Kent & Medway Cancer Collaborative

Lung Tumour Site Specific Group meeting
Thursday 19th September 2024
Parkview Meeting Room, Mercure Hotel, Maidstone, ME17 1RE
13:30-16:30

Final Meeting Notes

Present	Initials	Title	Organisation
Tuck-Kay Loke **(Chair)**	**TKL**	Consultant Respiratory & General Physician	MTW
Sophie Hurcomb	**SHu**	MDT Coordinator	MTW
Grace Gilbert	**GG**	Pathway Navigator	MTW
Ravish Mankragod	**RM**	Consultant Respiratory Physician	MTW
Riyaz Shah	**RS**	Consultant Medical Oncologist	MTW
Shona Sinha	**SS**	Consultant Histopathologist	MTW
Dominic Chambers	**DC**	Consultant Histopathologist	MTW
Deana Giles	**DG**	AGM for Respiratory	MTW
Neil Crundwell	**NCr**	Consultant Radiologist	MTW
Nicola Davis	**ND**	Consultant Clinical Oncologist	MTW
Jennifer Pang	**JP**	Consultant Clinical Oncologist	MTW
Riyaz Shah	**RS**	Consultant Medical Oncologist	MTW
Shona Sinha	**SS**	Consultant Histopathologist	MTW
Ravish Mankragod	**RM**	Consultant Respiratory Physician	MTW
Fay Fawke	**FF**	Deputy Lead Cancer Nurse	DVH
Simiat Ojo	**SO**	STT Nurse	DVH
Amy Peacock	**AP**	Macmillan Lung Cancer CNS	DVH
Chieh-Yin Huang (Phil)	**CYH**	Consultant Radiologist	DVH
Pippa Enticknap	**PE**	Deputy General Manager	EKHUFT
Toni Fleming	**TF**	Macmillan Lead Lung Cancer CNS / TLHC Responsible Assessor	EKHUFT
Saleheen Kadri	**SK**	Lung Cancer & Service Lead	EKHUFT
Nicola Chaston	**NCh**	Consultant Cellular Pathologist	EKHUFT
Chris Hopkins	**CH**	Cancer Data Manager	EKHUFT
Callum Blanch	**CB**	Information Analyst	EKHUFT
Emma Forster	**EF**	Head of Improvement	KMCA
Ritchie Chalmers	**RC**	Medical Director	KMCA

Ann Courtness	**AC**	Macmillan Primary Care Nurse Facilitator	KMCA
Annemarie Frenchum	**AF**	Programme Manager - TLHC	KMCA
Karen Glass **(Minutes)**	**KG**	PA / Business Support Manager	KMCA / KMCC
Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Lead	KMCC
Denise Thompson	**DT**	Cancer Team Lead	MFT
Sarah Paterson	**SP**	FDS Lung CNS	MFT
Heather Foreman	**HF**	Macmillan Lung and Mesothelioma Cancer CNS	MFT
Catherine Bodkin	**CB**	Macmillan Lung and Mesothelioma CNS	MFT
Kolera Chengappa	**KCh**	Respiratory Consultant	MFT
Sarah Paterson	**SP**	Faster Diagnosis Lung CNS	MFT
Hannah Stanford Weeks	**HSW**	Implementation Lead	MSD
Caroline Wordsworth	**CW**	Patient Partner	
Apologies			
Claire Pearson	**CP**	Macmillan Lung Cancer Clinical Nurse Specialist	DVH
Jonathan Bryant	**JB**	Primary Care Cancer Clinical Lead	KMCA
David Osborne	**DO**	Data Analyst	KMCA
Samantha Williams	**SW**	Administration and Support Officer	KMCC
Suzanne Bodkin	**SB**	Cancer Service Manager	MFT
Jane Brown	**JB**	Consultant Clinical Oncologist	MTW
Louise Gilham	**LG**	Mesothelioma UK CNS (Kent)	MTW
Gillian Donald	**GD**	Clinical Scientist	MTW
Sandra Wakelin	**SWa**	Macmillan Lung Cancer ANP	MTW
Simon Webster	**SWe**	Consultant Respiratory Physician	MTW

