Thyroid Tumour Site Specific Group meeting
Tuesday 16th March 2021
Microsoft Teams
09:30 – 12:30

Final Meeting Notes

Present	Initials	Title	Organisation
Jeremy Davis **(Chair)**	**JD**	Consultant ENT Surgeon	MFT
William Gauslin	**WG**	Cancer General Manager	MFT
Debbie Hannant	**DH**	Head & Neck CNS	MFT
Cynthia Matarutse	**CMat**	Lead Cancer Nurse	MFT
Delphine Nkuliza	**DN**	F1	MFT
Anya Selwyn	**AS**	STR Higher ENT (Otolaryngology)	MFT
Lesley Northam	**LN**	Lead Sonographer	DVH
Bikram Bhattacharjee	**BB**	Consultant Radiologist	DVH
Sue Honour	**SH**	Lead Head & Neck and Thyroid CNS	EKHUFT
Robert Hone	**RH**	Consultant ENT Surgeon	EKHUFT
Craig Hickson	**CH**	ENT Registrar	EKHUFT
Gyorgy Vittay	**GV**	Consultant Histopathologist	EKHUFT
Edmund Lamb	**EL**	Clinical Director of Pathology	EKHUFT
Eranga Nissanka-Jayasiriya	**ENJ**	Consultant Head & Neck Histopathologist	EKHUFT
Nicola Chaston	**NC**	Consultant Pathologist	EKHUFT
Elizabeth Hall	**EH**	Principal Biochemist	EKHUFT
Muhammed Eraibey	**ME**	Consultant Radiologist	EKHUFT
Claire Mallett	**CMal**	Programme Lead – Personalised Care & Support	KMCA
Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Karen Glass **(Minutes)**	**KG**	Administration & Support Officer	KMCC & KMCA
Annette Wiltshire	**AW**	Service Improvement Facilitator	KMCC
Nick Rowell	**NR**	Consultant Clinical Oncologist	MTW
Pauline Mortimer	**PM**	Head & Neck CNS	MTW
Siva Sivapriyan	**SS**	Consultant in Diabetes & Endocrinology Medicine	MTW
Gemma McCormick	**GM**	Clinical Oncology SpR	MTW
Julian Hamaan	**JH**	Consultant ENT & Thyroid Surgeon	MTW

Jesse Kumar	**JK**	Consultant Endocrinologist and Diabetes Physician	MTW
Chris Singleton	**CS**	Senior Programme Manager – KMCA	NHS Kent & Medway CCG
Bana Haddad	**BH**	Macmillan GP & Clinical Lead – PC & S	NHS Kent & Medway CCG / KMCA
Rakesh Koria	**RK**	Macmillan GP Associate Advisor Kent & Medway	NHS South Kent Coast CCG
Navdeep Upile	**NU**	Consultant Otolaryngologist ENT Surgeon	QVH
Apologies			
Padmini Manghat	**PM**	Consultant - Biochemistry	DVH
Vikram Dhar	**VD**	Consultant Surgeon	EKHUFT
Chris Theokli	**CT**	Consultant ENT / Head & Neck	EKHUFT
Ali Al-Lami	**AAL**	Consultant ENT/ Head & Neck Surgeon	EKHUFT
Pippa Miles	**PM**	Senior Service Manager	EKHUFT
Alistair Balfour	**AB**	Consultant ENT	EKHUFT
Maria Acosta	**MA**	Consultant of Nuclear Medicine	MFT
Coimbatore Praveena	**CP**	Consultant	MFT
Mary Boyle	**MB**	Consultant Cellular Pathologist	MTW
John Shotton	**JS**	Otolaryngology Consultant	MTW
Ann Fleming	**AF**	Consultant Histopathologist	MTW

Item		**Discussion**	**Agreed**	**Action**
1.	**TSSG Meeting**	**<u>Apologies</u>** • The apologies are listed above. **<u>Introductions</u>** • JD welcomed the members to the meeting and the group introduced themselves. • JD asked if it could be noted for all future meetings that both an email and a diary invite is sent to the attendees with an additional reminder before the meeting. This would ensure the group shared these details with their relevant admin teams to promote full attendance at future meetings.		**AW / KG**

