance at QEQM Hospital with ongoing work at William Harvey Hospital. • In terms of support, clarification is sought regarding immunotherapy data collection and integration into the national AOS dataset. • TSB commended EKHUFT for maintaining a seven-day service despite workforce pressures and for sustained leadership on the Cancer Care Line. • TSB recognised the team's commitment to staff development and innovation, particularly NMP expansion. • TSB confirmed that KMCA will coordinate an updated dataset incorporating immune checkpoint inhibitor data once input from all Trusts is gathered. **MFT** • Over the past six months, the AOS has faced significant staffing and service challenges but is now rebuilding and stabilising. • The current team comprises of one Band 8 Lead, four Band 7 CNSs (one is currently on long-term sick leave) and they are supported by Consultant Lead Afroditi Karathanasi (AK). • In terms of activity in the past six months, there have been 779 new AOS referrals and 3740 reviews conducted. • Key pressures include: - Workforce instability with only one CNS in post, resulting in data gaps while patient care was prioritised. - ED pressures with very high patient volumes and ongoing difficulties engaging ED teams and ensuring understanding of immunotherapy-related toxicities.	

		- A capacity strain on the inpatient oncology ward, requiring additional AOS input. - A lack of admin support continues to hinder service efficiency and data capture. • Developments and achievements include: - Recruitment being completed to rebuild the CNS workforce. A seven-day service will be reinstated, launching this week. - The Hotline service being covered by AO staff during weekdays and the inpatient ward covering out-of-hours. A hotline training programme is underway for new ward staff. - AOS Awareness Week. This was celebrated with Trust-wide engagement including presentations, comms features, and an information stand at the main entrance. - An ongoing teaching programme for medical and nursing teams, focusing on oncology emergencies and immunotherapy complications. - Professional development. CNS Cherie Neill is undertaking clinical assessment training and there is a plan for full team participation. • Clarity is needed from the TSSG regarding InfoFlex data collection and reporting direction. • Additional support is also needed to improve HNA completion for AOS patients. SE highlighted that Hayley Martin (Macmillan Personalised Care & Support Facilitator – MFT) can support with HNAs and InfoFlex data implementation. • TSB commended the team for rapidly reinstating the service and establishing a seven-day model despite staffing challenges. • TSB also praised the team's visibility and engagement during AOS Week and expressed confidence that the new team will deliver positive, sustainable improvements. **DGT** • DGT have a nurse-led AOS operating at Darent Valley Hospital. The team comprises of one Band 8a Lead, three Band 7 CNSs (two of whom are NMPs), one Band 6 AO Nurse and one Band 4 Nurse Associate. • The AOS team shares an office and admin support with the Palliative Care team. • The AOS team provide a seven-day service. • With regard to activity in the last six months, there have been: 2001 face-to-face reviews, 138 clinic reviews, 36 neutropenic sepsis cases and 18 MSCC cases recorded. • There is ongoing work to improve admission avoidance recording on InfoFlex in preparation for launching a cancer SDEC service. • Long-term staff sickness has impacted service delivery, though all team members have now returned. • There are rising caseloads and increasing patient complexity, particularly relating to immunotherapy-related toxicities. • There is upcoming maternity leave within the team. Recruitment to backfill the post is underway with interviews scheduled for the end of the month. • There is an absence of a AOS Clinical Lead, which remains a risk register item. • Two CNSs have completed NMP qualifications. • Two nurses have successfully completed advanced clinical skills training.	

