Kent and Medway Cancer Collaborative

Breast Tumour Site Specific Group meeting
Tuesday 23rd March 2021
Microsoft Teams
09:00 – 12:00

Final Meeting Notes

Present	Initials	Title	Organisation
Seema Seetharam (Chair)	**SSe**	Consultant Breast & Oncoplastic Surgeon	DVH
Michelle McCann	**MM**	Operational Manager for Cancer & Haematology	DVH
Teresa Sewell	**TS**	MDT Coordinator	DVH
Vicky Stevenson	**VS**	Support Worker	EKHUFT
Vanessa Potter	**VP**	Breast CNS	EKHUFT
Doraline Phillips	**DP**	Consultant Histopathologist	EKHUFT
Louise Barker	**LBa**	Breast Care Nurse	EKHUFT
Nadia Houston	**NH**	Open Access Follow Up CNS	EKHUFT
Sally Kum	**SKu**	Nurse Consultant	EKHUFT
Hyon-Mok Sohn	**HMS**	ST2 SpR Clinical Radiology	EKHUFT
Kerry Arnold	**KA**	Breast CNS	EKHUFT
Rebecca Greene	**RG**	Breast Care Nurse	KIMS
Claire Mallett	**CM**	Programme Lead – LWBC/PC&S	KMCA
Karen Glass (Notes)	**KG**	Administration & Support Officer	KMCC
Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Facilitator	KMCC
Rini Paul	**RPa**	Macmillan Breast CNS	MFT
Samantha Tomlin	**ST**	SMART Clinical Sister	MFT
Sue Green	**SGr**	Macmillan Recovery Package Facilitator	MFT
Tara Rampal	**TR**	Consultant Perioperative Anaesthetist	MFT/Kent & Medway Prehabilitation Service
Louise Black	**LBl**	Breast Care Nurse	MFT
Will Gauslin	**WG**	Cancer General Manager	MFT
Jo Bonnett	**JB**	Macmillan GP & Cancer Lead	NHS Kent & Medway CCG
Laura Alton	**LA**	Senior Programme Manager – KMCA	NHS Kent & Medway CCG
Bana Haddad	**BH**	Macmillan GP / Clinical Lead – LWBC/PC&S	NHS Kent & Medway CCG
Stefano Santini	**SSa**	Macmillan GP & Cancer Lead	NHS Kent & Medway CCG

Deepika Akolekar	**DAk**	Consultant Breast and Oncoplastic Surgeon	MTW
Catherine Harper-Wynne	**CHW**	Consultant Medical Oncologist	MTW
Jennifer Glendenning	**JD**	Consultant Clinical Oncologist	MTW
Deborah Allen	**DAl**	Consultant Radiologist	MTW
Russell Burcombe	**RBu**	Consultant Clinical Oncologist	MTW
Claire Ryan	**CR**	Macmillan Nurse Clinician	MTW
Maher Hadaki	**MH**	Consultant Clinical Oncologist	MTW
Rema Jyothirmayi	**RJ**	Consultant Clinical Oncologist	MTW
Sarah Egan	**SE**	Macmillan Breast Specialist Radiographer	MTW
Radhika Merh	**RMer**	Doctor	MTW
Sarah Kirwan	**SKi**	Consultant Radiologist	MTW
Gill Donald	**GD**	Clinical Scientist	MTW
Savita Honakeri	**SH**	Consultant Histopathologist	MTW
Julia Hall	**JH**	Consultant Clinical Oncologist	MTW
Carys Thomas	**CT**	Consultant Clinical Oncologist	MTW
Rebecca Spencer	**RS**	Breast Care Nurse	QVH
Simon Mackey	**SM**	Consultant Plastic, Reconstructive and Aesthetic Surgeon	QVH
Liz Simmons	**LS**	Patient Representative	
Christine Howarth	**CHo**	Patient Representative	
Liz Taffs	**LT**	Patient Representative	
Lin Douglas	**LD**	Patient Representative	
Vanessa Hardy	**VH**	Patient Representative	
Apologies			
Vanessa Ashby	**VA**	Macmillan Secondary Breast CNS	DVH
Olena Dotsenko	**OD**	Consultant Histopathologist	EKHUFT
Pippa Miles	**PM**	Senior Service Manager	EKHUFT
Lesley Boast	**LB**	Breast Care Nurse	KIMS
Andreas Prachalias	**AP**	Consultant HPB Surgeon	King’s College Hospital
Deirdre Cooke	**DC**	Clinical Trials Practitioner	MFT
Mohsen El Gammal	**MEG**	Consultant Oncoplastic Breast Surgeon	MFT
Rupika Mehta	**RMeh**	Consultant Radiologist	MFT
Andrew Lindsey	**AL**	Breast Unit Manager	MTW
Katherine Firth	**KF**	Breast Care Nurse	MTW
Charlotte Harris	**CHa**	Breast Screening Nurse	MTW