		• JD asked the group if they were happy for the meeting to be recorded for minuting purposes. There were no objections raised. **Review previous minutes** • JD confirmed the minutes from the previous meeting on the 6th October 2020 could be signed off as a true and accurate record. • JD highlighted that this meeting would alternate between a Monday and Tuesday to aid EKHUFT colleagues. • If you attended this meeting and are not captured on the attendance list please contact **karen.glass3@nhs.net** separately and she will update the distribution list accordingly. **Review previous actions** • The action log was reviewed, updated and will be circulated along with the final minutes from today's meeting.		
2.	**Supported self-management and Personalised Care**	**Update provided by Claire Mallett and Bana Haddad** • CMal highlighted the national expectation is that by 2021 every person diagnosed with cancer will have access to personalised care, which will be fully supported by the CNS's and Support Workers. This will provide patients with Holistic Needs Assessments (HNA's), a care plan, health and well-being information, and Treatment Summaries (TS). CMal added this has been working really well for patients across K&M. • CMal confirmed all K&M Trusts provide support for their breast cancer patients on the stratified follow-up pathway which is supported by a live digital system. Prostate and Colorectal stratified cancer pathways are due to go live imminently. CMal added the National Planning Guidance is due to be published by the end of March 2021 with further recommendations regarding the implementation of follow-up pathways.		**KG circulated the presentation on the 18.03.2021**

		• CMal highlighted that Covid has prompted a more virtual way of working. CMal mentioned CNS's have conducted the follow-up consultations primarily by telephone which has paved the way for establishing stratified pathways. • CMal referred to some Transformational Funding which they hope to have agreed shortly for the next stage of work. This will include the development of the clinical pathways and to provide a digital support solution via InfoFlex in which protocols and documentation will be embedded. • CMal explained the reason for their update today is to see if the Thyroid TSSG members would be interested in taking the supported self-management programme forward for their patients. CMal confirmed the CA would be able to offer some funding towards the digital work. They have provided some Cancer Support Workers to support this work already in other tumour groups. If so they would ask for representation from each trust to help develop the protocols, pathway processes and treatment summaries. CMal added most of this can be achieved virtually. • RK promoted the work both CMal and BH are doing which would effectively deliver much more than just financial savings, but also better holistic and continuity of care for their patients. • NR is unsure how this would work effectively for Thyroid cancer patients as it could increase the complexity of the pathway for patients who need to be seen face to face. CMal understands this would be for a smaller cohort of patients. CMal explained with the less complex Thyroid patients going onto a self-management follow-up they would not need to come back into hospital. This would effectively free up time for Clinicians to see the more complex patients. • SH suggested that for some of their smaller group of low risk patients it could work as these numbers would add up over a 10-year period. • NR explained he would like to see a more concrete proposal with ideas on how it could work before committing any time to this. • CMal understood NR's reluctancy and explained there is some national expectation for most tumour groups to promote and implement the remote follow-up pathway.		

		CMal agreed to speak to some of her peers in other Cancer Alliances where this has already been set up, to get some supporting documentation and arrange to speak to some of those Clinicians. A separate meeting could then be set up after this. **Action** – JD asked if CMal could come back to him directly with further supporting evidence and they can discuss separately how to take this forward. **Action** - CMal asked if there could be Surgical, Oncological and CNS representation from each trust in order to help develop and set up the Treatment Summaries. JD suggested that they could also take this action outside of this meeting.		**JD / CMal** **JD / CMal**
3.	**Thyroid Ultrasound reports**	**Thyroid v Head & Neck – update provided by Jeremy Davis** • JD confirmed they are still struggling with the Thyroid Ultrasound reports. They are still getting Community Ultrasounds which are still not as detailed as NICE Guidelines would expect. • RK suggested that once a decision had been made by Secondary Care as to the minimum requirements needed this can then be escalated to Laura Alton as one of the commissioners (who has an ultrasound background) to ensure all our providers abide by this and if not to look at it as a learning event. • JD mentioned both him and the DVH team have put together a data set which he projected to the group. **Action** – JD agreed to share the data set details with CS who will take this forward with the providers and individual commissioners of those services within the Integrated Care Partnerships (ICP). JD asked for Nic Goodger to be included as the Head & Neck TSSG Chair.		**JD / CS / LA**
4.	**Presentation of data all Trusts**	• JD alluded to the Cancer Clinical Leadership meeting (formerly called the TSSG Leads meeting) which took place on the 9th March 2021. They discussed again separating the Thyroid performance data from the Head & Neck data and for the Cancer Alliance to pursue if this is possible to do.		**KG has circulated the performance data on the**