		• There is active participation in the Community Investment Programme Working Group, progressing plans for a new cancer SDEC service at Darent Valley Hospital. • All team members now have access to imaging requests, improving efficiency and patient flow. • There is continued completion of MSCC and neutropenic sepsis audits (data is slightly delayed but progressing). • There is a need for the appointment of a Clinical Lead to provide medical oversight and strategic direction for AOS. • TSB acknowledged the commitment and resilience of the DVH team in sustaining a seven-day service despite challenges. • TSB expressed support for the development of the cancer SDEC service, recognising it as a positive advancement for patient care. **MTW** • The AOS team continues to provide a seven-day service, maintaining full coverage despite significant recruitment challenges and staff transitions. • Two experienced team members recently transferred to MFT, but the service has sustained both its AO and SDEC provision throughout. • The AOS triage phone is managed by the team during working hours. • In terms of activity and performance, the SDEC service has: - Triaged 2437 within working hours. - Had 748 patients attend the AO SDEC. - Had a business case approved to expand from four to five days (currently Tuesday-Friday, 09:00–17:00). - Ensured that the emergency inpatient pathway continues to operate seven days a week (09:00–17:00). - Prioritised data collection around SDEC activity. New patient reviews are recorded but not all follow-up contacts are due to workload demands across multiple pathways. • The team comprises of one Band 8A Lead, seven Band 7 Nurse Practitioners, three Band 6 Triage Nurses, one Band 4 Navigator, one Band 4 Support Worker, and one Band 3 Administrator. • There is one NMP currently in post and an additional Nurse is undertaking NMP training. • Oncology SPRs, SHOs, and Fellows support the SDEC on rotation. • There is increasing Consultant input, particularly for CUP cases. • The team continues to develop AO Passports for clinical competency assessment. • In terms of developments and achievements, the MTW AOS has: - Sustained the operation of a seven-day AOS and ongoing SDEC service growth. - Plans to extend SDEC provision to Tunbridge Wells Hospital to ensure equitable access across both sites. - Received positive patient feedback, highlighting the value of the service. - Conducted exploration of virtual ward pathways. - Worked collaboratively with Palliative Care colleagues to enhance continuity of care. • Key pressures include: - Recruitment challenges and workload strain across three parallel service areas (emergency, SDEC, and triage).	

		- Staff wellbeing. This remains a concern following sustained pressures post-COVID and during transformation programmes. • In summarising: - CWi commended all AO teams across Kent and Medway for achieving such a high level of service delivery despite significant workforce pressures. - TSB acknowledged staff vulnerability and wellbeing challenges, noting that dedication and passion remain strong across teams. - CWi suggested a regional approach to psychological support for AOS Nurses, potentially led by Clare Reeder's CaPS-KM team, who have successfully supported palliative care staff at EKHUFT. • TSB confirmed Clare Reeder's ongoing involvement with AOS teams, including: - The delivery of Level 2 psychological training for AOS Nurses. - Support for complex oncology MDT cases and outpatient clinics. - Presentation at the previous Acute Oncology & Palliative Care TSSG. - The development of a business case to make her role substantive, ensuring continuity of psychological support services. • **<u>Action</u>: KMCA/TSSG to coordinate an updated dataset incorporating immune checkpoint inhibitor data once input from all Trusts is gathered.**	**KMCA/ TSSG**
5	**Patient Experience of Care-Experts by Experience**	**<u>Limbo Land – update provided by Tracey Ryan & Chris Wheal</u>** • Limbo Land is a series of short films capturing patients' experiences of waiting – for investigations, results, diagnoses, or treatment decisions – and the associated uncertainty and anxiety. • The project was led by the Working Together patient group with KMCA support, aligning with the Personalised Care programme to identify psychological-support needs. • Films include contributions from patients and professionals (GPs, CNSs, psychologists) offering reassurance and coping strategies. • Initially intended as one film, the richness of patient input led to nine individual videos now hosted on the KMCA website. • The films are relevant not only to cancer patients but to anyone awaiting significant medical results/treatment plans. • CWhe shared his personal journey with prostate cancer and the motivation behind the project. • CWhe emphasised that while every cancer experience is different, feelings of fear, anxiety and isolation are universal. • The films aim to help others feel 'normal' in those emotions and to promote understanding among professionals. • Patients experience profound uncertainty and emotional strain during waiting periods. • Support strategies include open communication, mental self-care, and accepting that it is OK not to feel OK. • The importance of relationships with CNSs, doctors and wider healthcare teams for emotional and practical support was noted.	

