Kent and Medway Cancer Collaborative

Lung Tumour Site Specific Group meeting
Thursday 11th March 2021
Microsoft Teams
13:30 – 16:30

Final Meeting Notes

Present	Initials	Title	Organisation
Majid Mushtaq **(Chair)**	**MMu**	Respiratory Consultant	DVH
Jenny Gyertson	**JG**	Lung Cancer CNS	DVH
Karen Connolly	**KCo**	Lung Cancer CNS	DVH
Marie Payne	**MP**	Lead Cancer Nurse & Clinical Services Manager	DVH
Michelle McCann	**MMc**	Operational Manager for Cancer & Haematology	DVH
Toni Fleming	**TF**	Lead Lung Cancer CNS	EKHUFT
Pippa Miles	**PM**	Senior Service Manager	EKHUFT
Sanjay Sharma	**SSh**	Respiratory Consultant	EKHUFT
Saleheen Kadri	**SK**	Respiratory and General Internal Medicine Consultant	EKHUFT
Julie Nolthenius	**JN**	Consultant Radiologist	EKHUFT
Serena Gilbert	**SGi**	Cancer Performance Manager	KMCA
Irene Nhandara	**IN**	Programme Lead – Early Diagnosis	KMCA
Karen Glass **(Minutes)**	**KG**	Administration & Support Officer	KMCC & KMCA
Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Facilitator	KMCC
Kolera Chengappa	**KCh**	Respiratory Consultant	MFT
Cynthia Matarutse	**CM**	Lead Cancer Nurse	MFT
Afroditi Karathanasi	**AK**	Consultant Medical Oncologist	MFT
James Shaw	**JS**	Deputy General Manager	MFT
Catherine Hayward	**CH**	Lung Cancer CNS	MFT
Ravish Mankragod	**RM**	Consultant Respiratory Physician	MTW
Alia Nasir	**AN**	Consultant Radiologist	MTW
Amit Goel	**AG**	Consultant Histopathologist	MTW
Neil Crundwell	**NC**	Consultant Radiologist	MTW
Gillian Donald	**GD**	Clinical Scientist	MTW
Riyaz Shah	**RS**	Consultant Medical Oncologist	MTW

Donnisha Best	**DB**	Assistant General Manager – Respiratory Medicine	MTW
Maria Karina	**MK**	Consultant Medical Oncologist	MTW
Jack Jacobs	**JJ**	Macmillan GP & Cancer Lead	NHS Kent & Medway CCG
Chris Singleton	**CS**	Senior Programme Manager – KMCA Commissioning	NHS Kent & Medway CCG
Mavis Nye	**MN**	Patient Representative	
Apologies			
Tracey Ryan	**TR**	Macmillan User Involvement Manager	KMCC
Karen McDonald	**KM**	Haematology Matron	MTW
Mathilda Cominos	**MC**	Consultant Clinical Oncologist	MTW
Russell Burcombe	**RB**	Consultant Clinical Oncologist	MTW
Timothy Sevitt	**TS**	Consultant Clinical Oncologist	MTW
Dominic Chambers	**DC**	Consultant Histopathologist	MTW
Sona Gupta	**SGu**	Macmillan GP & Cancer Lead	NHS Kent & Medway CCG
Stefano Santini	**SSa**	Macmillan GP & Cancer Lead	NHS Kent & Medway CCG
Bana Haddad	**BH**	Macmillan GP & KMCA Clinical Lead for LWBC/PC&S	NHS Kent & Medway CCG

Item		Discussion	Agreed	Action
1.	**TSSG Meeting**	**<u>Apologies</u>** • The apologies are listed as above. **<u>Introductions</u>** • MMu welcomed the members to the TSSG meeting and stated the last scheduled meeting had to be cancelled due to the impact of COVID on lung services. • MMu asked the group if there were any objections to the meeting being recorded for minuting purposes, there were no objections raised. **<u>Action log Review</u>** • The action log was reviewed, updated and will be circulated along with the final minutes from today's meeting.		

		Review previous minutes • The minutes from the previous meeting on the 7th October 2020 were reviewed and signed off as a true and accurate record.		
2.	**GIRFT – action plans from each Trust (high level summary)**	**DVH – update provided by Majid Mushtaq** • MMu stated they have had a number of dates for visits but are yet to take place. JG and MP confirmed they have not had a definitive date since March / April 2020. MMu agreed to provide feedback to the group when the visit has taken place. **EKHUFT – update provided by Pippa Miles** • PM confirmed they are awaiting a new date as the previously scheduled visit was cancelled due to Covid. PM added they have completed some of the previous actions, are continuing to meet and it is working progress. **MFT – update provided by Kolera Chengappa** • KCh confirmed they had an initial GIRFT review and they found the process quite useful. However, the follow up and actions have also been put on hold due to Covid. • KCh mentioned he had a meeting last week to discuss moving the actions on but there is yet to be any progress to date. • KCh suggested looking at multiple MDM discussions as an efficiency measure. He added they had a slight excess in the inpatient lung cancer mortality rates and they are in the process of reviewing this. • KCh explained the data comes from the Trust and a spreadsheet will be provided with the data required and will be analysed prior to the meeting.		

