Kent and Medway Cancer Collaborative

Breast Tumour Site Specific Group meeting
Tuesday 14th November 2023
Orida Hotel, Maidstone, ME14 5AA
09:00-12:30
Final Meeting Notes

Present	Initials	Title	Organisation
Seema Seetharam **(Chair)**	**SS**	Consultant Breast & Oncoplastic Surgeon & Clinical Lead for Breast Cancer Services	DVH
Pawel Trapszo	**PT**	Consultant Oncoplastic & Reconstructive Breast Surgeon	DVH
Marie Payne	**MP**	Macmillan Lead Cancer Nurse	DVH
Adeyinka Pratt	**AP**	MDM Streamlining Project Manager	DVH
Ceepa Vijayamohan	**CV**	Breast CNS	DVH
Ahmed Abdelmawla	**AA**	Specialty Registrar – General Surgery	DVH
Sylvia Hurley	**SH**	Breast CNS	DVH
Jackie Wright **(Guest Speaker)**	**JW**	Breast CNS	Future Dreams
Olena Dotsenko	**OD**	Consultant Histopathologist	EKHUFT
Louise Barker	**LB**	Breast CNS	EKHUFT
Vanessa Potter	**VP**	Lead Breast CNS	EKHUFT
Rebecca Greene	**RG**	Metastatic Breast CNS	EKHUFT
Suzannah Fitzgerald	**SF**	Nurse Specialist Oncology - Family History / Genetics	EKHUFT
Ritchie Chalmers	**RC**	Medical Director	KMCA
Karen Glass **(Minutes)**	**KG**	Administration & Support Officer	KMCA & KMCC
Annette Wiltshire	**AW**	Service Improvement Lead	KMCC
Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Suzanne Bodkin	**SB**	Cancer Service Manager	MFT
Danielle Freeman	**DF**	Breast CNS	MFT
Samantha Tomlin	**ST**	Breast CNS	MFT
Helen Coote	**HC**	Macmillan Metastatic Breast CNS	MFT
Delilah Hassanally	**DH**	Consultant Oncoplastic Breast Surgeon	MFT
Dilukshi Wickramasinghe	**DW**	Senior Clinical Research Practitioner	MFT
Charlotte Moss	**CM**	Consultant Medical Oncologist	MTW
Catherine Harper-Wynne	**CHW**	Consultant Medical Oncologist	MTW

Jennifer Glendenning	**JG**	Consultant Clinical Oncologist	MTW
Russell Burcombe	**RB**	Consultant Clinical Oncologist	MTW
Gemma Hegarty	**GM**	Consultant Clinical Oncologist	MTW
Elizabeth Whitehouse	**EW**	Breast CNS	MTW
Julia Hall	**JH**	Consultant Clinical Oncologist	MTW
Madison Corse	**MC**	AGM Cancer Performance	MTW
Claire Ryan	**CR**	Macmillan Consultant Nurse	MTW
Roberto Laza-Cagigas	**RLG**	Senior Exercise Physiologist / Operations Lead	NHS Kent & Medway ICB
Pam Golton	**PG**	Macmillan Breast Reconstruction CNS	QVH
Rebecca Spencer	**RS**	Macmillan Breast Reconstruction CNS	QVH
Alexandra Molina	**AM**	Consultant Plastic Surgeon	QVH
Liz Simmons	**LS**	Patient Partner	
Apologies			
Anil Poddar	**PE**	Consultant General & Oncoplastic Breast Surgeon	EKHUFT
Emma Bourke	**EB**	Macmillan Personalised Care & Support Facilitator	MFT
Denise Thompson	**DT**	Assistant Project Manager	MFT
Jan Hackney	**JH**	Breast CNS	MTW
Rema Jyothirmayi	**RJ**	Consultant Clinical Oncologist	MTW
Jonathan Bryant	**JB**	Primary Care Clinical Lead	NHS Kent & Medway ICB
Helen Graham	**HG**	Research Delivery Manager (Cancer)	NIHR
Lin Douglas	**LD**	Patient Partner	
Christine Howarth	**CH**	Patient Partner	

