Kent & Medway Cancer Collaborative

Haematology Tumour Site Specific Group meeting
Monday 19th May 2025
Park View Meeting Room, Mercure Great Danes Hotel, Ashford Road, Maidstone. ME17 1RE
09:00-12:40
Final Meeting Minutes

Present	Initials	Title	Organisation
Ritchie Chalmers (Chair)	**RC**	Medical Director	KMCA
Deborah Willcox	**DW**	Senior Research Nurse	MTW
Victoria Harris	**VH**	Clinical Trials Co-ordinator	MTW
Simeon Blackbourn	**SB**	MDT Co-ordinator	MTW
Christopher Bonner	**CB**	Macmillan Clinical Psychologist	MTW
Kanwal-Zia Robinson	**KZR**	Haematology CNS	MTW
Sarah Updyke	**SU**	Haematology CNS	MTW
Carolyn Gupwell	**CG**	Haematology CNS	MTW
Claire Herbert	**CH**	Haematology CNS	MTW
Tracy Symonds	**TS**	Haematology & Lymphoma Research Practitioner	MTW
Olena Dotsenko	**OD**	Consultant Pathologist	MTW
Samantha Williams (Minutes)	**SW**	Administration & Support Officer	KMCC
Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Lead	KMCC
Hayley Paddock	**HP**	Electronic Prescribing Pharmacist	KMCC
Karen Glass	**KG**	PA/Business Support Manager	KMCA/KMCC
Sue Green	**SG**	Project Manager for Living with & Beyond Cancer	KMCA
Claire Mallett	**CM**	Programme Lead for Living with & Beyond Cancer	KMCA
Natalie Heeney	**NH**	Consultant Haematologist	DVH
Faye Barrow	**FB**	MDT Co-ordinator	DVH
Charan Basra	**CBa**	Haematology CNS	DVH
Marie Payne	**MP**	Macmillan Lead Cancer Nurse	DVH
Lemun Mutlu	**LM**	Consultant Immunologist & Allergist	EKHUFT
Jayne-Marie Osborne	**JO**	Consultant Haematologist	EKHUFT
Melene Locke	**ML**	Clinical Trials Research Nurse	EKHUFT
Sarita Workman	**SWo**	Clinical Nurse Specialist	EKHUFT

Stefanie Goodchild	**SGo**	Haematology CNS	EKHUFT
Claire Bingham	**CBi**	Personalised Care Facilitator	EKHUFT
Kerry Holmes	**KH**	Haematology CNS	MFT
Joy Ezekwesili	**JE**	Advanced Specialist Pharmacist – Cancer Services	MFT
Sudarshan Gurung	**SGu**	Consultant Haematologist	MFT
Peter Thom	**PT**	Haematology Registrar	MFT
Bhagya Herath	**BH**	Consultant Haematologist	MFT
Nahla Osman	**NO**	Consultant Haematologist	MFT
Amanda Harris	**AH**	Patient Partner	
Apologies			
Sarah Howland	**SH**	General Manager	EKHUFT
Patricia Chan	**PC**	Pharmacist	EKHUFT
Pippa Enticknap	**PE**	Deputy General Manager	EKHUFT
Jindriska Lindsay	**JL**	Consultant Haematologist	EKHUFT
Sreetharan Munisamy	**SM**	Consultant Haematologist	EKHUFT
Miguel Capomir	**MC**	Haematology/Oncology Pharmacist	EKHUFT
Iresha Dharmasena	**ID**	Consultant Haematologist	EKHUFT
Danielle MacKenzie	**DN**	Macmillan Nurse for Personalised Care	EKHUFT
Moya Young	**MY**	Specialty Registrar – Haematology	EKHUFT
Catherine Roughley	**CR**	Consultant Haematologist	EKHUFT
Tracey Spencer-Brown	**TSB**	Head of Nursing for Oncology & Haematology	MTW
Miles Pope	**MP**	MDT Support Co-ordinator	MTW
Clare Oni	**CO**	Haematology Registrar	MTW
Dhalvir Midda	**DM**	Deputy Chief Pharmacist	MTW
John Schofield	**JS**	Consultant Pathologist	MTW
Clare Wykes	**CW**	Consultant Haematologist	MTW
Lolly Banerjee	**LB**	Consultant Haematologist	MTW
Clare Reeder	**CRe**	Macmillan Consultant Clinical Psychologist in Cancer Care	MTW
Summer Herron	**SH**	General Manager – Cancer Performance	MTW
Charmaine Walker	**CWa**	Cancer Performance Manager	DVH
Pooja Chhabhaiya	**PCh**	Principle Pharmacist	DVH
Ann Courtness	**AC**	Macmillan Primary Care Nurse Facilitator	KMCA
Jonathan Bryant	**JB**	ICB Primary Care Cancer Clinical Lead	KMCA