MTW – update provided by Neil Crundwell

- NC stated their last visit was very successful and he feels it was a worthwhile process. MMu asked if they had any advice to offer as MTW are ahead of the other Trusts. NC suggested they approach the whole process in an open way and listen to the interesting advice provided.

Action - SG provided the following questions on the MS Teams chat relating to the GIRFT questions. MMu asked if they could be included in the minutes.

KG - completed

Key Question	Supplementary points/questions
Describing the Clinical Improvement and how other trusts could benefit	
How would you briefly describe the good practice?	• This is how we would introduce the best practice.
What were the benefits?	• How did quality [1] or productivity improve? • How long did it take for you to see the benefits?
When did this practice start, or has it always been in place?	• Please try and give a month and a year. • If it was a change at first, what was the motivation for making it? • If it's always been in place, do you have any idea why it might be in place in your trust and not others?
Managerial considerations	
Was the change designed to fit well with any local or national strategies?	• If so, which strategies? How did the improvement fit with them?
Did implementing the good practice involve any costs or risks?	• If so, can you demonstrate how the benefits outweighed those costs and risks?
Was an agreement with an external supplier	• If so, can you demonstrate that agreement worked

		needed to deliver the good practice? Were any bids for financial investment, from within or from outside the trust, needed to implement the good practice? Did you need any Project/Programme/General Manager or administrative support to deliver this? **Evaluating the change** Where there been any learning points or drawbacks about the good practice? **Practical Advice and Guidance to help other trusts implement the change** Can you more precisely describe the care processes/pathway or clinical change you implemented? Can you describe how to project/programme to implement the improvement worked? Was any analysis or capacity planning undertaken to plan the change? Who were the key stakeholders involved in delivering the change?	well? • If so, can you demonstrate those costs were affordable and obtained? • If so, what support was required? • Was there an impact on another part of the trust or other NHS services in the area? If so, could you resolve them? If so, how? • Would you have approached anything differently? • Please attach any relevant documentation. • Please attach any relevant documentation. • Any further information would be helpful. • Why and how were they engaged, and to what benefit?		
3.	**UK Lung Cancer Coalition Report**	**<u>Update provided by Majid Mushtaq</u>** • MMu stated he found the report was very nicely presented, there was some national, regional and TSSG guidance on the effect of Covid on cancer pathways. MMu added personally he did not find it particularly informative. There is a particular reference to the Lung Cancer Screening programme but this is not viable for the South East in the near future.		**KG circulated the presentation on the 12.03.2021**

4.	**Performance**	**DVH – update provided by Marie Payne** • MP confirmed they have met the performance targets for 2ww and 31-day for November 2020 – January 2021. • MP explained they did not meet the 62-day targets for November or January due to diagnostic delays and complex pathways. • Compliance to the 28-day FDS was not met in January due to 2 out of 4 breaches. • MP explained they were having some issues with the Beautiful Information (BI) data capture for the overall data completeness target. MP added this was not captured in December or January but predict February as being at 92%. **EKHUFT – update provided by Pippa Miles** • PM confirmed they have met the 2ww and 31-day performance targets for December - February. PM explained in order to meet these targets they have daily calls to discuss any capacity issues. • PM explained they did not meet the 62-day performance targets for December – February due to diagnostic delays, patient choice and complex pathway cases. PM confirmed they will be doing EBUS from next week at EKHUFT. All previous EBUS cases were sent to GSTT but this has resulted in delays with appointments and getting results back. • PM mentioned they are reviewing all of the Pathway Navigator job plans to focus on the 0 – 28-days element of the pathway. There will be a new STT nurse joining TF's team which should help the first part of the pathway and improve the 62-day target. • PM explained the eGFR (Glomerular filtration rate) cases which have gone to Birmingham have also caused some delays. • PM confirmed they were not complaint for the 28-day FDS for December – February this is due to having issues at the first part of the pathway. To address this, they are		**KG circulated all the performance slides on the 12.03.2021**

