Kent & Medway Cancer Collaborative

**Haematology Tumour Site Specific Group meeting**
**Tuesday 28th April 2026**
**Auditorium, Academic Centre, Maidstone Hospital, Hermitage Lane, Maidstone. ME16 9QQ**
**13:30 – 17:00**
**Final Meeting Minutes**

| Present | Initials | Title | Organisation |
|---|---|---|---|
| Vicki Stables (Chair) | **VS** | Consultant Haematologist | MTW |
| Dunnya De-Silva | **DDS** | Consultant Haematologist | MTW |
| Clare Oni | **CO** | Consultant Haematologist | MTW |
| Evangelia Dimitriadou | **ED** | Consultant Haematologist | MTW |
| Fathi Al-Jehani | **FAJ** | Consultant Haematologist | MTW |
| Lolly Banerjee | **LB** | Consultant Haematologist | MTW |
| Jamie Carter | **JC** | Deputy General Haematology Manager | MTW |
| Kirsty Thompson | **KT** | Haematology Manager | MTW |
| Sarah Updyke | **SU** | Haematology CNS | MTW |
| Carolyn Gupwell | **CG** | Haematology CNS | MTW |
| Claire Herbert | **CH** | Haematology CNS | MTW |
| Kavi Robinson | **KR** | Haematology CNS | MTW |
| Alexis Corrigan | **AC** | Consultant Radiologist | MTW |
| Olena Dotsenko | **OD** | Consultant Pathologist | MTW |
| Samantha Williams (Minutes) | **SW** | Administration & Support Officer | KMCC |
| 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 |
| Ritchie Chalmers | **RC** | Medical Director | KMCA |
| Fay Fawke | **FF** | Deputy Lead Macmillan Cancer Nurse | DVH |
| Natalie Heeney | **NH** | Consultant Haematologist | DVH |
| Sanjeev Madaan | **SM** | Consultant Urological Surgeon | DVH |
| Jayne-Marie Osborne | **JO** | Consultant Haematologist | EKHUFT |
| Claire Bingham | **CB** | Personalised Care Facilitator | EKHUFT |
| Kerry Mitchelsen | **KM** | Lead Haematology CNS | MFT |
| Nahla Osman | **NO** | Consultant Haematologist | MFT |

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| Sharon Griffin | **SG** | Screening Professional Clinical Adviser | MFT |
| Manisha Mishra | **MM** | Medical Student | KMMS |
| Rithika Narain | **RN** | Medical Student | KMMS |
| Emily Mean | **EM** | Macmillan Clinical Specialist Myeloma Physio | HHFT |
| Amanda Harris | **AH** | Patient Partner | |
| **Apologies** | | | |
| Melene Locke | **ML** | Senior Cancer Research Nurse/Team Lead | EKHUFT |
| Pippa Enticknap | **PE** | Deputy General Manager | EKHUFT |
| Michelle Bevans | **MB** | Clinical Nurse Specialists | EKHUFT |
| Jindriska Lindsay | **JL** | Consultant Haematologist | EKHUFT |
| Miguel Capomir | **MC** | Haematology/Oncology Pharmacist | EKHUFT |
| Danielle MacKenzie | **DN** | Macmillan Nurse for Personalised Care | EKHUFT |
| Sarita Workman | **SWo** | Clinical Nurse Specialist | EKHUFT |
| Helen Downs | **HD** | Chief Pharmacy Technician | EKHUFT |
| Lemun Mutlu | **LM** | Consultant Immunologist & Allergist | EKHUFT |
| Tracey Spencer-Brown | **TSB** | Head of Nursing for Oncology & Haematology | MTW |
| Deborah Willcox | **DW** | Macmillan Lead Haematology & Lymphoma Research Nurse | MTW |
| Ola Okuwa | **OO** | Senior Oncology Pharmacist | MTW |
| John Schofield | **JS** | Consultant Pathologist | MTW |
| Michelle Janney | **MJ** | Macmillan Haematology & Lymphoma Research Nurse | MTW |
| Dhalvir Midda | **DM** | Deputy Chief Pharmacist | MTW |
| Vijayavalli Dhanapal | **VD** | Consultant Haematologist | DVH |
| Chinwe Ifeji | **CI** | Specialist Cancer Pharmacist | DVH |
| Faye Barrow | **FB** | MDT Co-ordinator | DVH |
| Pooja Chhabhaiya | **PC** | Principle Pharmacist | DVH |
| Ann Courtness | **AC** | Macmillan Primary Care Nurse Facilitator | KMCA |
| Jonathan Bryant | **JB** | ICB Primary Care Cancer Clinical Lead | KMCA |
| Tracey Squire | **TS** | Macmillan User Involvement Manager | KMCA |
| Joanne Jackson | **JJ** | Early Diagnosis Project Manager | KMCA |
| Janet Hayden | **JH** | CNS | King’s College Hospital |
| Joanna Large | **JLa** | CNS | King’s College Hospital |
| Shreyans Gandhi | **SGa** | Consultant Haematologist | King’s College Hospital |
| Sudarshan Gurung | **SGu** | Consultant Haematologist | MFT |