Emma Lloyd	**EL**	Cancer Pathways Improvement Project Manager	KMCA
Ellinor Wellving	**EW**	Clinical Nurse Specialist	King's College Hospital
Janet Hayden	**JH**	Clinical Nurse Specialist	King's College Hospital
Joanna Large	**JLa**	Clinical Nurse Specialist	King's College Hospital
Emil Kumar	**EK**	Consultant Haematologist	King's College Hospital
Annaselvi Nadar	**AN**	Matron – Faster Diagnosis	MFT
Suzanne Bodkin	**SBo**	Cancer Service Manager	MFT
Hayley Martin	**HM**	Macmillan Personalised Care & Support Facilitator	MFT
Mehrukh Arshad	**MA**	IMT1	MFT

Item		Discussion	Action
1.	**TSSG Meeting**	**Apologies** • The apologies are listed above. **Introductions** • RC confirmed that she would be Chairing this meeting due to LB being unwell and welcomed the members to today's face to face meeting. • If you attended this meeting and are not captured on the attendance list above please contact Samantha.williams23@nhs.net directly and the distribution list will be amended accordingly. • RC asked everyone to think about how the TSSG can be taken forward, run and led. The CRG is not set up fully at present and requires volunteers for the group. The CRG will act as a forum to increase clinical leadership and support the Agenda for Haematology going forwards, they will bring in every part of the MDT (Oncology, Nursing, Diagnostics, Leadership etc). There is a need to think about Pathways and Strategy for this Tumour Group for the next 5 years. It is important to think about how we, as a region can use resources to improve services. There is a budget of £11million in the Cancer Alliance. The ICB will become a strategic commissioning service with the remaining services being located within the Acute Providers. There will be devolution of specialist commissioning into the ICB's.	

		Action Log Review • The action log was reviewed, updated and will be circulated to the members along with the final minutes from today's meeting. **Review Previous Minutes** • The final minutes from the previous meeting which took place on the 18th November 2024 were not reviewed but were previously agreed as a true and accurate account of the meeting.	
2.	**CRG Update**	**Update provided by Ritchie Chalmers** • RC advised that the Expression of Interest and Job Descriptions for the CRG members and the TSSG Chair (1 PA role) has been sent out three times to Haematology TSSG Members and welcomed interest. **Action – AW to re-send out the TSSG Chair Job Description and CRG Job Description and EOI to all Trusts.** • The CRG will be a sub-group from the TSSG and will consist of Haematology, Nursing, Radiology, Surgery, Oncology and Primary Care roles. The aim of the group is to be the interface between the TSSG and the Alliance. The CRG will meet once a month for 1hr and 30minutes and attracts 0.5 PA. • LM asked for a Consultant Haematologist with Myeloma /Lymphoma to be included in the CRG. • RC meets with the leads of the TSSG every month to push progress. • DVH highlighted that Consultants there are not able to go above 12 P.A.'s, they do not have enough Consultant Haematologists and are not able to take on any more roles. **Action – RC to contact John Wade (Medical Director) at DVH to discuss the 12 P.A. limit.** • SGu added that they have no Clinical Director at MFT and there is no Cancer Clinical Director at DVH.	**AW** **RC**

3.	**Dashboard**	**Update provided by Richie Chalmers** • RC went through the Live Dashboard Data and encouraged everyone to gain access. David Osborne (who has just won an award) has put this system together and is receptive for any information/metrics that TSSG members wish to see. This data is used to distribute funding, it comes from the ICB Data Warehouse and is updated monthly. RC encouraged everyone to liaise with David. • FDS has fallen at Kent & Medway from 68% to 55% in the last 6 months. 62 day performance is at 79% compared with 82% six months ago. • FDS Performance at MFT is at 65%, DGT at 60%, MTW at 56.9% and EKHUFT at 40%. • 62 day Performance at DGT is at 94.3%, MTW at 87.4%, EKHUFT at 73.5% and MFT at 68.8%. **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 at https://forms.office.com/r/svyPSvktHw. • Email David.Osborne11@nhs.net to say 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.	**Data Pack circulated to the group on Thursday 15th May.**
4.	**Personalised Care Update**	**Presentation provided by Claire Mallett** • The Personalised Care Update Presentation provided an overview of the following :-	**Presentation circulated to the group on Monday 19th May.**

