Kent & Medway Cancer Collaborative

Haematology Tumour Site Specific Group meeting
Monday 23rd February 2026
Microsoft Teams
10:00-12:30
Final Meeting Minutes

Present	Initials	Title	Organisation
Vicki Stables (Chair)	**VS**	Consultant Haematologist	MTW
Deborah Willcox	**DW**	Senior Research Nurse	MTW
Sarah Eastwood	**SE**	Macmillan Personalised Care Project Manager	MTW
Sarah Updyke	**SU**	Haematology Clinical Nurse Specialist	MTW
Carolyn Gupwell	**CG**	Haematology Clinical Nurse Specialist	MTW
Claire Herbert	**CH**	Haematology Clinical Nurse Specialist	MTW
Tracy Symonds	**TS**	Haematology & Lymphoma Research Practitioner	MTW
Clare Oni	**CO**	Consultant Haematologist	MTW
Alexis Corrigan	**AC**	Consultant Radiologist	MTW
Pritha Roy	**PR**	Consultant Oncologist	MTW
Evangelia Dimitriadou	**ED**	Consultant Haematologist	MTW
Elvis Aduwa	**EA**	Consultant Haematologist	MTW
Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Hayley Paddock	**HP**	Electronic Prescribing Pharmacist	KMCC
Karen Glass	**KG**	PA/Business Support Manager	KMCA/KMCC
Bana Haddad	**BH**	Clinical Lead	KMCA
Claire Mallett	**CM**	Programme Lead for Living with & Beyond Cancer	KMCA
Natalie Heeney	**NH**	Consultant Haematologist	DVH
Charanjit Basra	**CB**	Macmillan Lead Haematology CNS	DVH
Thais Ferrari	**TF**	Principle Clinical Scientist	DVH
Vijayavalli Dhanapal	**VD**	Consultant Haematologist	DVH
Jayne-Marie Osborne	**JO**	Consultant Haematologist	EKHUFT
Lemun Mutlu	**LM**	Consultant Immunologist & Allergist	EKHUFT
Claire Bingham	**CBi**	Personalised Care Facilitator	EKHUFT
Sudarshan Gurung	**SG**	Consultant Haematologist	MFT
Bhagya Herath	**BHe**	Consultant Haematologist	MFT

Suzanne Bodkin	**SB**	Cancer Service Manager	MFT
Elisaveta Parry	**EP**	Pharmacist	MFT
Kirsty Hearn	**KH**	Service Manager	MFT
Sarah Arnott	**SA**	Consultant Haematologist	MFT
Kerry Michelsen	**KM**	Lead Macmillan Haemato-oncology CNS	MFT
Apologies			
Michelle Bevans	**MB**	Clinical Nurse Specialist	EKHUFT
Nipin Bagla	**NB**	Consultant Histopathologist	EKHUFT
Pippa Enticknap	**PE**	Deputy General Manager	EKHUFT
Moya Young	**MY**	Consultant Haematologist	EKHUFT
Miguel Capomir	**MC**	Haematology/Oncology Pharmacist	EKHUFT
Danielle MacKenzie	**DN**	Macmillan Nurse for Personalised Care	EKHUFT
Melene Locke	**ML**	Senior Cancer Research Nurse	EKHUFT
Tracey Spencer-Brown	**TSB**	Head of Nursing for Oncology & Haematology	MTW
Fathi Al-Jehani	**FAL**	Consultant Haematologist	MTW
Rebecca Bourne	**RB**	Head of Nursing – Haematology & Outpatients	MTW
Dhalvir Midda	**DM**	Deputy Chief Pharmacist	MTW
Joanne Patterson	**JP**	Associate Head of Pharmacy	MTW
John Schofield	**JS**	Consultant Pathologist	MTW
Olena Dotsenko	**OD**	Consultant Pathologist	MTW
Jennifer Ireland	**JI**	TBC	MTW
Joyce Van Den Camp	**JVDC**	Macmillan Haematology Clinical Nurse Specialist	DVH
Noyere Ohwode	**NO**	Thrombosis Clinical Nurse Specialist	DVH
Ian Vousden	**IV**	Director	KMCA
Ann Courtness	**ACo**	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
Sam Williams (Minutes)	**SW**	Admin & Support Officer	KMCC
Ellinor Wellving	**EW**	Clinical Nurse Specialist	King’s College Hospital
Janet Hayden	**JH**	Clinical Nurse Specialist	King’s College Hospital
Amanda Harris	**AH**	Patient Partner	