| Item | | Discussion | Action |
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| 1. | TSSG Meeting | **Apologies**<br>• The apologies are listed above.<br>**Introductions**<br>• VS welcomed the members to today's face to face meeting.<br>• 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.<br>**Action Log Review**<br>• The Action Log was reviewed, updated and will be circulated to the members along with the final minutes from today's meeting.<br>**Review Previous Minutes**<br>• The final minutes from the previous meeting which took place on the 23rd February 2026 were not reviewed but were previously agreed as a true and accurate account of the meeting. | |
| 2. | CRG Update | Not discussed due to time constraints. | |
| 3. | Dashboard | Not discussed due to time constraints. | **Data Pack circulated to the group on 23rd April 2026.** |
| 4. | Single Point of Access (SPOA) | **Update provided by Ritchie Chalmers**<br>RC explained that SPOA is a new referral management system. NHS England have decided that this will be implemented from October 2026, which will change the way referrals are being managed from Primary Care into Secondary Care. It is based on the Northumbrian Gastroenterology model, originated by Jim Mackie and is a very | |

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| | | innovative system. Patients at present are being bounced backwards and forwards and this new system will enable them to get to the next point in their journey as quickly and efficiently as possible.<br><br>SPOA uses an amalgamation approach. All referrals will come into SPOA between primary and secondary care to get the patient to the next step like a Watsapp type approach. There will be a rapid response rate of 24-48 hours with specialist input. This will work well in Haematology.<br><br>Conversations are visible to patients through the NHS App, between Primary and Secondary Care. It will make a system that patients can interact with. SPOA is being rolled out in all specialties that have agreed to partner with us. A live discussion is going to be held to co-design this together with Primary and Secondary Care. There is the opportunity to launch this across Kent and Medway and the financial resource is there. It is a much better system for patients, primary and secondary care and we are working to get a system that's works for us all. There is a need to get the benign pathways working properly so they can manage the cancer pathways more appropriately.<br><br>The commitment will happen in the next six months, working with Gastroenterology first at MTW, it will go live in one area with feedback. The aim is for 10 specialties to go live by October 2026. There is a bid to support Colorectal to launch SPOA in the Cancer Pathways. There has been good engagement from Primary Care at a recent meeting.<br><br>The turn off ability to refer will change in ERS in July. RC stressed that they need good data capture with strategic commissioning for the future.<br><br>VS recommended holding another delegate meeting to understand the concept of SPOA. | |
| **5.** | **MDT Streamlining** | **<u>Presentation provided by Sanjeev Madaan</u>**<br><br>• MDT workloads in UK Cancer Care have become unsustainable due to rising demand and complexity, limiting meaningful case discussion.<br><br>• MDT streamlining - removing straightforward, protocol-driven cases from full discussion - helps preserve time for complex cases while maintaining care quality through predefined Standards of Care.<br><br>• A structured pre-MDT review team assesses cases using standardised data, with all streamlined cases still visible to the MDT. | **Presentation circulated to the group on 29th April 2026.** |

