Kent and Medway Cancer Collaborative

Lung Tumour Site Specific Group meeting
Thursday 31st March 2022
Microsoft Teams
13:30 - 16:30

Final Meeting Notes

Present	Initials	Title	Organisation
Tuck-Kay Loke (Chair)	**TKL**	Consultant Respiratory & General Physician / Clinical Director - Outpatients	MTW
Riyaz Shah	**RS**	Consultant Medical Oncologist	MTW
Alia Nasir	**AN**	Consultant Radiologist	MTW
Gill Donald	**GD**	Clinical Scientist	MTW
Katharine Clark	**KCl**	Chemotherapy Day Unit - Unit Manager	MTW
Jennifer Pang	**JPa**	Clinical Oncologist	MTW
Dominic Chambers	**DC**	Consultant Histopathologist	MTW
Russell Burcombe	**RB**	Consultant Clinical Oncologist	MTW
Louise Gilham	**LG**	Macmillan Lung/Mesothelioma UK CNS (Kent)	MTW
Tim Sevitt	**TS**	Consultant Clinical Oncologist	MTW
Suraj Menon	**SM**	Consultant Radiologist	DVH
Michelle McCann	**MM**	Operational Manager for Cancer & Haematology	DVH
Amy Peacock	**AP**	Macmillan Lung CNS	DVH
Burhan Khan	**BK**	Respiratory Consultant	DVH
Bradley Smith	**BS**	Lead Radiology Manager for Cancer Services	DVH
Toni Fleming	**TF**	Macmillan Lead Lung Cancer CNS	EKHUFT
Ramin Baghai-Ravary	**RBR**	Respiratory Consultant	EKHUFT
Saleheen Kadri	**SK**	Respiratory and General Internal Medicine Consultant	EKHUFT
Sanjay Sharma	**SS**	Respiratory Consultant	EKHUFT
Samantha Cree	**SC**	Cancer Improvement Manager & Speech and Language Therapist	GSTT
Sarah Barker	**SBa**	Project Manager – Early Diagnosis	KMCA
David Osborne	**DO**	Data Analyst	KMCA
Serena Gilbert	**SG**	Cancer Performance Manager	KMCA
Ian Vousden	**IV**	Programme Director	KMCA
Colin Chamberlain	**CC**	Administration & Support Officer	KMCC

Karen Glass (Minutes)	**KG**	Administration & Support Officer	KMCC & KMCA
Annette Wiltshire	**AW**	Service Improvement Facilitator	KMCC
Suzanne Bodkin	**SBo**	Cancer Pathway Manager	MFT
Jennifer Priaulx	**JPr**	Macmillan Cancer Transformation Project Manager	MFT
Kolera Chengappa	**KCh**	Respiratory Consultant	MFT
Frances Weller	**FW**	Macmillan Lung Cancer CNS	MFT
Heather Foreman	**HF**	Lung Cancer CNS	MFT
Holly Groombridge	**HGro**	Cancer Commissioning Project Manager	NHS Kent & Medway CCG
Bana Haddad	**BH**	Macmillan GP & Cancer Lead / Clinical Lead – LWBC	NHS Kent & Medway CCG
Rakesh Koria	**RK**	Macmillan GP Associate Advisor for Kent and Medway & NHSE GP Appraiser	NHS Kent & Medway CCG
Emma Yale	**EY**	Head of Service Improvement for Cancer	NHSE/I
Mavis Nye	**MN**	Patient Representative	
Apologies			
Pippa Enticknap	**PE**	Senior Service Manager – CCHH Care Group	EKHUFT
Karen Harrison-Phipps	**KHP**	Consultant Thoracic Surgeon	GSTT
Cathy Finnis	**CF**	Programme Lead – Early Diagnosis	KMCA
Tracey Ryan	**TR**	Macmillan User Involvement Manager	KMCC
Cynthia Matarutse	**CM**	Macmillan Lead Cancer Nurse / Head of Nursing	MFT
Ravish Mankragod	**RM**	Consultant Respiratory Physician	MTW
Mathilda Cominos	**MC**	Consultant Clinical Oncologist	MTW
Neil Crundwell	**NC**	Consultant Radiologist	MTW
Simon Webster	**SWe**	Consultant Respiratory Physician	MTW
Sandra Wakelin	**SWa**	Lung Cancer CNS	MTW
Helen Graham	**HGra**	Research Delivery Manager (Cancer)	NIHR
Nirupa Murugaesu	**NM**	Consultant in Medical Oncology	St George's University Hospitals NHS Foundation Trust