		• AW mentioned that PM has produced the performance data today which is only Thyroid data. **Action** – JD asked AW to take this action forward with the Cancer Manager teams and the Cancer Alliance to be able to clearly distinguish the Thyroid data only for future meetings. **EKHUFT – update by Robert Hone** • RH confirmed that 2ww compliance is very good for December / January and predicted compliant for March 2021. • RH admitted he was unsure of the breach reasons highlighted on the report. RH referred to the USS for Thyroid may come back as inconclusive for FNA which will then become a breach. RH added there is no way around that but they are trying to fix this at the Rose Clinic. RH mentioned they are doing fortnightly MDT's in which the complex cases will roll on if there is not a diagnosis at the first appointment. • JD mentioned it would be virtually impossible to meet the 28-day FDS when doing a diagnostic lobectomy as they will not know if it is cancer until later. JD confirmed they would still need to meet the 62-day cancer standard. • JD and RH agreed having a weekly MDT would not work effectively as there are not enough patients and there are insufficient resources. • EKHUFT have met the 28-days to diagnosis standard, with an overall data completeness at 80%. RH alluded to some issues in January with theatre capacity but have now re-opened and will be shortly operating every day. • RH mentioned moving the Thy3 cases back to being operated on within 3 months or to repeat the ultrasound. RH highlighted that some patients were cancelled during December and January due to Covid or having a positive Covid swab. • RH added one of the Independent Sector providers stopped all treatment in December but they restarted again in March. All 2ww clinics have continued.		**18.03.2021** **AW / Cancer Managers**

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<tr><td></td><td></td><td><u>MTW – update by Nick Rowell</u>

• It was noted that the MTW figures included the Head & Neck performance data and had not been separated as EKHUFT had. NR confirmed he had nothing to add from the MTW slides. JD agreed this did not really elaborate on the true Thyroid figures.

• NR suggested there needed to be better MDT Co-ordinator training due to some inconsistencies with diagnostic codes at their MDT meetings.

<u>Action</u> – JD asked AW to see if there was any Cancer Alliance support to help with the appropriate MDT Co-ordinator training. CM agreed to discuss with Ian Vousden who would be familiar with any previous training done.

<u>MFT – update by Will Gauslin (slides received after the meeting)</u>

• WG confirmed 100% compliance for 2ww referrals from November – January within the Thyroid specialty.

• WG highlighted that the Beautiful Information (BI) team had issues separating the Head and Neck data from the Thyroid data for 31-day and 62-day performance targets. WG has asked if this can be done by searching for the ICD-10 codes to obtain this detail. WG added as such they were 100% compliant in February for 31-day and 62-day targets.

• WG confirmed compliance for 28-day in November - 42%, December – 85% and January – 14%. WG explained a very experienced MDT Co-ordinator retired during the first wave of Covid and their replacement did not really understand the requirements of the role. WG added they have now recruited a more experienced person to this post and will start in May.

QVH – update – slides distributed but no update given.</td><td></td><td>AW / CM</td></tr>
<tr><td>5.</td><td>Clinical Pathway Discussion</td><td><u>Pathway of Care – updated by Jeremy Davis</u>

• AW confirmed most of this document had already been agreed however, the follow</td><td></td><td></td></tr>
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<tr><td></td><td></td><td>up part of the pathway required agreement today and can then be signed off.

• NR thinks the issue is that the policy statement is particularly permissive so is therefore not particularly effective guidance. NR mentioned the national guidance states that thyroid cancer patients are followed up for life. NR thinks this is particularly excessive compared to other tumour groups and should be less proscriptive.

• NR suggested they amended the TSH suppression section to state it is only indicated for those of intermediate to high risk of relapse.

<u>Action</u> – JD agreed to update this particular section of the POC considering NR and SS comments. JD suggested the document is then published and kept under review.

<u>High Operational Policy - H&N and Thyroid</u>

• AW hoped this document could be agreed and signed off today. AW admitted she is having difficulty with the population section of the document which is currently still outstanding. JD suggested AW looked at the Trusts websites to obtain this data.

