Kent and Medway Cancer Collaborative

Breast Tumour Site Specific Group meeting
Tuesday 11th November 2025
Via MS Teams
09:00-12:30

Final Meeting Minutes

Present	Initials	Title	Organisation
Deepika Akolekar **(Chair)**	**DA**	Consultant Oncoplastic Breast Surgeon	MTW
Ahmed Abdelmawla	**AA**	Specialty Doctor - Breast	DVH
Michelle Crosbie	**MC**	Operational Manager for Cancer and Haematology	DVH
Sylvia Hurley	**SH**	Macmillan Lead Breast CNS	DVH
Dawn Stewart	**DS**	Pathway Lead	DVH
Marie Thorne	**MT**	Macmillan Breast Cancer Support Worker	DVH
Nicholas Williams	**NW**	Consultant General Surgeon	EKHUFT
Eduvejes Villareal	**EV**	MacMillan Breast Clinical Nurse Specialist	EKHUFT
Saima Sagheer	**SS**	Specialty Doctor	EKHUFT
Suzannah Fitzgerald	**SF**	Nurse Specialist Oncology	EKHUFT
Vicky Stevenson	**VS**	Breast Support Worker	EKHUFT
Doraline Phillips	**DP**	Consultant Cellular Pathologist	EKHUFT
Catherine Gawler	**CG**	Operations Manager - Breast Surgery	EKHUFT
Krishnamurthy Murthy	**KM**	Locum Consultant	EKHUFT
Michalis Charalambous	**MCh**	Consultant Breast Surgeon	EKHUFT
Matthias Koslowski	**MK**	Consultant Histopathology	EKHUFT
Chiledu Chianakwalam	**CC**	Consultant Breast Surgeon	EKHUFT
Claire Bingham	**CB**	Macmillan Personalised Care Facilitator	EKHUFT
Vanessa Potter	**VP**	Lead Breast Care CNS	EKHUFT
Mehvish Nazeer	**MN**	Specialty Doctor	EKHUFT
Wendy Cunningham	**WC**	Breast CNS	EKHUFT
Rebecca Greene	**RG**	Metastatic Breast CNS	EKHUFT
Fiona Mahon	**FM**	Breast CNS	EKHUFT
Kirstie Wiltshire	**KW**	Senior Radiographer L Screening	EKHUFT

Anil Poddar	**AP**	Consultant General Surgeon	EKHUFT
Louise Barker	**LB**	Breast Cancer Clinical Nurse Specialist	EKHUFT
Louise De Pledge	**LDP**	Metastatic Breast Clinical Nurse Specialist	EKHUFT
Bana Haddad	**BH**	Clinical Lead / GP	KMCA
Jonathan Bryant	**JBry**	Clinical Lead / GP	KMCA
Serena Gilbert	**SG**	Cancer Performance Lead	KMCA
Claire Mallett	**CM**	Programme Lead – Personalised Care and Support	KMCA
Karen Glass **(Minutes)**	**KG**	PA / Business Support Manager	KMCA & KMCC
Colin Chamberlain	**CCha**	Administration & Support Officer	KMCC
Sam Williams	**SW**	Administration & Support Officer	KMCC
Suzanne Bodkin	**SB**	Cancer Service Manager	MFT
Melissa Williams	**MW**	Faster Diagnosis Breast Service CNS	MFT
Hayley Martin	**HM**	Macmillan Personalised Care and Support Facilitator	MFT
Samantha Tomlin	**ST**	Breast CNS	MFT
Jennifer Tonkin	**JT**	Metastatic CNS	MFT
Delilah Hassanally	**DH**	Consultant Oncoplastic Breast Surgeon	MFT
Vasileios Karydakis	**VK**	Consultant Oncoplastic Breast Surgeon	MFT
Ibrahim Ahmed	**IA**	Consultant Breast Surgeon	MFT
Nuriyat Abdulrasheed	**NA**	Clinical Nurse Specialist (Breast OAFU)	MFT
Dilukshi Wickramasinghe	**DW**	Research Nurse - Breast	MFT
Ritchie Chalmers	**RC**	Medical Director	MTW
Emily Sharp	**ES**	Trainee Breast CNS	MTW
Elizabeth Whitehouse	**EW**	Breast CNS	MTW
Ana Loureiro	**AL**	Breast CNS	MTW
Rebecca Phipps	**RP**	Breast CNS	MTW
Amanda Rabone-Young	**AR**	Consultant Radiologist	MTW
Carys Thomas	**CT**	Consultant Oncologist	MTW
Dhalvir Midda	**DM**	Deputy Chief Pharmacist	MTW
Juanita Caseley	**JC**	Breast ANP	MTW
Michal Uhercik	**MU**	Consultant Oncoplastic Surgeon	MTW
Julia Hall	**JH**	Consultant Clinical Oncologist	MTW
Charlotte Moss	**CM**	Consultant Medical Oncologist	MTW
Claire Ryan	**CR**	Macmillan Consultant Nurse	MTW

