Kent and Medway Cancer Collaborative

Gynaecology Tumour Site Specific Group meeting
Thursday 3rd November 2022
Great Danes (Mercure) Hotel, Maidstone
09:00 – 12:30
Final Meeting Notes

Present	Initials	Title	Organisation
Rema Iyer (Chair)	**RI**	Consultant Gynaecological Oncologist	EKHUFT
Andy Nordin	**AN**	Consultant Gynaecologist & Gynae-oncologist	EKHUFT
Hristina Hristova-Angelova	**HHA**	Consultant Radiologist	EKHUFT
Edmund Inetianbor	**EI**	Gynae-oncology ATSM Specialist Registrar	EKHUFT
Danko Perovic	**DP**	Gynae Specialist	EKHUFT
Nicola Chalmers	**NC**	Gynae CNS Support Worker	EKHUFT
Laura Lawrence	**LL**	Gynae Oncology Support Nurse	EKHUFT
Justin Elliot	**JE**	Staff Nurse	EKHUFT
Jenny Sharp	**JS**	Pre-surgical preparation practitioner	EKHUFT
Bev Saunders	**BS**	Radiologist	EKHUFT
Michelle McCann	**MMC**	Operational Manager for Cancer & Haematology	DVH
Claire Mallett	**CM**	Programme Lead – Personalised Care & Support	KMCA
Annette Wiltshire	**AW**	Service Improvement Lead	KMCC
Karen Glass (Minutes)	**KG**	Administration & Support Officer	KMCC & KMCA
Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Emma Bourke	**EB**	Macmillan Personalised Care and Support Facilitator	MFT
Hasib Ahmed	**HA**	Consultant Obstetrician and Gynaecologist	MFT
Hany Habeeb	**HH**	Consultant Gynaecologist	MFT
Helen Morgan	**HM**	Radiotherapy Advanced Practitioner/E Proms project manager	MTW
Omer Devaja	**OD**	Consultant Gynaecologist & Consultant Gynae-oncology Surgeon	MTW
Michelle George	**MG**	Macmillan Gynae-oncology CNS	MTW
Ying Ying Lou	**YYL**	Consultant Obstetrician & Gynaecologist	MTW
Pollyanna Law	**PL**	Junior Sister	MTW
Roxani Dampali	**RD**	Gynae-oncology Clinical Fellow	MTW
Gemma Levett	**GL**	Staff Nurse	MTW

Stephen Attard-Montalto	**SAM**	Consultant Gynaecologist and Gynae-oncology Surgeon	MTW
Andreas Papadopoulos	**AP**	Consultant Gynaecologist & Gynae-oncological Surgeon	MTW
Vickie Gadd	**VG**	Macmillan Gynae-oncology CNS	MTW
Debbie Smith	**DS**	Macmillan Gynae-oncology CNS	MTW
Alistair Ward	**AW**	FY1 AMU	MTW
Apologies			
Rob MacDermott	**RM**	Consultant Obstetrician, Gynaecologist and Urogynaecologist	DVH
Vicky Morgan	**VM**	Macmillan Lead Gynae-oncology CNS	EKHUFT
Miranda Foad	**MF**	Clinical Trials Administrator	EKHUFT
Tracey Ryan	**TR**	Macmillan User Involvement Manager	KMCC
Kannon Nathan	**KN**	Consultant Clinical Oncologist	MTW
Rema Jyothirmayi	**RJ**	Consultant Clinical Oncologist	MTW
Gaynor Reeve	**GR**	Macmillan Gynae-oncology CNS	MTW
Julie Akers	**JA**	Macmillan Specialist Radiographer	MTW
Laura Alton	**LA**	Senior Programme Manager – KMCA	NHS Kent & Medway ICB