Item		Discussion	Action
1.	TSSG Meeting	**Apologies** • The apologies are listed above. **Introductions** • VS welcomed the members to today's meeting, announced that this was a re-set of this meeting and asked everybody to introduce themselves. • 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. **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 19th May 2025 were previously agreed as a true and accurate account of the meeting.	
2.	CRG Update	**Update provided by Vicki Stables** • VS advised that the Haematology CRG has been set up (meeting every 6 weeks), it operates within the TSSG Structure and provides an advisory body that acts as an interface between Clinical Specialists and Cancer Alliances to improve patient experience and outcomes, standardise care, pathways, share guidelines and protocols. • Data needs to be looked at to ensure there are not huge discrepancies between each of the sites.	**Presentation circulated to the group on 27th February 2026**

		• The CRG will aim to address quick wins that can be shared. • The CRG will drive forward discussions held at this TSSG in order to progress and there are members of the CRG that have allocated time in their week to focus on undertaking tasks. • VS outlined the members of the CRG, consisting of Haematology, Radiology, Histopathology and Immunology Consultant, CNS and Clinical Lead for Primary Care. • AC will be able to help with ensuring all Consultants across the patch document staging, which is important for data collection. • VS asked for everyone's thoughts and priorities of what they would like to see the CRG progress and drive forward. • VS confirmed that the HOG will run separately from the CRG.	
3.	**Dashboard**	**<u>Update provided by Vicki Stables</u>** • VS highlighted that there are live Dashboards showing data, based on key performance indicators, FDS and 62 day performance. • VS went through the slides showing recent data for Haematology. • The FDS rates are fairly low at Kent & Medway from the rest of the country and other Cancer Alliances at 54.9%. National average is 62.8%. 62 day performance is better at 83.1% and has risen. • FDS Performance at MFT is at 64.0%, MTW at 58.4%, DGT at 57.9% % and EKHUFT at 36.4%. • 62 day Performance at MTW is at 94.5%, DGT at 92.4%, MFT at 83.9% and EKHUFT at 69.3%.	**Data Pack circulated to the group on 19th February 2026**

		• The performance indicators need to be focused on to gain higher targets. VS outlined the Cancer Diagnoses per quarter at each of the sites and asked each site to discuss their shared experiences of barriers to achieving the 28 days FDS and 62 days treatment. • VS reported MTW problems with scheduling and pharmacy (accessing drugs rapidly). ED added that they have an FDS CNS that has transformed the way their pathway works and patient experience. The CNS also carries out the follow-up of patients and Consultants are able to downgrade if they do not have cancer. The FDS Nurse is an excellent resource and addition to the team. The triaging is still Consultant led. AC highlighted that from an imaging point of view, biopsies are a crunch point in their capacity and most cross-sectioning imaging can be solved. • SA from MFT stated that they are able to access imaging quickly and have easy access to core biopsy. There have some issues with turnaround times for Histology, with some improvement recently. Agreement from their Cancer Board has enabled them to triage USC Referrals, a third of them was able to be downgraded and they do have USC Bone Marrow slots. They do not have an FDS Nurse as it is all Consultant triaged. MFT are using the Community Ultrasound Services more. SG added that they are making sure the USC Referrals are reviewed by a dedicated Consultant within 24 hours. In terms of 62 day performance they have delays in resources on the nursing side. • BH outlined that USC Rejection in Secondary Care is not written in the National Guidance. It is working well at MFT. BH explained the process that Gynaecology USC are working with and suggested that Haematology gain clarity from the whole county and look at the Gynaecology guidance to enable them to work in the same way to vet referral. • SA will be working on a CRG Action to look at a network-wide criteria for USC to standardise what referrals are appropriate for the USC Pathway. VS confirmed that the CRG will be looking at their pathways to update them. Nahla Osman from MFT has written a set of advice and guidance and advice for GP's to access off their local portals. This work will be presented at the next TSSG to see if any other site wishes to adopt this guidance. • NH from DVH stated that they are doing well with 62 day performance and are managing patients in a timely fashion. There is a need to ensure the Data is clean in the Dashboard and it could be improved. DVH do not have a an FDS Nurse, though it would be beneficial to have one. Imaging apart from Ultrasound is going well, the delays come from other specialties (ENT and Lung). They triage all their referrals for USC. NH agreed that they should have a more unified response to downgrading USC referrals. NH currently writes a	

