Kent and Medway Cancer Collaborative

Gynaecology Tumour Site Specific Group meeting
Thursday 4th November 2021
Microsoft Teams
09:00 - 12:30

Final Meeting Notes

Present	Initials	Title	Organisation
Rema Iyer (Chair)	**RI**	Consultant Gynae-oncologist	EKHUFT
Fani Kokka	**FK**	Consultant Gynae-oncologist	EKHUFT
Mohamed Ismail	**MI**	Consultant Gynaecologist and Obstetrician	EKHUFT
Kate Entwisle	**KE**	Consultant Radiologist	EKHUFT
Andy Nordin	**AN**	Consultant Gynaecologist & Gynae-oncologist	EKHUFT
Clement Perera	**CP**	Locum Staff Grade	EKHUFT
Bev Saunders	**BS**	Consultant Radiologist	EKHUFT
Vicky Morgan	**VM**	Macmillan Lead Gynae-oncology CNS	EKHUFT
Samantha Daniels	**SDa**	Macmillan Gynae-oncology CNS	DVH
Rob MacDermott	**RM**	Consultant Obstetrician, Gynaecologist and Urogynaecologist	DVH
Fay Fawke	**FF**	Macmillan Lead Uro-oncology CNS / Deputy Lead Cancer Nurse	DVH
Michelle McCann	**MM**	Operational Manager for Cancer & Haematology	DVH
Anahit Zakaryan	**AZ**	Consultant Obstetrician Gynaecologist	DVH
Sarah Rose	**SR**	Principal Genetic Counsellor/Line Manager	GSTT
Vishakha Tripathi	**VT**	Consultant Genetic Counsellor in Cancer Genetics	GSTT
David Osborne	**DO**	Data Analyst	KMCA
Claire Mallett	**CM**	Programme Lead – LWBC/PC&S	KMCA
Karen Glass (Minutes)	**KG**	Administration & Support Officer	KMCC & KMCA
Tracey Ryan	**TR**	Macmillan User Involvement Manager	KMCC
Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Facilitator	KMCC
Hany Habeeb	**HH**	Consultant Gynaecologist	MFT
Sue Green	**SGre**	Macmillan Recovery Package Facilitator	MFT
Karen Flannery	**KF**	Macmillan Gynae-oncology CNS	MFT
James Shaw	**JS**	Deputy General Manager	MFT
Sharon Griffin	**SGri**	Consultant Gynaecologist	MFT
Ying Ying Lou	**YYL**	Consultant Obstetrician & Gynaecologist	MTW
Andreas Papadopoulos	**AP**	Consultant Gynaecologist & Gynae-oncological Surgeon	MTW
Vickie Gadd	**VG**	Macmillan Gynae-oncology CNS	MTW
Omer Devaja	**OD**	Consultant Gynaecologist & Consultant Gynae-oncology Surgeon	MTW

Stephen Attard-Montalo	**SAM**	Consultant Gynaecologist and Gynae-oncology Surgeon	MTW
Gary Rushton	**GR**	Consultant Pathologist	MTW
Michelle George	**MG**	Macmillan Gynae-oncology CNS	MTW
Chloe Smethurst	**CS**	Macmillan Gynae-oncology CNS	MTW
Rema Jyothirmayi	**RJ**	Consultant Clinical Oncologist	MTW
Justin Waters	**JW**	Consultant Medical Oncologist	MTW
Julie Akers	**JA**	Macmillan Specialist Radiographer	MTW
Roxani Dampali	**RD**	Gynae-oncology Clinical Fellow	MTW
Hersha Patel	**HP**	Gynae-Oncology Sub-Spec Fellow	MTW
Laura Alton	**LA**	Senior Programme Manager – KMCA	NHS Kent & Medway CCG
Bana Haddad	**BH**	Macmillan GP & Cancer Lead / Clinical Lead – LWBC/PC&S	NHS Kent & Medway CCG
Sona Gupta	**SGu**	Macmillan GP & Cancer Lead	NHS Kent & Medway CCG
Apologies			
Ed Inetianbor	**EI**	Gynae-oncology ATSM Specialist Registrar	EKHUFT
Henk Wegstapel	**HW**	Consultant Laparoscopic, General and Colorectal Surgeon	MFT
Kannon Nathan	**KN**	Consultant Clinical Oncologist	MTW
Stefano Santini	**SS**	Macmillan GP & Cancer Lead	NHS Kent & Medway CCG
Kate Regan	**KR**	Macmillan Primary Care Nurse Facilitator	NHS Kent & Medway CCG