		reviewing the first part of the pathway and the STT nurse will help. The overall data completeness was 70% for December, 94.8% for January and 74.6% for February. PM confirmed they now have some dedicated admin support to help with the 28-days pathway and to improve data collection and accuracy. PM added the Pathway Navigators have had some refresher training to ensure the data is input accurately on InfoFlex and this should improve the overall data completeness. • PM confirmed CT-guided biopsy issues have improved, have a good escalation process in place and waiting times have improved. **MFT – update provided by James Shaw** • JS confirmed they have no issues with compliance for 2ww or generally 31-day targets. JS explained for the 62-day target this is not so good and they were 33.33% compliant in November, 100% in December and 0% in January. The breaches were due to complex diagnostic pathways, patient choice and outpatient appointment delays. • JS highlighted with regards to compliance for the 28-day FDS they were only compliant in December and they still have concerns with their overall data completeness due to staffing issues. JS confirmed they have only one MDT Co-ordinator who inputs the data onto InfoFlex so they are trying to get more staff. **MTW – update provided by Neil Crundwell** • NC was pleased to announce the excellent results for 2ww, 31-day and 62-day for the months of November and December with a slight slip in January. They have 1 patient sat at 104-days and their backlog is coming down. MMu agreed it all looks good. • NC confirmed they are working on the 28-day FDS and the gap between Consultation and sampling they are working on to make it better. • SGi explained that from April 2021 they will be looking at the 28-day standard with the data being published in July and to become an official target from October. SGi added there will be a renewed focus on the 28-day to diagnosis.		

		• MMu is encouraged by the data presented due to the situation they have all been in due to Covid. **<u>62-day Performance data – update provided by Serena Gilbert</u>** • SGi provided an update detailing the current lung cancer treatment for the Covid period. In December 2020 K&M treatments given for this month were 85.4% - which is a normal amount of treatments in a normal year. From March to December – K&M performance was 86%. SGi added this is great performance figures in the midst of a pandemic. • SGi explained there have been a number of patients who have not presented during Covid and the concern is how to encourage those patients back in. SGi referred to some good Lung Cancer advertising campaigns across K&M. SGi asked if the patients that come back in with advanced cancers, how prepared are the Trusts to accommodate them. SGi summarised that there were less referrals coming in and therefore less treatments. • RS commented that there has been a huge shift in patients that were treatable to patients who are now untreatable. RS explained if the patient has not presented to Primary Care, they are now coming into clinics with huge brain metastases and are dying with very advanced lung cancer. RS added the patients SGi is alluding too will not be coming in due to this delay in treatment. • IN mentioned there have been running both national and local lung cancer campaigns directed by NHSE/I and K&M. IN confirmed there has been information targeted towards patients and Primary Care Clinicians to highlight the difference between Covid and lung cancer symptoms and to encourage patients to attend their diagnostic appointments. • MMu explained the triage clinics are very busy and with post Covid patients and possible lung cancer patients it is taking time to sift through these patients. This will have an impact on the 2ww and 28-day patients and they are all PET+.		

		Performance data slides for future meetings – update provided by Majid Mushtaq / Annette Wiltshire • AW confirmed the new performance data template was agreed at the recent Cancer Clinical Leadership (formerly TSSG Leads) meeting and so will be adopted for all future TSSG meetings (excluding AO & CUP). **Action** - MMu asked if the performance data slides template could be circulated with the minutes and for the Cancer Managers to be aware of this new template.		**KG**
5.	**Clinical Pathway Discussion**	**High Operational Policy – update provided by Majid Mushtaq** • AW stated the pathology and imaging sections have been removed from the document as the website links were no longer valid. Once these sections have been agreed the HOP document could be finalized. • MMu mentioned there will be an updated Radiology TSSG document which can be added to the HOP document. MMu confirmed the rest of the document has been agreed.		
6.	**Research update**	**Update provided by Riyaz Shah** • RS confirmed that clinical research and trials have been hit very hard by Covid and had to be shut down for a while. He added they are open now but they are having to be very selective with which patients are eligible. RS surmised that this year will be low-recruiting compared to previous years.		
7.	**Clinical Audit**	**Mesothelioma Service – update provided by Kolera Chengappa** • KCh has been in contact with RS and they feel it would be sensible to set up a West Kent Mesothelioma MDT in the first instance which will include MFT, DVH and MTW. If the logistics work and it adds value to the service they can then widen the MDT out		**KG circulated the slide to the group on the**