Item		Discussion	Agreed	Action
1.	**TSSG Meeting**	**<u>Apologies</u>** • The apologies are listed above. **<u>Introductions</u>** • CHW initially welcomed the attendees to today's face to face meeting as SS had been delayed in traffic. CHW explained this would be the last meeting that both CHW and SS		

		would be chairing as there would be a new Chair / Deputy Chair coming into post imminently. • If anyone attended the meeting and has not been captured in the list above please email **karen.glass3@nhs.net** directly. **Action log Review** • The action log was reviewed and updated by KG after the meeting and will be circulated together with the final minutes from today's meeting. **Review previous minutes** • The minutes from the previous meeting which took place on the 23rd May 2023 were reviewed at today's meeting and were signed off as a true and accurate record. • CHW emphasised the importance of the Cancer Leads attending this TSSG meeting to ensure changes could be made and if they were not available they should delegate this responsibility. MP was present at today's meeting and explained this is not included within their job plans. RC confirmed she had a plan moving forward.		
2.	**Introduction of new Cancer Alliance Medical Director**	• SS introduced RC as the new Medical Director for Kent & Medway Cancer Alliance. RC explained she would be dedicating 50% of her time as the Medical Director and 50% as the Chief of Service within the Diagnostics Division at MTW. • RC planned to attend this full round of TSSG meetings and will be a familiar face moving forwards. RC would be working closely with JB the Primary Care Clinical Lead for the ICB who unfortunately sent his apologies for today's meeting. • RC thanked the TSSG Chairs for their support and strong clinical leadership in driving forward their respective TSSG's. • RC mentioned the K&M CA will soon be embedded within the K&M Integrated Care Board		

		(ICB) and as such will function as the bridge between the ICB and the TSSG's. The aim will be to develop an ICB clinical strategy whilst utilising the data, CA funding and to be clinically led by the TSSG experts. The TSSG's are key to driving forward the clinical strategy and shaping their service for the next year, 5-years and 10-years. • They need to have good quality pathways in place such as the Best Practice Timed Pathway which will improve performance, shorten diagnosis pathways, reduce variation, improve patient experience of care and meet the Faster Diagnosis Standard – 28-day pathway. • RC suggested they focus on what is pertinent to K&M particularly within those areas of deprivation and inequality. • RC is keen for each of the TSSG's to have MDT leadership & specialist clinical roles in attendance – this should include pathology, radiology, oncology, surgical & nursing. RC emphasised the importance of the Radiology and Pathology Networks linking in with the Cancer Alliance to be an integral part of the horizon planning for the next 5-10 years. RC was pleased to see there was histopathology support at today's meeting which has not been the case for some of the other TSSG meetings. • RC acknowledged the requirement to have effective job planning in place for the TSSG members so they are able to push forward with the agenda and make improvements. RC agreed to look into providing some project support. They have started to meet with Senior Leadership Teams across the trusts, including the Medical Directors, Chief Operating Officers and Chief Executives to ensure transparency and for them to be sighted on future plans. • RC highlighted the importance of reinstating the monthly TSSG Clinical Leadership group meetings from the New Year. They will use data collated by David Osborne (CA Data Analyst) to help support these meetings. • RC hoped to use the next Breast TSSG meeting as a pathway planning meeting. This will include the Faster Diagnosis and National Planning Guidance to create a strategy document and for them to be able to divert resources to where it is needed. RC needs this		

		groups help to be able to do this. CHW mentioned they have a clinical pathway in place and it is important for them not to reinvent the wheel. They need clinical metrics in place, delivery targets and to be able to audit in a more strategic way. CHW emphasised that all specialties are under resourced with different pressures and they are coping with a reduced workforce.		
3.	**MDT Streamlining**	**<u>Update by Ritchie Chalmers</u>** • RC highlighted the importance of MDT streamlining a national project initiated by Professor Martin Gore prior to his untimely death. The main aims for streamlining are: i) To ensure there is adequate time for the discussion of cases where needed and to allow more time to focus on complex patient cases and not to discuss benign cases. ii) To ensure that valuable diagnostic and clinical time is used more effectively by creating more flexibility in the management of the MDT meeting. iii) To increase the transparency and consistency of care by agreeing the treatment or care any patient should expect to receive across K&M. • RC mentioned the Lung tumour group have more streamlined MDT now in place compared to Breast and other tumour groups. They need to work together across all of their specialties to encourage MDT streamlining. • Digital Pathology is due to be implemented across K&M from April 2024. This will enable images to be uploaded digitally with staff also being able to work remotely. This will help support the pathology workforce in the future. • There are no plans to outsource cancer patients as this could expose them to a level of risk, but would be less impactful for benign patients. • RC explained targets will be achieved when they are doing the right thing clinically and resources can be diverted to the area of the pathway which is failing. There are different pressures across the different parts of the MDT Team and they need to understand the		