Jennifer Weeks	**JW**	Breast Physician	MTW
Fiona Andersen	**FA**	Breast Care Nurse	MTW
Rebecca Phipps	**RPh**	Breast Care Nurse	MTW
Rui Borges	**RBo**	Breast Surgical Care Practitioner	MTW
Susannah Lowe	**SL**	Macmillan Matron/Chemotherapy Lead	MTW
Sona Gupta	**SGu**	Macmillan GP & Cancer Lead	NHS Kent & Medway CCG
Jack Jacobs	**JJ**	Macmillan GP & Cancer Lead	NHS Kent & Medway CCG
Helen Graham	**HG**	Research Delivery Manager	NIHR
Anita Hazari	**AH**	Consultant Plastic Surgeon	QVH
Rachael Liebmann	**RL**	Consultant Histopathologist	QVH
Maudie Vanden Berghe	**MVB**	Patient Representative	

Item		Discussion	Agreed	Action
1.	**TSSG Meeting**	**Apologies** • The apologies are listed above. **Introductions** • SSe welcomed the attendees to the meeting and the group introduced themselves. If there is anyone who attended the meeting but is not listed above please email karen.glass3@nhs.net directly. • SSe asked the group if they would be happy for the meeting to be recorded for minuting purposes. There were no objections raised. **Action log Review previous actions** • The action log was reviewed, updated, agreed and will be circulated together with the final minutes. **Review previous minutes**		

		• The minutes from the previous meeting on the 3rd November 2020 were reviewed and signed off as a true and accurate record.		
2.	**Performance**	**<u>DVH – update provided by Michelle McCann</u>** • MM confirmed DVH did not meet the 2ww target in February 2021 due to clinical capacity issues and radiology resources to support the One Stop Clinic. They have conducted a Capacity & Demand exercise to identify the gaps and are working with the Division to develop a restart programme for additional capacity to clear the backlog. • DVH have met the 31-day target for this period. 62-day target has not been met due to available surgical capacity for the breast team. MM confirmed patients are now being booked in for April which is not during the cancer waiting times. • MM highlighted there were 3 104-day patients in February, 1 patient at 120 days, 1 patient at 106 days – both had a difficult cancer diagnosis with multiple diagnostics. MM added they have a backlog of 7 patients in February with a confirmed cancer for over 62-days. • MM confirmed 28-FDS they are compliant in February at 61.4% and overall data completeness is 65.93%. MM added they are providing additional training for MDT Co-ordinators to ensure the correct fields are populated ready for the shadow monitoring of the FDS standard in July. • Key risks for DVH are the reduced numbers of surgical slots and a reduced number of RAC one stop clinics due to social distancing and radiology resources. MM mentioned they are still having a few issues due to patient choice and the CNS's are contacting these patients to reassure them of their fears of coming into hospital. • MM highlighted that they have put on additional one stop clinics on Saturday's, evenings and Friday mornings. MM concluded they have had confirmation that the contract at QVH has been extended until the end of April but it is still not enough for them to get back on track.		**KG circulated the performance data for each Trust on 07.04.2021**

		EKHUFT – update provided by Sally Kum • SK confirmed EKHUFT have met the 2ww and 31-day target from December 2020 – February 2021. • SSe and SK discuss having a separate clinic which is not a one stop clinic for breast pain patients which would then release 20% capacity. • SK mentioned they had a 37% increase in 2ww referrals in October during Breast Awareness month which highlighted younger patients and this has caused issues imaging these patients. • SK referred to the breaches in 62-day targets in December due to theatre capacity and nebular cancers needing an MRI. SK mentioned as of April 2021 they are planning to resume theatre capacity back to pre-Covid levels. They are currently using the Independent Sector – One Hospital, BMI Chaucer, KCH and should return to the WHH and QEQM by April. **MFT – update provided by Will Gauslin** • WG apologized for the slightly outdated template used for the meeting today this is due to the member of staff that collates this detail is off sick. • WG confirmed they have maintained compliance for the 2ww standard consistently and during this time they have seen a dip in referral numbers. WG confirmed they had 357 2ww referrals in November, 199 in December and 168 in January. • WG highlighted some issues with swabbing in November and December due to the results coming back as inconclusive. This resulted in patient treatment delays and breaches for the 31-day standard. • WG explained the national target was not met in November for 62-day and resulted in 3 patient breaches. These have been delays in chemotherapy, diagnostics and patient self-isolation.		