		letter to the USC Co-ordinator and then they reply back to the GP. DVH receive USC referrals from three different areas (Bexley, South East London and Kent and Medway), which is challenging, resulting in three different USC Cancer Proformas. DVH have their own GP Haematology Referral Guidelines which are on the Intranet to view and are linked on the platform. These are not being used by the GP's. VD added that the delay in 28 day FDS is due to Histology and is waiting 2 weeks to obtain a biopsy result. **Action – BH to feed back to Primary Care colleagues to use Haematology Referral Guidelines and will liaise with Chris Singleton regarding other areas/Alliances and see what can be unified.** • JO from EKHUFT have problems with capacity, they do downgrade, numbers may be worse as any MGUS they are not seeing in a Cancer Pathway, they are downgrading. It can take up to 6 weeks to obtain a guided biopsy, they have no capacity in our Day Units to give chemotherapy, their lag is 3 weeks at present to start cancer treatment. Ward capacity is only 8 beds, every aspect of their Pathway is slow, also had problems with Histology turnaround times as they haven't recruited Histologists. Every stage is broken and targets are not being met. • VS summarised that all of these issues need to be picked up on a higher level with the Cancer Alliance as the services, sites and spaces have not been expanded. **Action - VS encouraged everyone to take this information back to their own local Governance meetings to discuss improvements.** • OD will be providing a Histopathology update/oversight at the next TSSG. • AC highlighted that Imaging do not have a single governance structure and advised that the Cancer Network might be a way to take this forward. AC would be happy to be copied into any discussions with Imaging departments to support them with weaknesses and strengths. • VS went through the Data Slides highlighting data of new cases per year, % diagnosed at Stage 1 or 2 and overall survival at 1, 2 and 5 years. • VS encouraged everyone to gain access to the Live Dashboard. **<u>How to sign up to the Cancer Pathways and Cancer in Primary Care Dashboards</u>**	**BH** **ALL**

		• 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.	
4.	**Personalised Care Update**	**Presentation provided by Claire Mallett** • The Personalised Care Update Presentation provided an overview of the following :- • National Cancer Plan – Improving Performance, Survival, Quality of Life for people being diagnosed with, treated or living with Cancer. There are 3 ambitions - Meeting Cancer Waiting Time Standards. By 2035, 3 in 4 people diagnosed with Cancer will be cancer-free or living well with cancer after 5 years. Improving the quality of life for people being diagnosed with, treated or living with cancer. • Key Commitments, the plan is structured around 6 key themes. i) Driving up NHS Cancer Performance ii) Becoming a global leader in cancer outcomes by 2035. iii) Designing cancer care around people's lives. iv) Delivering world class cancer care through world class research. v) Tackling cancer in children and young people. vi) Prioritising rare and less common cancers. • Top Line Messaging. • Neighbourhood Cancer Care. Living with and Beyond Cancer. Implementing Stratified Pathways. In Haematology they have completed a CLL Pathway which is live in three Trusts. Some Trusts are looking	**Presentation circulated to the group on 27th February 2026**

		at using a Patient Portal which will enable patients to log in and obtain blood test results. There is an ambition to look at more Pathways. • It is important that all patients are offered an HNA and CM works closely with CNS's and Cancer Support Workers, with Consultants imputing into Treatment/Care Summaries. Key priorities are to support Training. • What Matter's to Kent and Medway Cancer Patients – Top concerns were money or financial Issues, tiredness, exhaustion or fatigue, eating, appetite or taste changes, pain or discomfort, mental health, other medical conditions and physical symptoms. • Programme Updates - CS has been working with a community interest company called 'Menopause and Cancer' to set up peer support groups. Fatigue Animation and Limbo Land (series of patient and professional videos). Physical Activity has been included in national planning guidance with nine workshops delivered. • A Resources Padlet has been developed which will be available on the Cancer Alliance Website shortly, which highlights all the different resources and support for patients and for staff to signpost. • They are developing a pilot with Gravesham Council called Outswimming Cancer, which will provide a 1 hour open session for people that have had cancer, aiming to get them more active. VS asked CM to provide any posters so that members can display them in their departments for patients and encouraged everyone to watch the Limbo Land video's.	
5.	**Histopathology Updates**	Not discussed.	
6.	**National Non-Hodgkin Lymphoma Audit**	**<u>Presentation provided by Vicki Stables</u>** • VS explained that this is the only National Audit for Haematological Cancer, which evaluated patterns of care and outcomes for people with NHL in England and Wales.	**Presentation circulated to the group on**