		• As a central theme, listening and understanding from professionals is vital to patient wellbeing. • Members praised the film as powerful, moving, and inspiring. • There is recognition of how patients' voices are now shaping services and professional practice. • MP highlighted pride in local patient representatives being recognised nationally. • TS asked Trust colleagues to share the films with patients and encourage them to provide feedback (a feedback form will be added to the KMCA website). • CWhe reiterated that partnership working between patients and professionals benefits both groups. • **<u>Action</u>: Trust colleagues to share the films with patients and encourage feedback.**	**All Trusts**
6	**Staying Safe from Suicide**	**<u>Update provided by Amy Daniels</u>** • AD presented on the 'Staying Safe from Suicide' guidance (2025) and its relevance to acute and palliative care settings. • AD emphasised that suicide prevention is everyone's responsibility, not solely mental health services. • The guidance encourages a holistic, person-centred approach, moving away from risk prediction tools and static stratification, which are unreliable due to the highly changeable nature of suicidal thoughts. • Key points from the guidance include: - A focus on understanding individual situations, co-producing safety plans, and managing both immediate and long-term safety. - How risk assessments should prioritise patient needs, rather than using global risk categories (low, medium, high) to guide treatment or discharge. - Understanding that relational safety is crucial: building trusted, collaborative, therapeutic relationships is the strongest predictor of positive clinical outcomes. - An emphasis on multi-agency collaboration, ensuring safe discharge or transfer to appropriate support environments. • With regard to implementation and current work, MTW have: - Established complex case panels to review high-risk patients collaboratively. - Been considering adoption of guidance principles into day-to-day practice and aligning training and support. - Worked on the development of a mental health hub providing resources, training (including free suicide prevention courses), and pathways for staff. - Worked towards developing a mental health strategy for the Trust which will be published in November 2025, outlining five-year priorities for suicide prevention, including safe outpatient and preventative care. - Engaged with service users and mental health experts as these are central to strategy development. • TSB acknowledged the importance and sensitivity of the topic, emphasising its relevance across acute and palliative care settings. • AD highlighted learning from patients with cancer diagnoses experiencing suicidal thoughts and stressed the importance of collaborative approaches, clear pathways, and early intervention.	

		• AD invited colleagues to contribute to developing outpatient pathways and integrating suicide prevention guidance into clinical practice.	
7	**Cancer Care Line**	**<u>Update provided by Claire Whiteley</u>** • The EKHUFT Cancer Care Line operates seven days a week (09:00-17:00), offering a single point of contact for patients, carers, and professionals. • The line is primarily staffed by Band 3 administrators during weekdays, and covered by Band 4 AO clinical support staff at weekends and on Bank Holidays. • Following a review prompted by staff sickness in 2023, the service was restructured — Band 4 clinical staff now work one day a month on the line, improving cross-team communication and feedback into tumour site-specific groups. • The Cancer Care Line provides both practical assistance (e.g. scan or appointment queries) and emotional support for patients in distress or crisis. • Call volumes continue to increase year-on-year, with monthly activity between 2800 and 3100 calls. • A single staff member can handle approximately 100–150 calls per day, reflecting significant patient demand and reliance on the service. • The increase aligns with rising cancer incidence and more patients living longer with chronic or palliative disease. • The Cancer Care Line manages both routine and urgent (red flag) calls, including suspected sepsis, spinal cord compression, or major bleeding. • Staff follow a defined proforma to escalate urgent cases and coordinate rapid clinical response. They also manage CNS call-backs, action administrative tasks, and ensure prompt follow-up. • A major component of the role is emotional support, providing a calm and reassuring voice for patients in crisis. • The introduction of validation forms for CNS clinic activity has improved documentation and identified previously unclaimed income for clinical work. • There is ongoing positive feedback received from patients, GPs, and hospital teams, particularly highlighting accessibility and responsiveness. • Negative feedback mainly relates to patient frustration during emotional distress, which staff manage sensitively and redirect appropriately. • TSB commended the service as an exemplar model of accessibility and patient-centred communication, suggesting potential for replication across Kent and Medway – something which has been raised previously at the TSSG. • MP queried staffing levels, noting the high volume of calls. In response to this, CWhi confirmed staffing is typically at three to four team members but is occasionally reduced to two. • In summing up, TSB: - Recognised that EKHUFT are the only Trust currently operating such a dedicated Cancer Care Line.	