Item		**Discussion**	**Agreed**	**Action**
1.	**TSSG Meeting**	**Apologies** • The apologies are listed above. **Introductions** • RI welcomed the members to the virtual meeting with the focus of today's meeting being on genetic testing. • HH questioned why MFT's performance data was not being presented by the Clinician (HH) as are all the other trusts today. This has been noted for future meetings. **Action log Review** • The action log was reviewed, updated 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 22nd April 2021 were reviewed, agreed and signed off as a true and accurate record.		
2.	**Mainstreaming of genetic testing for ovarian cancer patients**	**Presentation provided by Sarah Rose & Vishakha Tripathi** • RI introduced SR and VT from the genetics team based at GSTT. Traditionally, patients have been referred to GSTT for counselling and consenting for BRCA testing but the plan is for this to be undertaken locally. • SR highlighted the aim of the session is to discuss mainstreaming genetic testing for women with epithelial ovarian cancer, serous endometrial cancer, primary peritoneal cancer or fallopian tube cancer. • SR explained they are still available to accept referrals but added there are many patients who would benefit from being tested locally. SR highlighted the publication of the National Genomic Test Directory which was updated in October 2021 this indicates who should have genetic testing, the reason and who should order it. • The genetic testing criteria for ovarian cancer is high grade non-mucinous epithelial ovarian cancer at any age and is for BRCA1, BRCA2 and PALB2. The testing is funded nationally. There are two types of testing offered at GSTT rapid testing (takes 4 weeks) and routine testing (takes 10-12 weeks). • SR explained in order for the patient to go through the genetic testing procedure after diagnosis they would need a blood sample (5ml EDTA) and to also go through the consent process (which is stored locally). The genetic testing process not only impacts the patient but also their family so they need to know why they are having the test and the implications of it. For most patients the genetic test result will be normal, with only 5 - 10% of the cancer being hereditary. SR agreed to share an updated version of the leaflet to include PALB2 which is given to patients. • SR provided a list of patient indications for when to refer a patient to clinical genetics which include: i) Patient / Clinician has psychological concerns about testing or mental health issues that could impact post-testing coping		**Awaiting copy of the presentation**

		ii) Patient diagnosed with ovarian cancer / fallopian tube / primary peritoneal cancer / uterine serous cancer under 50 and needs MMR deficiency analysis iii) Patient has a family history of ovarian cancer / fallopian tube / primary peritoneal cancer / uterine serous cancer (high risk family) iv) Family history of other cancers v) Known mutation in the family vi) Patient found to have a somatic mutation vii) Clinician unsure if patient is eligible for testing viii) Patient has a BRCA1 / BRCA2 mutation ix) Patient has had testing and been found to have a variant of uncertain significance. • SR referred to a Clinical checklist and consent form which can be printed off and used in clinics. SR stated the importance of ensuring the correct return email is used so the result goes back to the right place. • JW raised the issue of patients signing the consent form when they are not necessarily seen face to face. SR confirmed they accept verbal consent initially and then the form can be signed electronically via an email sent to the patient which can be saved for the future. • JR highlighted the importance of having nurse led specialised clinics to see patients as there are limited numbers of Gynae Oncologists currently in Kent. VG hopes to be released to take this forward for MTW before December. **Action – RI asked SR if she could send the relevant genetic testing details / forms to AW who will then circulate to the group.**		**SR / AW**
3.	**Testing strategies for Lynch Syndrome in people with endometrial cancer**	**<u>Presentation provided by Rema Iyer</u>** • RI provided an update on the basics of testing for Lynch Syndrome. The prevalence of Lynch Syndrome in endometrial cancer is 3.2%. The lifetime risk of developing endometrial cancer for people with Lynch Syndrome is 40 – 60%. This presents before any other cancer such as colorectal when associated with Lynch Syndrome. • RI highlighted the updated NICE guidelines from October 2020 in which they recommend Lynch Syndrome testing for patients diagnosed with endometrial cancer. To use Immunohistochemistry (IHC) to identify tumours with mismatch repair (MMR) deficiency. RI added if the tumour exhibits MMR these patients should be referred to genetics for Lynch Syndrome testing.		**Presentation circulated on 9th November 2021**