		i) HNA and Care Planning. ii) PSFU Implementation - CLL is now up and running. There is a CLL portal in place and EKHUFT are training on this now. iii) Physical Activity – Training and Assessment Resource. Physical Activity has been included in national planning guidance. A survey was conducted to see how confident staff would feel about discussing Physical Activity with patients and information/training sessions were put in place to improve this. iv) Limbo Land - This is a series of patient and professional videos. Patients often feel like they are in a state of limbo not knowing what the future holds when they have a diagnosis of cancer. v) Fatigue - Information from HNAs and QoL Survey shows fatigue is a big issue. SG has been working with colleagues to launch a video to support patients experiencing fatigue. vi) Menopause Peer Support Patient Group Pilot. vii) Scheduling CNS and CSW Events - speakers have been invited along to talk about domestic abuse and cancer as well and supporting young people who have cancer. viii) Personalised Care Training • HNA's and Care Plans Completed – Cancer Alliances in England, last 3 months (Nov 2024 – Jan 2025) Data. CS expressed that there is a need to talk about diagnosis. There is a huge variation and learning needs to be actioned. • HNA at Home Data • Concerns – All Cancers (Oct – Dec 2025) Data. Money and Finance were the biggest issues, followed by worry, fear and anxiety.	

		• PSFU – 2025/26 – KMCA aims include ensuring all PSFU Pathways funded by KMCA have a fully operational PSFU. Develop KMCA Service specification outlining PSFU. Agree reporting/monitoring requirements and action to embed KMCA PSFU Service. Ensure sustained delivery of PSFU and personalised care benefits. • Recording of physical activity on Infoflex by provider – All tumour groups 2024/25 – Data. • Resources	
5.	**Cancer Psychological Service for Kent & Medway (CaPS-KM)**	**<u>Presentation provided by Christopher Bonner</u>** CB is a Macmillan Clinical Psychologist and has previously worked at St Barts. • The Cancer Psychological Service for Kent & Medway (CaPS-KM) covers all 4 acute Trusts. The CaPS-KM team are separate but work closely with the Oncology Counselling teams. • CaPS-KM has received 2-years of funding from KMCA and Macmillan (May 2024-26) with the hope of being a fully commissioned service from 2026. • The aims of the service are to :- i) Build on previous scoping to understand local psychosocial services ii) Demonstrate unmet psychological need iii) Set up and evaluate a Kent & Medway-wide cancer psychological service iv) Secure permanent NHS funding. • They have a small team in place based at MTW including :- o India Barton (Macmillan Assistant Psychologist) o Sophie Lansdowne (Honorary Assistant Psychologist)	**Presentation circulated to the group on Monday 19th May.**

		○ Janet Bates (Macmillan Counsellor) ○ Dr Chris Bonner (Macmillan Clinical Psychologist) ○ Dr Clare Reeder (Macmillan Consultant Clinical Psychologist and Service Lead) ○ Rachel Maciag (Trainee Clinical Psychologist) • CB highlighted what the team have carried out to date :- i) Scoping and relationship building ii) Patient engagement – 4 patients on Steering Groups iii) Setting up a clinical service iv) Teaching and supervision – - Level 2 psychological skills training for cancer CNS's & AHP's - Haematology & Oncology Doctors - Level 1 + training and psychological support for CSW's • CB highlighted the type of patient their team would be keen to see and the referral process which is in place. CB explained there is a single point of referral and the psychological team will triage to either a counsellor or to psychological support. They will aim to see a patient within 1-2 weeks with the caveat that they are a very small resource covering the whole of K&M. They are happy to support families of patients but would not see children directly. However, they can support children through the family and also schools. • CB confirmed the referral process in place for each trust and the direct email for CaPS-KM - mtw-tr.caps-km@nhs.net and clare.reeder@nhs.net. • CB added that funding is only for cancer diagnosed patients and they will need to build a Business Case in order to fund this service after 2 years and demonstrate that this reduces attendance in A&E. • CB is happy to arrange teaching sessions for Junior Doctors and MFT asked for the CaPS team to come to their teaching sessions and provide a workshop.	