Item		**Discussion**	**Action**
1.	**TSSG Meeting**	**<u>Apologies</u>** • The formal apologies are listed above. **<u>Introductions</u>**	

		• TKL welcomed the members to today's face to face meeting and asked them to introduce themselves. • 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 to the members along with the final minutes from today's meeting. **Review previous minutes** • The final minutes from the previous meeting which took place on the 14th March 2024 were reviewed and agreed as a true and accurate record.	
2.	**Lung Optimisation pathway – update**	**MSD Lung Pathway Improvement Project – update by Hannah Stanford-Weeks & Emma Forster** • HSW and EF outlined the aims of the MSD improvement programme: • **Map** future state of the lung diagnostic and treatment pathways. • **Identify** gaps in current service to assess capability and compliance levels for future need. Identify areas for improvement and highlight risks associated with non-improvement. • **Co-create** business case for change, including additional resources to facilitate business case for service improvements. • **Implement** service improvements. • **Evaluate** the changes and share best practice. • The progress to date was outlined across each of the Trusts in relation to this project. The PID has been completed and signed off by KMCA. It was noted that further engagement was	**Presentation slides were circulated to the group on Friday 20th September 2024**

		required by MTW as Simon (Webster) has now stepped down as the Lead for lung cancer. • In terms of next steps, the plan is to: • Have mapping workshops completed by November 2024. • Complete gap analysis workshops and have action plans developed by December 2024/January 2025. • Phase 2 launch for Thoracic pathways to GSTT by January 2025. • Launch of the KMCA Lung Steering Group by January 2025. • Finally, have the Business Case development completed by March 2025. • RC stated the importance of driving the CA funding resource into the right place.	
3.	**Audits:** **Abnormal chest x-ray to CT pathway**	**<u>Abnormal CXR / Urgent CT Pathway report – September 2024 – presentation provided by Simiat Ojo</u>** • SO introduced herself as the STT CNS for DVH and explained the background to this audit. • Previously, the GP would send a request for a CT scan to the radiology department following an abnormal chest x-ray (CXR) under the Lung Diagnostic Pathway. A checklist would be completed and a CT scan would be requested by the radiology admin team within 72 hours for the next available date – it was noted this was a prolonged pathway. • In order to support the new process, the Trust employed a STT nurse (SO) to facilitate a new smooth and clinically focused pathway (a secondary care-led pathway). • The radiologist/reporting radiographer would insert 'lung pathway' into the CXR report on PACS, which would then trigger an urgent CT lung pathway referral. • The aims and objectives of the audit include: i) To streamline the existing pathway, reduce the diagnostic timeframe and improve	**Presentation slides were circulated to the group on Friday 20th September 2024**

		patients experience. ii) To improve the management of suspected cancer 2ww referrals in line with the NOLCP faster diagnosis standard. iii) To comply with the standard set nationally of 3-5-day turnaround for CXR-CT report. iv) Adopt the same principle to ensure a positive effect for other tumour sites. v) To establish a strong working relationship between radiology and the lung team to prevent delays, encourage early diagnosis and prompt referral to oncology in order to treat lung cancer. • SO navigated through the patient pathways: i) Abnormal Chest X-Ray to CT Pathway from the GP ii) Abnormal Chest X-Ray to CT Pathway from ED / AEC iii) 28-day FDS pathway • SO compared the timeline data from April 2023 to April 2024 for patients having a CXR / CT scan and access to the reports which were on the whole within 24 hours. Any delays were generally out of their control. • CT scans are offered at: i) Darent Valley Hospital - Dartford ii) Queen Marys Hospital – Sidcup iii) Livingstone Community Hospital - Dartford • SO concluded from the audit: i) The implemented changes were generally positive between the GP, patient and secondary care provider. The target timeline of CXR-CT report within 96 hours was generally achieved with the exemption of involved variables. ii) Patient's compliance with the process was positive and there was improved	