Gemma Hegarty	**GH**	Consultant Clinical Oncologist	MTW
Jennifer Glendenning	**JG**	Consultant Clinical Oncologist	MTW
Jonathan Adlam	**JA**	Consultant Radiologist	MTW
Spoorthi Shetty	**SSh**	Locum Consultant Breast Surgeon	MTW
Savita Honakeri	**SH**	Consultant Histopathologist	MTW
Sarah Qureshi	**SQ**	Consultant Medical Oncologist	MTW
Sarah Eastwood	**SE**	Macmillan Personalised Care Project Manager	MTW
Jane Brown	**JBro**	Consultant Clinical Oncologist	MTW
Mathini Sridharan	**MS**	Doctor	MTW
Layloma Hamidi Latifi	**LHL**	Consultant Oncoplastic Breast Surgeon	MTW
Liz Simmons	**LS**	**Patient Partner**	
Christine Howarth	**CH**	**Patient Partner**	
Christine Lee	**CL**	**Patient Partner**	
Apologies			
Cathie Cooper	**CCo**	Breast CNS	MFT
Russell Burcombe	**RB**	Consultant Clinical Oncologist	MTW
Martine Milton	**MM**	Lead CNS – Breast Care	MTW
Rema Jyothirmayi	**RJ**	Consultant Clinical Oncologist	MTW
Priya Palanisamy	**PP**	Consultant Radiologist	MTW
Jan Hackney	**JH**	Breast CNS	MTW

Item		Discussion	Agreed	Action
1.	**TSSG Meeting**	**<u>Apologies</u>** • The formal apologies are listed above. **<u>Introductions</u>** • If anyone attended the meeting and has not been captured within the attendee list above please email **karen.glass3@nhs.net** directly. There were no formal introductions.		

		Action log Review • The action log was reviewed and the updated version will be circulated together with the final minutes from today's meeting. **Review previous minutes** • There were no objections to the accuracy of the previous meeting minutes which took place on the 6th May 2025 and were signed off as a true and accurate account of this meeting.		
2.	**MDT Streamlining discussion**	**DVH – update provided by Ahmed Abdelmawla** • DA acknowledged the really good Breast MDT streamlining practices which are in place across the patch. • AA referred to the streamlining model in place at DVH which is excellent due to their collaborative team work. • AA provided an update on their MDT streamlining service including: ○ Overview ○ Patient Identification for MDM ○ Digital tools and technology ○ Criteria for MDM inclusion – automatic and conditional ○ Investigations and Tracking Process ○ Management of Benign Cases ○ M3 / U3 meetings ○ Coordination with Radiology and Pathology ○ Workflow Control and Efficiency – done by MDM Coordinator ○ Decision-Making and Documentation ○ Post MDM review and Audit • In summary, AA explained the benefits of their MDM model: ○ Streamlined process from clinic to MDM discussion		**Presentation slides for DVH and EKHUFT circulated to the group on the 12th Nov 2025.**