Item		**Discussion**	**Agreed**	**Action**
1.	**TSSG Meeting**	**Apologies** • The apologies are listed above. **Introductions** • RI welcomed the members to the face to face autumn meeting. KG, AW and CC apologised as they were late arriving due to the traffic and weather conditions. • If you attended the meeting and have not been captured within the attendance log above please contact karen.glass3@nhs.net directly. **Action log Review** • The action log was reviewed, updated and will be circulated together with the final minutes		

		from today's meeting. **<u>Review previous minutes</u>** • The minutes from the previous meeting, which took place on the 5th May 2022 were agreed and signed off as a true and accurate record.		
2.	**PIFU** **Cancer Alliance Update** **InfoFlex training** **Ovarian Help Us to Help You (HUHY) campaign**	**<u>Personalised Care - update by Claire Mallett</u>** • CM referred to the BGCS risk stratified follow up pathways in the management of ovarian, cervical, endometrial and vulvar malignancies. • Next steps include: i) Ongoing training and development with CNS's and CSW's supported by the Cancer Alliance funding. ii) Formalise process to use Personalised Care and Support (PCSP) data with teams iii) Engage with trusts to improve data quality across personalised care interventions in COSD returns. • CM highlighted the Cancer Quality of Life Survey which is a national survey run by NHS England and NHS Digital. People are invited to complete the survey around 18 months after having a cancer diagnosis. The overall aim is to improve the support for patients to live as long and as well as possible. The QoL survey has shown that sleeping difficulties and fatigue are key symptoms affecting patients at 18 months post diagnosis. • It was noted that K&M are massively under-resourced with regards to psychosocial provision. • K&M psychosocial mapping exercise identified: i) Variation in training and supervision for people offering Level 2 psychological support. ii) Inequity of access to level 3 counselling and specific psychological interventions iii) Variable level 3 capacity to meet demand and prioritise urgent cases		**All updated slides were circulated on the 4th November 2022**

		iv) No level 4 provision across the patch. • Recommendations include: i) Development of psycho-oncology service ii) Additional level 3 and 4 work-force iii) Increased shared practice of working for level 3 services (eg referral process, supervision access) • The aim is to work closely with Macmillan to identify how these gaps can be filled. **InfoFlex Gynae PIFU pathway – update by Claire Mallett** • CM referred to the Infoflex Gynae PIFU pathway and agreed protocols across the patch. • CM mentioned the Gynae PIFU training dates with the InfoFlex team. To book a slot contact matthew.hine@nhs.net: i) Monday 21st November 13:30 – 15:30 ii) Tuesday 22nd November 10:00 – 12:00 iii) Thursday 24th November 13:30 – 15:30 iv) Friday 25th November 10:00 – 12:00 • Natalie Williams has collated some screenshots on how the Gynae PIFU tracking pathway can be found on InfoFlex. **Action – CM to set up a Task & Finish group to explore PIFU pathways for low risk ovarian cancer, including options for a patient portal with PROMS monitoring.** • CM noted that CA125 levels detected in a blood test is not always a reliable indicator of malignancy compared to PSA blood test monitoring as in prostate cancer follow up pathways. **Cancer Alliance – update by Claire Mallett**		**CM**

		• CM provided an update on the National Cancer Programme 2022/23 and the projects relating specifically to K&M. i) Faster diagnosis and operational improvement ii) Early Diagnosis iii) Treatments and Personalised Care iv) Cross Cutting Themes • CM referred to the roll out of the Non-site specific (NSS) pathway which has recently gone live at DGT. • Roll-out of the new timed pathways for Gynae. • **Galleri Grail** – K&M are one of eight Cancer Alliances across the UK to be part of this pilot which comprises of a blood test for those invited aged from 50 – 77 to detect an early cancer signal. K&M will be part of the second round of this pilot which starts at Dartford imminently. There will be a request for an operational / clinical lead from each trust to be able to escalate queries to. • **Help Us to Help You campaign** – to target ovarian cancer and get women into the system earlier. This campaign will be led by both Cathy Finnis and Sarah Barker. They will be working closely with the charity Target Ovarian Cancer (TOC) and Primary Care to raise awareness of ovarian cancer often diagnosed at a later stage. The campaign is due to start imminently and will run for 3-4 months. • They are in the process of developing targeted public awareness materials including social media, leaflets, posters and Z cards (to be distributed via community partners) • In the process of developing an educational webinar for Primary Care – to take place in early December in order to implement some interventions to improve early diagnosis and safety netting. • If there are any patients or Secondary Care colleagues interested in supporting this campaign please contact Cathy cathy.finnis@nhs.net or Sarah sarah.barker60@nhs.net directly.		