		pressures everyone is under. MDT leads need to have ring-fenced protected time with their MDT Co-ordinators to empower them to have targeted MDT discussions. • CHW agreed there are pressures across all of the specialties including Oncology and it is important the CA do some planning for the future.		
4.	**MBC data on incidence & prevalence MTW. Data to progress work force and service planning**	**<u>Metastatic Breast Cancer Incidence and Prevalence Data from 1st January 2019 to 1st September 2023 - update provided by Claire Ryan</u>** • CR highlighted that patients with metastatic breast cancer are living longer due to new drugs being available with patients requiring more complex care. The number of patients on active treatment over this period of time has increased by 58%. i) 1st January 2019 – 152 patients ii) 1st January 2020 – 181 patients iii) 1st January 2021 – 199 patients iv) 1st January 2022 – 205 patients v) 1st January 2023 – 240 patients vi) To date – 300 patients • The number of deaths has remained largely stable since 2020 but have increased due to an ageing population. • There were 5 designated metastatic clinics in place but this has now reduced to 3. They have been unable yet to appoint a band 7 nurse but have trained up 2 x band 6 nurses. • The proportion of presentations with De Novo Metastatic Breast Cancer has reduced from 31% in 2019 to 21% in 2022. This number varied during the pandemic – 20% in 2020 and 30% in 2021. • Method of presentation for patients includes: i) A&E / Hospital presentation – 25% - AOS team in place.		**Presentation circulated to the group after the meeting**

		ii) GP referral – 43% iii) OAFU – 9% iv) Oncology follow up – 11% v) Clinical Trials – 1% vi) Referral from another area / private setting – 8% vii) Other – 3% including NSS pathway into SC. • There is a lot of inequity in workforce provision across K&M in terms of Consultant Nurse, CNS, CSW and Oncologists. They cannot keep going on the same trajectory as this will lead to future risks. The group agreed they need to: i) Invest more in their CSW's - review their job descriptions / renumeration and recruit more into this role. ii) Invest in ACP academic and experiential learning iii) Grow own talent – key training roles for K&M iv) Review of models of care v) Some care and treatment models to be centralized vi) To code and record activity appropriately – to re-invest back into their services including training plans. **Action - RC and CR agreed to discuss outside of this meeting the collating of the metastatic cancer data and suggested that David Osborne could help support this.** • RB acknowledged that patients with metastatic breast cancer require a more detailed consultation which the consultants are not being paid for. • RC referred to the detailed Carnall Farrar Oncology Review which was carried out in 2021 which will help steer their future workforce and succession planning discussions.		**RC / CR / DO**
5.	**SACT with toxicities of special interest as applied to breast cancer, pathways**	**<u>Toxicities of special interest - update by Catherine Harper-Wynne</u>** • CHW explained Kent Oncology Centre are the only CA that have no oncology beds and are therefore reliant on the Emergency Department and Acute Oncology Service.		**Presentation circulated to the group after the meeting**

	and education	• CHW outlined the following issue: i) New treatments that have toxicities outside of previous SACT and / or at toxicity of concern re mortality / morbidity and admission. ii) Neutropenic sepsis established in clinical pathways across ED and medical teams; these new toxicities are not well established iii) Particular toxicities include: ➢ Immunotherapy toxicities affecting all body systems ➢ Antibody drug conjugates with very toxic payloads eg TDxD and pneumonitis – respiratory teams, national guidance is being produced. • CHW highlighted the importance of improving the management of toxicities as this will result in an increasing number of mortalities. There is also the need to review the availability of beds to control this issue. • RC referred to the Centralised Telephone Triage Centre Service for quality advice. • CHW explained KOMS access should be available on every trusts' desktop. • CHW directed the group to the Kent and Medway Cancer Collaborative website for Medicines and Prescribing details - Medicines & Prescribing (kmcc.nhs.uk), ESMO guidelines - www.esmo.org/guidelines and NHSE Cancer Drugs Fund list - https://www.england.nhs.uk/cancer/cdf/cancer-drugs-fund-list/ . These details are updated on a fortnightly basis. • CHW emphasised there are a number of people who should be attending the KMCC SACT Group meeting which she chairs and are not present. There is a requirement for oncologists and other key staff (such as cancer managers) to attend these meetings regarding toxicities as this is a patient risk issue. • CHW stated the importance of improving communication / liaison between ED, AOS and Oncology. Junior staff education re toxicities also needs to improve. This can be discussed at the forthcoming AO, CUP and NSS Forum TSSG meeting on the 29th November 2023.		