		- Praised the model's integration with other tumour site groups and its tangible impact on patient experience and system efficiency. - Highlighted that the Cancer Care Line provides immediate, compassionate support and clear communication during times of uncertainty.	
8	**Palliative Care: Trust Service Updates**	**<u>EKHUFT</u>** • EKHUFT provide a seven-day palliative care service which has been in place for approximately five years, with 24/7 telephone advice across the patch. • The service operates across three hospital sites, providing consistent specialist support to inpatients and outpatients. • The service is led by 1.0 WTE Consultant Nurse Lucie Rudd (LR) jointly with Palliative Medicine Consultants to clinically lead End of Life Care across the Trust. • Workforce includes 1.8 WTE Lead Nurses across sites, 10.87 WTE Band 7 CNSs and two Band 4 Support Workers. • A registrar has been in post at William Harvey Hospital for the past year – a positive addition to the team. • A vacancy in palliative medicine remains open. Resident doctor support has been available intermittently. • With regard to key developments and achievements: • There has been implementation of robust data collection for referrals, interventions, and outcomes – a significant milestone after five years of development. There are plans to develop this into a Palliative Care activity dashboard for ongoing monitoring. • There are dedicated inpatient palliative care beds established at William Harvey Hospital (six beds) and QEQM Hospital (five beds). Beds are located within General Medicine but admitting rights are held by the palliative care team. • Significant environmental improvements have been completed at QEQM Hospital (funded by East Kent Charity) which includes refurbishment with murals and artwork which has enhanced patient and staff wellbeing and boosted morale and ownership among staff. A celebration event is planned for November 2025 and will be attended by the Mayor and feature a patient story to highlight positive impact. • There has been collaborative work with Clare Reeder's CaPS-KM team to deliver wellbeing and resilience training for CNS staff (feedback has been highly positive). • Staffing shortages and long-term sickness is impacting the ability to maintain seven-day cover. • Operational pressures are limiting progress on quality improvement initiatives and long-term strategy work. • There are medical workforce gaps, particularly within the Consultant and Registrar tiers. • In terms of strategic priorities and future plans, these include: • To continue developing the End of Life Care Quality Improvement Plan across the Trust.	

		• The long-term goal to create an ambulatory care environment with AO colleagues to prevent avoidable ED admissions for palliative patients. • Ongoing data and outcomes work to strengthen service reporting and visibility. • The EKHUFT Palliative Care team is actively engaged in several system-wide forums including: the Kent and Medway End of Life Care Steering Group (which has strategic oversight), the East Kent Locality Group (which focuses on local delivery and innovation) and Acute Trust Palliative Leads Group (enabling shared learning across Trusts). • TSB thanked LR for her update and acknowledged that AO and Palliative Care often operate in the background, highlighting the value of this forum in providing greater visibility and collaboration opportunities across Trusts. **MTW** • The Palliative Care team at MTW is currently focusing on workforce development, with the aim of progressing towards a seven-day service model to improve access and continuity of care. • The team continues to deliver in-house Sage and Thyme training to enhance staff communication skills and confidence in end of life discussions. • There is ongoing involvement in the Trust's End of Life Care workstream, supporting continuous quality improvement. • There is also active engagement with the implementation of the ReSPECT programme, promoting patient-centred decision-making and consistency across clinical areas. **MFT** • The Medway Palliative and End of Life Care Service operates a collaborative model between the Hospital Palliative Care team and the End of Life team, now working closely together through daily ward rounds and weekly MDT meetings. • The hospital Palliative Care team provides a seven-day service (reinstated recently following staffing recovery). • The End of Life team plans to extend to seven-day cover pending funding approval from the Acute Trust. • The service benefits from an in-reaching hospital team supported by Medway Community Healthcare, ensuring continuity between hospital and community care. • August 2025 data activity shows that there was a total of 192 referrals across both teams (56 for End of Life Care, 46 for Fast Track discharge, 45 for symptom control, 22 for Namaste Care and five for hospice transfer). • Fast Track patients form a significant portion of referrals, with delays in care home placements contributing to bed pressures. • Key pressures include: • Early identification of palliative and EOL patients remains inconsistent, leading to delays in initiating end-of-life pathways and access to anticipatory medications (e.g. midazolam restrictions).	