		communication within the service. iii) Their priority is to ensure the timely process of the patient's diagnostic journey – from abnormal CXR to CT. • Proposed changes include: i) Having a stratified database collection and capturing patient experience feedback. ii) To look into potential over-image infection. • CYH explained the main bottleneck on the CT pathway is due to not having enough CT reporters. TLHC will be the solution moving forward. It was agreed the importance of getting symptomatic patients onto the lung pathway quicker.	
4.	**SEISMIC study**	**<u>SEISMIC Study – update provided by Nicola Davis</u>** • ND highlighted the SEISMIC Study was published in the Lancet – for Respiratory Medicine. • ND outlined the background to the study: i) RT fields in patients with locoregional node involvement must incorporate all known sites of disease to maximise the likelihood of cure or disease control. ii) Despite known imperfect accuracy of PET for evaluation of mediastinal LNs in patients with NSCLC, and the consequent potential for geographic miss of PET-occult LN metastases, international guidelines recommend RT fields be constructed on the basis of PET-identified extent of disease alone. iii) Systematic mediastinal LN staging by EBUS improves accuracy of staging in patients with early stage NSCLC. iv) Patients with locally advanced NSCLC commonly undergo only selective LN sampling. • A prospective, international, multicentre, single-arm, international study was conducted at 7 tertiary lung cancer centres in four countries (Australia, Canada, Netherlands and USA).	**Presentation slides were circulated to the group on Friday 20th September 2024**

		• Patients aged 18+ with suspected or known locally advanced NSCLC underwent systematic EBUS staging before combination chemoradiotherapy or high-dose palliative radiotherapy. • Primary endpoint = the proportion of participants with PET-occult mediastinal lymph node metastases shown following systematic endoscopic staging. • The findings of the patient study include: i) 155 patients underwent systematic EBUS staging and were eligible for analysis. ii) Discrepancy in extent of mediastinal disease identified by PET and EBUS-TBNA was observed in 57 (37% [95% CI 29–44]) patients. iii) PET-occult lymph node metastases were identified in 18 (12% [7–17]) participants, including 16 (13% [7–19]) of 123 participants with clinical stage IIIA or cN2 NSCLC. iv) Contralateral PET-occult N3 disease was identified in nine (7% [2–12]) of 128 participants staged cN0, cN1, or cN2. v) Identification of PET-occult disease resulted in clinically significant changes to treatment in all 18 patients. vi) In silico dosimetry studies showed the median volume of PET-occult lymph nodes receiving the prescription dose of 60 Gy was only 10.1% (IQR 0·1–52·3). vii) No serious adverse events following endoscopic staging were reported. • Interpretation of the findings: i) Systematic EBUS in patients with locally advanced or unresectable NSCLC is more accurate than PET alone in defining the extent of mediastinal involvement. ii) Standard guideline-recommended PET-based radiotherapy planning results in sub-optimal tumour coverage. iii) Systematic EBUS staging should be routinely performed in patients with locally advanced NSCLC being considered for radiotherapy to accurately inform radiation planning and treatment decision making in patients with locally advanced NSCLC. • RC highlighted that the EBUS arm should be part of the Endoscopy Network programme moving forwards and the requirement to audit the numbers so they can resource this service appropriately. It was agreed to take this offline and discuss separately.	

		Action – TKL agreed that EBUS would be a point of focus for the newly set up Clinical Reference Group within the Lung TSSG. TKL highlighted the need for there to be broader discussions regarding how EBUS services are configured so they can all deliver quality assured diagnostic and staging services.	**CRG**
5.	**Dashboard**	**Update provided by Tuck-Kay Loke** • TKL navigated through the live K&M Cancer Pathways data dashboard for lung cancer. K&M have one of the lowest survival rates for lung cancer in the country, with more patients being diagnosed late. • Overall, K&M 62-day performance is similar to six months ago, but the FDS performance has fallen from 77.7% to 74.2%. FDS performance is lowest at EKHUFT (63.8%) and 62-day performance is lowest at MFT (57.4%). It was noted that performance was very low for patients diagnosed or treated at GST. • The National Optimal Lung Cancer Pathway (NOLCP) targets met less than 50% of their patients. • The waiting time for decision to treat and first treatment was noted to be longer at MFT. The proportion of patients receiving the DTT by day 42 was higher prior to the last quarter of 2021. • DO asked what parts of the pathway do the Trusts want to target for improvement and what additional data do they want to see on the dashboard? **MFT** • They have endoscopy and imaging capacity issues. • Require another CT scanner. • Only have 2 endoscopy rooms which causes resource issues. **EKHUFT**	**Presentation slides were circulated to the group on Friday 20th September 2024**