Item		Discussion	Agreed	Action
1.	**TSSG Meeting**	**Introduction of new Chair** • AW introduced and welcomed TKL as the new chair for the Lung TSSG, taking over from Majid Mushtaq who has now retired. **Apologies** • The apologies are listed above. **Introductions** • TKL welcomed the members to the meeting. **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 30th September 2021 were reviewed and agreed as a true and accurate record. **Future meetings** • The next meeting was agreed to take place face to face on **Thursday 22nd September 2022**. A central venue to be confirmed in due course.		
2.	**Radiology updates**	**MTW** • Naveen Sharma was not present on the call to provide an update.		

		DVH – update provided by Suraj Menon • SM explained he does not have a specific national update on radiology guidance for today's meeting. • TKL referred to outstanding updates for - UK practice for CT guidance and brain metastases. KC explained there is NICE guidance for routine scanning of brain metastases. There were no further relevant updates for the local / regional imaging group.		
3.	**Targeted Lung Health Checks**	**Presentation provided by Holly Groombridge** • HGro provided an update on the TLHC – South Kent Coast pilot for EKHUFT which is using Buckland CDC. This programme will be fully funded by NHSE through K&M Cancer Alliance. • Patients invited for the TLHC will be aged 55 – 74, who have ever smoked and will cover a population of 25,662. • NHSE have used TLHC as the proposal for a National Lung Cancer screening programme – which is out for consultation until June 2022. Expectations from early 2023/24 to begin planning for an additional site within K&M for 2024/25. • K&M CA are currently working with EKHUFT radiology team to model low dose CT capacity. They are also working with the CCG and EKHUFT to develop DPIA (Data Protection Impact Assessment) in order to be able to identify patients. • An incidental findings stakeholder group are producing management pathways together with early support from LMC and specialty leads. They have secured both InfoFlex and Aidance AI software for radiology reporting to ensure patients are tracked properly. • They are working closely with the Roy Castle Foundation to set up engagement events around the South Kent Coast area to maximise patient engagement. The		**Presentation circulated on the 5th April 2022.**

		programme is due to go live in August 2022 with invites going out to patients in July 2022. • Next steps include working with EKHUFT to recruit the workforce including nurses. Establishing training schedules and working in collaboration with the national team for the go live date. Presentation to the East Kent Clinical Cabinet to support the GP engagement is due in April and will help with DPIA sign off. They are continuing to work with the incidental findings group for sign off on the management pathways. • HGro explained the current national findings for the TLHC programme are that 273,319 patients have been invited nationally, roughly 35% of these did not attend. Total number of scans performed nationally is 51,842 of which 572 lung cancers were diagnosed, 63% stage 1 and 14% stage 2. • HGro emphasised that all eligible patients will be invited for the TLHC. A risk score will determine the high and low risk patients with only the high-risk patients going for a low dose CT. Low risk patient's will be discharged until they are recalled. HGro explained initially only those patients identified by the GP will be invited via a staged approach. They hope to be able to offer a self-referral option in due course. • HGro explained EKHUFT radiologists will be reporting the scans with routine work being outsourced. • SK suggested setting up a sub working-group to discuss the management of additional incidental findings. IV agreed this has been recognised nationally and have purposely targeted a smaller population area to ensure there will be sufficient capacity. There are a number of working groups which have been established to take this work forward within EKHUFT, one of which is regarding incidental findings. Anyone who would like to be part of this would be very welcome. • TKL commented on the importance of addressing the inequalities of access and care for high risk lung cancer patients. Also, for MDT leads to be up to date in dealing with the workload which is generated from incidental findings. The nodule MDT is not yet well established across the trusts. • SK asked for radiology representatives from EKHUFT to be invited to the next TSSG		