		• RI confirmed all patients with endometrial cancer are having IHC to look for MMR mutations. If the result is positive they are being referred to genetics for Lynch Syndrome testing. RI added they have started HRD testing which is funded by the NHS. However, there is no funding available for the block preparation part of the testing. GR explained there is a meeting planned after their MDM in December. GR is interested to hear that EKHUFT are sending blocks to the Marsden. They are still waiting to have the pathway agreed. **Action - AP asked for it to be minuted that there is a discrepancy in the testing and that the TSSG strongly supports that this service is offered to all of their patients. JW suggested the EKHUFT pathway is clarified and asked if both blocks and slides were sent to the Marsden. RI agreed to find out and let them know.**		**RI**
4.	**Performance**	**<u>DVH – presentation provided by Rob MacDermott</u>** • RM agreed with HH regarding the issue of receiving the performance data late and is sure this is due to a challenged service which is working on all the different tumour sites. HH emphasised they are responsible for the numbers of breaches within their trusts. HH thinks they need to find a way to make this better. RM agreed and added they are all doing their best under the circumstances. • RM highlighted the drop off in performance targets due to Covid and breaches due to capacity issues and staff shortage particularly within pathology. • With regards to informing patients of a cancer diagnosis or not within 28-days they are doing pretty well at this target. • RM mentioned on a Tuesday he gets a weekly PTL (Patient Tracking List) spreadsheet for all patients on the cancer pathway. He goes through this with his co-ordinator after Friday's MDM to identify the bottlenecks in the pathway. They have put on additional rapid access clinics to cope with the demand. • RM mentioned Abhishek Gupta has now left the team and his replacement does not start until December which will be a strain for them in November. Additionally, they have more referrals coming through and highlighted the pressures within Primary Care. **<u>EKHUFT – presentation provided by Andy Nordin</u>**		**All performance presentations circulated on 9th November 2021**

		• AN provided an update using the standard format template plus additional slides detailing the financial year from April 2020 – March 2021. • AN highlighted there were 3245 2ww referrals within this yearly period which is slightly down on the previous year due to the pandemic. The gynae oncology team ran rapid access clinics throughout this period and were compliant throughout. However, they are particularly challenged with the 28-day FDS and are not yet compliant with the 75% target. They are in a better position now to meet the 62-day target but this has also been very challenging for EKHUFT. Regardless of this Kent & Medway are still one of the best performing Cancer Alliances in the country. • AN mentioned approximately 40% of their patients are not diagnosed through the 2ww pathway even though the numbers of referrals have gone up dramatically and the cancer conversion rate is still roughly the same. • AN highlighted the impact Covid has had on their patients due to late presentation. Ovarian cancer is generally stage 3 / 4 which remains pretty much unchanged. However, cervical cancer - 57% of patients have presented late with stage 3 / 4 or unknown. 32% uterine – stage 3 /4 / unknown and vulva / vagina – 47% stage 3 /4 / unknown. • AN explained the improvement in 62-day performance is largely due to a new locum consultant Danko Perovic who has seen approximately 1000 patients in the rapid access clinics and has cleared a lot of their backlog. AN added they have no patients currently over 104-days with very few over 62-days. AN highlighted the hard work of the CNS's tracking the patients on their pathway. **MFT – presentation provided by Hany Habeeb** • HH explained they have consistently met the 2ww performance target and have no capacity issues. They put on additional clinics as required. • HH mentioned MFT had 3 breaches in August for the 62-day target which was due to complex pathways and the patients requiring additional diagnostic tests. • HH stated the 28-day FDS has been challenging getting the results back in order to inform patients within 28-days if they have a cancer diagnosis or not. They are trying to get cross cover to cover staff shortage and leave. They have appointed additional consultants for the rapid access clinics and are seeing patients on day 7 compared to day 14 previously. They have seen an improvement in diagnostic turnaround times with CT / MRI's being done on day		

