Gynae TSSG Meeting
Thursday 8th October 2020
MS Teams
09:00 – 12:00

Final Meeting Notes

Present	Initials	Title	Organisation
Rema Iyer (Chair)	**RI**	Consultant Gynae Oncologist	EKHUFT
Sona Gupta	**SG**	Macmillan GP – Cancer Clinical Lead	Canterbury and Coastal CCG
Corinne Stewart	**CS**	Assistant Director of Commissioning	DGS CCG
Marie Payne	**MP**	Macmillan Lead Cancer Nurse / Clinical Services Manager	DVH
Samantha Daniels	**SD**	Gynae Oncology CNS	DVH
Rob MacDermott	**RMD**	Consultant Obs and Gynae	DVH
Andy Nordin	**AN**	Consultant Gynaecologist / Lead Clinician	EKHUFT
Diana Frimpong	**DF**	Specialist Obs & Gynae (Oncology Team)	EKHUFT
Edmund Inetianbor	**EI**	Gynae-oncology ATSM Specialist registrar	EKHUFT
Kannon Nathan	**KN**	Consultant Clinical Oncologist	EKHUFT
Jo Williams	**JW**	Senior Gynae Oncology Research CNS	EKHUFT
Vicky Morgan	**VM**	Gynae CNS	EKHUFT
Diane Miles	**DM**	Gynae CNS	EKHUFT
Nicky Chalmers	**NC**	Gynae CNS Support worker	EKHUFT
Fani Kokka	**FK**	Consultant Gynae Oncologist	EKHUFT
Vishakha Tripathi	**VT**	Consultant Genetic Counsellor	GSTT
Ian Vousden	**IV**	Programme Director	KMCA
Claire Mallett	**CM**	Programme Lead – Living With & Beyond Cancer	KMCA
Irene Nhandara	**IN**	Programme Lead – Early Diagnosis	KMCA
Karen Glass (Minutes)	**KG**	Administration Officer	KMCC & KMCA
Annette Wiltshire	**AW**	Service Improvement Facilitator	KMCC
Colin Chamberlain	**CC**	Admin Support	KMCC
Tracey Ryan	**TR**	Macmillan User Involvement Manager	KMCC

Hany Habeeb	HH	Consultant Gynaecologist	MFT
Karen Flannery	KF	Macmillan Gynae Oncology CNS	MFT
Stephen Attard-Montalto	SAM	Consultant Gynae Oncologist	MTW
Andreas Papadopoulos	AP	Consultant Gynae Oncologist	MTW
Justin Waters	JWa	Consultant Medical Oncologist	MTW
Rema Jyothirmayi	RJ	Consultant Oncologist	MTW
Vicky Gadd	VG	Gynae Oncology CNS	MTW
Gaynor Reeve	GR	Gynae CNS	MTW
Michelle George	MG	Gynae Oncology CNS	MTW
Amie Thomas	AT	Gynae Research Nurse	MTW
Chloe Smethurst	CS	Gynae Oncology CNS	MTW
Daniel Gorman	DG	Research Nurse Gynae / Oncology	MTW
Gary Rushton	GR	Consultant Pathologist	MTW
Bana Haddad	BH	Macmillan GP	NHS Kent & Medway CCG
Sarvi Cornell	SC	Programme Lead for Cancer	Swale CCG
Cat Perry	CP	Patient Representative	
Apologies			
Serena Gilbert	SG	Data Performance Manager	KMCA
Stefano Santini	SS	Macmillan GP	West Kent CCG

Item		Discussion	Agreed	Action
1.	**TSSG Meeting**	**Introductions** • RI welcomed the group to the meeting. • If you attended this meeting and are not listed above please contact karen.glass2@nhs.net directly and the attendee list will be updated accordingly. **Apologies** • The apologies for this meeting are listed above.		