6.	**RT implications of nodal RT data, recent trial data**	**<u>RT implications of modal irradiation – update provided by Jennifer Glendenning</u>** • Total lymph node irradiation (TLNI) is the treatment of the lymph nodes in the body with high energy x-rays (radiotherapy). The x-rays cause biological effects which reduce the number of white blood cells (your blood count will fall), making the immune system less effective. Lymphoedema is increased with nodal radiotherapy. Older trials did not show Lymphoedema had increased by the use of nodal RT. • Radiation induced malignancy is an issue particularly in younger women and they need to be mindful of. • There is currently a 10-week radiotherapy wait at KOC and a shortage of oncologists nationally due to their metastatic work load. A new LINAC machine is required but it is at a cost of £1 million. • JG suggested the term 'axillary radiotherapy' can cause confusion and should be avoided. • Careful MDM discussion is required when omitting ANC. i) There is uncertainty relating to the selection of patients who should undergo axillary radiotherapy when ALND is omitted. ii) There are conflicting trends with the de-escalation of axillary surgery on the one hand and broadened indications for extended regional lymph node irradiation after ANC on the other. • The 2023 data on the oncological implications of incomplete axillary staging does not yet support replacing ANC with radiotherapy in the neoadjuvant setting. • Radiotherapy capacity implications need to be addressed before wider IMC radiotherapy can be implemented.		**Presentation circulated to the group after the meeting**

7.	**CDF**	• CHW referred to the Cancer Drugs Fund (CDF) which is a source of funding for cancer drugs in England. • The list is updated fortnightly and can be found on the following link - https://www.england.nhs.uk/wp-content/uploads/2017/04/National-CDF-list-v1.281.pdf. • CHW suggested looking up the details on the link above for Abemaciclib and Olaparib. • CHW mentioned NHS Predict will move from version 2 to version 3 (and will include details on chemotherapy and radiotherapy toxicity). Consultant Oncologists need to be clear on the information provided and the overall benefit for the patient.		
8.	**FDS** **Performance Questions** **Performance data all trusts to present** • **DGT** • **EKHUFT** • **MFT** • **MTW**	• SS acknowledged from David (Osborne's) slides that K&M FDS performance has improved from 87% to 91% in the last 6 months. However, their 62-day performance has dropped from 87% to 79%. The urgent suspected cancer backlog is one of the best nationally at 2.8% with the England average being 3.8%. • RC highlighted the importance of giving a diagnosis of cancer or not within the 28-day performance target. They do not seem to be able to achieve this target so well for those who have a cancer diagnosis. It was suggested having a graph detailing cancer vs non-cancer FDS performance for comparison purposes. We need to improve on the speed at which we diagnose patients with cancer so that we can in turn improve treatments and outcomes. • CHW referred to the mental health crisis particularly for their younger breast cancer patients and the importance of giving them a timely diagnosis. **Action – East Kent and West Kent to provide a small-scale (1 month) audit of their pathology cases for ER (-), PR (+) and HER2 to identify where there are delays, additional resource required and getting the results back within 28 days. RC agreed to speak to both pathology teams. OD agreed to help from an East Kent perspective. To be updated at the next TSSG meeting within the Performance section of the agenda.**		**Performance presentations circulated to the group after the meeting.** **RC / OD**