3.	**Lynch Syndrome**	**<u>Update by Rema Iyer</u>** • RI explained that Lynch Syndrome is the most common inherited cancer predisposition. It accounts for 5% of all Colorectal cancers and 3% of Endometrial cancers. • Lynch Syndrome can affect as many as 1 in 270 people in the UK. Only 5% of those affected will have a diagnosis. There is likely to be an increase in diagnostic rates nationally through more frequent testing. • The Planning Guidance stipulates that Lynch Syndrome testing is in place for colorectal and endometrial cancer. • All newly diagnosed colorectal cancer and endometrial cancer patients identified as likely to have Lynch Syndrome should be referred for genetic testing (either locally or at specialised genetics centre) in line with NICE guidelines DG27 and DG42. • SAM confirmed they do germline testing at MTW. AN emphasised the additional workload burden this would have on the Gynae service with no additional resources in place. • Next steps include: i) MDT Lynch champions – options • Clinician role • Genetics Associate ii) Stakeholder group to develop pathway – membership? iii) Training sessions from regional / national leads – names of nominees • SAM mentioned there is a Familial Cancer Clinic set up at MTW which is Clinician / Nurse led and they are currently managing the low number of patients. There is yet to be an FCC established at EKHUFT.		**Slides were circulated on the 4th November 2022**

4.	**Performance**	**<u>Faster Diagnosis Standard update from all trusts</u>** • RI highlighted the challenges meeting the 28-day FDS – as 14 days can be lost initially in Primary Care which only leaves 14-days in Secondary Care to carry out tests and to confirm a diagnosis of cancer or not. • HH mentioned they have 4 Rapid Access Clinics at MFT per week and if they see patients at day 7 it is easier to achieve the 28-day FDS. MFT have 2000 patients in their backlog. They previously had 3 RA clinics and now have 7. • SAM – they will have a STT nurse in place next week for Colorectal, Urology, Lung and Gynae which will improve the RA pathway. • AN cited an issue with the documentation at EKHUFT and notifying patients who do not have cancer and can be taken off of the pathway. AN suggested: i) Electronic proforma for RAC – put in place. ii) Document and capture the details by day 28 would achieve this target but this is currently not happening. • RI mentioned the CNS's triage all cases and they either go straight to the Gynae RA clinic or Gynae Oncology. • HH explained from an MFT perspective patients are seen on day 7 – ideally histology is received 3 weeks from referral. They should be doing daily results letters and not weekly. HH added delays in radiology would have an impact on meeting the 28-day FDS. • HA stated that 4 out of every 6 referrals are "inappropriate." The STT nurse triages the RA referrals in order to reduce the 2ww clinic. **<u>DVH – update provided by Michelle McCann</u>** • Please refer to the circulated performance slide pack for an overview of the Trust's data.		**All performance slides were circulated to the group on the 4th November 2022.**

- DVH are doing well with regards to data completeness.
- Histology delays from MTW.
- Best Practice Timed Pathways meeting has now taken place.
- Continuing issues with the quality of referrals from Primary Care.
- New Early Diagnosis co-ordinator is now in place which will help support the 28-day FDS.
- There are 4 patients waiting over 62-days – 3 have been diagnosed with cancer. They have 0 patients waiting over 104 days. Valid reasons for their breaches.
- PET-CT is an issue for DVH.

EKHUFT – update provided by Andy Nordin

- Please refer to the circulated performance slide pack for an overview of the Trust's data.