		Review actions log previous meeting • The previous action log was not discussed at the meeting today. **Review minutes previous meeting** • RI confirmed the previous meeting minutes were a true and accurate reflection of the meeting and were therefore signed off. **Update by Rema Iyer** • RI provided a detailed update on the various changes in practice during Covid-19. This included: - i) Rapid Access Clinics ii) Referral numbers from March to September 2020. iii) Surgery which was prioritized Priority Level 1a to Priority Level 3 according to BGCS Guidelines including the numbers of operative procedures from April to September. iv) Covid Surgical and UKCOGS Studies v) Follow-ups including the introduction of the Patient initiated follow-up (PIFU) in both East and West Kent		**KG circulated this presentation on the 13.10.2020**
2.	**Inherited Susceptibility to ovarian cancer**	**Update by Vishakha Tripathi** • VT explained ovarian cancer is the leading cause of cancer-related deaths among women worldwide, with a lifetime risk being 1 in 50 and a late diagnosis being a major issue. • VT confirmed the importance of improving cancer outcomes and identify those at an increased risk and offer risk-reducing outcomes. To increase both public and		**KG circulated this presentation on the 13.10.2020**

		patients' awareness of a genetic risk and the opportunities for prevention and early intervention. • VT highlighted that Epithelial ovarian cancer accounts for 90% of ovarian cancers. • BRCA1/2 inherited mutations are the most common cause of Ovarian Cancer. • RI agreed her support in counselling patients for BRCA testing and setting up a workshop to run formally with a fully trained CNS. • VG mentioned she had completed the genetics model at GSTT and was keen to take this forward and setting up a clinic. VG wondered who would finance this. VG added genetic testing should be available for Gynae in the same way it is for Breast and Colorectal. • JW would be keen to set a clinic up and mentioned she was trained a year ago at GSTT by the genetics team but due to lack of funding it was forced to stop. AT also agreed to be involved and suggested an equivalent research nurse from EKHUFT.		
3.	**Performance all Trusts** • **2ww** • **62-day and breaches** • **28-day**	**<u>DVH – update by Rob MacDermott</u>** • RMD mentioned 2ww referrals numbers were down to 76.2% in June and 81% in July. The main reasons for this were due too: - i) Triaging appointments based on a scan added a slight delay ii) GP's arranged scans within the community and secondary care were unable to speed the process up to obtain the results • RMD confirmed there was no drop off in performance for 31 and 62-day targets with no patients sat at 104-day. RD added they were also compliant at 28-day from May – July ensuring patients were told if they had cancer or not.		**KG circulated the performance presentations on the 13.10.2020**

		EKHUFT – update by Andy Nordin • AN confirmed EKHUFT were compliant for 2ww and 31-day performance data. However, AN was unable to provide further detail for 62-day targets which were quoted as 50% for June, 84.6% for July and 60% for August. • AN mentioned there had been an 82% increase in 2ww referrals from 1818 patients to 3310. • AN confirmed as a result the MDT workload had increased with 34 new cases being discussed each week which they are addressing with the Trust and are looking urgently for further admin support. **MFT – update by Hany Habeeb** • HH confirmed they had done very well over the 3-month period and were fully compliant for 2ww, 31-day and 62-day. Additionally, there was no backlog on the 104-day pathway. • HH referred to the 28-day FDS which MFT were also fully compliant with the 70% national target. HH clarified the overall data completeness was unvalidated due to staffing issues and was being addressed by the Data Assurance Team. **MTW – update by Andreas Papadopoulos** • AP confirmed there had been an increase in referrals from 2018 to 2020 and when lockdown hit there was a significant decrease from March to May 2020. However, MTW were fully compliant for 2ww and 31-day performance data. • There had been a drop in 62-day performance in July (66.7%) and August (69.2%) but these were heading back in the right direction to pre-pandemic levels.		