• The group agreed this document could then be signed off today.</td><td></td><td>JD</td></tr>
<tr><td>6.</td><td>Research</td><td><u>Audit of thyroid ultrasound & histology correlation – update provided by Craig Hickson</u>

• CH explained this is an audit proposal which both CH and AB had discussed previously regarding the U grading of ultrasound nodules and how the histology correlates locally. CH stated his concerns that they were under-grading ultrasound scans and secondly over-grading U grades so carrying out more surgery than they should be.

• CH confirmed there is no standard for which to audit this and referred to two other regions which have done similar work including London and Sheffield. CH suggested comparing their local results with London (UCL) and Sheffield.</td><td></td><td>KG circulated the presentations on the 18.03.2021</td></tr>
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		• CH proposed to do a retrospective analysis of all patients undergoing USS of the thyroid or USS scan of the thyroid + FNAC. • DN confirmed this is the audit that she has already taken forward at MFT. **<u>Audit of thyroid ultrasound & histology correlation – update provided by Delphine Nkuliza</u>** • DN confirmed this audit was started initially with Adam Haymes and JD. • The background of the audit: - i) U grading of thyroid nodules associated with different rates of malignancies (higher U grade, higher likelihood of malignancy) ii) No national figures correlating U grade with percentage risk of malignancy. • The aim was to determine: - i) U3 nodules 30-40% ii) Correlate in house U grading with subsequent histopathology to contribute to correlation rates nationally iii) Under-grading USS > higher rate of malignancy • DN confirmed there was a retrospective analysis of 772 patients undergoing hemi or total thyroidectomies between 01.01.2018 – 30.04.2018 at MFT and DVH. This resulted in 33 patients undergoing surgery following a USS and U grading. • DN explained that it is pretty much in keeping with UCL and Sheffield results, however there is a lower malignancy rate for U2 and U3 in North Kent. DN highlighted the main issue is due to the USS results are not being performed as well as they could be with no clear U grading for the majority of the USS. There is a requirement to standardize USS reports to ensure clear U grading, so they can plan appropriately. • DN suggested as a future long-term re-audit they should look at the results and include Thy grading which was not done in this particular audit.		

7.	**Biochemistry update**	**<u>Update provided by Edmund Lamb</u>** • EL explained he had no presentation for the group today. • EL mentioned they continue to provide a Thyroglobulin and Thyroglobulin Antibody service for EKHUFT which is running well with no issues. • EL confirmed they have revised their referral CUP point for sending Thyroglobulin Antibody samples to Birmingham. These were previously referred when there was an antibody concentration level of greater than 2 and there has been no interference at those levels. This has now changed so they are only referring to Birmingham if the antibody concentration exceeds 3. This has reduced the percentage of samples sent away from 40% down to 25% which means they are now providing a complete service to 75% of their patients. EL confirmed they will keep this under continual review. • EL explained the only other thing that has changed from the previous meeting is that they had previously insisted on a red top sample in line with Birmingham recommendations. However, this is no longer required by Birmingham so they are now re-checking their assay, which gives the same results for Thyroglobulin using a red top and yellow top sample. They should have that data within the next week or so to be able to compare the sample data. MFT and DVH do not use the red top samples so this has created a barrier in transferring their work to EKHUFT. They hope to be able to let them know in the next couple of weeks that a yellow/gold top sample will also be able to be used. MTW will shortly be in a position to be able to send their work to EKHUFT as well. • NR admitted he is concerned with the cut off numbers (25% of the overall thyroglobulin test) which equates to 1:4 patients not having their results back and hence unnecessary appointments being scheduled. • EL concluded as soon as they have more samples, the sooner they will have more experience to judge. • JD thanked EL on behalf of the Thyroid Community, they are very appreciative of the		