		• Communication skills and confidence among ward staff remain variable — Advanced Communication Skills Training is offered at the Wisdom Hospice (next session is 3rd to 4th December 2025), though external uptake has been limited. • There being no admin support in post currently, however recruitment is planned. • System interoperability issues. There is a lack of interface between the Rio (community) and EPR (acute) systems which causes duplication of records. • Delays in syringe driver access and set-up on some wards, though work is underway to ensure consistent provision. • Incomplete documentation of patients' spiritual, religious, and cultural preferences, and their preferred place of care/death. • The ongoing slow access to KMCR. • In terms of developments and achievements: • The service is now fully staffed clinically and maintaining a seven-day presence. • There is ongoing delivery of Advanced Communication Skills Training via the Wisdom Hospice. • The Namaste Care Practitioner is delivering innovative, person-centred support for frail and palliative patients. • Dementia-friendly rooms have been created on frailty wards and there are activities such as aromatherapy, sensory stimulation, and 1950s-themed reminiscence sessions for patients and families. • A simulation-based teaching programme has been developed to improve early recognition of patients nearing end of life. • TSB commended the collaborative progress between teams and the creativity of the Namaste Care initiative, which has had a clear impact on patient and family experience. **DGT** • DGT continue running a seven-day service. • Between April and September 2025, the service received 863 new referrals and undertook 1375 ward review appointments. • Staffing challenges include there being no Consultant (the previous Consultant retired; recruitment ongoing) and the current Palliative Lead CNS is leaving at the end of next week. An additional experienced CNS is also leaving. • ReSPECT forms are mostly paper-based and there have been challenges uploading them to the KMCR system. • Recruitment is being made for 1.8 WTE Band 7 CNSs and a 0.6 WTE Band 6 Support Nurse (to be developed to Band 7 within 12 months). • Interim arrangements include Ellenor Hospice Consultants providing two hours a week to support via Microsoft Teams, at MDTs, by phone and on-site if necessary. • One CNS has completed NMP training and two additional CNSs will be commencing with prescribing training shortly. • Key developments/QI projects include:	

		• Exploring the Community Investment Programme for a front-door palliative care service. • A QI project to improve palliative care integration within departments. • Supporting escalation via the at-risk register. • **<u>Action</u>: LR to send TW a copy of the CNS competency framework to support Band 6 to Band 7 transition.** • **<u>Action</u>: All Trusts to encourage additional palliative care representatives to join the CRG.**	**LR** **All Trusts**
9	**Metastatic Breast Case Study**	**<u>Update provided by Kelly Morphew</u>** • KM is currently the only CNS in the metastatic breast cancer service, working alongside Nurse Consultant Claire Ryan (CR), three CSWs and an Oncology Pharmacist. • The service, established in 2014, had treated 273 patients by February 2025. • Patients are living longer due to advances in treatments, including 25 of 26 NICE-approved drugs over the last 10 years. • The CNS-led clinics include: acute triage (three times a week; 562 assessments January–July 2024), pre-treatment (once a week; 105 assessments), hybrid clinic with Pharmacist (once a week; 658 assessments), and new patient follow-up (once a week). • There is a weekly metastatic breast MDM for complex cases with Consultants, Radiologists, the trials team, and Pharmacist present. • There are monthly new patient information sessions, including outreach clinics (Crowborough). • Challenges include: the increasing prevalence in workload without workforce expansion, complex treatment decisions, navigating molecular testing, and discussions around palliative intent. • KM provided an overview of a case study of a patient with metastatic relapse post-2022 with an invasive lobular breast cancer diagnosis. The patient experienced multiple admissions (six between July and September 2025) with delayed advance care planning (ACP) and palliative discussions. There was a rapid deterioration despite active treatment, illustrating the need for earlier ACP and clearer end-of-life communication. • Key challenges identified include: - Time constraints limiting completion of ReSPECT forms, DNAR, and ACP discussions. - A difficulty recognising the dying phase vs. treatment-related toxicity in acute settings. - High complexity and unpredictability of metastatic breast cancer management requiring multidisciplinary support. • In terms of suggestions, CWi suggested updating referral criteria to support episodic care and earlier patient involvement, with a focus on opioid stewardship for chronic pain. CR also suggested embedding palliative care in CNS clinics to support ACP, DNAR and end-of-life discussions. • TW emphasised the importance of earlier palliative referrals to improve symptom control and community integration. • It was agreed that there could be a potential collaboration between MTW CNS clinics and Hospice in the Weald to support earlier and more effective palliative care input.	