		• 28-day FDS compliance had dropped in June and July but MTW were fully compliant in August. • AP mentioned MTW have utilised KIMS as an independent sector provider. • Lack of ITU access due to Covid meant that major resections could not take place at MTW but this returned in June to full capacity. • AP highlighted that between 20 and 40 patients were discussed at MDT. • JWa referred to the UK Oncology Data Network which enables access to analyse data in real time. The project is starting at MTW with the view to roll out to other trusts. AN agreed this is good news. • IV confirmed the appointment of Amara Arinzeh who is the Data Analyst for Kent & Medway Cancer Alliance and Serena Gilbert who is now the performance lead. IV ensured for future meetings the InfoFlex data presented could be tailored and be more meaningful. IV agreed to speak to CIMS to iron out any InfoFlex issues discussed with the data collection. **Ovarian Cancer Pathway (MTW) presentation – Andreas Papadopoulos** • AP referred to challenges within the Gynae cancer pathways and the impact this has had due to Covid. • AP mentioned the development of a virtual pathway using a specialist nurse to triage patients most likely to have cancer. AP added they have put on hold investigating the elderly who may have co-morbidities. • Endometrial cancer accounts for 73% of all diagnosed Gynae cancers followed by Ovarian (12%), Cervical (8%) and Vulval (7%). • AP explained the typical pathway of each patient from day 1 through to day 42.		

		• AP added the pathway has improved as patients are seen in the appropriate clinic and are told their diagnosis by a Consultant at their first meeting.		
4.	**Research**	**<u>CRN KSS Update by Jo Williams</u>** • JW confirmed over the last year their portfolio of trials had shrunk but there were 5 trials still recruiting. i) ICON 9 ii) COMICE iii) PROTECTOR iv) EORTC 1514 v) EORTC VU34 • MTW closed their research studies in the spring / summer but are now re-opening them. **<u>Research Lead</u>** • AT agreed to take on the role as the Research Lead at the previous Gynae TSSG meeting.		
5.	**Audit**	**<u>Endometrial cancer audit – Diana Frimpong</u>** • DF updated the group on the regional review of Endometrial cancer audit for Kent & Medway. • The aim of the audit was to assess the clinical indications for pelvic lymphadenectomy, the impact of triage of adjuvant ERBT and the clinical outcomes. • Methods included: -		**KG circulated this presentation on the 13.10.2020**

		i) Retrospective review ii) Endometrial cancer 2013 – 2016 iii) Infoflex, pathology systems, MDM summaries, electronic records • DF confirmed the background to this audit included: - i) ASTEC – No benefit for routine lymphadenectomy, it may have a role in triage for adjuvant therapy ii) NCRAS review of geographical variances – Kent & Medway outliers with high lymphadenectomy rates iii) KMCC – Bilateral pelvic lymphadenectomy (BPLND) is offered for grade 2 and grade 3 presumed early stage endometrial adenocarcinoma unless clinically inappropriate • The results identified 1020 patients but only 668 sets of patient data were reviewed. This resulted in 143 deaths over the study period, 90.3% - 1-year survival, 84.7% - 3-year survival and 83% - 5-year survival. • DF identified of the 143 deaths, 89 were cancer related, 10 other cancer, 13 unrelated and 31 un-known. She added the largest timeframe to recurrence was 36 months. • DF concluded: - i) Pelvic lymphadenectomy at primary surgery enabled management of selected node negative intermediate / high risk histology uterine cancer without adjuvant EBRT, with comparable pelvic recurrence to irradiated node positive cases ii) A comparison of outcomes from the national cohorts comparing varying management pathways would provide further insight into the impact of these interventions.		

		• AN agreed the date of recurrence data is very important and to be able to safely discharge the patient at 3 years for endometrial cancer. **National Ovarian cancer audit – Andy Nordin** • AN confirmed he would not be able to share the detail of the National Ovarian cancer audit as it is currently unpublished data. This detail however should be published later this month. • AN referred to the incidence and mortality rates for ovarian cancer which vary among CCGs and Cancer Alliances. He added the proportions of patients diagnosed at early and late stages vary considerably around the country. • AN mentioned there were patients in Kent & Medway that have not had chemotherapy but had surgery. • AN highlighted the following treatment: - i) Ovarian treatment modalities from January 2016 to December 2018 inclusive ii) FIGO stage iii) Age group iv) Morphology v) Charlson co-morbidity score vi) Variation by cancer alliance (which included those under FIGO stage 2, 3, 4 and unknown in addition to their summary data) vii) Sub-groups data available on CancerStats2 later this week. • AN suggested that Kent & Medway were worse at capturing co-morbidities compared to other Cancer Alliances which could be due to geographical deprivation and an older age category across the patch.		