		○ Improved communication and inter-departmental coordination ○ Reduced delays in diagnosis and treatment ○ Enhanced patient outcomes and experience **MFT – update provided by Ibrahim Ahmed** • IA admitted he had no slides to present at today's meeting and provided a verbal update. • IA explained at MFT they have specific sections for their MDT including screening, biopsies, post-operative plus discussions. He added for many years they have not missed any cases – including biopsies/ operations due to having log books which are updated by the MDT Coordinators. In terms of their benign cases they planned to do a pre-MDT but this became difficult due to staff shortages. These cases are now discussed separately by the Radiologists prior to the MDT. • IA highlighted the delays which are multi-factorial including: ○ MDM Coordinator / cross cover due to sickness / AL ○ They have no shortage of clinical staff – surgeons ○ Shortage of Pathology and admin team ○ More engagement and training is needed for their site specific MDT Coordinators who are often expected to cover multiple tumour groups. ○ IA believes the MDT should not be used as a platform for admin work. **EKHUFT – update provided by Anil Poddar** • AP explained the previous MDM models circulated would not work for EKHUFT. They are carrying on with their own form of streamlining. The worry they have is missing cancers or biopsy results in time for the MDM. • Currently, they discuss all biopsies and post-operative cases. AP felt the MDM was running smoothly at both WHH and QEQM. They are discussing a lot of cases but are unable to cut their MDM numbers down without compromising patient care or		

		missing something. **MTW – update provided by Michal Uhercik** • MU explained their current MDT structure at MTW is divided into various sub-categories / different specialties and at different times: ○ Low risk screening ○ High risk screening ○ B3 lesions ○ High risk core biopsies ○ Microbubbles ○ Radiology and general discussion ○ Complex post-ops ○ Post-ops • They discuss a high volume of approximately 90 – 100 patients at their MDT which lasts for about 3 hours. There is always a drive to safely remove cases they do not need to discuss. • They have recently removed their low risk core biopsies. However, the MDT coordinator keeps a list of patients for radiology to confirm concordance with benign histology. • They would be keen to safely take off the following from their MDT: ○ Benign screening patients – 10-12 patients per week. ○ Indeterminate B3 lesions – 3-4 patients currently ○ Benign cases • MC and DA discussed the importance of having clear, documented Pathways of Care (PoC) in order to define which patients, require MDT discussion, noting that while some units have SOPs, there is a need for greater consistency and accountability. • K&M pathologists – DA asked due to the large number of patients being discussed at		

		MDM if all reports needed to be double read? She understands if this is new locum consultant or registrar but not well-established experienced consultants. SH explained they need to review B1, B2 and B3 cases but does not feel they need to review the post op cases. They definitely need to review the outsourcing cases. • DP mentioned the Royal College of Pathologists have released clear MDM guidance. It states as a minimum they need to review the reports in preparation for the MDM. If they are reporting within sub speciality teams with substantive colleagues they are not mandated to review slides. They must review slides if it is work from a locum, outsourced or external referral. As clinicians they should take more responsibility for their own work. DP mentioned they are doing an audit of "misses" at EKHUFT to evidence their change of practice to show it is not impacting patient safety. • DA concluded the national RCP guidelines are clear and K&M should be following these to free up pathology resources for other work.		
3.	**KMCA PCSP Physical Activity project**	**<u>Update provided by Claire Mallett</u>** • CM highlighted the huge benefits of physical activity particularly for cancer patients. • The national planning guidance ask for 2024/25 was to make physical activity a core item to be assessed / recorded for COSD in a similar way to tobacco, alcohol and the menopause. The aim is to meet the Chief Medical Officers requirements of a minimum of 75 - 150 minutes of physical activity per week. The additional ask was to support the organisations the CA works with and offer a brief behavior change or other interventions to support increased physical activity. • CM highlighted the approach the KMCA took: i) Baseline survey around Physical Activity – with CNS / CSW's – April / May 2024 ii) Supported streamlined changes to InfoFlex to improve ease of recording data iii) Partnered with Everyday Active to deliver a variety of training programmes /		**Presentation circulated to the group on the 12th Nov 2025**