		DGT – update provided by Marie Payne • **Please refer to the circulated performance slide pack for a full overview of the Trust's data.** • DVH are consistently meeting the FDS target for GP referral. They have an Early Diagnosis Coordinator now in post due to some CA transformational funding. The One Stop Clinic is also supporting the 28-day FDS pathway. • 62-day performance has been a challenge for October due to the consultant strikes and delays within histology and Out-Patient Appointments. Patient choice and patients with complex investigations are also causing delays. • Their backlog numbers are creeping up for patients waiting over 62-days. 1 patient is waiting over 104-days – no cancer diagnosis – OPA in December – due to nipple discharge. • RC suggested an alternative pathway is put in place for patients with nipple discharge as they should not be on an urgent cancer pathway. CHW stated all patients with breast symptoms come through the urgent cancer pathway route. • SS mentioned radiology delays are improving however, pathology is getting worse. • **EKHUFT – update provided by Vanessa Potter** • **Please refer to the circulated performance slide pack for a full overview of the Trust's data.** • EKHUFT are meeting the FDS target for GP referral. FDS screening dipped in October. They are working closely with the care group to improve this target. • 62-day performance has been met since January 2023. The main reasons for the increase in breach numbers are due to diagnostic capacity (Mammogram US), radiology and histology delays, patient choice and the impact from industrial action.		

- They continue to perform above the standard for the 31-day performance target.
- There are 8 patients waiting over 62-days and harm reviews have been completed with daily escalations to book as quickly as possible.

MFT – update provided by Suzanne Bodkin

- **Please refer to the circulated performance slide pack for a full overview of the Trust's data**.
- MFT are consistently meeting the FDS target for GP referral due to insourcing support for the One Stop clinics.
- They have not met the 62-day performance target in September or October due to surgical capacity, diagnostic delays, consultant strikes, patient choice and complex pathways.
- There are 12 patients waiting over 62-days – 3 of whom are DGT patients. They have 1 patient waiting over 104-days referred to DGT in 38-days.

MTW – update provided by Madison Corse

- **Please refer to the circulated performance slide pack for a full overview of the Trust's data.**
- MC mentioned they have been struggling with their FDS completeness but is now starting to improve.
- The MDT Co-ordinator is working well with the surgical and operational teams. They are meeting with the screening team on a weekly basis.
- There are 5 patients waiting over 62-days with no patients waiting over 104-days. These delays are caused by patients requiring more diagnostic tests.

Action - RC suggested setting up a mastalgia pathway so they are able to manage these patients

		in a different way. RC is working with NHS111 to get an algorithm drawn up in conjunction with NICE Guidelines. • There are 8 – 10,000 mastalgia breast referrals every year. There is no additional radiology capacity so they need to find a way to reduce their workload. There is a very small 0.5% mis-rate for cancer.		**Group**
9.	**Prehabilitation**	**<u>Multimodal prehabilitation in the Community - update provided by Roberto Laza Cagigas</u>** • RLC provided the group with an update on the importance of prehabilitation for K&M cancer patients. It enables people with cancer to make the most of their lives by maximizing the outcomes of their treatment whilst minimizing the consequences of treatment such as fatigue, breathlessness and lymphoedema. • QuestPrehab is a free mixed-model multimodal prehabilitation programme for patients diagnosed with cancer in K&M. They provide them with the tools to improve their lifestyle and get healthier before, during and after cancer treatment. They work virtually with the patient to advise on the following: i) Nutritional guidance ii) Clinically led support iii) Physical activity iv) Peer Support v) Supporting self-management vi) Healthy lifestyle vii) Sleep and recovery viii) Psychological support • The Craetus app helps patients log their progress and structure their weekly activities. • There are regular live streaming exercise sessions during the week which cover all modalities. • RLC outlined the improvements of 2 case studies who embarked on this programme. They		

		have successfully improved their overall health and continue to follow a healthy lifestyle. • RLC highlighted that the prehabilitation programme has been funded by the K&M CA and is a free service for all cancer patients. • The methods received for referral include: i) Online form – https://www.questprehab.com ii) InfoFlex iii) Patient self-referral iv) Primary Care referral • RLC encouraged the attendees to take a leaflet outlining the referral method. They currently have no capacity issues. They have received both good and bad feedback from patients utilising the programme. • RLC clarified their service is open for both rehab and prehab patients. However, they are not able to offer their service to patients on an end of life pathway. • If there are any further questions please email - roberto.lazacagigas@questprehab.com directly.		
10.	**Synthesia A1 App** **BCK App**	**Synthesia A1 App - update provided by Russell Burcombe** • RB updated the group on the Synthesia A1 App which is a web-based video platform. It can be used to add video snippets and avatars onto the app for their patients. • RB is the only person licensed as the master user but he is able to provide user access to anyone that is interested. He mentioned there are a library of films embedded into the app and these are accessible in multiple languages. • The app could be hosted on various websites includes the MTW Oncology Centre page and also BCK app.		