		• These results were from MTW, but each Trust site should have their own results. • It allows organisations to benchmark themselves against guidance/performance of other sites. Data is looked at quarterly over a 3 year time period to ensure indicators are accurately reported and recorded. • Data included number of patients discussed at MDT Meetings within first four weeks of diagnosis. MTW is achieving this in a timely fashion by National Standards. It also looked at high grade and low-grade data. • At MTW due to time resources and CNS's not being present at all consultations, there is no data recorded, this may be due to data not being recorded accurately within their MDT. • NH from DVH have their Cancer clinics with a Consultant and there is always a CNS present and available. CB agreed that they are heavily involved and will request PET Scans and Echos to improve FDS. There are three CNS nurses at DVH and one is allocated to be in clinic. Cards are given to patients to call the CNS if they have any queries and the CNS are happy to chase up their PET appointments. A CNS is also allocated to the inpatient ward on Monday and Fridays. • SU stated that at MTW, CNS's are very good with documentation and are always available to see a patient and provide information. There are challenges with Infoflex, which could be the issue. • JO from EKHUFT have a CNS present when they run a new patient clinic. They have CNS's 3 days a week at the WHH, including a Registrar and Cancer Support Worker. They are hoping to increase this so that they are able to see new patients on the ward. EKHUFT have 5 CNS's and 2 Cancer Support Workers. **Action – VS would like the CNS team from each site to provide an update on how one week looks/screen shot overview and present this at the next TSSG, in order to help share resources in the service with flow and move forward in a different way.** • VS went back through the data slides and could see there was a big discrepancy between the National Audit Lymphoma Data and the Dashboard. The 62 day treatment at MTW and MFT is becoming harder to achieve.	**27th February 2026** **CNS's.**

		• Data completeness for MDT Meeting is poor at MTW, is running below the target and data input is an issue. Registrars are now being asked to complete the data to improve this. • Once data has been collected, Risk Concerns are identified for each indicator and graded using Red, Amber and Green Rag Rating System, depending on the score they will have full, partial or limited assurance. There are various recommendations then to be made. • Recommendations at MTW are to have a dedicated SpR to ensure data is accurate, to re-audit next year, increase CNS dedicated to Lymphoma and discuss Aseptic Centralisation. • NLA point for discussions – We need to report back to NHS England as a TSSG on our Treatment Variation Metrics and to meet 85% of patients treated with chemotherapy for high-grade NHL that started treatment within 62 days of urgent referral. • EKHUFT and MTW Waits for Chemotherapy have become longer in the last few years. • Take Home Points from National Lymphoma Audit and Dashboard - Data is more useful when it is accurate. There is a need to look at how we are entering our Data at MDT's using Infoflex etc, are we all using the same domains and document staging? VS asked AC to feedback to Radiologists that when they are reporting PET Scans, staging is to be included in the report. • DVH are recording MDT outcomes live on Infoflex. At MFT the MDT Co-ordinator drafts a report and this is sent to the Consultants, which is checked, edited and returned within 24 hours. SA remarked that Infoflex is a stand-alone system and everyone should have access. At EKHUFT the Consultant checks the outcomes from MDT and they go back to the MDT Lead for vetting. AT MTW the Registrar documents the outcomes, which provides a good educational opportunity for them, but it is not put direct into Infoflex. VS suggested that all sites would benefit from Infoflex training. CM added that the Infoflex team would be happy/responsive to any training and support that is required and are available to work locally with Infoflex contacts. Infoflex is under procurement at present but may stay for the next year. AC queried whether Infoflex can be integrated with Sunrise, CM will look into this.	

7.	**CNS Updates**	**DVH** CB reported that a Business Case for a Part-time Band 7 CNS and full-time CNS has been submitted. They are catching up on Patient Leaflets. **MTW** CG stated that their team has been going through an in-undated, over-worked and stressful period. They have an additional WTE Band 7 CNS and there is long-term sickness within the team. CNS's have not been able to attend Consultant Clinics as much as they would like to. There is a big issue with Pharmacy work, which is working progress. Myeloma Accreditation was awarded in November 2025 and a Myeloma Support Group has been set up (runs every 3 months), which is beneficial for patients and Medway patients are also attending. HNA's are being carried out by their Band 4, whose job is currently under review due to finances and MTW may lose this Band 4 later on this year. VS congratulated the team on gaining accreditation. **MFT** KM highlighted that they have one full-time Band 8a, who is a Prescriber, 2 full-time and 2 part-time Band 7's, 2 full-time Band 4's. Two CNS Clinics per week, which have 16 patients. A CNS MPN Clinic has 12 patients, 2 face to face Post Bone Marrow Clinics which has 16 slots. All CNS's are trained in bone marrow. CNS's carry out 3 ward rounds per week and cover all the Consultant face to face Clinics. HNA data has significantly improved with 100% now being offered a diagnosis. A Band 4 carries out HNA's for all new patients. **EKHUFT** No EKHUFT CNS's present at meeting. JO advised that they have 5 Malignant CNS's, with 4 WTE on the Thrombosis side. The plan is to obtain a non-malignant CNS to cover ITP. The team have 2 Cancer Support Workers who carry out the questionnaires.	
8.	**Research Updates**	**MTW** DW reported that OASIS is waiting to open, look at samples from potential Myeloma patients. There is a study looking at DLBCL and another study is looking at tissue. RATIFY is waiting to open at MTW. RADAR is coming to a	