		• WG confirmed MFT have been compliant for 28-day FDS for November – January. • WH highlighted severe operational pressures at MFT for breast screening compliance in January due to almost 50% of the cancer compliance team off sick including the MDT Co-ordinator support. This has had an impact on their overall data completeness. They have been able to utilize KIMS as the IS provider. **MTW – update provided by Deepika Akolekar (awaiting presentation)** • DA confirmed they had an increase in 2ww referrals in December following Breast Awareness month in October 2020 which has been challenging for the Trust in terms of workload. They have met the 31-day and 62-day targets from December – February. • DA mentioned they have a backlog of 4 patients waiting over 62-days currently. • Compliance to the 28-day FDS is averaging at 85% with overall data completeness not measured. • DA highlighted the same challenges as the other trusts. They initially had issues with theatre capacity but have subsequently been able to operate on all the cancer patients at QVH and KIMS. • MTW have outsourced one-stop clinics in order to meet the one stop capacity. The main breach reasons are due to complex pathways, MRI biopsies, genetic referrals and Covid delayed patients. • In terms of the reset and recovery plan they are recovering their theatre capacity at MTW and reverting back to their usual job plans (before COVID) and to increase the one stop capacity with radiology. • DA concluded the benign work has been impacted by COVID but they are looking to resolve this in the next few months. • SSe thanked the trusts for their comprehensive update and it is good to see what the challenges are at the other trusts. SSe highlighted at DVH they have not had access		

		to the IS but they hope to have their capacity back by the 1st May. SSe anticipates for the next 6 weeks they will struggle on to deal with their high capacity levels. • JG emphasized that Letrozol is an acceptable first treatment, surgery should take place within 6 months and therefore the patient can come off of the PTL.		
3.	**Prehabilitation Medicine & Beyond**	**<u>Update provided by Catherine Harper-Wynne</u>** • CHW emphasised this is a subject very close to their hearts and RBu and RT have spent a lot of time trying to implement this. CHW has also become involved due to her involvement with Kent University. • CHW specified NHSE are very dismissive of prehabilitation due to it being difficult to implement, control and objectively record. However, this is no reason not to look at breast cancer and lifestyle interventions. • CHW explained there is an increased risk of breast cancer for patients due to obesity, metabolic rate and a high BMI. • CHW referred to a French Audit based on an unhealthy lifestyle which highlights that smoking and alcohol are not strong evidence bases for a patient to get breast cancer. CHW stated weight gain for breast cancer patients due to their metabolic rate being impacted. There have been a number of trials relating to the human diet and exercise for breast cancer patients. • CHW highlighted: - i) "Lifestyle Program" helps high risk breast cancer patients to enhance adherence to diet and exercise modification programs. ii) Promoting healthy lifestyle reduces risk factors involved in breast cancer recurrence and ensures psycho-physical, wellbeing and compliance to endocrine therapy, iii) Our study supports incorporation of supervised exercise program and dietary intervention into breast cancer treatment. iv) A multidisciplinary approach allows greater adherence to healthy attitudes in		**KG circulated all agreed presentations to the group on 07.04.2021**