		workshops on Physical Activity – www.everydayactivekent.org.uk iv) Developed a TKMCA training resource – signposting to support and information • CM highlighted the Physical Activity resources padlet developed by Sue (Green) before she retired which provides local support. • Gravesham Council and Everyday Active approached KMCA to replicate a project with Chesterfield County Council called "Outswimming Cancer." CM explained it is very early days but they plan to work with the council and DVH cancer teams to support patients. • CM explained that fatigue impacts approximately 80% of cancer patients and Sue was leading on a project to support K&M patients. A short-animated presentation covering diet, exercise and nutrition has been circulated within CM's slides. **Cancer-related Fatigue Management film animation** • The video, created by a dedicated team of clinical nurse specialists, cancer support workers and allied health professionals, offers practical advice and emotional support to help patients and their families better understand and manage one of cancer's most common and disruptive side effects. It can also be a valuable resource for professionals working with cancer patients. You can watch the video on the Kent and Medway Cancer Alliance website – www.kentandmedwaycanceralliance.nhs.uk/cancer-related-fatigue • Listen to Dr Jonathan Bryant, GP and Kent and Medway Cancer Alliance Clinical Lead talk about the film, in an interview with Sophie Sutton, on BBC Radion Kent Make a Difference - Radio Kent - Listen Live - BBC Sounds (around 1:42). **Limbo land - patient experiences of uncertainty and cancer** • A series of films of capturing personal cancer experiences, including professional perspectives on roles and support available limbo land - personal cancer experiences		

			Cancer Alliance • CM concluded KMCA are working with a community-based organisation supporting cancer patients going through the menopause. CM would be grateful if the relevant patient leaflets would continue to be shared to raise awareness of this ongoing work.	
4.	**Pilot of self-referrals to Family History clinics**	**Update provided by Suzannah Fitzgerald** • SF outlined a 6-month pilot project for patient self-referral to breast family history clinics, aiming to reduce unnecessary administrative work and improve patient engagement. A meeting has taken place with Ian Vousden (Director – CA), Vishakha Tripathi – lead Genetic Consultant (GSTT), Bana (Haddad) and Dawn Langdon. • SF outlined the following details: i) 100 – 120 referrals per month ii) 60% breast clinic referrals iii) 40% via ERS (GP referrals) iv) Approximately 30% of patients will not engage with this service - which is admin intensive • Their main aim is to provide a more efficient, streamlined patient-led service. BH would support any direct access initiatives which would reduce GP appointments. Laura Alton (Senior Programme Manager CA) has reassured them the trusts will not be losing any money if the referrals do not come via ERS (to use the self-referral clinic code) and would actually save Primary Care money. It was agreed the pilot would run alongside existing referrals in house before going out to PC to ensure they have a robust service in place. They will be mirroring the Cancer Risk Assessment Service carried out at GSTT. • SF outlined the first stage of their pathway proposal including: i) Patient given flyer if eligible for referral – no clinic referral letter required		**Presentation circulated to the group on the 12th Nov 2025**

		ii) Clinician to notify family history team iii) Patient to contact family history service by email (preferred) or telephone iv) Send out questionnaire v) Questionnaire returned – the remaining points will stay the same vi) Triaged vii) Near population – letter and discharge viii) Mod / High – OPA • SF explained the second stage of this work would be to roll out to GP's. SF mentioned EKHUFT is looking at developing an electronic triage system which would run alongside this work. • DA thanked SF for the presentation and this should be the way forward for eligible K&M patients. DA added they should all come as a central referral to the team. • In terms of the electronic triage referral system DA would be keen for this to be developed and rolled out across K&M. SF agreed to speak to VP for themto start with EKHUFT and then roll out to the rest of K&M. This will involve working closely with their SUNRISE team. DA concluded they need to have a robust, Kent-wide centralised referral system in place to be able to cross cover and is not hospital based. **Action – Deepika would be keen to have an update on the self-referral pilot and patient satisfaction survey at the next TSSG meeting.**		**SF**
5.	**Radiology update – guidance on the management of Phyllodes**	**<u>Update on phyllodes management - provided by Amanda Rabone-Young</u>** • ARY provided an update on phyllodes management based on the recently published guidance in the British Journal of Surgery. • ARY explained phyllodes breast tumours are rare (0.5%) and are most common in females between the ages of 40 – 50. They are split into 3 sub-types: i) Benign – 50 – 70%		**Presentation circulated to the group on the 12th Nov 2025**