		close. They have MagnetisMM which is a relapsed refractory Myeloma study and asked if anyone has any patients that have failed first line and has had a CD38, IMID please refer them to DW. They also have PROPEL which is looking at rehab for patients that have had induction and chemotherapy. OPTIMISE is a Flip 3 positive study for upfront treatment. DW has sent through a Research Newsletter to VS. **MFT** SG stated that they only have one active clinical trial which is the RAINBOW study. Their Research Nurse had long term sickness, but they now have a new Research Nurse in place and hoping to contribute to research more going forwards. They have a number of registry studies but are lacking in interventional studies. **EKHUFT** JO highlighted that they have open MagnetisMM, RADAR, CML, Lymphoma and CADENCE opened last week. OPTIMISE is just opening. CAMELOT is for non-intensive treatment. Hoping to open another CML in people who are resistant to first and second line treatment. **DVH** NH outlined they have no Clinical Trials at DVH. There is no Research Lead, it is a role not acknowledged by the Trust and they have no dedicated Haematology Trials Nurse. SG asked if a Clinical Lead was job planned, JO is working on this for EKHUFT and is trying to incorporate this into the Consultants Job Plan. VS outlined that it is minimally represented at MTW but is not reflected in the work undertaken. LM added that her role in the CRG/TSSG is regarding managing immuno-deficiency aspects and managing the risk of infection in immuno-comprised patients and is happy to support with pathways of blood sciences.	
9.	**AOB**	• VS outlined the CRG/TSSG (Alliance guided) targets for the next 6-12 months which included :- - Re-cap/Review service configuration at each of the 4 sites - MDT Streamlining/standardising - Histopathology Reporting	

		- National Lymphoma Audit and improving 62 performance etc - Updating Guidelines - Pathways : PIFU/MGUS/CLL - SLA's with Referral Centres • Targets going forwards for next 1-2 years included :- - One Site for treating AML/PCNSL - Middle Grade Cover/Rota - Standardised Auditing • VS asked for suggestions from everyone regarding what they would like the CRG to drive forward and be represented in the TSSG Meeting. • JO recommended sharing education with the Registrars, each of the Consultants would then only need to present once or twice per year. VS agreed with this proposal. JO undertakes teaching once per month for the laboratory staff across Kent and runs Haematology teaching once per month and invited anyone to join. • VS asked everyone in the meeting to share their teaching dates/times/locations. • AC advised that he will be visiting the East Kent MDT's to see the similarities/differences to enable everyone to learn from each other. AC will also be reaching out to DVH/MFT Radiologists to resolve any local issues. • VD suggested a pathway for IT's for the whole of Kent and mentioned that they have an Aseptic Pharmacy in MTW that would also cater for other Kent Hospitals. EP advised that Maidstone have a non-licensed unit and until that unit becomes licensed they cannot supply to other hospitals outside the Trust. There are discussions with the Chief Pharmacist that they are going to build industrial units in Kent, but there are no finances at present and a site needs to be located. NH agreed that at DVH it is challenging not having an Aseptic Unit and trying to insource from private providers. SA at MFT do have an onsite unit with brilliant Pharmacy support, but are struggling with chemotherapy administration. JO at EKHUFT reported structural problems with their unit. VS recommended taking these issues to HOG to discuss at a deeper level.	

		• VS highlighted that at the next April TSSG they would like to celebrate successes and thanked everyone for attending today's meeting.	
	Next Meeting	• Tuesday 28th April 2026 – 1.30pm to 4.30pm, Auditorium, Academic Centre, Maidstone Hospital	