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| | | • A 2024 pilot at DGT showed improved efficiency (shorter meetings, faster case discussions) with 37% of cases safely streamlined.<br><br>• Safety was maintained with no adverse events and staff reported time savings and better-quality discussions.<br><br>• Despite initial concerns and implementation challenges, streamlining proved safe, effective and scalable, with future potential for AI-supported decision-making.<br><br>SM added that the whole team has to be on board with Job Plans modified to support Consultants.<br>SM has a SOP and is happy to share the template with all Trusts.<br><br>VS stated that their Terms of Reference need to be updated and understand the process/amend the pathway. There is a need to continue as a network and each Trust to carry out internal in-house streamlining.<br><br>MDT 's times are shorter and changes have been made to efficiencies, but MTW do need to need to evaluate the MDT lasting for 2 hours. The group were keen to explore and discuss at the CRG in terms of next steps. | |
| **6.** | **HOG Update** | **<u>Update provided by Hayley Paddock</u>**<br><br>• Rasburicase guidelines updated and circulated. One comment received, will be finalised and published soon.<br><br>• Arsenic and ATRA for high risk APML. Commissioning paper updated, consolidation for high risk now the same as that for low to intermediate risk, following the schedule from the AML17 trial. Protocol and regimens being updated.<br><br>• Regimens now live on ARIA and protocols on KMCC website.<br><br>• Belantamab, pomalidomide and dexamethasone for 2nd line MM.<br>• Epcoritamab for R/R FL after 2 or more lines of treatment – please note the step-up dosing is different to that of DLBCL indication therefore care required when selecting the regimen.<br><br>• Pirtobrutinib for CLL after a BTK inhibitor. Protocol being drafted. | |

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| | | JO highlighted data from a poster presented at BSH regarding using a quicker infusion time for Isatuximab. HP will have a look at the data and also find out when SC Isatuximab is due to be available and discuss options at next HOG meeting. | |
| **7.** | **Prehabilitation** | **<u>Presentation provided by Emily Mean</u>**<br><br>• EM is a Physiotherapist, based at a 10 bedded unit at Basingstoke and employed by Cancer Services. They do not have any oncology beds there. Prehabilitation is provided across two sites including Basingstoke and Winchester.<br><br>• The Prehabilitation for People with Cancer Presentation provided an overview of the following Clinical and Implementation Guidelines (September 2025).<br><br>• Systematic review of available literature about prehabilitation before and during cancer treatment – this has increased substantially since original guidance was published.<br><br>• 6 key areas: Prehabilitation Implementation / Health Economics and Business Cases / Behaviour change and technology / Nutrition / Psychology / Exercise.<br><br>• Agreed Definition - "Prehabilitation is a need-based multi-modal intervention, before and during treatment, to optimise physical, nutritional and psychological status, enhance readiness for and tolerance of treatments and improve recovery and/or quality of life. Prehabilitation involves screening before needs-based assessment, enabling individualised prescription of exercise, nutrition and psychological interventions supported by behaviour change techniques"<br><br>• Levels of Prehabilitation included Specialist, Targeted and Universal.<br>• The Graphs shown outlined patient benefits of Prehabilitation and Rehabilitation.<br><br>• Key elements of Prehabilitation for the patient included Exercise, Psychological Support and Nutrition.<br><br>• EM stated that they do not have an Oncologist Physio at HHFT for inpatients or outpatients, but do offer Frailty Project in Lymphoma, COP Physical Activity, Exercise Class, Walk and Talk for Myeloma and Signposting/Referrals to local gyms/third sector. | **Presentation circulated to the group on 29th April 2026.** |

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| | | VS asked how they have managed to keep the funding in place for Prehabilitation which had been lost in Kent and Medway. EM explained that their funding was secured in 2025 from Charitable Funds. There has now been a restructuring of the budget that has allowed EM to be kept in post.<br><br>Myeloma patients would benefit the most from prehab but due to braces / bone disease it is very difficult to provide prehab. EM is happy to provide individual advice as required.<br><br>VS enquired whether there was data or evidence to show it had improved outcomes. EM explained that they do collect objective measures before and after seeing each patient. The national pre-outcome measures are due out in Summer 2026.<br><br>AH mentioned that her local yoga service had been closed due to receiving no referrals and there had also been no new referrals for a Pilates class.<br><br>VS requested an updated list of resources that are available so that patients could be referred. JO is happy for AH to provide information on classes and RC stated that this can then be put on the Cancer Alliance Website. | |
| **8.** | **Haematology Referrals Audit & Guidance** | **<u>Presentation provided by Nahla Osman</u>**<br><br>• The Assessment of the Efficacy of the use of USC Pathway in MMH. The Aim was to assess the appropriateness, completeness and outcomes of USC Haematology Referrals.<br><br>• The Development of Quick Haematology Referral Guidance was to clarify appropriate USC indications, standardising referral expectations and improving quality and consistency of information provided.<br><br>• The USC QIP was a retrospective study that looked at the USC Referrals to Haematology during February and March 2024, reviewing the completeness and indication.<br><br>• Pie Charts outlined the Referral Diagnosis in 31 USC referrals, 1 in 16 patients were referred with Lymphoma and a graph detailed the type of appointment.<br><br>• Less than half of those who attended a USC slot has had a cancer diagnosis. There was a total number of 20, with 8 diagnosed with cancer and 6 required USC. The Cancer Diagnosis to referrals ratio – less than 25% had a cancer diagnosis. | |