10	**10 Year Health Plan & Strategy**	**Update provided by Chris Singleton** • The final draft version is targeted for submission to the Secretary of State by the end of November 2025. The exact release date is unclear and is dependent on political decision. • KMCA has rescheduled the planned face-to-face Cancer Conference to 08.01.2026 to review the 10-year plan and plan local delivery. • The plan is near the final draft stage from NHSE; local implications to be considered once officially released.	
11	**Breakout groups**	• TSB asked CC to organise four breakout rooms so that colleagues could focus on how the 10-year cancer strategy impacts services, priorities for TSSG, and collaborative working. **Group 1) Early Diagnosis, Digital & Acute/Community Care – feedback provided by Emma Lloyd** • Early diagnosis and screening programmes can reduce acute hospital presentations. • There is a need for real-time shared data between hospitals, hospices and community services for smooth transitions. • AO ambulatory units were suggested to support patient flow and improve transition home. • Community-based chemotherapy delivery and AO outreach services could help to support care at home (e.g. bloods, pump management, pre-chemo assessments). **Group 2) Palliative Care Focus – feedback provided by Lucie Rudd** • Key issues include bottlenecks in accessing care in the right place at the right time, community service capacity, and social care alignment. • Patients are often admitted to hospital unnecessarily due to a lack of responsive community services. • Suggested solutions include: a single point of access for palliative care, the development of ambulatory units for palliative/AO to provide same-day care (e.g. drains, antibiotics, hypercalcemia management), and integration with community services to allow patients to return home when safe. • These initiatives are aligned with ongoing Kent & Medway end-of-life care work. **Group 3) Patient Information, Digital Access & Community Links – feedback provided by Marie Payne** • There is a focus on patient empowerment and timely information along their journey. • The aspirational goal is to have one digital system across the NHS accessible to all providers. • The importance of front-door hospital access linking AO, palliative care and community services was noted. • The group highlighted challenges in contacting the right person in acute care - improved communication channels are therefore needed. **Group 4) Collaboration & Education – feedback provided by Rosemary Chester** • The group noted the benefit of increased palliative care representation at the TSSG. • A focus on joint education and training for AO and palliative care teams was noted.	
12	**AOB**	**Cancer Information and Support Hub - update provided by Tom Allum**	

		• The Hub was re-established in May 2025 and includes an Information Centre and Macmillan Infopod. It is staffed by Macmillan Information Support Workers and volunteers. • Hubs exist at other Trusts but are often unstaffed, providing only resource access. • Between January and October 2025, the service had a total of 553 service users. The most frequent referrals are to: the Welfare & Benefits Advice service, counselling (MTW Counselling/CaPS-KM psychological support), the Crossroads Carers & Volunteering service, the Harmony Trust (complementary therapies) and 'Look Good, Feel Better' workshops. • The impact of the staffed hubs includes: - Staff awareness and personal connections improving referral suitability and engagement. - Enabling holistic assessments and discussions around service user needs. - Providing emotional support in non-clinical settings. - Staff assisting with information in digital and other accessible formats, supporting NHS Long Term Plan objectives. - Collecting non-identifiable data to identify trends (tumour type, pathway stage, visit reasons, demographics) to guide service improvements. • The service has received positive feedback from MTW patients highlighting accessibility and support. • Data from HNAs helps link key patient concerns to the Hub's services. • Evidence shows staffed hubs improve engagement, referral effectiveness, and emotional support, supporting the case for resourcing these hubs in other Kent and Medway Trusts. **<u>Other</u>** • TSB requested feedback on the meeting format and emphasised the need for more palliative care members in the CRG. • CS acknowledged the need for face-to-face meetings, noted financial constraints and encouraged feedback to support potential future in-person sessions. • **<u>Action</u>: Members to submit feedback to CC/TSB regarding how they felt today's meeting went.**	**All members**
	Next Meeting	• To be confirmed.	