		meeting. SK offered his support for this programme and agreed to speak to his colleagues. They are appointing 2 new consultants. IV confirmed there has been radiology input with both Iain Morrison and Julie Nolthenius. However, more consultant radiology and lung physician input from EKHUFT would be welcome.		
4.	**Adequate samples & molecular testing**	• TKL highlighted the importance of the next agenda item regarding how they deal with specimens adequately and that the correct ones go to the molecular labs for processing. • TKL referred to the previous discussion of sending all samples for processing to the Genomic Laboratory Hub at GSTT. • DC explained the funding for the test directory is being diverted to the GLH. With regards to the samples the main ones are EBUS, CT guided biopsies and bronchial biopsies with occasional bone biopsies. There are issues with fixation and rapid turn-around times. The national optimal lung cancer pathway recommends complete histological diagnosis within 3-4 days with full molecular diagnosis within 10 days. • DC mentioned there are issues regarding tissue adequacy. DC added West Kent – MTW, MFT and DVH have moved their EBUS clinic to the beginning of the week. They are doing reflex testing on all samples. • DC stated there appears to be a lot of conflicting guidance around NHSE and the national optimal lung cancer pathway in relation to turnaround times which is not particularly helpful. • RS does not believe the GLH have the capacity to take on reflex testing for the whole of K&M. RS stated when biopsies are taken there should be adequate tissue for molecular testing. EBUS is easy to control but there is variation of practice for CT guided biopsies. RK suggested that they keep track of the failure rate for both and have this information to feed back into the TSSG. • GD referred to 49 cases which have been sent away with an average turnaround of about 3 weeks, which includes a week prep time. From the 49 cases there have been 7 NGS failures (10%). There appears to be no correlation with the volume of		

		tumour. KRAS – has shown a mutation in a third of cases which were sent. 2 BRAF mutations out of 49 were identified. Rapid response testing covers most of the mutations covered so far. They have discovered in EGFR's an 8% mutation rate. • There has been an issue with RNA panels and a 39% failure rate has been identified. GD cannot see a correlation with fixation or sample type and has not found a single variant yet within the 49 cases. • GD attended a biomedical conference recently which discussed salvage pathways. They found that about a third of the patients who had deteriorated really quickly had died before the NGS result was back. Tissue requirements for both DNA and RNA panel – 500 microns. • TKL summarised the importance of ensuring that patients who need a diagnosis quickly will have access to the right tests so treatment plans can be modified appropriately. Not all patients will be well or fit enough to get treatment requiring NGS. Therefore, sending all their samples in one direction might not be the most efficient method. Some cases can be offered more than just reflex testing on molecular mutations and the GLH could be of more use. • The GLH covers a huge catchment area and the samples may not last the journey if not initially processed in the correct way. If this makes no difference to the management of the patient would this be the best use of this precious resource. • TKL emphasized the importance of capturing the clinical data better in order to share with pathologists. • TKL would like a system wide approach for all K&M trusts to ensure all the information is consistent and can be audited.		
5.	**Lung Cancer Improvement Project**	**<u>Update provided by Emma Yale</u>** • EY explained the Lung Cancer Pathway Improvement group was set up after the last Lung TSSG meeting and the optimal lung pathway. The first meeting took place on the 1st December 2021 and is chaired by Rakesh Koria – Primary Care Lead.		**Presentation circulated on the 5th April 2022.**