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<u>PIFU – update by Andreas Papadopoulos</u>

AP mentioned the work involved in setting up patient-initiated follow-up (PIFU) with the drivers for this being the BGCS document and Covid-19.
AP explained a Clinician will assess the suitability of patients for PIFU via face-to-face or telephone consultation.
If a patient is on a PIFU pathway and have any concerns or symptoms there is a process in which they can telephone a designated CNS, the CNS will triage and decide what follow-up is needed.
AP listed the eligibility criteria for PIFU as being: -

i) Completed primary treatment and are clinically well
ii) Patients are willing and able to access healthcare if on PIFU
iii) No significant treatment related side-effects that need ongoing management
iv) No recurrent disease
v) Not to be on active or maintenance treatment
vi) Not to be on a clinical trial where follow up schemes are defined and limited to hospital-based follow up
vii) Not have a rare tumour with uncertain risk of recurrence and need for ongoing management
viii) Able to communicate concerns without a significant language barrier or psychological co-morbidity and have competence to agree to PIFU

AP compared BGCS and Kent Oncology treatments for Cervical, Endometrial and Ovarian cancer which are tailored to the patient.
MG mentioned they are incorporating HNA reminders to put the onus on the patients to follow up.

<u>EKHUFT – PIFU – Update by Vicky Morgan</u>
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		• VM provided an update on PIFU from an EKHUFT perspective. • VM explained the benefits of PIFU – which eases the pressure on current NHS services, frees up Consultant time, reduced travel costs for patients, relieves patient anxiety and consequently less patients in clinics. • VM mentioned some patients were recruited quite quickly when lockdown was enforced. • VM confirmed 1 patient declined PIFU but was then subsequently followed up face-to-face. They had 35/36 patients recruited into PIFU with early stage endometrial cancer. • VM added they used InfoFlex to track, book and follow up appointments. • VM clarified the patients were also involved in the process in creating the PIFU leaflet which is user friendly.		
7.	**Personalised Care & Support**	**<u>PIFU – update by Claire Mallett and Bana Haddad</u>** • CM explained the national long-term plan for patients diagnosed with cancer. To enable patients to have access to personalized care, health needs assessment, care plan and health & well-being information and support. • By 2023, there will be stratified, follow up pathways in place for people who are concerned their cancer may have recurred. Currently there are stratified pathways in place for breast, prostate and colorectal cancer. • CM updated the group about the prehabilitation service which is now available across Kent & Medway. CM confirmed this service was available in the community but is currently running virtually due to Covid. The premise of this service is to		**KG circulated this presentation on the 13.10.2020**

		support patients in becoming fitter before treatment and advises on exercise, nutrition and psychological support. • There is funding available to support the digital workstreams including eHNAs and Treatment Summaries. • MP mentioned DVH have initiated a PIFU service and would be grateful for Cancer Alliance support. • CM and BH are keen to support the group and provided their contact details.		
8.	**IMRT for cervix cancer**	**<u>Update by Kannon Nathan</u>** • KN provided an update on the Cervix IMRT / VMAT developments on behalf of the Kent Oncology Centre. • KN highlighted how radiotherapy has evolved for more precision-based treatments over the years. IMRT – can create volume, target with multiple beams from different directions and getting dose coverage but takes longer. VMAT is quicker compared to IMRT. • KM explained the improvements with IMRT / VMAT are: - i) Reduced toxicity to organs at risk ii) Improved target coverage, allows for improved dose homogeneity radiotherapy iii) "boost" macroscopic enlarged lymph nodes – simultaneously rather than serial treatment (aim combined dose total 60Gy) iv) Sensitive organs: Small Bowel, Rectum; Large Bowel **<u>Action</u>** – RI asked if KN would circulate the Clinical Drawing form from his presentation as it could be used when seeing patients in clinic or when doing an EUA (Examination Under Anaesthetic). KN was happy to circulate the form by email.		**KG circulated this presentation on the 13.10.2020** **KN**