- There have been 4230 2ww RA referrals in 2021/2022 compared to 1818 in 2013/2014.
- 62-day referral to treatment performance has fluctuated over the last 3 years.
- 31-day decision to treat generally meeting this Cancer Waiting Time.
- There are 200-260 Gynae cancers diagnosed each year and this has not changed year on year. The 2ww conversion to cancer in 2020/21 was 4.5%.
- Breakdown of total Gynae cancers in 2021/22 include:

  i) Uterus – 118
  ii) Ovary – 77
  iii) Cervix – 32
  iv) Vulva – 22
  v) Vagina – 4

- 60% of cancers diagnosed come through the GP 2ww referral route with 40% as an emergency presentation in A&E.
- There are currently 17 patients waiting over 62-days but have a treatment booked or date for further investigations. There is 1 patient waiting over 104-days which is a complex case.
- PET-CT is no issue at EKHUFT.

MFT – update provided by Hany Habeeb

- Please refer to the circulated performance slide pack for an overview of the Trust's data.

- MFT are not far off meeting 28-day FDS. They generally meet the 31-day.
- 62-day performance – they have small numbers, there are delays within diagnostics and also timely reporting for the MDM.
- There are currently 3 patients waiting over 62-days with 1 patient waiting over 104-days.
- HH stated particular challenges and areas for improvement include:

  i) Appointing patients for RAC by day 7
  ii) EUA by day 14
  iii) Timely communicating the results to patients
  iv) Pre-ordering investigations
  v) Radiology delays (diagnostic – interventional)

MTW – update provided by Andreas Papadopoulos

- Please refer to the circulated performance slide pack for an overview of the Trust's data.

- AP provided a breakdown of the total 321 Gynae cancers diagnosed at MTW which include:

  i) Endometrial – 169
  ii) Cervix – 45
  iii) Vulva/Vagina – 20
  iv) Ovarian / PPC – 87

- The collection of data has improved slightly at MTW and also the recording of residual disease.
- 28-day FDS continues to be achieved due to a well-established triaging process and having good 2ww clinic capacity. They will be implementing a new STT nurse led triaging pathway on the 7th November. This will improve their performance and ensure patients are seen and sent for the necessary diagnostics as early as possible.
- AP alluded to staffing issues within oncology – they have recruited 2 new Consultants so

		should start to see improvements. • There have been some capacity challenges within radiotherapy due to staffing levels. • There are 9 patients waiting over 62-days with 3 waiting over 104-days.		
5.	**Faster Diagnosis Standard**	• RI confirmed this agenda item had been discussed sufficiently under the performance section above.		
6.	**NG12 referral form**	• This agenda item was not discussed.		
7.	**Audit**	**<u>National Ovarian Cancer Audit – update by Andy Nordin</u>** • AN provided an overview of the Ovarian Cancer Audit Feasibility Pilot which is funded by the charities (BGCS, OCA, TOC). The newly announced National Ovarian Cancer Audit which will be developed over the next 12+ months will be publicly funded. This will be led by the Royal College of Surgeons in association with the London School of Hygiene and Tropical Medicine. • The reports are publicly available to view on the Gynae Cancer Hub. CancerStat2 can be accessed via the trusts Cancer Managers and this will allow visibility of the granular data of all trusts across the UK. • The Ovarian Cancer Audit Feasibility Pilot came out in February 2020 which looked at the disease profile in England in terms of incidence, mortality, stage and survival for ovary, fallopian tube and primary peritoneal carcinomas. • AN disease profile report – 2013 – 2017: i) 1-year net survival varied across the 19 CA's between 62.9 and 75.2% (K&M average 67.8%) ii) 5-year net survival varied across the 19 CA's between 28.6 and 49.6% (K&M average 32.1%)		**No audit slides have been circulated**