		<u>BCK App – update provided by Russell Burcombe</u> • RB thanked CC for his support in adding the K&M staff biographies onto the BCK App. They are now 75% complete. Flyers will also be created and printed to raise awareness of the App to their Breast Cancer patients.		
11.	**Future Dreams Breast Cancer Charity**	**<u>Update provided by Jackie Wright</u>** • JW explained she previously worked for the NHS but is now employed by the Future Dreams charity which is based in Kings X, London. • The charity was founded in 2008 by Sylvie Henry and Danielle Leslie – a mother and daughter who were both diagnosed in 2008 and died in 2009 within a year of each other. • The charity's mission is that nobody should ever have to face breast cancer on their own. Access is open to all and is not confined to where you live in the UK. • The 3 pillars of the charity include: i) **AWARENESS** – to raise awareness of the signs and symptoms of breast cancer and promote early detection and diagnosis. ii) **RESEARCH –** to fund research into secondary breast cancer. iii) **IN PERSON AND ONLINE SUPPORT** – Future Dreams House is the only dedicated breast cancer support centre in the UK and the hub for all in-person and online support services. • The support services the charity provides includes: **i)** Community Groups ii) Workshop Information – 50% in person and 50% online iii) A wide range of workshops – yoga, ballet, hypnotherapy mindfulness, pilates, film club, cooking etc		**Presentation circulated to the group after the meeting**

		iv) Breast Clinical Nurse Specialist Events v) 1:1 therapy vi) Online information hub vii) Additional activities coming late 2023/2024 – community acupuncture, webinars, microblading, nipple tattooing, group physio for fatigue etc. viii) Post-operative bra's – sponsored by Victoria Secrets for those patients unable to afford them. • JW provided the following contact details to the group: i) Jackie@futuredreams.org.uk ii) www.futuredreams.org.uk iii) Facebook/futuredreamscharity iv) Instagram@futuredreamscharity v) Twitter@futuredreams		
12.	**CNS Updates**	**DVH update** • Full time endocrine CNS is now in post. **EKHUFT update** • Open access follow service is in place at the WHH and is doing well. The plan is to broaden the eligibility criteria to QEQM. • 3 x Cancer Support Workers are in place and complete the HNA's at diagnosis. • Nurse Consultant in post at the WHH. • 1 Metastatic Nurse in post – requirement for another. **MFT update** • 2 new CNS's now in post – 4-6 weeks - plan to re-open the OAFU pathway – there is currently a 9-month backlog in place. • To also re-start the Family History Service.		

		MTW update • There is a lack of equity in terms of metastatic CNS's across the patch – which needs resolving. • It is vital to have an Early Breast Cancer Oncology nurse at MTW. • 3 CNS's, 1 CSW and 2 admin staff now in post.		
13.	**Research update**	**Update by Catherine Harper-Wynne** • CHW explained MTW send out all research opportunities across K&M when they become available. • There is a shortage of research nurses both nationally and also within K&M. • MTW are accepting cross-referrals. • CHW highlighted the issue of getting staff to work in the metastatic clinic at MTW.		
14.	**Clinical Audit updates**	i) TAD audit – discussed at the previous TSSG meeting to carry out a 1-year audit of data on Targeted Axillary Dissection (TAD) across all K&M trusts – end of treatment to surgery. **Action - JG suggested carrying out a K&M wide-audit on Absolute Neutrophil Count (ANC) completion rates, including nodal involvement harvesting and the proportion of patients whose oncological treatment is impacted. CHW referred to the KSS fellowship award which closes on the 1st December and suggested they applied for a band 4 fellow to carry out this audit.**		**JG / CHW**
15.	**AOB** **Fatigue Management**	• There were no further updates raised under AOB. • KG circulated the details to the group relating to Fatigue Management and Patient Partners after the meeting.		

	Patient Partners Engagement	• SS thanked the attendees for their support and attendance at today's meeting and a meeting date would be circulated once the new Chair had been appointed.		
12.	**Next Meeting Date**	• **TBC**		**KG to circulate meeting invite details**