		ii) Borderline – 12 - 26% iii) Malignant – 20 - 30% • There are roughly 60 malignant phyllodes tumours diagnosed per year in England. • ARY explained there has been variable management of phyllodes in the UK but also across Europe. Often the management has been incorporated into other guidelines such as soft tissue sarcomas. Historically, there is concern they may be overtreating some of the benign sub-types. • The new guidelines and patient information has been generated from a variety of different areas including surgeons, radiologists and pathologists based in the UK but also India and Ireland. • ARY highlighted the most common way of diagnosing phyllodes is from a symptomatic lump or through screening. • ARY outlined the MDT management for phyllodes tumours: i) **Benign** – discuss at local Breast MDT – proceed to surgery. ii) **Borderline** – discuss at local Breast MDT – refer to Sarcoma MDT to decide unit for management. iii) **Malignant** - discuss at local Breast MDT – refer to Sarcoma MDT to decide unit for management – CT staging. • **Adjuvant treatment – radiotherapy** – benign and most borderline phyllodes – not recommended. Malignant phyllodes consider if there is a large or multifocal lesion or margin is <5mm and further surgery is not possible. • **Adjuvant treatment – chemotherapy** is not recommended in the management of non-metastatic phyllodes tumours. • **Distant metastasis** – most common within the first 2-years with a median survival of 12-months.		

		• ARY referred to surveillance options in place for these patients after receiving treatment for benign, borderline and malignant lesions. • Additionally, mentioned within the published guidance is Germline testing for specific women. • In summary: i) Phyllodes diagnosis can be challenging ii) Importance of MDT management iii) Avoid overtreatment of benign phyllodes iv) Tailored margins based on subtype v) Axillary surgery not recommended vi) Tailored, risk-based ongoing surveillance **Action – Karen agreed to circulate the published paper including the supplementary materials – flow charts and summary for MDT / clinical use. Actioned after the meeting.** • DA thanked ARY for the update brought together at the last minute. She felt it was self-explanatory and a significant benefit in terms of US resources for benign phyllodes who are seen 6-monthly. DA suggested K&M adopted this national guidance. • IA asked in terms of the borderline and malignant phyllodes should they be discussed in the Sarcoma MDT before proceeding to surgery. IA explained at MFT they treat benign, borderline and malignant phyllodes at a local level. He added post-operatively they refer to the Sarcoma Unit to discuss borderline and malignant phyllodes. He was not aware they should also be discussing pre-operatively with the Sarcoma MDT. **Action - ARY referred back to the flowchart but agreed to double check the justification as she was not aware this was not widely being carried out.**		**KG** **ARY**

6.	**15-year data on early breast cancer and sentinel node**	**<u>Axillary procedures in a selected age group in early breast cancer – update provided by Anil Poddar</u>** • AP explained he has been a breast surgeon for 25-years and was keen to share his personal 15-year audit on axillary procedures for a selected group of early breast cancer patients. • AP highlighted the following: i) Sentinel lymph node biopsy (SLNB) which is done for staging and not treating the patient. ii) Morbidity of SNB – is better than axillary dissection but is still substantial - including arm pain and swelling (after 2 years), lymphoedema, intercostal brachial neuralgia, shoulder stiffness and some experience an allergic reaction to the blue dye. • AP wondered if they were over treating these patients and if they could avoid doing axillary surgery for a selected group of patients. • AP mentioned there is increasing evidence that axillary treatment or assessment is unnecessary in early BC for elderly patients. • Four randomised controlled trials looked at omitting SNB in a selected groups of patients. While the SOUND trial only included patients with tumours less than 2 centimetres, the other three included both T1 and T2 tumours. • AP's retrospective data collated from December 2010 to August 2025 for patients over the age of 70 and were T1 (Grade 1 / 2) with specific inclusion criteria outlined. Multifocal cancers were excluded. • There was a total of 173 patients, average age being 75 and tumour size of 11mm. Most of the cancers diagnosed were grade 2 and PT1c. 18 of these patients had positive SNB.		**Presentation circulated to the group on the 12th Nov 2025**