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| | | • Referral Filling identified missed important information in a significant proportion of the forms.<br><br>• NO explained the Referral Guidance for Lymphadenopathy, Paraprotein and Abnormal Immunoglobulins, Neutropenia, Pancytopenia and Haemochromatosis.<br><br>• The message outlined the emphasis on filling of USC Forms to ensure proper assessment. Active Referrer email that is monitored regularly should be included. Referrer is expected to respond to the specialist within a certain time (24 hours) to ensure swift processing of the referral. All effort should be made by all parties to ensure appropriate use of the USC slots.<br><br>**ACTION - JO asked members to look at the 2ww Proforma that had been circulated on Monday 24th April and feedback their comments.**<br><br>**ACTION – VS asked for Kent and Medway Primary Care Referral Guidance (and EKHUFT's equivalent) to be shared and discussed in the CRG.** | **ALL**<br><br>**CRG Members** |
| **9.** | **Genomics for Histopathology** | **<u>Presentation provided by Olena Dotsenko</u>**<br><br>• The Genomics for Histopathology Presentation provided an overview of the following :-<br><br>• Concept of Lymphoma Diagnosis/Multi-parameter Disease Definition.<br>• Lymphoma Diagnosis is different to Pathological Diagnosis of most solid cancers.<br>• Biological Attributes – Genomics in Lymphoma – B and T cell gene re-arrangement (clonality), Targeted DNA -based NGS and FISH.<br>• Genomic Testing in Lymphoma – Large B-Cell Lymphomas and low-grade B-Cell Neoplasms.<br>• B-Cell Lymphomas, Mature T-Cell and NK-Cell Neoplasms – Summary of Genetic alterations and their clinical utility.<br>• Low Uptake of Genomic Testing in Lymphomas – unique and multifactorial challenges.<br>• Challenges in Genomic Testing in Lymphomas.<br>• Optimal Service Model (SIHMDS) and NICE NG47 Recommendations in 2003 and 2016.<br>• Haematological Malignancy Diagnostic Service (HMDS) Network Meeting held on 27th February 2026. Evolving the NHS Genomic Medicine Delivery Model from April 2026. Genomics has an important role to play in delivering the 10-year Health Plan and Main issues. | **Presentation circulated to the group on 29th April 2026.** |

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| | | • Specific Haem-Onc NHS GMS Service Specification Requirements. National Haem-Onc Genomic Testing Delivery Model and Service Specification Response.<br>• Haem-Onc and Genomics Oversight Group included the purpose and membership.<br>• End to End Regional Service Review outlined the Objectives and Next Steps.<br>• Aims and Workstreams – 2024 to 2026 included Tissue Pathways, Optimised and Standardised Genomic Testing GEP and NGS and ctDNA.<br>• Map of West Kent SE-HMDS (SE LGH at KCH) – Variant networked SIHMDS Model.<br>• Cancer National Genomic Test Directory – TATs.<br>• Integrated Reporting Challenges – TA. Graphs showing Network of Excellence/CGIP Audit and West Kent networked HMDS Realities.<br>• Issues in Haematopathology included the increase in number of cases and more complex cases, increase in number of cases requiring genomic analysis, same capacity/no additional support to integrate results into reports, sending material to SE HMDS at King College Hospital, SE HMDS Turnaround Time and receipt of the results for genomic testing – complicated pathway and integration of genomic testing results into histopathology reports.<br>• Table of Haempath cases with Genomic Requests in West Kent from 2024 to 2026.<br>• Suggestions on how to streamline the genomics pathway. | |
| **10.** | **Parallel Planning Clinic** | Not discussed due to time constraints. | **Presentation circulated to the group on 29th April 2026.** |
| **11.** | **A Clinical Audit of 'Follow-Up Standards for Infection Prophylaxis in Patients post-Chimeric Antigen Receptor T Cell** | **<u>Presentation provided by Manisha Mishra</u>**<br><br>• The Clinical Audit of 'Follow-Up Standards for Infection Prophylaxis in Patients post- Chimeric Antigen Receptor T Cell Therapy at MTW NHS Trust Presentation provided an overview of the following :-<br><br>• **Introduction** – CART therapy has transformed outcomes in haematological malignancies. Patients receiving CAR-T therapy receive multiple prior lines of therapy and CAR-T compounds the risk of infection with complications like cytopenias and hypogammaglobulinemia. Currently in the UK, CAR-T is delivered by a shared-care model with no national guidelines on infection prophylaxis and immune monitoring. | **Presentation circulated to the group on 29th April 2026.** |