		• RJ mentioned the radiologists should be on board when looking at the MRI's for the MDM's. • RJ highlighted the importance of this being accurate or there would be the possibility of missing the tumour which would be a terrifying thought. RJ thanked KN and the Radiotherapy team who were not present today but have put a lot of effort into getting ready to treat.		
9.	**NG12**	**<u>Post-Menopausal Bleeding & HRT Guidance – update by Rob MacDermott</u>** • RI referred to the NG12 form which was revised early last year. RI explained as a consequence they were getting an increase in 2ww referrals for patients having post-menopausal bleeding when on Hormone Replacement Therapy. RI added this is really increasing their workload and the majority of these patients do not need to be seen in Secondary Care. • RI highlighted that RMD had gathered some evidence which will be presented today. • RMD explained that for more than 10 years the West Kent 2ww referral form excluded breakthrough bleeding (BRB) on HRT – unless the bleeding persisted for more than 4 weeks after stopping HRT. • Since the introduction of the Kent-wide 2ww form there had been more referrals for women who have BTB on HRT. In light of this evidence there needed to be more explicit detail on the form about BTB on HRT so that they are able to concentrate on seeing women with higher risk of cancer. • RMD referred to a fantastic review on BRB on HRT which had been circulated by RMD earlier this week: - **https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/tog.12553@10.1002/(ISSN)1744-4667(CAT)Menopause(VI)Menopause**		**KG circulated this presentation on the 13.10.2020**

		• RMD explained it is incredibly common for BTB in the first year and quoted from the review: - *"for a great number of women, unscheduled bleeding may be without prevailing pathology, and these women do not need fast-tracked referral unless there are any high-risk factors or particular clinical concern present. For them, stopping HRT abruptly in the face of continuing vasomotor pathology may lead to increased medical consultations, depressive symptoms and a decrease in their quality of life."* • RMD confirmed there is a reduced risk of getting endometrial cancer in women taking the continuous combined HRT particularly within obese women. • RMD added the likelihood of endometrial cancer in women taking HRT is 1 in 2000 – 1 in 5000 per year and substantially below the 3% NICE threshold for a 2ww criterion. RMD suggested sticking to NICE Guidance. • RMD thinks there is harm seeing low-risk women in a 2ww clinic due to the stress on Clinicians and nurses, additional clinics being added with potentially less specialised Clinicians who may miss an important diagnosis. RMD added there will still be a proportion of non-urgent patients that will still have cancer and their diagnosis will be delayed as a result. • RMD suggested they reverted back to the old West Kent 2ww form which stated that abnormal bleeding had to persist for more than 4 weeks after stopping HRT. • RI thanked RMD for his presentation and confirmed they would not be able to make any changes to the current NG12 form but they could add some guidance about ovarian cysts and post-menopausal bleeding. • SG mentioned the Cancer Commissioners and Macmillan GP's spent a long time going through the NG12 forms and to make them as compliant to NICE as possible. SG confirmed the forms are incredibly hard to change because they are not uploaded centrally and each GP practice would have to upload each form. SG		

		admitted it would be very useful for GP's to have additional guidance and training. SG proposed that Rakesh (Koria) would be happy to lead on these educational sessions. • RMD asked if it would be possible to change the rapid access criterion in light of this presentation. HH agreed with RMD and added they are getting a lot of inappropriate referrals particularly within the last 6 months as the GP's are not seeing the patients. • RI explained since COVID the EKHUFT clinical team have received the referrals which they triage, advice is given and this is followed up with a telephone consultation. • The group agreed if the NG12 form could be changed they should change it. **Action** – SG agreed to look into changing the NG12 form with the commissioners if at all possible and added Kent & Medway wide education sessions for GP's would be necessary as well.		**SG**
10.	**AOB**	• No further discussions under this agenda item as the meeting had run over by 30 minutes.		
11.	**Date of next meeting**	• AW and RI to discuss the next meeting date which is planned for April 2020. **Action** - KG to send out the meeting invites when the date has been agreed.		**AW / RI** **KG**