		• The treatment report published in November 2020 had the biggest impact on: i) National surgery, chemotherapy and IDS rates ii) Variation in treatment by Cancer Alliance iii) Variation in treatment by Trust of diagnosis (CancerStats2) • AN highlighted the overall treatment modality for all stages from Jan 2016 – Dec 2018 (inclusive). 21.9% of women did not receive any anticancer treatment (no chemotherapy or surgery). For those aged 80 and above 60% received no chemotherapy or surgery. • AN referred to treatment by FIGO stage, age group and variation by cancer alliance between January 2016 to December 2018 (inclusive). • Patients in K&M have the same chance of getting surgery but are less likely to have access to chemotherapy when compared to the national average. • In terms of the short-term mortality report which was published in March 2022 – 31% of patients will die within 1 year of diagnosis, of which 13% within 2 months, 8% - 2-6 months and 8% 6-12 months. • Patients presenting through an emergency route have a 1:2 chance of dying within 1 year of diagnosis. The elderly tends to be affected more and will die without treatment. Additionally, this is the case within the most deprived areas of the population – 67% compared to 71% in the least deprived areas. • The final paper which will include an overview of the profile and treatment analysis from 2015 – 2019 will be published in Feb 2023. AN agreed to provide an update at the next meeting. **<u>Sentinel Node and Endometrial cancer – update by Omer Devaja</u>** • OD highlighted the Sentinel Node service has been in place since 2013 and is the new gold standard service. • OD thanked his colleagues for the data provided for this retrospective study which looked at:		

		- The management of early gynae cancers as well as survival by stage and grade. Endometrial cancer is curative if diagnosed early and the patient has had surgery. - Lymph node status is one of the most important prognostic factors. - Lymphadenectomy. - Current role of paraaortic lymphadenectomy for endometrial cancer staging. - The sentinel node is the first lymph node to receive lymphatic drainage and metastasis from the primary tumour. - Technique utilised for SLND in endometrial cancer – blue dye, Tc99 and Indocyanine green - Overview of the FILM study. - Ultra-staging of negative pelvic lymph node decreases the true prevalence of isolated paraaortic dissemination. • MTW audit results for 2.5-year audit for endometrial cancer with 115 patients enrolled focussed on: - Aged 60 – 70 - BMI average 29 (17 – 51) - 92% laparoscopic – surgical approach - 60& had comorbidities - 4% conducted laparoscopically - Pathology. - Post-op data - Sentinel Node Detection – 90 (78.3%) – stage of disease is higher and linked with obesity. They aimed to reached 85% so are slightly disappointed. Recommended SLND for all grades of disease. • The TSSG gave approval today for MTW to offer SLND for all grades. • AN referred to the BGCS guidelines which state that sentinel node biopsies should not be offered for grade 1 disease and use lymphadenectomy to triage adjuvant radiotherapy. RI stated grade 1 full lymphadenectomy is controversial. AN will always discuss sentinel node management with his patients. AP highlighted that patients with a higher BMI it is harder to		

		detect the sentinel node.		
7.	**CNS Updates**	**DVH update** • Roll-out of qFIT. • Additional Rapid Access Clinics to be put in place. • Implement a buddy system to provide cross cover. **EKHUFT update** • Family history clinic is not yet in place. • Patient expectations are increasing. • Appointed a dedicated research nurse. • PIFU service has started and they have potentially identified a couple of patients. **MFT update** • Oncology continuity and cover has been an issue. • Staff changes – amongst Band 6's. **MTW update** • 50-60 patients are on the PIFU pathway currently. • Better cover for the Tunbridge Wells hospital now additional staff in place. • Pan-Kent CNS meeting will take place following today's meeting. • Family history clinic in place since earlier this year. Have seen 40 patients with 6 onward referrals to GSTT. • Patient Satisfaction Survey – feedback has been good. • Staff changes.		
8.	**AOB**	• AP asked how he could obtain a user name and password in order to gain access to		

		CancerStats2. The group suggested he contacted Susan Young directly – susan.young@nhs.net. • RI thanked the group for their attendance and participation at today's meeting.		
9.	**Next Meeting Date**	• **To be confirmed.**		