		to incorporate Kent wide. KCh suggested this is run on a weekly / fortnightly basis. • With regards to attendance they would ideally like input from 2 Surgeons, (Karen and Andrea Bille), 2 Oncologists, Radiologists, RS, GSTT colleagues and Chest Physicians who have an interest in pleural disease at the MDM meeting. KCh is keen to encourage better access to trials / drugs which is currently lacking. • KCh suggested the MDM meeting could take place late morning on a Thursday as this is generally the MDM day for most Trusts. It would be preferable to run via Microsoft Teams but it is vital to have both admin / IT support to coordinate the referrals coming through. • MMu think it is a fantastic idea and is very long overdue. MMu stated the biggest hurdle has already been accomplished by having MDM's via Teams through-out Covid. • KCh mentioned he was yet to speak to Simon (Webster) and Ravish (Mankragod) at MTW. KCh is confident that Louise (Gilham) would be happy to champion this meeting at MTW. • KCh suggested setting up a smaller group with key individuals from each site to discuss the logistics of setting this general treatment MDM up and agreed to report back at the next meeting. • TF is concerned that EKHUFT are being left out and they have the highest numbers of patients. KCh / MMu understood but it makes sense to let the pilot run in one location for 2-3 months and then widen it out to EKHUFT. RS is very encouraged by this and thinks it would work well as a pandemic Mesothelioma MDM. MMu asked that TF and LG are actively involved in setting this up as they have a special interest in Mesothelioma. **Action** – MMu asked if Mesothelioma UK would fund an MDT Coordinator to help coordinate. TF agreed to check with other leads from Meso UK to see what is happening in other counties.		**12.03.2021** **TF**

		MDT Referral Form – update provided by Riaz Shah • RS confirmed this agenda item had already been discussed.		
8.	**Genomics Service**	**Update provided by Gillian Donald** • GD confirmed they are now testing for all of Kent and have turnaround times of 3.5 - 4 days. They have met recently with the Genomic Laboratory Hub at GSTT who have confirmed that the funding will stop in July when they take over doing Next Generation Sequencing. GD will no longer be able to provide the service. GD added GLH are looking at a 21-day turnaround time and they will not have the capacity to provide the service. • GD confirmed the funding stream would be changing in July and will transfer directly to GLH from NHSE who will provide the test directory from that point. The GLH is located at GSTT for the South England. • GD explained it is under discussion at MTW as it will affect K&M patients due to the increased turnaround times. GD confirmed there have been 7 GLH sites commissioned across England to provide this service. • MMu confirmed they have the support of the TSSG and are keen for the service to be kept in Kent. KC agreed the service should be kept in house and the current MTW service is very good. • SGi confirmed that this has been nationally directed but understands the concerns regarding turnaround times. • RS conveyed his concern that K&M patients were not receiving a comprehensive genomic analysis service but understands this has been hit hard due to Covid. **Action** – SGi suggested the Oncologists linked in with the GSTT team in order to articulate their concerns and backed them up with some facts to present back. SGi proposed that Olaf Hartberg (colleague from GLH) is invited to present at a future meeting.		**DC / AW**

		• MMu would like to set up a small sub-group from MTW of Pathology, Oncology and relevant operational managers to discuss the issues further. SGi thought there was already a group set up. • RS suggested setting up a Genomic MDT as there is currently no molecular MDT in Kent so they are behind the curve on this. MMu agreed this is an important development for Lung cancer as a whole.		
9.	**CNS Updates**	**<u>EKHUFT – update provided by Toni Fleming</u>** • TF confirmed they are about to appoint 2 Band 6 STT nurses which is currently out to interview. • They should be receiving additional funding for another Band 7 CNS for later in the year and if successful will have 3.9 WTE CNS'. • TF concluded they are working with the respiratory team to get the 2ww rapid access clinics up and running so things are improving dramatically. MMu admitted he has been very impressed with how the EKHUFT service has improved. **<u>MFT – update provided by Catherine Hayward</u>** • CH confirmed they have 2 WTE CNS' in the team, with Heather (Foreman) back now from redeployment so they are back up to capacity. • CH mentioned they are still seeing most patients virtually but in the rapid access clinic this is generally face to face. Oncology appointments are also held virtually via Attend Anywhere. • CH added they continue to do CNS post-op clinics virtually but will start to do face-to-face again as needed. • There are no formal plans or funding yet in place for STT nurses at MFT but this is work in progress.		