		7, however the report may not be ready for the MDT. • HH mentioned they have very good support from their cancer team. HH is doing an audit of 400 referrals to rapid access clinics and hopes to be able to present the data at the next TSSG meeting. **Action – HH asked if he could have a 20-minute slot at the next TSSG meeting.** • They are supporting their GP colleagues by offering advice and education to help limit the numbers of inappropriate referrals. HH highlighted the VISS (Vague and Indeterminate Signs and Symptoms) service currently piloted at DVH and is due to roll out to MFT which will help with the numbers of inappropriate gynae referrals. • HH stated that gynae diagnostics and treatment is delivered across two sites (MTW and MFT) which has resulted in some delays due to capacity issues. Another reason for breaches is due to complex pathways and patients requiring additional diagnostic tests. HH is in consultation with the radiology service manager to receive the reporting results in time for the MDM. MFT have no current theatre or outpatient capacity issues. • RM mentioned if a patient requires radiotherapy as part of their cancer treatment at DVH, they will breach 100% of the time as the patients are going to GSTT. The patient is discussed at the local MDM, then GSTT MDM which is making the pathway longer. RJ admits she is very frustrated with the whole situation and GSTT are not accepting the local MDM radiology outcomes and decisions. RJ has agreed to only send a limited number of patients now to GSTT for certain radical treatment. JW agrees wholeheartedly with RJ. JW mentioned they have appointed a new specialty doctor who has a lot of experience in radiotherapy planning and hopes he will be able to start in December to support the ongoing service. **<u>MTW – presentations provided by Andreas Papadopoulos</u>** • AP mentioned the MTW performance slides did not come to him directly and agreed with the other trusts the importance of the cancer managers sharing the data earlier. • AP provided an update on additional data collated by their InfoFlex team. They had a total of 268 patients which is down on their usual figures. • AP confirmed they have had a slight stage shift on endometrial cancer cases seen. AP explained there is still discrepancy with the data collected and also missing data. They are setting up a separate team to understand why the data is not being collected accurately or		**HH / RI / AW**

		input into the correct fields or if it is an inherent problem with InfoFlex. AP suspects it is a data collection issue. • AP explained the reason for the dip in MTW's 62-day performance status is due to oncology workforce issues and reduced 2ww capacity which has now been addressed. • AP highlighted their data completeness for 28-day is 56.3% which is being investigated further. They are planning to recruit a new gynae CNS to support the pathway through triage. They have had no theatre capacity issues but there has been diagnostic delays. **<u>Staging Data Completeness – presentation provided by David Osborne</u>** • DO mentioned NHSE have recently produced a dashboard which highlights data on staging completeness. • DO highlighted the comparison of the gynae cases discussed at MDT and reported with a full stage compared to other tumour types. He added there was a drop-in data performance mid-2020 and they are not sure of the reason why. DO explained there is a drop-in data across the 4 trusts and asked for comments. AP wondered if it was a lag in staged data and asked if it was a catch-up issue. AN is concerned about the figures presented for EKHUFT for October 2018 which is not accurate. AN mentioned there has been some issues with the ovarian cancer feasibility pilot audit and they have been using EKHUFT as a test case for InfoFlex. However, there is an issue with InfoFlex which Chris (Hopkins) is trying to address and they are not sure if it is a generic InfoFlex issue or K&M one. • AN suggested DO spoke to Chris Hopkins to find out what the specific gynae data issues are. AP admitted he is frustrated by the whole issue which has been ongoing for so long. He has been assured by the BI team at MTW that their data is being collated correctly. SAM suggested this was a software problem and not a recording one and has been an issue for many years **Action – AP asked if DO would share his data slides so he could share and discuss them with the MTW cancer board and InfoFlex team. (KG circulated the slides on the 9th November 2021) CM agreed to speak to Steve Morris and Natalie Williams who are responsible for managing the InfoFlex system at EKHUFT. KG to share the minutes from this meeting with them both in order to address the issue directly.**		**CM / KG**
5.	**PIFU**	**<u>MTW – presentation provided by Michelle George</u>** • MG explained they have been working on PIFU (Patient initiated follow up) at MTW before		**Awaiting PIFU presentation**