6.	**MDT Streamlining**	This was not discussed.	
7.	**Myeloma Diagnostic WG – Lab & Clinical Guidance Update**	**<u>Presentation provided by Leman Mutlu</u>** • The Update on Kent & Medway Myeloma Diagnostic Working Group and SLiM-CRABI Presentation provided an overview of the following :- • Diagnostic Criteria for Myeloma and Smoldering Myeloma • Criteria for SLiM-CRAB • Diagnostic Tests – Screening Tests, Tests to establish Diagnosis, Tests to estimate Tumour Burden and Prognosis. • Prognostic Factors (for diagnosed Myeloma) • Treatments for Myeloma • Practice Points for Immunologists in relation to Myeloma • The purpose and practices of the Kent and Medway Myeloma Diagnostic Working Group which formed in 2023 – Excellence in Blood Sciences Diagnostics of Myeloma • Kent and Medway Paraprotein Management Algorithm – Requesting and Testing and Laboratory Reporting of New Paraproteins Flow Charts • Kent & Medway Myeloma Care Map • Kent & Medway Myeloma Diagnostic Working Group has helped Harmonisation of Testing : All Paraproteins are now detected the same way in Kent and Medway – Capillary Zone Electrophoresis – now in MTW. Harmonisation of Reports – Training and Competence check for reporters. • Clinically Suspected Myeloma and MGUS Follow Up. • Referral Guidelines for Paraproteins – DVH Haematology Referral Guidelines • M-Protein Referral Guidance Flowchart • Sebia National Meeting was held in Birmingham in June 2024 • MGUS Follow Up Models and Stratification.	**Presentation circulated to the group on Monday 19th May**
8.	**Immunoglobulin Replacement Therapy – Best**	**<u>Presentation provided by Sarita Workman</u>**	**Presentation circulated to the group on**

	Practice Standard	• The Immunoglobulin Replacement Therapy – Treatment Options Presentation provided an overview of the following :- • Immunoglobulin Replacement – First infusion given in 1952 – subcutaneous and Intramuscular treatment used until 1970's. Intravenous products were introduced - Enable higher doses with less frequency. • Immunoglobulins are an important part of the immune system (B-cells/antibodies). There are three main types – Immunoglobulin M (IgM), Immunoglobulin A (IgA) and Immunoglobulin G (IgG). • People with immunodeficiencies are less able to fight infections as their immune system is not working properly, either partially or not at all. They generally get infections more frequently and will also tend to take longer to recover from them. • Primary immunodeficiencies (PIDs) are immunodeficiencies that people are born with or develop spontaneously later in life without any obvious reason. Approximately 20% of patients will also have close family affected. • Secondary immunodeficiencies (SIDs) are those that are acquired later on in life, caused by something and can be due to infections, some types of cancer or from certain drug therapies such as chemotherapy, immunosuppression, antimalarial treatment or epileptic medication. • With regard to immunoglobulin replacement :- - Viral inactivation steps have been improved. - There is greater tolerability and faster infusion rates with newer generation products - Most are stable at room temperature. - There are new products mostly 10% concentration although 5% remains on market. - There are over >1000 donations per batch. - They have pH inactivation. - Pasteurisation, microfiltration, solvent/detergent (Triton-X 100) and UV inactivation takes place. - Sugars and amino acids are introduced as stabilisers – this has better tolerability. • In terms of comparing IVIG and SCIG :-	**Monday 19th May.**