		• AP concluded his data is based on one surgeon and asked if they should consider omitting SNB for patients aged over 80 with grade 1 BC as this would not have changed their outcome. • DA thanked AP for his brilliant audit including the SOUND trial. DA agreed the evidence has been highlighted in AP's data. • JG clarified this would be for a specific group of patients whose care is surgery and radiotherapy to the breast, with no axillary staging / treatment and endocrine therapy. GSTT are doing this for their T1a and T1b patients but not T1c. However, there would still need to be a discussion between the surgeon and patient.		
7.	**Update on nodal involvement following completion of ANC**	**<u>Axillary Clearance Outcomes in Breast Cancer Patients (2023-2024) – update provided by Mehvish Nazeer</u>** • MN explained the objectives of her study: i) To review axillary clearance cases at WHH between 2023 – 2024 ii) Correlate with tumour biology and chemo status with further nodal disease in concomitant with z11 and AMAROS criteria • MN reported on nodal involvement rates in different breast cancer subtypes, finding that a significant proportion of patients had no further nodal disease after axillary clearance, with results comparable to external data. • MN presented an audit of nodal involvement following completion axillary clearance in breast cancer patients, comparing local data with external benchmarks and highlighting the need for further analysis using nomograms to guide de-escalation of axillary surgery. • In summary: i) 135 total number of patients		**Presentation circulated to the group on the 12th Nov 2025**

		ii) 8 patients were withdrawn from analysis due to incomplete data iii) 88 patients were Er+ve Her2-ve – median age 65 iv) 28 patients were Her2+ve – median age 60 v) 11 patients were triple negative – median age 68 • In conclusion: i) Still need a definitive plan to de escalate axilla as tumour biology is different. ii) MV to further apply this data especially for ER positive cohort for MD Anderson / MSK Normogram – hope to update at the next TSSG. • DA thanked MV for her excellent presentation and asked how this has changed practice at WHH? • MV explained the audit did not identify clear criteria for safely omitting further axillary surgery, emphasising the need for additional analysis using nomograms and tumour biology to inform de-escalation strategies.		
8.	**Breast pain pathway – feedback from extraordinary meeting / discussion**	**<u>Kent & Medway Breast Pain Pathway Redesign – update provided by Ritchie Chalmers</u>** • RC highlighted numerous previous discussions on the relevance of the Breast Pain Pathway, to digitally triage patients of low clinical risk and patients presenting with a definitive breast cancer symptom. RC thanked those who attended the previous Extraordinary Breast TSSG meeting which took place on the 18th September 2025. • RC has also had separate discussions at MFT and EKHUFT MDT meetings. • Overall, there has been agreement to do something different for women who present with a very low risk of breast cancer. • Since the Extraordinary Breast TSSG meeting conversations have progressed on a national level and they have been asked by Tim Briggs (from the GIRFT team) to support a potential national breast pain approach. RC explained every breast clinic across the UK have imaging issues and they should be concentrating on patients		

		presenting with the signs and symptoms of breast cancer. • Their aim would be to set up a Kent & Medway-wide breast pain pathway in line with the national ask and GIRFT for Cancer Alliances. • RC encouraged members to think about the importance of the initial triage of patients presenting with symptoms of breast cancer compared to patients presenting with a breast problem which could be dealt with differently. • RC alluded to a conversation she has had with MFT using a community-based model for women with breast pain potentially through the women's health hubs. This could be developed further across K&M. • JG and RC emphasised the importance of including discriminatory questions in triage documents, such as the ability to localise pain and detailed family history, in order to identify patients at a higher risk of cancer. • IA, AP and RC discussed the need for a unified, Kent-wide approach to avoid duplication and resource strain, with RC noting ongoing work with ICB and IT providers to develop a system-agnostic solution. • RC concluded if the group are in agreement she will continue to work with the ICB to find an agreeable system to use. **Action – Ritchie suggested setting up a small working group – to include each organisations MDT lead, DA and the CRG working group.** • In terms of the SOP's there is documentation in place for those trusts who are running the self-managed pathways in the ASPIRE trial. The aim would be to see all symptomatic women in their One Stop Clinics. • DA emphasised the importance of all trusts following the same guidelines and having a mutual understanding for a way forward.		**DA / CRG / MDT Leads**