		Covid. The PIFU service was initiated in August 2020 as a pilot study for one year. • MG provided an outline of the patient pathway; the specific referral criteria and the data is collated on an excel spreadsheet. • There were 21 endometrial cancer patients on the PIFU programme from MFT, DVH and MTW. 3 out of 21 patients were offered a Holistic Needs Assessment (HNA), were signposted to support services as required and offered psychological support by their CNS team. • MG referred to a pan-Kent CNS meeting which took place today prior to the TSSG in order for the CNS's to support each other. **EKHUFT – presentation provided by Vicky Morgan** • VM explained at EKHUFT they follow up their patients for 3 years post end of treatment. PIFU is offered at 6 weeks post-operative follow up and an HNA is completed. • VM confirmed they have 42 patients in PIFU with only 2 patients that have declined PIFU due to anxiety and preferred to be seen in the 6-monthly follow up clinic. One of these patients has now been discharged. A PIFU leaflet is sent out with the post-operative clinic letter. An HNA is completed and contact numbers are provided for the patients if they have any issues. • Next steps include an audit of patients in PIFU and to roll out PIFU to their other tumour sites. **PIFU update provided by Claire Mallett** • CM and BH are keen to work with the gynae CNS teams to develop an online tracking system rather than using an excel spreadsheet to manage the numbers of follow up patients. This would be implemented through InfoFlex as they have done with other tumour groups including breast, colorectal and prostate. CM added the funding will be provided to establish a gynae standardised clinical protocol. • CM highlighted the varying follow up times across the trusts - EKHUFT - 3 years compared to the other trusts - 5 years. • CM asked for the groups views and comments regarding taking this forward digitally. • RI confirmed at EKHUFT they have been following up early endometrial cancers for 3 years which was the agreed general consensus at the last TSSG. AN suggested the historical follow		**from MG** **Presentation circulated on 9th November 2021** **Presentation circulated on 9th November 2021**

		up document which he sent to RI recently should be looked at and discussed further to have a uniform protocol approach across K&M. RI stated the BGCS guidelines state 5 years for follow up of early endometrial cancer patients. RM thinks 3 years would be a good length of time. HH confirmed at MFT their patients are followed up for 5 years. • CM asked if there could be some focused conversations across the patch prior to the next TSSG meeting and understands this would need to be signed off by the TSSG as a whole. It was agreed there needed to be a uniform protocol across K&M. • SAM highlighted not all stage 1 endometrial cancer patients can be stratified as having the same risk. He would not be happy to follow up a stage 1 endometrial cancer for 3 years and then discharge as there is a risk of recurrence. AN suggested they use the already in place PIFU BGCS guidelines. RI stated PIFU is risk stratified and will be for low risk endometrial cancers. SAM emphasised the importance of adopting the BGCS guidelines across the patch for patients on PIFU. **Action – it was agreed a poll should be conducted to get the general consensus of the TSSG regarding following BGCS guidelines for PIFU. RI asked for a PIFU representative from each trust – meeting to be arranged prior to the next TSSG for final agreement and sign off. Post meeting a gynae PIFU meeting has been arranged for the 10th January 2022 – 09:00 – 11:00.**		**Group**
6.	**Research**	• There was no specific research update at the meeting. SAM confirmed Amie (Thomas) is on maternity leave. RJ confirmed Daniel Gorman and Julia Sunnucks are the new research leads at MTW. Amie is now working directly with the gynae CNS team. • RJ confirmed the research group meetings have recently re-commenced at MTW and they are looking to start some new trials. RJ agreed to update at the next meeting. • RI mentioned they have advertised for a new research nurse at EKHUFT.		**KG added both DG and JS to the distribution list for future meetings**
7.	**CNS Updates**	**<u>DVH – update provided by Samantha Daniels</u>** • They formerly had 2 part-time CNS' but this has now merged in to 1 full-time CNS post. • An advertisement has gone out for a support worker who should be able to help in streamlining services (such as genetic testing) and helping with annual leave cover. **<u>EKHUFT – update provided by Vickie Gadd</u>**		

		• The Trust have employed 3 new band 6 CNS' (1 full-time and 2 part-time). • An advertisement has gone out to recruit a trials nurse advert closes today. **MFT – update provided by Karen Flannery** • The Trust are moving forward with the PIFU workstream and KF is working closely with the support of SGre. • The gynae team at MFT have been very busy and Ifeoluwa Alayo - generic support CNS is helping to support the service. **MTW – update provided by Michelle George** • There have been some staffing changes since the last meeting. • Enhanced supportive care clinics and late effects clinics are both up and running. • RJ mentioned she has restarted the bid for additional funding for an advanced care practitioner for gynae oncology. This individual will help with clinics and prescribing. • TR offered her support with any forthcoming patient surveys. **Gynae CNS breakout meeting – update provided by Michelle George** • Update from this morning's meeting included discussions relating to: i) PIFU ii) HNA's iii) Issues regarding the shared ownership of patients iv) Personalised care v) Patient satisfaction surveys and patient experience.		
8.	**Urgent pathways for women presenting with PMB on HRT**	**Unscheduled bleeding on HRT pathway - presentation provided by Ying Ying Lou** • RI mentioned the NG12 form was changed about 2 years ago and they are getting an increasing number of referrals for women bleeding when on HRT. RI explained Tunbridge Wells have set up an alternative pathway. Patients are seen under the 2ww umbrella initially and then moved onto an urgent clinic so they do not have to wait months to be seen. • YYL outlined at the last TSSG meeting they discussed making some changes to the NG12 referral form specifically to take off the unscheduled bleeding on HRT. These changes will take		**Presentation circulated on 9th November 2021**