		• The lung cancer caseload is consistently high and they have a number of complex pathway patients. • Struggle with radiology in terms of CT guided biopsies and EBUS. Bottleneck in CT reporting. **DVH** • Lack of respiratory consultants. Hope to have a new lead in place by the next TSSG. • Diagnostics and reporting of CT's is an issue. **MTW** • Capacity and resource issues which leads to their performance not being consistent. • MDT leadership – transition period as Simon Webster MDT lead has resigned from this role. Looking to appoint a new lead.	
6.	**Case study – who's problem is it anyway?**	**Case study – presentation provided by Tuck-Kay Loke** • TKL outlined the case study of a 78-year old female patient with Adenocarcinoma Lung T1cN1M0. She had a right upper lobectomy in January 2020 and was given Adjuvant Carboplatin/Vinorelbine. She was diagnosed with a pulmonary embolism in May 2020 and completed adjuvant chemotherapy in July 2020. There was a new recurrence in November 2022. • TKL outlined the patient's cancer journey from Oncology to the General Respiratory Clinic to being admitted to Orthopaedics. • After this case, there was an obligation to exercise a duty of candour on the basis of the severity of this patient's journey. It was declared by MTW as a Serious Incident and an After-Action Review (AAR) was initiated. TKL sought comments from the radiology lead and promised to discuss this case with the TSSG. • The group confirmed that all of the trusts use the AAR principles (outlined in the slides). • It was agreed that the GP could also contact the CNS's directly if they had any concerns about	**Presentation slides were circulated to the group on Friday 20th September 2024**

		the treatment of their patients. TF mentioned there needs to be a more robust post-surgical follow up system in place, this can be carried out by the Lung CNS.	
7.	**TLHC update – introduce Annemarie Frenchum**	**<u>TLHC update – provided by Callum Blanch</u>** • AF was introduced to the group as the new TLHC programme lead for the KMCA. • CB highlighted the process in place for the TLHC programme for South Kent Coast in which 18,758 invites have been sent with a 45% acceptance rate. This number has decreased from 65% due to the longer distance patients now have to travel to the Buckland Hospital. There are 24 GP surgeries who have now gone live. A second round of invites will be sent out to the non-responders. • There have been 6,543 telephone assessments - a 35% uptake with a 5% DNA rate. 4,381 people were deemed as high risk, 4,344 were referred for a CT with 37 who were not. • The SKC CT referral rate is 66%, compared to nationally which is 47% with 21% DNA rate. • There have been 2,399 people referred to the One You Smoking Cessation service. 689 people accepted this appointment – 29% compared to nationally which is 22%. • They have completed 4,039 CT scans, 228 people DNA – 6% compared to 5% nationally. This could be due to patients not wanting to travel or being on holiday. • The new National Comms states a CT scan should be reported within 28-days. There has been wide variation in this target since SKC set up the TLHC programme. • To date there have been 41 lung cancers diagnosed with 6 other cancers - 1.2% conversion rate. Broken down this included 18 x stage 1, 6 x stage 2, 8 x stage 3 and 6 x stage 4 lung cancer. • There were 2,677 patients found with Incidental Findings including:	**Presentation slides were circulated to the group on Friday 20th September 2024**