		important project that EL and his team have taken on. **Action** – EL agreed to provide a short update at the next TSSG meeting in the Autumn and by then will have received samples from across the K&M patch.		**EL / AW**
8.	**Future developments**	**Medullary thyroid cancer – query supra-regional discussion MDT** • Due to time constraints, this agenda item was not discussed.		
9.	**Community Ultrasound**	• It was felt that this item had been discussed sufficiently under other agenda items.		
10.	**CNS Updates**	• There was no CNS update provided today from across the Trusts.		
11.	**Audits for 2020**	**BAETS Audit – update provided by Robert Hone** • RH confirmed he has just become the local audit lead and to encourage that every audit is presented. • RH confirmed the BAETs requirements are: - i) Every Thyroid surgeon should do a minimum of 20 procedures per year ii) Supports the regular audit of thyroid surgeons through the United Kingdom Registry of Endocrine and Thyroid Surgery (UKRETS – national database) audit • RH confirmed that Thyroid contribute 55% to UKRETS, with Endocrine at over 80%. RH added it was agreed a few years ago at the TSSG meeting that they would all contribute to UKRETS. RH suggested this should become part of the ENT surgeon's annual appraisal. • RH mentioned the numbers of surgeons performing 20 Thyroidectomies per year is		

		65% for ENT and 80% for Endocrine. • RH proposed that they present their own UKRETS data as an audit from 01.01.2020 – 31.12.2020. RH stated this can be anonymous and collated separately. RH would be happy to collate this for October. JD would also like comments from non-surgeons. • JD suggested discussing with AW separately the BAETS subscription costs and if the Cancer Alliance would be happy to support this. • However, JD concluded that the audit should be put on hold until the GIRFT report had published their recommendations and can then be discussed at the TSSG meeting.		
12.	**Linked Commissioners**	• CS confirmed this agenda item relates to both him and Laura Alton who are the new cancer commissioners for NHS Kent & Medway CCG. They will be providing CCG updates at all TSSG meetings. CS confirmed he would be covering all the future Thyroid TSSG meetings.		
13.	**CCG Update**	• CS explained the K&M CCG is newly formed and is operating well. The aim is to have more uniform pathways with equitable access to cancer services for the population of K&M. • CS mentioned there is a lot of other linked cancer work going on including diagnostics in which all the trusts are involved. CS referred to the Community Diagnostic Hubs in which there should be one within each Integrated Care Partnership area (4 in K&M) but this is still in early discussions. • JD admitted his frustration at not being able to view the US reports on the K&M PACS system due to the imaging providers not linking up. JD asked if there is any update on this without the need for separate log ins. CS confirmed there is some work underway within the K&M Diagnostics Programme to address this and he will be able to feed back from a cancer perspective. JD requested that QVH and the TSSG Leads were included in this decision-making process.		

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<tr><td>14.</td><td>CA Update</td><td><u>Update provided by Claire Mallett</u>

• CM confirmed the predominant aims for the Cancer Alliance recovery phase are: -

i) Restore urgent cancer referrals at least to pre-pandemic levels
ii) Reduce the backlog at least to pre-pandemic levels on 62-day
iii) Ensure sufficient capacity to managed increased demand moving forward, including for follow up

• CM referred to the Long-Term Plan – national priorities which include the Rapid Diagnostic Services, Targetted Lung Health Check Programme, Personalised Care and Stratified follow up.

• CM mentioned the current Rapid Diagnostics Services which include the VISS pilot at DVH and Rapid Lymphadenopathy pilot at EKHUFT. CM also highlighted the Colon Capsule Endoscopy pilot and Cytosponge pilot.

• CM referenced the 28-day Faster Diagnosis Standard, supporting Primary Care Network colleagues to implement the Early Diagnosis Direct Enhanced Service (ED DES) and various programmes designed to reduce health inequalities.

• CM agreed to share any updates regarding the Planning Guidance which is due to be published imminently.</td><td></td><td>KG circulated the presentation on the 18.03.2021</td></tr>
<tr><td>15.</td><td>Date & time for future TSSG's</td><td>• JD suggested that future meetings were alternated between Mondays (Autumn round) and Tuesdays (Spring round) due to there being less bank holidays later in the year. Therefore, the next meeting should take place on a Monday. JD hoped the meetings next year could be face to face.

<u>Action</u> – JD agreed in consultation with Nic Goodger (H&N TSSG Chair) they should agree the next meeting date later today after the H&N TSSG meeting.</td><td></td><td>AW / KG</td></tr>
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16.	AOB	• NU asked about the Thyroid U3's and the cm issue, as the American guidelines differ from the British. • JD mentioned the variation in both national and international guidelines regarding smaller thyroid nodules but there should be new national guidelines due out in 12 months' time. • JD thanked the group for their attendance and support at today's meeting.		