		• The objectives agreed as part of this group include: i) Increase referrals to pre-pandemic levels – these are very low (70%) for lung in comparison to other tumour types. ii) Consistently deliver the 28-day FDS iii) Improve patient outcomes • 4 workstreams have been developed: i) Patient engagement and communications ii) Primary Care iii) Implementing Optimal pathway from referral to diagnostic iv) Data Quality • EY highlighted the key achievements to date which include: i) Communication plan which has been developed with generic messaging to target health inequality groups. This will be shared out together with timelines to ensure the health services which have been ramped up are able to meet the increase in demand coming through the system. ii) Patient information leaflet has been developed so patients that have an abnormal CXR can go straight to CT without the need to go back to PC and to make them aware of this process. iii) Primary Care education plan has been launched – work alongside other health professionals within PC and not just GP's/ nurses to identify the risk factors for a potential lung cancer and refer into SC accordingly. iv) Straight to CT from abnormal x-ray pathways to remove days from the beginning of the pathway. v) Median 62-day treatment time has reduced to 51 days. vi) EBUS project to establish locally delivered services. • In terms of next steps: i) Working with some industry support and Secondary Care providers to do some detailed pathway mapping in order to understand the steps and experience for the patient from the point of referral and identify where the		

		non-value-added delays are and to streamline pathways. ii) Launch of the local communication campaign. iii) Development of the diagnostic bundles. iv) Development of optimal Lung Pathway dashboard which is available to clinicians in real time. v) Pilot of self-presentation x-ray service – DVH to bypass PC straight into SC. vi) Extend the project to community pharmacists for those patients who still do not want to trouble their GP with a cough. The pharmacists can do a direct referral into SC as appropriate. vii) Link with CCG Respiratory Network and build upon other respiratory conditions patients may have to build a more cohesive service into SC. • TKL congratulated and thanked both EY and RK for all their hard work.		
6.	**Implementing care bundles**	**<u>Update provided by Tuck-Kay Loke</u>** • TKL referred to a previous pathway improvement group meeting he attended in January with guest speaker Matt Evison from Manchester University hospital. ME spoke about implementing diagnostic bundles and the importance of involving patient groups. • TKL provided the following BMJ publication link - promoting early diagnosis and recovering from covid in lung cancer through public awareness campaigns. Promoting early diagnosis and recovering from the COVID-19 pandemic in lung cancer through public awareness campaigns: learning from patient and public insight work | BMJ Open Respiratory Research • Discussion on how to improve direct access to CT, to ensure timely tests were completed – involved staging and diagnosis without compromising the patient's timelines within the optimal lung cancer pathway. • ME stressed the importance of involving pharmaceutical companies and their joint contract with Astrazeneca for direct patient CXR, specific criteria was in place and		

		this was organized locally. Pharmaceutical companies have the resources, educational pathways and the time to invest. • TKL stated that Manchester have been able to ringfence their CT slots across many of their sites. They had specific ringfenced slots at 8am for lung cancer patients. This has made a huge impact and taken days off of the lung cancer pathway. The Manchester group have about 300 new lung cancer referrals every year which is very similar to K&M. • RS highlighted a previous meeting with Matt Evison in which EBUS providers working together to book quicker investigations had dramatically improved the service. TKL suggested running EBUS and PET side by side so there is one queue and is booked through InfoFlex. • SK mentioned EKHUFT struggle to get CT guided biopsies and these can take from 10 days to 1 month. TKL is aware of some issues at EKHUFT and proposed to take this conversation offline to discuss further. TKL suggested they have a system wide approach to manage the thrust and fall in demand and capacity. TKL would like to have CA support as their cancer performance is always in the limelight due to the small numbers but high conversion rates.		
7.	**Research update**	• There was no-one present on the call to provide a research update.		**Presentation circulated on the 5th April 2022.**
8.	**Audit updates**	**<u>Evaluation of EBUS service delivery across the UK: - A nationwide survey – update by Ramin Baghai-Ravary</u>** • RBR referred to this audit which was carried out by his colleague Syed Hassan who is due to be a new consultant. He looked at the EBUS service across the UK and differences in the way the service is delivered. • The audit was carried out via an email/telephone review which looked at the EBUS service across the UK and SH collated 1 response from each Trust. Overall, he had a good national response.		