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| | **Therapy at MTW** | • **Background and Rationale** - Infection accounts for 50% of non-relapse mortality post CAR-T therapy. Predictable immune suppression: neutropenia, B cell aplasia, and hypogammaglobulinemia. CRS/ICANS and consequent steroid use increase infection risk. Distinct early (bacterial) and late (viral) infection phases. Shared-care delivery without unified national surveillance standards.<br><br>• **Audit Question** - *"Are the standards of follow-up for infection prophylaxis in patients post-CAR T therapy for haematological malignancies at Maidstone and Tunbridge Wells (MTW) NHS Trust compliant with current local, national and international guidelines?"*<br><br>• **Objectives** - To determine current follow-up regimes for CAR-T patients at MTW NHS Trust and to assess the structure, timing, and appropriateness of interventions. To compare the monitoring against national and international standards for follow up frequency, infection prophylaxis, IgG monitoring and IVIG, and vaccination planning. To recommend improvements and re-audit.<br><br>• **Methods** – Design: Retrospective clinical audit. Sample: 24 adult CAR-T recipients. Data: EPR & correspondence. Analysis: Descriptive compliance percentages. Standards: ASTCT 2024, UK Tertiary CAR-T SOPs.<br><br>• **Domains audited** - Follow-up structure, Antimicrobial prophylaxis, IgG monitoring and Vaccination planning.<br><br>• **Ethics** – Not research (HRA tool confirmed) and Gatekeeper approval secured.<br><br>• **Results** – Cohort and Transfer of Care - Median age: 62 years. 96% diffuse large B-cell lymphoma, 95% developed CRS/ ICANS. 83% required tocilizumab +/- steroids. 54.2% mortality at time of analysis. Infection accounted for 46.2% of deaths.<br><br>• **Documentation Finding** - Only 33% discharge letters initially available on EPR. 67% required direct retrieval with 3 permanently unavailable.<br><br>• Infection Prophylaxis Compliance Graph. Compliance – Surveillance and Vaccination – included structured 4-weekly follow up, monthly IgG monitoring and Baseline lgG. Vaccination documentation in discharge letters included Covid, routine 6-month vaccines and Zoster.<br><br>• Limitations and Recommendations were outlined. | |

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| | | • **Conclusions** – The Audit demonstrated Strong initiation of prophylaxis, Significant non-compliance in surveillance of IgG, Absence of structured follow-up and fragmented documentation in shared-care. Post CAR-T follow-up standards at MTW are not fully compliant with external guideline benchmarks.<br><br>• A formal SLA and clinic template are proposed to be implemented to enhance governance, accountability, and patient safety.<br><br>FAJ stated that the data is very worrying. NH mentioned that at DVH their Consultants and CNS's have access to the London Care Records and can see the progress notes from Kings to look back at all patients results. VS agreed that baseline NG levels should be carried out locally. MM has written out an SLA for CAR-T. JO added that they have no SLA's at EKHUFT. | |
| **12.** | **Audit – MDT Efficiency & Effects on 62 Day Pathway** | **<u>Presentation provided by Rithika Narain</u>**<br><br>• 'Is the West-Kent Haemato-Oncology MDT Efficient' Presentation provided an overview of the following :-<br><br>• **Audit Aim** – To evaluate the efficiency of the West Kent haemato-oncology MDT in three domains: factors that reduce the efficiency of the MDT process **before**, **during**, and **after** the MDT and to provide recommendations to improve efficiency.<br><br>• **Objectives**- Audit the MDT against the 2016 National Institute for Health and Care Excellence (NICE) standards for MDT efficiency and the 2022 West-Kent Haematology MDT Terms of Reference.<br>• Evaluate participation, attendance, and documentation practices during MDT.<br>• Evaluate data availability, patient selection and the number of patient deferrals during an MDT.<br>• Identify MDT process inefficiencies and provide recommendation which improve MDT efficiency.<br>• Provide recommendations to update the West-Kent haematology MDT terms of reference.<br>• Complete a re-audit cycle to see if suggested recommendations improve MDT efficiency.<br><br>• **Audit Design** - 5 MDTs were the statistically significant sample size for this audit.<br>• The audit dates selected were: 7th, 14th, 21st, 28th November and 5th December 2025.<br>• 192 patients were discussed. The audit standards were defined using 2016 NICE standards for MDT efficiency, 2022 West-Kent Haematology MDT terms of service and available literature. | **Presentation circulated to the group on 29th April 2026.** |