		- IVIG requires venous access, every 3-4 weeks (with a duration of 3-4 hours depending on dose). This treatment can be delivered in a hospital or at home with the help of an infusion partner or nurse. - SCIG requires subcutaneous access on a weekly basis with a pump, a daily push and monthly fSCIG. The pump process takes one hour, the push 10 minutes and the fSCIG 4 hours. The treatment is a home therapy and infusion can take place without a partner. • Important Considerations :- - All patients should have a risk assessment and be consented prior to commencing IVIG/SCIG. - It is really important to do rotation of products. - Shared decision-making, including incorporating patient choice. - Safety bloods. - IgG trough levels need to be monitored at least annually. - There should be a 6 monthly review to see if there are any infections/problems with infusions. - Support. - Psychological input. - Signposting to charities. LM stated that there is an intention to articulate standards of care for immunoglobulin treatment.	
9.	**Clinical Audit – MFT Steroid Dosage in Myeloma**	**<u>Presentation provided by Peter Thom</u>** • The Dexamethasone Dosage in DRD/RD Patients Presentation provided an overview of the following :- • Objectives included :- - Reviewing Dexamethasone dosing in non-transplantable patients receiving DRD/RD. - Comparing the outcomes/complications of 40mg dexamethasone with reduced dose regimes in an elderly cohort. - Assessing the clinician approach to dose changes. • Background	**Presentation circulated to the group on Monday 19th May.**

		• Multiple Myeloma & Flow Chart • IMWG 2014 Diagnostic Criteria • Treatment – General Principles • Transplant Ineligible • DRD and RD • Steroid Side Effects in the Elderly included Infection, Peripheral Oedema, Hypertension, Hyperglycaemia, Cushing's Syndrome, GI, Osteoporosis, Myopathy and Neuropsychiatric. • Factors effecting susceptibility to steroid SE's include Age, Co-morbidities, Concomitant use of other Immunosuppressive agents, Treatment dose and length and Underlying Malignancy. • Medway Population on DRD/RD • ECOG Performance Status • Type of Measurable Disease for IgG, IGA, IgD, Kigh Chain and Number of Patients • ISS Disease Stages 1, 2 and 3 and Number of Patients. • Starting Dosage of Dex and Average Treatment Length • Treatment Response on DRD • RD Patients and Complications Information on 20 Patients • Dose Reduction • Conclusion :- - There is no link between steroid dose and initial response to DRD treatment. - The vast majority don't have early relapse when their Dex dose is reduced. - Patients with fewer side effects are typically on lower doses of steroid. - Clinicians have already reduced the starting steroid dose and are happy to further wean because of side effects or previous good response. - Optimal Dex dosing is unclear in this older, comorbid patient group. - DRD has only recently been NICE approved, however data for patients on longer treatment will be useful. • Suggestions :- - Patients to start on 20mg dose weekly as standard. - Consider dose reduction to 10mg in over 75s, those with a BMI of <18.5 and those with many comorbidities.	

		- If there is a good response, consider dose reduction from cycle 7. - Consider stopping Dex after cycle 12. SGu stated that more data might be required. It was agreed no change to the RD Protocol at present.	
10.	**National Audit – Backbone Audit and Lymphoma Audit**	The Backbone and Lymphoma Audit were not discussed.	
11.	**CNS Updates**	There were no CNS Updates discussed.	
12.	**Research Update – East Kent Research Update and MTW Research Update**	**<u>Presentation provided by Melene Locke</u>** • The East Kent Research Update Presentation provided an overview of the following :- i) Current Portfolio of Commercial Myeloma Trials - MajesTEC-7, MagnetisMM-32, MagnetisMM-16 and SPARK. ii) Current Portfolio of Academic Myeloma Studies – RADAR : Myeloma XV and COSMOS. iii) Current Portfolio of Lymphoma Studies – REMoDL-A, PETReA, Foundation UK and STATIC (all non-commercial). MPN – MITHRIDATE (non-commercial). • Studies in Set Up – MODIFY, CAMELOT, GOLSEEK-4 and PetreaPLUS. • Recruitment and Challenges to recruitment and activity. • Team Successes :- - Despite Golseek-2 closing quickly and being under target, they were site selected to participate in Golseek-4 and Dr Young was invited to be UK CI. - AQUILA was published with Dr Lindsay the UK CI and EKHUFT were the top recruiter. - New partnerships with investigators and sponsors.	**Presentations circulated to the group on Monday 19th May.**

		- Multiple EOI's currently with sponsors following invitations to participate. - Networking at events leading to interest in study site. - Panagiota, the study nurse, was invited to present at the Janssen Tec-7 global study co-ordinator meeting on how EKHUFT successfully recruit and screen patients. • The MTW Research Presentation was not discussed but will be circulated to all members.	
13.	**AOB**	• No issues raised. • Chemo Top Tips will be circulated to all members.	**Chemo Top Tips were circulated to the group on Monday 19th May.**
	Next Meeting	• Date in November 2025 – To be confirmed	