		• The audit looked at different variables including if there was a dedicated/combined bronchoscopy list, two thirds of the trusts had a combined list. Most trusts had only one operator but some had two. The second operator's experience varied also from consultant to trainee as did the number of patients on each list (2-4). The allocated time as per NICE guidelines is 45-60 minutes and this was the case in the majority of trusts. • Most trusts did not have a cyto-pathologist present for EBUS. • SH concluded there was a lot of variation which could impact on the quality of sampling, costing and even safety. It would be beneficial to set up a national consultation group. • RBR added he would have liked to add some additional variables to SH's survey but this had already taken place by the time RBR was involved. RBR would like to have known further details such as: i) Does the EBUS go through an MDT ii) Look at performance status, suitability and indication iii) Size of the needles, number of needle passes and time the needle passes forwards and backwards within each node iv) Any haem extraction techniques in the laboratory v) Any protocol for sarcoid. vi) Safety check list, patient information list, sedation protocol • TKL stated the importance of highlighting both the practice variability and processing. • TBR suggested it would be good to set up a local working group to discuss techniques and share best practice. BK agreed it would be good to discuss locally the differences in practice across the K&M. TKL agreed he would be happy to share his experience and he does an EBUS list at MTW on a Thursday. **Action - TKL suggested they set up a meeting outside of the TSSG to understand the different EBUS practices in order to be able to improve their service. They will then be in a position to report back to the TSSG at a later date. TKL asked the group to liaise**		**TKL**

		directly with him and hoped that a more experienced member would chair that sub-group. TKL agreed to send out an invite after the meeting and invited others to join as appropriate. • SG mentioned she recently sent out some documentation regarding variation in lung cancer treatments to all trusts but only received one response back from EKHUFT. SG suggested they also think about the importance of how well the trusts are performing against the GIRFT recommendations and to share both internally and across all of the alliances.		
9.	**CNS Update**	**<u>EKHUFT – Toni F provided an update on behalf of all trusts</u>** • TF explained that she hoped to provide a more in-depth update at the next TSSG meeting as there has been a huge turnaround of staff at all the trusts. DVH have had a number of CNS team changes. • TF confirmed their workload continues to be high. TF mentioned there appears to be investment within the CNS workforce but there is still a long way to go to bring them in line with national guidance. EKHUFT's PTL has increased from 80 patients to 150. They saw over 500 new diagnoses last year at EKHUFT. • EKHUFT have STT nurses in post. MTW are looking to have a 2ww nurse based in respiratory. Will be good to see how these new roles will help improve the patient's pathway. • TKL would like an update on what the resource allocation and gap analysis is across the trusts in order to deliver services for K&M. TF agreed that data should be available for the next TSSG meeting.		
10.	**Performance data presentation**	**<u>DVH – update by Michelle McCann</u>** • Please refer to the performance slides for an overview of their individual Cancer Waiting Times data.		**Performance presentations circulated on the 5th April 2022.**

		• MM highlighted there are consultant's vacancies within DVH which has had an impact on both triage and rapid access clinics. • BK mentioned there are only 3 respiratory consultants and are really struggling. They are looking to recruit. • BK referred to a massive backlog in radiology reporting which is reflected in their current data. Mitigating actions are to prioritise rapid access patients over routine patients. **EKHUFT – update by Saleheen Kadri** • Please refer to the performance slides for an overview of their individual Cancer Waiting Times data. • SK explained they have also had workforce issues – in particular MDT Co-Ordinator and Lung Pathway Navigator and data input into InfoFlex. • SK highlighted an issue with CT guided biopsies which can take from 10 days to a month to be reported. They are liaising with their radiology colleagues to get ring-fence CT scans (2 per day) and CT guided biopsy slots. TF mentioned they are trying to get GPs to refer patients in with a CT but added a number of patients are being referred in without a blood test. • SK explained patient choice can be an issue for those who are not willing / able to travel which can have an impact on the assessment of some patients at the beginning of the pathway. • SK mentioned since recruiting the STT nurse the pathway has improved. • Covid is still having an impact on diagnostics and treatments being cancelled. SK highlighted the importance of their CNS's who work very hard to deliver the best service for their patients. • SK outlined the high capacity and demand within EKHUFT compared to other trusts.		