		i) Coronary calcification – 2,181 ii) Emphysema – 2,141 iii) Aortic Valve Calcification – 107. • Next steps: i) Nov 2025 – roll out Canterbury North and South ii) April 2025 – CT bid for roll out in Thanet iii) Spirometry – funding issue – classed as not gold standard iv) Nov 2024 – recalls start v) Re-inviting the non-responders • RISK noted that a specific cohort of patients could potentially be missed by the GP surgeries as they have not been noted as being a smoker. • TF highlighted the extra number of patients identified has not had a dramatic impact on their Lung MDM. • TKL thanked TF and the EKHUFT team personally and on behalf of the Lung TSSG for the immense work they have put into getting the TLHC programme up and running and the excellent results to date in diagnosing patients earlier.	
8.	**Digital Pathology update**	**<u>Digital Pathology update – provided by Shona Sinha</u>** • SS outlined the benefits launching Digital Pathology and the impact this will have on the service when it goes live. • The Laboratory Information Management System (LIMS) is the software used in K&M which allows the effective management of pathology testing and reporting. • SS explained the difference between analog and digital workflow in pathology. It was noted that within Cytology they will still use a microscope.	**Presentation slides were circulated to the group on Friday 20th September 2024**

		• SS highlighted the benefits of digital pathology in terms of: i) Efficiencies and Improved Workflow ii) Improved Workforce Factors and Collaboration iii) Improved Patient Safety iv) Evolving Technology / Research & Development Opportunities • The initial implementation impact and mitigation includes: i) System training will be provided by the supplier with ongoing support from the Kent & Medway Pathology Network team. ii) Each pathologist will need to verify their digital reporting against their analogue reporting to ensure clinical care level continuity. iii) This will impact the rate of reporting for the duration of verification which will vary for each pathologist for an estimated period of 1-3 months. No more than five pathologists will be validating at one time. iv) The digital pathology project has accessible funding to utilise other resources during the validation phases. **v)** Removing patients from cancer pathways when endoscopic findings are normal / benign will help alleviate the pressure and allow pathologists to concentrate on cases of significant clinical significance. • SS mentioned they have extra funding in place to recruit locums to help during the validation phase.	
9.	**LCNS updates from MFT**	**<u>Update provided on behalf of the LCNS team by Catherine Bodkin</u>** • CB provided an update on behalf of all of the Lung CNS's in Kent & Medway. The full details have been circulated to show the changes (in red) over the past 6-months. • CB explained the CNS's meet regularly in between the TSSG meetings. She highlighted that their workload has increased massively. Using the current patient to CNS ratio, MFT and EKHUFT are still both under staffed. More service development is needed but more resource	**Presentation slides and draft annual report was circulated to the group on Friday 20th September 2024**

		is needed to achieve this. **Action - CB agreed to finalise the Annual Report for Lung Clinical Nurse Specialists for Kent and Medway and then circulate to the group.** • CB concluded the TSSG Lung CNS role will be taken over by DVH from MFT for the next two years.	**CB**
10.	**Meso UK SLA agreement**	• Meso UK require an SLA agreement in place for their K&M patients. This will ensure patients are discussed at an established meso MDT having a consistent approach to the management of surgery, chemotherapy, radiotherapy, research trials and clinical audits. **Action – EF agreed to support from a CA perspective and will speak to TF, LG, RS outside of this meeting to move this historic action on. The CRG will also be integral to these discussions and moving this action forward.**	**EF**
11.	**Clinical Reference Group update**	• TKL confirmed EOI were sent out by AW for the CRG roles. A new working group has now been set up and includes the following members: i) **CNS** – Toni Fleming ii) **Radiologist** – Neil Crundwell iii) **Histopathologist** – Dom Chambers iv) **Medical Oncologist** – Riyaz Shah v) **Clinical Oncologist** – Jenny Pang vi) **Surgeons** – John Pilling and Karen Harrison-Phipps vii) **Physician** – Tuck-Kay Loke viii) **GP Lead** – Jonathan Bryant • The CRG consists of a group of specialists within the MDT who have an interest in the cancer strategy, governance of the TSSG, new developments, to mitigate and manage risks and horizon scanning. • The posts are for one year and renumeration of 0.5 PA is provided. The first CRG meeting is	

		scheduled to take place in October. They will provide an update on progress at the next TSSG meeting in 2025.	
12.	**AOB**	• There were no further discussions under AOB.	
13.	**Next Meeting**	• **Weds 26th March 2025 – 13:30 – 16:30 – venue to be confirmed.**	**KG to circulate the meeting invites.**