		breast cancer high risk patients. • CHW suggested there should be a continual assessment of the patient's physical activity, to be able to provide advice and refer onto other services such as TR prehabilitation service. **Update provided by Rema Jyothirmayi** • RJ highlighted the importance of exercise for a breast cancer patient pre-surgery and CHW will provide the evidence for this. • RJ confirmed they have not been running any specific exercise programmes. However, locally they set up the '5k Your Way' initiative pre-Covid for patients either on cancer treatment or who have finished treatment. The group meets on the last Saturday of the month. RJ also referred to the national parkrun which meets every Saturday at 9am (pre-Covid) and the hope is this will be reinstated by June 2021. • RJ highlighted the Health and Wellbeing events which are not just specific for breast cancer patients and provide information guidance. The Kent Oncology Centre and survivorship group have been running these sessions 4 times per year, currently virtually for patients but they hope to return to face to face sessions. **Update provided by Tara Rampal** • TR introduced herself as a Consultant Anaesthetist and Clinical Strategy Director for the Kent & Medway Prehabilitation service. • TR explained the purpose of today's meeting is to raise the awareness of the services available for patients in K&M. TR highlighted that 4 million people in the UK are currently living with cancer which is growing due to the ageing population. • The principle of the prehabilitation is to elevate the platform from which cancer patients take on treatment and to increase their functional mortality so they have better clinical outcomes. This means they will spend less time in hospital and have a quicker return to a good quality of life.		

		• TR explained that exercise works synergistically with nutrition, lifestyle choices and stress management. TR added that anxiety management has been proven to increase psychological resilience and helps patients have adherence and compliance with the exercise provided. TR stressed the prehab advice given has to be meaningful, proscribed, supervised and needs to change for the 2-6 weeks before the operation. • TR stated it is crucial that prehab has to be patient centred to gain the maximum patient adherence to the service. TR added often the patients come to them with other comorbidities such as Diabetes and not just breast cancer. They are also working closely with Medway Council and Kent County Council to tap into pre-existing exercise and smoking / alcohol cessation programmes. • TR stated that prehabilitation was crucial before the pandemic and has also saved lives during the pandemic. TR confirmed the service went live in March 2020 and is part of the South East London prehab service and includes Kent. They receive referrals into the service from GP's, CNS', patients, Oncologists and Surgeons. **<u>Update provided by Russell Burcombe</u>** • RBu stated survival outcomes have been proven to be better for patients who exercise before, during and after treatment and provides a 35-40% reduction in cancer-specific mortality. Exercise also improves tolerability of adjuvant treatment. • RBu is passionate about the importance of exercise and to push forward with this for their patients. There are strong evidence-based recommendations that exercise helps alleviate anxiety, depression, fatigue, quality of life, patient will sleep better and have improved bone health. • RBu confirmed there are a number of physiological pathways which support the use of medicine to improve outcomes in all cancers. • RBu referred to the fewer dose reductions if patients exercise during chemotherapy. • RBu confirmed he has had agreement from GenesisCare to share the slides detailing the quality of life experience audit for 111 patients. This has shown some real benefits after the exercise programme particularly in regards to mental health and energy		

		levels. • RBu feels it is imperative to be able to offer the same level of service to NHS patients as well as the private providers. RBu suggested they integrate with the prehab service offered by TR with additional use of the breast cancer patient app to provide exercise programmes on the app. RBu hopes to be able to continue this work with Cancer Alliance and charitable funding. • CHo admitted she is very excited to learn of this update and is sure it will be a huge benefit to patients. CHo congratulated the teams involved and looks forward to hearing about more developments. CHo asked if Fitbit data can be linked to the app as it is more user friendly for many than the Apple app. RBu thinks that would be a great idea but the sticking point is cost as the Apple Health app is free compared to Garmin and Fitbit. **Action** – SSe asked if TR could share the contact details after the meeting with KG and this can then be circulated to the TSSG members. • **TR provided the following details after the meeting**: - **Referring Patients** We would welcome any patient with a cancer diagnosis (chemo, radio, immuno, hormonal or surgery treatment plan) • either via the referral tab on our website - www.kentandmedwayprehab.org • direct link- https://www.kentandmedwayprehab.org/self-refer/ • Infoflex • kmccg.kentandmedwayprehab@nhs.net		**TR / KG – actioned after the meeting**
4.	**Patient App update**	**Update provided by Russell Burcombe** • RBu confirmed there is not much more to update on the patient app other than Apple have changed the licensing and download regulations which would have meant investing both time and money to manage that. Instead they are using the “Patient		