		time to implement and due to capacity issues, they have come up with an alternative pathway to manage these patients in the interim. • YYL provided an update on an audit of 3 months data for 51 patients and the outcomes of these patients. • YYL asked if they needed to see these patients in the rapid access clinic and on an urgent pathway. • HH mentioned if the women are having abnormal bleeding and have not been examined this should happen quickly. YYL agreed they should be seen in a gynae clinic and examined by an HRT specialist within 6 weeks. RM thinks having a dedicated menopause service is a good way forward and to keep these patients away from cancer doctors as this is not an appropriate use of the service. HH added unless the NG12 form is changed there will be continued pressure on the services they provide. • RI explained they are not able to offer an HRT service for their patients at EKHUFT so all patients will be seen under the 2ww clinic, investigated and then downgraded. RI concluded all trusts will have their own individual issues.		
9.	**Cancer Alliance update**	**<u>Presentation provided by Claire Mallett</u>** • CM provided an overview of the key national cancer programme key actions for 2021/22. These include getting patients into the system, investigate and diagnose and provide treatment. • From a K&M perspective, CM highlighted the various Rapid Diagnostic Services including the VISS pilot at DVH and the plan to roll this out to MFT and EKHUFT. Additionally, the Rapid Lymphadenopathy pilot at EKHUFT with plans to roll out to West Kent. CM referred to the ongoing work for the 28-days Faster Diagnosis Standard which has been rolled out for all tumour groups. • They are working closely with South East London colleagues to ensure tertiary pathways and communication links are in place. • In terms of Early Cancer Diagnosis, K&M have been chosen to pilot Galleri Grail which started in October in Dartford. All appointments for the next three months are fully booked. CM highlighted additional projects including AI for lung cancer, an upskilling course for primary		**Presentation circulated on 9th November 2021**

		care staff, establishing cancer champions in Medway and Swale and the targeted lung health checks to initially start in EKHUFT. • They have made good progress with breast, colorectal and prostate to implement the Personalised Stratified follow up pathways. Once the gynae protocol has been established they can have a more targeted conversation regarding setting up the patient portal for the endometrial / gynae pathway. • CM mentioned they have been doing lots of work with cancer support workers and CNS's to develop the personalised care interventions such as HNA's. There has also been additional training and support for primary care staff on personalised care and support and the cancer care reviews.		
10.	**CCG Update**	**<u>Update provided by Laura Alton</u>** • LA confirmed they have now received some funding from the central cancer team to develop a lynch syndrome pathway. After LA's meeting with MTW next week they can agree how to commission that pathway across K&M which is now a CA and CCG priority. • LA highlighted that the Gallery Grail trial went live on the 25th October and there is only a 1-2% rate of onward referral to a cancer pathway. This trial will work its way round Kent and has started in Dartford. • With regards to the Lymphadenopathy pilot in EKHUFT the data is showing a 15% conversion to a positive cancer diagnosis. This is looking like a very good pathway with good conversion rates and is consistently meeting the 28-day FDS. LA suggested it was a good time to pick up the gynae timed pathway again to help integrate that pathway between primary and secondary care. • Community Diagnostic Centres (CDC) are currently in phase 1 and a CDC will go live at Buckland Hospital (Dover) and also in West Kent (site yet to be agreed). It is envisaged there will be 6 CDC's in K&M in total due to population numbers. K&M have also been chosen for the next phase of the targeted lung health check pilot which may also be sited at Buckland Hospital as smoking rates are high in that area of the patch. • LA mentioned K&M CCG will no longer exist on the 31st March 2022 and will transition to become part of the Integrated Care System with place paced partnerships to develop local care and services.		

		• With regards to the digital strategy they are looking at the development of Ardens within Primary Care. Ardens is an excellent cancer stratification tool it contains the most up to date forms which can also be amended more easily. • LA concluded they are waiting for next steps with regards to the Kent Oncology Review.		
11.	**AOB**	• There were no further comments raised. • RI thanked the group for their attendance and contributions at the meeting today.		
12.	**Next Meeting Date**	• The next meeting to be agreed but is likely to be in April 2022 and hopefully face to face.		