9.	**Feedback from Brighton meeting – GIRFT data / treatment variation** **Dashboard review and review of reconstruction data**	**<u>Update provided by Deepika Akolekar and Ritchie Chalmers</u>** • DA personally thanked David Osborne for the excellent data he has produced. • **FDS and 62-Day Performance:** DA noted a decrease in FDS performance across K&M but an improvement in 62-day performance, particularly at EKHUFT. They have previously discussed the contributing factors such as workforce constraints, radiology and pathology turnaround times. • **MTW Recovery Plan:** In response to RC's query, DA outlined MTW's recovery plan, including improved pathology turnaround, recruitment of radiologists and additional clinics, with the aim of reducing delays and improving 62-day performance. • **Histopathology Turnaround Times:** DA referred to the delays in histopathology turnaround times for DVH and MFT compared to MTW - identifying courier and pre-lab booking issues. RC acknowledged that the data shows a 2-3-day histopathology delay but improves after day-7. It was agreed to conduct a booking process audit and time-motion study at MFT (SB) and DVH (MC) to address where the delays are coming from. SH reassured the members they were not prioritising MTW specimens over MFT / DVH and is based on how they arrive within histopathology lab. **Action - RC, SB and MC agreed to discuss this further offline.** • **Data Completeness and Recording Issues particularly at MTW:** RC suggested the MDT co-ordinators should have a discussion regarding the data entry process taking place during the MDT which is clearly working well at EKHUFT. RC wondered what specific field the Breast MDT co-ordinator is completing at EKHUFT which differs to the other 3 trusts. It was agreed to also discuss this further within the TOSG stakeholder meeting. • **Treatment Variation and Coding Practices:** The group discussed the significant treatment variation across K&M, focusing on oncoplastic provision, mastectomy rates, immediate reconstruction and the impact of coding practices, with agreement to audit coding and clinical parameters for accuracy and improvement.		**Presentation slides circulated to the group on the 12th Nov 2025** **RC / SB and MC**

		• **Oncoplastic Provision and Mastectomy Rates:** RC explained areas with lower oncoplastic delivery had higher mastectomy rates. They discussed the need to understand and address the underlying causes, including coding accuracy and patient factors. • **Coding and Data Accuracy:** IA mentioned the importance of correct coding for oncoplastic procedures, with DA describing efforts to inform coders about operation titles and MCh noted possible under-recording of oncoplastic work. • **Audit and Systematic Review:** RC proposed conducting audits of coding practices across organisations and using the working group to review and standardise documentation, with agreement from others to ensure accurate reporting and funding. RC suggested this was picked up through the CRG and working group set up to review the triage document. • **Immediate Reconstruction and National Targets:** DA referenced national targets for immediate reconstruction rates (25%), discussed unit-level performance, and called for surgical volunteers from each unit to further examine discrepancies and improve service delivery. DA and RC agreed to include the MDT lead and CRG to take this forward. • **Clinical Parameters and Deprivation Index:** JG and RC suggested breaking down the data via PCN and clinical parameters, considering local population differences, to better understand and address treatment variation. • **Radiotherapy Data Discrepancies:** JH raised concerns that radiotherapy rates for DVH appeared inaccurately low, possibly due to patients being treated at Queen Mary's Hospital in Sidcup and not being captured in the ICB data warehouse. RC agreed to foll this up with David Osborne. **How to sign up to the Cancer Pathways and Cancer in Primary Care Dashboards** • Register for access to Kent and Medway ICB Power BI reports by completing the form a https://forms.office.com/r/svyPSvktHw.		

		• Email David.Osborne11@nhs.net to inform him that you have completed the form for access to the dashboard. It can take up to a week for the ICB to grant access. • Once access has been granted, you can access the dashboard at https://app.powerbi.com/home?ctid=4cfbd3c4-a42e-48a1-b841-31ff989d016e. Click on the **KM ICB Main** app and you will see **Cancer in Primary Care** and **Cancer Pathways** listed on the left-hand menu.		
10.	**AOB** **Impact of the Transformation Project on Breast Services at MTW**	• There were no further discussions raised under AOB. DA thanked the group for their attendance and contribution at today's meeting. She hoped the next meeting would be face to face finance permitting. • IA asked if the next Breast TSSG meeting could avoid the bank holiday week as this creates scheduling challenges for MFT's MDT. DA ensured future meeting dates would avoid such conflicts.		
10.	**Next Meeting Date**	• **Thursday 7th May 2026 - Lecture Theatre, Postgraduate Centre, 1st Floor, William Harvey Hospital, Kennington Road, Willesborough, Ashford. TN24 0LZ**		**KG has circulated the meeting invite**