		Journey" application with a drop down for breast cancer, Kent. RBu stated that means that anyone who wishes to download the breast cancer patient app are no longer able to open it unless they are an existing user. • RBu mentioned he has recently taken delivery of 2000 flyers which include the new download instructions. A3 posters will also be put up advertising the changes. • RBu concluded in the next few weeks/months they hope to be able to launch the early / secondary breast cancer sections integrated onto the app. **Action** – RBu asked for EKHUFT and MFT teams to provide a more comprehensive directory of who is who at their trusts including photos and they can include "Meet the Team" on the app from the various trusts. • SSe confirmed they have a nominated person at DVH who is collating the details to be sent to RBu. SSe repeated the plea to EKHUFT and MFT to send this necessary detail to RBu.		**EKHUFT / MFT**
5.	**Clinical Audit**	**Staging imaging – presentation provided by Hyon-Mok Sohn** • HMS provided a presentation on "Evaluating the Breast MDT's use of staging CT against the national breast cancer staging guidelines." • HMS highlighted the benefits of reducing unnecessary CT studies for the patient which included a reduction in radiation dose, anxiety, plus time and cost to the patient. Additionally, benefits to the department included a capacity / scanning saving and also a reduction in cost / time. • HMS explained the method used included the identification of 69 patients who were on a Breast cancer MDT list between 1st October 2019 – 31st March 2020 and had a staging CT or PET study indicated for review. The majority of these were CT studies. They looked for evidence of distant metastatic disease by looking at the PET CT reports and MDT entries on the radiology system. • HMS confirmed at MTW they mainly follow the RCR guidelines.		**KG circulated the presentations to the group on the 07.04.2021**

		• HMS explained out of the 69 patients identified, 58 had acceptable indications 84% – (not including HER-2 positive) and 63 had acceptable indication 91% (including HER-2 positive). • HMS concluded that even though they had small numbers of patients for the audit and limited follow up time, the data does support using the indications from RCR. He added that triple negative and HER-2 positive disease may not be an indication but suggested this audit was followed up using greater patient numbers. **Omitting Bone Scans in Breast Cancer Staging – presentation provided by Deborah Allen** • DA explained the rational is to reduce the number of tests that the patients have to have at their first initial staging. Royal College guidance states that a CT scan alone is an adequate test to assess the bones for staging in breast cancer. • DA compared national audits from Nottingham, Swindon, Gateshead and Dublin. DA explained in all cases the false negative and false positive rate of a bone scan was higher. All of these Centre's no longer perform routine bone scans in staging breast cancer. • DA highlighted the MTW 3-month audit (Jan to March 2020) for patients identified with metastatic breast disease from the MDM lists. DA reviewed the initial CT and BS from when the diagnosis of metastatic disease was made as long as it was within 6 weeks of each other. • DA identified 50 patients, 36 of whom had bone metastases (72%). The results of the CT and BS compared showed 32/36 patients with bone metastases were detected on their CT and 31/36 detected by bone scan. • DA concluded the audit data was shared with the current Breast Oncologists, a nuclear medicine colleague and also went through both the Divisional / Radiology Clinical Governance teams: - i) A small risk of a false negative with CT alone – in the local audit these patients		

		with low volume oligometastatic disease ii) Passed by relevant CG teams leading to change in policy iii) If CT alone, the scan needs to be extended to include upper femora; part of the new policy iv) Radiologist education to ensure bones reviewed carefully (not just to rely on the bone scan), cases reviewed in MDM and REALM meeting v) If the patient has symptoms of bone pain, positive or equivocal findings on CT (including 'difficult bones'), a bone scan is still required. • SSe asked what the role of the PET CT would be? DA stated that in high risk patients they should be doing a PET straight away. DA added the national guidance is if there is an inflammatory breast cancer the patient should have a PET scan.		
6.	**Risk Reduction Mastectomies**	**<u>Update provided by Simon Mackey</u>** • SM confirmed QVH provide a hub and spoke free flap reconstruction service for Kent, Surrey and Sussex patients. SM added they see a lot of different practice from a lot of different hospitals. QVH were informed that they were in the top 10 percentile for units performing mastectomies without a clear indication based on the data GIRFT could view. SM added as a unit they do not perform mastectomies and it is difficult for them to have representation at every Kent, Surrey and Sussex hospital MDT. • SM highlighted the immediate reconstructions performed at QVH from 2018 – 2020 were 685 free flap patients from across the region, 175 of these patients were immediate reconstruction, 49 patients had risk reduction procedures – 45% were documented as BRCA or another gene mutation, 20% - based on strong family history, 35% - 17 cases – have no clear documentation about - genetic status or family history. • SM explained they have not been able to be fully quorate at the MDT meetings and there has been variation across the region. • SM highlighted they are trying to reduce this variation in mastectomies in order to comply with ABS guidance. The plan is to create a flowchart for risk-reducing patients in order to do this which they will send to the group for comments prior to the next		