		• Additionally, there is a fixed-term 9-month maternity contract to cover CH as a Lung CNS post and the closing date for applications is 17th March 2021. **MTW – no update provided** • No MTW CNS was present at the meeting. No update provided. **DVH – update provided by Karen Connolly** • KC and JG are the 2 WTE CNS' and there is a part time Band 6 - Early Diagnosis CNS – Julie who is working 2 days per week for Lung and is shared with UGI. Julie does the pre-appointment assessments on the telephone with the patients and provides advice regarding the tests before seeing the doctor. • KC mentioned the referrals are ramping back up for the rapid access clinics and they have had a lot of younger inpatients with metastatic disease which has been quite difficult. • They are mixing their virtual and face to face clinics, with 70% of RAC being face to face. Most of the breaking bad news is also taking place face to face. • KC added their Pleurex Service is now up and running and is going well. They are hoping to take part in the 12-month AI Behold Project looking at the artificial intelligence reporting of chest x-rays within 30 seconds. The bid was put in last week and would run together with the Lancashire Hospital Trust.		
10.	**Cancer Alliance update**	**Update provided by Serena Gilbert** • SG highlighted the overall aims of the Cancer Recovery Phase are to: - i) Restore urgent cancer referrals at least to pre-pandemic levels ii) Reduce the backlog at least to pre-pandemic levels on 62-day (urgent referral and referral from screening) and 31-day pathways		**KG circulated the presentation on the 12.03.2021**

		iii) Ensure sufficient capacity to manage increased demand moving forward, including for follow up care • SGi alluded to the Straight to CT pilot which is an exciting opportunity taking place in EKHUFT. • SGi asked the group to get in touch if there were any issues the group required CA support with. • SGi confirmed they are very happy to be potentially involved in the next wave of the Lung Health Check Programme which will probably start in a years' time. Due to K&M's impressive overall performance figures during Covid they have been asked to be involved in more pilots / trials. • MMu anticipates the recovery plan being quite difficult and a spanner in the works would be a 3rd wave of Covid. MMu thinks this will be when, rather than if and this concerns him. MMu hopes there is enough resilience in the system to deal with the backlog and an increase in CT, PET and EBUS referrals.		
11.	**CCG update**	**<u>Update provided by Chris Singleton</u>** • CS mentioned both himself and Laura Alton have recently been appointed as the Senior Programme Managers for Cancer working with the CCG. CS is covering for LA today who will attend future meetings. • CS confirmed they are waiting for national planning guidance but know that cancer is both a national and CCG priority. Working as one CCG they hope to improve the access and equity of services for K&M patients. • CS referred to the K&M Diagnostic Imaging Board which has 5 workstreams are to build resilience, K&M approach to diagnostics and create as much uniformity as possible. The main programme workstreams include the Community Diagnostic Hubs, Service Delivery Models, Workforce, IT, Digital & Connectivity and Leadership & Productivity and all have an overlap with cancer.		

		• CS confirmed they are looking at benchmarking and the availability of NG12 imaging scans to have a particular focus on the direct access for lung and chest x-rays. Chest x-rays are now available by appointment only and not a walk-in service. • There are early discussions happening at EKHUFT regarding a pilot for low-dose CT scans for high-risk patients where a chest x-ray is abnormal. If this works well then this will be rolled out across K&M. • CS highlighted that they are a small CCG commissioning team but are available to help and provide support where required. • CS explained the Community Diagnostic Hubs are being set up for a certain population density area to ensure there is an improved availability and equity of diagnostic scans for the area and to reduce the footfall into acute trusts. CS added there is still a lot of ongoing work before these will be up and running.		
12.	**AOB**	• JJ asked from a Primary Care perspective what is the view of the respiratory clinicians regarding the referrals coming through to them. JJ added the patient numbers are increasing and he has also seen more late presentations in practice. • MMu suggested that patients should have been encouraged more to attend their GP Practice. However, he would encourage more referrals rather than less to be directed through the triage clinics. • RS alluded to the adhoc mini Lung TSSG meetings which had taken place during Covid and members from MTW were unable to attend due to clinical commitments. RS asked if these meetings could be fixed for just twice yearly so there could be improved attendance. RS also asked what the latest information was regarding the improvement to InfoFlex. • MMu confirmed they did have some adhoc Lung TSSG meetings in the last year but todays meeting should have taken place in December. MMu explained there were lots of apologies for that meeting so it was rescheduled.		

		• The group did not have a new update on InfoFlex for RS. • MMu thanked MN for her attendance and continued support of this meeting. MN admitted she is amazed at how well they have coped through the pandemic. MN mentioned she has made a video to encourage patients to attend their hospital appointments but understands how scared they must feel. • MMu thanked the group for their attendance today, continued support and to stay safe.		
	Next Meeting Date	• AW agreed to liaise directly with MMu with regards to the next TSSG meeting which was suggested to be held on a Thursday in September. KG to circulate the meeting invites once the date has been agreed.		**AW / MMu / KG**