		• TF explained Sarah Collins has elevated the radiology capacity issue to executive colleagues but added there is a huge capacity problem within the trust. • TS explained this has been an issue at EKHUFT for 2-3 years and all staff are working extremely hard. Only 30% of patients are having a reported CT chest at the first appointment which should be 100%. Following a 2ww referral to reported CT chest is on average 2-3 weeks so to achieve the 28-day FDS would be impossible. • TS suggested having dedicated CT slots would be the first step and would make a big difference to the front end of the pathway. However, 2 slots will not be enough particularly with the numbers of patients being referred into the service. TF mentioned radiology aim to recruit additional interventional radiologists as they only have 3 currently who are able to do CT guided biopsies across EKHUFT. This has a massive impact particularly when they are on AL. • IV explained he has spoken to SC today and she is doing her best to drive some of this work through the trust. This is a bigger issue than just cancer with regards to radiology and diagnostic support. IV and TKL agreed to discuss this issue offline and escalate through to senior colleagues within EKHUFT. **MFT – update by Jennifer Priaulx** • Please refer to the performance slides for an overview of their individual Cancer Waiting Times data. • JP explained their 28-day FDS completeness has improved so she is unsure about the missing data on the slides and agreed to look into this further. • JP mentioned the backlogs are mainly due to delays with multiple diagnostics. KC highlighted if the trusts are aiming to hit timed critical pathways they need to have flexible capacity and also some unused capacity. KC referred to ongoing delays within the prison population. • JP highlighted that COVID has affected the workforce at MFT as other trusts have alluded. They have a cancer action plan in place to monitor and reduce imaging turnaround times to 6 days across all the diagnostics.		

		MTW • Please refer to the performance slides for an overview of their individual Cancer Waiting Times data. • There was no individual update from MTW at the meeting today. TKL agreed to take this up locally. • TKL referenced the GIRFT visit to MTW in 2019 and local shared practice across the trusts. EKHUFT visit was postponed due to Covid and is due in the Spring (nfd). TF confirmed that Simon Webster shared MTW's GIRFT report after the previous TSSG meeting. **Action – TKL asked if they could check that the GIRFT report has been shared with the whole group.**		**KG**
11.	**Cancer Alliance/CCG update**	**Presentation provided by Holly Groombridge** • HGro provided an update on the National Cancer Programme 2022/23 priorities which include: i) Faster Diagnosis and operational improvement ii) Early Diagnosis iii) Treatments and Personalised Care iv) Cross Cutting Themes • HGro highlighted further detail with regards to specific K&M projects and programmes which include: i) Roll out of non-site-specific pathways to additional sites with the aim to have full K&M coverage by 2024. ii) Best practice timed pathways – including Lung. iii) Galleri Grail pilot – move to Maidstone on the 7th April, will then move to Sittingbourne, followed by Ashford and will finish in June 2022.Grail has		**Presentation circulated on the 5th April 2022.**

		recruited 70,000 participants as of the 21st March, half of the 140,000-national target. iv) Targeted Lung health checks launching – summer in EKHUFT. v) Recruited Cancer Alliance Workforce lead – to start in April. • IV emphasised the current challenges within diagnostic capacity and workforce particularly within lung which they can explore more formally through the Cancer Alliance. TS highlighted the screening challenges and managing patients.		
12.	**AOB**	• TKL thanked the members for their attendance at today's meeting and input into the discussions. There are ongoing challenges with regards to expanding capacity without diluting the quality provided, which has had knock on effect across other services. • TKL confirmed the diagnostic bundles conversation will be discussed offline and he would like to bring this back to the next TSSG meeting. • MN thanked the members for all their hard work throughout the pandemic. • TKL concluded a lot of hard work takes place offline and he paid special thanks to SG, KG and AW.		
13.	**Next Meeting Date**	• Thursday 22nd September 2022 – face to face • Venue to be confirmed		