		meeting. • SSe highlighted the importance of having a uniform policy across K&M.		
7.	**CNS Updates**	**<u>DVH – update provided by Seema Seetharam</u>** • SSe updated that Covid has helped implement the Stratified Pathways, telephone follow ups and virtual clinics. • DVH have a breast metastatic CNS and have also appointed a part-time breast care nurse to help with the backlog. **<u>EKHUFT – update provided by Vanessa Potter</u>** • VP confirmed they have appointed a Lead Breast CNS. • EKHUFT have started the Stratified Pathways which have been very successful. • They will be approaching Macmillan in April 2021 to highlight the need for a metastatic breast CNS. • Holistic Needs Assessments are working well and they are inputting these onto InfoFlex. • VS provided the following update on the MS Teams chat: - i) "Louise Houston, Breast CNS, has started OAFU with my support in EK. We are definitely bridging the gap now with OA patients by Louise giving a BCNS OAFU review appointment with HNA offered and invite to MF course approx 6 weeks post-active tx and to compliment this we have created an EK Breast OAFU booklet which been ratified and viewed as patient focused and is extremely informative/educational to patients. As an SW, I have also started to contact con led patients to offer post-tx HNAs approx 2 months after complete active-tx. Ideally, if the resource was there, all patients, regardless of follow up would be offered the BCNS review similar to the one Louise is currently		

		offering OAFU pts." **MFT – update provided by Rini Paul** • RP confirmed that Open Access follow-up is being worked on. • MTW are back to being fully-staffed. **MTW – update provided by Catherine Harper-Wynne** • CHW confirmed MTW are aiming to recruit an early breast cancer nurse to support the advanced care treatment pathway. RBu agreed this is an urgent area of extensive support required due to some patients having 4 or 5 treatment modalities (e.g. surgery, chemotherapy, radiotherapy and hormone treatment). • CHW added there is a requirement for all acute Trusts to have an early metastatic CNS which is vital for the improvement of services and for equity across the patch.		
8.	**Breast treatment summaries**	**Update provided by Claire Mallett** • CM confirmed some examples of Breast treatment summaries have been circulated to the group prior to the meeting. CM explained all patients should receive at least one TS during their cancer care. All patients going onto Stratified Pathways / open access / PIFU TS are all an important part of the self-management programme for patients. • CM explained the treatment summaries would essentially replace the discharge letter and provide a summary of treatment for both the patient and determine clear actions for Primary Care. • CM confirmed the majority of the information is auto-populated from InfoFlex data into a TS template which the treating Clinician would sign off. CM explained the TS templates will be embedded into InfoFlex as part of the personalized care / recovery package interventions. • CM asked for support from this group to engage and support the implementation of		**KG circulated the TS to the group prior to the meeting**

		the treatment summaries. • CHW questioned the need for a treatment summary as they send very detailed letters directly to the GP's and these are not always read. CHW wondered if this would be further repetition with no specific gain. CHW and RBu agreed as Oncologists they would not be able to implement and suggested this was completed by the CNS's. • BH mentioned the oncological letters sent to the GP are often very detailed whereas the TS would provide clear cut detail for both the patient and GP. • CHW referred to the one point of access for the Breast Moving Forward Programme is to signpost the patient in order to bridge the gap between End of Life and Survivorship Programme. CHW mentioned breast is different to the other tumour groups due to the multi-modality treatment involved. • RBu referred to the EOL TS which is excellent but they do not have the resource to do this. • SG provided the following update in the chat box on Teams: - i) "The Moving Forward course is far too generic to be used as a substitute for a TS, the only part of the TS it covers is the red flags - the Treatment Summary summarises that treatment, informs about side effects to be aware of from that treatment and what to do about them, tells the GP what extra support has been signposted/referred to from the treatment summarised etc." • SSe suggested that each Trust had the financial funding allocated by the CA to recruit a senior level Breast Care Nurse. The Breast CNS's are overstretched and overloaded with work and would be unable to take on extra tasks. • CM agreed to take this conversation off line with key individuals as this was a national requirement for the CA to progress. **Action** - SSe asked the members to send CM their comments regarding the treatment summaries in the next 2 weeks and this can then be taken forward as an agenda item at the next Cancer Clinical Leads meeting (26th May 2021).		**Group / Annette**