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| | | • RN outlined the following :-<br><br>• Patient selected for the West-Kent Haemato-Oncology MDT are appropriate.<br>• All the core members of the MDT should be present during the MDT.<br>• Ensure the required data set needed to discuss each patient is available.<br>• The number of patients per MDT should not exceed 38 and no late additions should be added to the MDT.<br>• The length of the MDT Meeting should not exceed 120 minutes and all cameras should be turned on in virtual MDT Meetings.<br>• No patients should be deferred to the next meeting.<br>• RN outlined the recommendations for pre-MDT, during and after MDT.<br>• **Actions included** - agree new terms of reference, discuss specific issues: Histopathology resource, MDT coordinator resource and re-audit in 3-4 months | |
| **13.** | **Discuss SLA Agreements between all Trusts & Tertiary Centres for Follow-Up Care** | Not discussed due to time constraints. | |
| **14.** | **CNS Updates** | **East Kent** - no update provided.<br><br>**MTW**<br><br>MTW are due to lose 2 CNS's due to retirement over the next few months. All posts are frozen due to recruitment freeze. The team are finding it challenging with the workload.<br><br>**MFT**<br><br>MFT have 4 CNS's. They have 16 slots of CNS Clinics. The Band 4 CSW carries out HNA's. All CNS's are carrying out Oral Chats and Ward Rounds. The Cancer Alliance have funded a post for 1 year and it is now a permanent role. CNS's also manage the Colorectal Team.<br><br>**DVH** | |

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| | | Management are not replacing any staff and this will go on for another year, though a Business Case has been submitted. DVH have 3 Cancer CNS's and 1 Cancer Support Worker. A thrombosis nurse and another non-malignant nurse are in place.<br><br>There is a ward round on Monday and Fridays. Due to financial pressures the ACP is on hold. It is challenging as there are only 2 CNS's to cover ward work. SACT Oral Clinic held on Wednesday and Friday. CNS's support Consultant Clinics on Tuesday and Thursday. HNA's are carried out in clinic. | |
| **15.** | **Research Updates** | **MTW -** Propel is open at MTW.<br><br>**MFT -** No update provided<br><br>**DVH** – No update provided<br><br>**Presentation provided by Melene Locke.**<br><br>JO presented the East Kent Research Update on ML's behalf.<br><br>• The East Kent Research Update Presentation provided an overview of the following :-<br><br>i) Current Portfolio of Commercial Trials - MajesTEC-7, MagnetisMM-16, Camelot, GOLSEEK-4 and CADANCE.<br>ii) Current Portfolio of Academic Studies – COSMOS, STATIC, PetreaPLUS and MITHRIDATE.<br><br>• Studies in Set Up – TRILLOGY-4, MODIFY and Optimise FLT3.<br><br>• Recruitment – Prioritising commercial and interventional studies. Recruitment 25/26 – 43 commercial. Recruitment 26/27 – 3 commercial so far (in screening).<br><br>• Challenges to recruitment and activity included Pharmacy/Aseptics – having to priorities studies, patients requiring treatment quickly and inpatient bed capacity for administering BiTe.<br><br>• Team Successes :- | **Presentation circulated to the group on 29th April 2026.** |

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| | | - Dr Young CI for CADANCE and GOLSEEK-4. 1st Global participant to GOLSEEK and 1st UK participant to CADANCE.<br>- Top Recruiters to RADAR, MAG-1, Majestec-7.<br>- Trying to utilise EKHUFT Clinical Research Facility at QEQM to deliver more studies and expand role of research nurse to include delivery of treatments.<br>- New partnerships with investigators and sponsors.<br>- Networking at events leading to interest in study site. | |
| **16.** | **AOB** | • JO raised, 'The use of Prophylatic Tociluzimab in myeloma patients receiving bi-specifics' – (there is a drive to do this nationally, due to a good safety profile and cost savings). There is no protocol for this yet but there is a need to start writing the pathways. | |
| | **Next Meeting** | • Wednesday 11th November 2026 – 9.30am to 12.30pm – Microsoft Teams | |