		• CHW agreed there are specific TS relating to specific treatments but there is a survivorship gap within breast in which the timing is crucial and is very different to the other tumour sites. CHW added with the national requirement there is not one size that fits all and suggested this was discussed further outside of this meeting. CM agreed and understood this is about embedding the support for patients going forwards.		**Wiltshire**
9.	**Cancer Alliance update**	**<u>Update provided by Claire Mallett</u>** • CM provided an update on the Cancer Alliance priority areas for the Phase 4 cancer recovery plan. However, due to the meeting overrunning CM's update was cut short and the full presentation will be circulated to the group. • CM confirmed these priority areas include: - i) Restore urgent cancer referrals at least to pre-pandemic levels ii) Reduce the backlog at least to pre-pandemic levels on 62-day (urgent referral and referral from screening) and 31-day pathways iii) Ensure sufficient capacity to manage the increased demand moving forward, including for follow up care • CM alluded to the Rapid Diagnostics programme including the VISS pilot which is currently running at DVH and the Rapid Lymphadenopathy pilot at EKHUFT. There is also a lot of ongoing work within the health inequalities remit. • CM mentioned the Faster Diagnosis Standard introduction – 28 days is currently being monitored in shadow form. The CA continue to support the trusts with the implementation of this new cancer standard potentially going live in October 2021. • CM concluded if there were any questions in light of the presentation to go back to CM directly and she will field questions to the CA team.		**KG circulated the CA slide pack on 07.04.2021**

10.	**CCG Update**	**<u>Update provided by Laura Alton</u>** • LA confirmed she is new to post and the CCG Commissioning role and has a clinical background in Radiography. • LA will provide support for the Breast TSSG group with regards to commissioning services and can be contacted directly (l.alton@nhs.net). • LA mentioned they are awaiting the National Planning Guidance but cancer will remain a CCG Commissioning priority. They are keen to support transformative clinical pathways and as one CCG this will help improve access and equity of cancer services across the K&M population. • LA stated between her and her colleague Chris Singleton they will split the TSSG's to support the development of business cases for new pathways and services, navigating through the new K&M CCG governance, finance and commissioning processes. This will include the Prehabilitation service and the Community Diagnostic Hubs which will begin later this year.		
11.	**Change in Pregnancy Guidance following NCEPOD Audit**	**<u>Update provided by Catherine Harper-Wynne</u>** • CHW provided an update to the group on the change in pregnancy guidance following the NCEPOD audit. CHW added the hormonal aspects of this document also needs updating. • CHW confirmed there are two new members of staff - Philippa Moth is the Obstetric Lead at MTW and Nicky Dineen is the Radiology Lead. • CHW highlighted that they should not be advising pregnant patients to have a Caesarean at 32 weeks and they should treat them until the end of the pregnancy term. CHW added all poor outcomes noted are due to an early delivery. • CHW mentioned they should try to ensure pregnant patients have 2 cycles of Chemotherapy in the third trimester pre-delivery. The patient would be monitored		**KG circulated the updated version of this guidance on 07.04.2021**

		closely with the aim to deliver as close to term as possible. • The risk of breast cancer recurrence is highest within the first 2 years after treatment. Most women with breast cancer should therefore wait at least 2 years after treatment before considering further pregnancy. • There should be a time interval of 2 weeks from the last chemotherapy session to the start of breastfeeding from the affected breast. • The Guys Obstetric team provided the following update which CHW thinks they should utilise: - i) Avoid gadolinium for MRI ii) Technetium preferred for Sentinel Node iii) Avoid 1st trimester pattern blue sodium iv) FNA avoid re breast background and just core biopsies v) Prednisolone or Hydrocortisone over Dexamethasone due to cognitive disfunction in the foetus vi) Can use GCSF but ideally not prophylactically vii) Anti-coagulation - patient in their 3rd trimester • CHW asked if everyone could update their part in the relevant sections and if the group agreed they can use the Guys update because it is more user friendly.		
12.	**AOB**	• Due to the meeting overrunning there was no further discussion under AOB. • SSe concluded the meeting by thanking the group for their continued commitment and support. SSe hoped to have the HOP and POC documents fully updated and signed off by the Autumn TSSG meeting.		
	Next Meeting Date	• **Tuesday 21st September 2021 – 09:00 – 12:00 – via MS Teams**		**KG to circulate the meeting invites**