

**Lung Tumour Site Specific Group Meeting**  
**Wednesday 25<sup>th</sup> March 2026**  
**Auditorium, Academic Centre, Maidstone Hospital, Hermitage Lane, Maidstone. ME16 9QQ**  
**13:30 - 17:00**  
**Final Meeting Minutes**

<b>Present</b>	<b>Initials</b>	<b>Title</b>	<b>Organisation</b>
Tuck-Kay Loke <b>(Chair)</b>	<b>TKL</b>	Consultant Respiratory & General Physician	MTW
Miles Scott	<b>MS</b>	Chief Executive	MTW
Shona Sinha	<b>SS</b>	Consultant Histopathologist	MTW
Ranjit Pagonda	<b>RP</b>	Respiratory Consultant	MTW
Grace Gilbert	<b>GG</b>	Lung Cancer Pathway Navigator	MTW
Timothy Sevitt	<b>TS</b>	Consultant Clinical Oncologist	MTW
Jennifer Pang	<b>JP</b>	Consultant Clinical Oncologist	MTW
Harman Saman	<b>HS</b>	Consultant Medical Oncologist	MTW
Livvie Elvidge	<b>LE</b>	Assistant General Manager – Respiratory	MTW
Katharine Clark	<b>KC</b>	Lung Cancer Clinical Nurse Specialist	MTW
Jan Christie	<b>JC</b>	Lung Cancer Clinical Nurse Specialist	MTW
Sylvia Amofa-Kra	<b>SAK</b>	Programme Manager – Lung Cancer Screening Programme	MTW
Jodie Hotine	<b>JH</b>	Lead Research Radiographer	MTW
Simiat Ojo	<b>SO</b>	Early Diagnosis Lung Clinical Nurse Specialist	DVH
Fay Fawke	<b>FF</b>	Deputy Lead Cancer Nurse	DVH
Rekha Bhalla	<b>RB</b>	Consultant Respiratory Physician	DVH
Amy Peacock	<b>AP</b>	Lung Cancer Clinical Nurse Specialist	DVH
Katherine Terry	<b>KT</b>	Lung Health Cancer Nurse	DVH
Hateme Haxha	<b>HH</b>	Lung Cancer Clinical Nurse Specialist	DVH
Toni Fleming	<b>TF</b>	Lead Macmillan Lung Cancer Clinical Nurse Specialist/ Mesothelioma UK CNS	EKHUFT
Jacqueline Motta	<b>JM</b>	Macmillan Lung Clinical Nurse Specialist	EKHUFT
Katie Moyler	<b>KM</b>	MDM Co-ordinator	EKHUFT
Syed Hassan	<b>SH</b>	Consultant Chest Physician	EKHUFT
Saleheen Kadri	<b>SK</b>	Respiratory Consultant	EKHUFT
Serena Gilbert	<b>SG</b>	Cancer Performance Lead	KMCA
Ritchie Chalmers	<b>RC</b>	Medical Director	KMCA

Annemarie Frenchum	<b>AF</b>	Programme Manager - LCSP	KMCA
Karen Glass	<b>KG</b>	PA / Business Support Manager	KMCA / KMCC
Colin Chamberlain	<b>CC</b>	Administration & Support Officer	KMCC
Samantha Williams ( <b>Minutes</b> )	<b>SW</b>	Administration & Support Officer	KMCC
Katherine Matthews	<b>KMa</b>	Acute Oncology Lead Nurse	MFT
Oluwafemi Familokun	<b>OF</b>	Lung Cancer Screening Programme Manager	MFT
Thomas Sanctuary	<b>TSa</b>	Respiratory Consultant	MFT
Kolera Chengappa	<b>KCh</b>	Respiratory Consultant	MFT
Sarah Paterson	<b>SP</b>	Faster Diagnosis Lung Clinical Nurse Specialist	MFT
Heather Foreman	<b>HF</b>	Macmillan Lung and Mesothelioma Cancer Clinical Nurse Specialist	MFT
Stephanie Fraser	<b>SF</b>	Thoracic Surgeon	GSTT
Nicky Downs	<b>ND</b>	Senior Trial Manager	Soton
Roisin Dunwoody	<b>RD</b>	Interventional Fellow	UCLH
Deepa Doshi	<b>DD</b>	Director of Services	Ruth Strauss Foundation
Caroline Wordsworth	<b>CW</b>	Patient Partner	
<b>Apologies</b>			
Suraj Menon	<b>SMe</b>	Consultant Radiologist & Clinical Director	DVH
Tamara Cook	<b>TC</b>	Lung Cancer Clinical Nurse Specialist	DVH
Adeyinka Pratt	<b>AP</b>	Project Manager for MDM Streamlining	DVH
Bridget Fuller	<b>BF</b>	Research & Development Manager	DVH
Jonathan Bryant	<b>JBr</b>	Primary Care Cancer Clinical Lead	KMCA
Ann Courtness	<b>AC</b>	Macmillan Primary Care Nurse Facilitator	KMCA
Danielle Mackenzie	<b>DM</b>	Macmillan Lead Nurse for Personalised Care	EKHUFT
Brett Pereira	<b>BP</b>	Respiratory Consultant	EKHUFT
Kawsar Ahmed	<b>KA</b>	Respiratory Consultant	EKHUFT
Victoria Hatcher	<b>VH</b>	Macmillan Upper GI Lead Clinical Nurse Specialist	EKHUFT
Afroditi Karathanasi	<b>AK</b>	Consultant Medical Oncologist	MFT
Gillian Donald	<b>GD</b>	Clinical Scientist	MTW
Nicola Davis	<b>ND</b>	Consultant Clinical Oncologist	MTW
Alicja Synowiec	<b>AS</b>	Consultant Oncologist	MTW
Taiba Farooque	<b>TF</b>	Histopathology SpR	MTW

Clare Reeder	<b>CR</b>	Consultant Clinical Psychologist	MTW
Sandra Wakelin	<b>SWa</b>	Macmillan Lung Cancer ANP	MTW
Brendon Conry	<b>BC</b>	Consultant Radiologist	MTW
Rupert Berkeley	<b>RBe</b>	Consultant Radiologist	MTW
Neil Crundwell	<b>NC</b>	Consultant Radiologist	MTW
Grace Gilbert	<b>GG</b>	Lung Cancer Pathway Navigator	MTW
Dominic Chambers	<b>DC</b>	Consultant Histopathologist	MTW
Deborah Willcox	<b>DW</b>	Research Nurse	MTW
Louise Gilham	<b>LG</b>	Mesothelioma UK Clinical Nurse Specialist (Kent)	MTW
Taiba Farooque	<b>TF</b>	Histopathology SpR	MTW
Sophie Hurcomb	<b>SHu</b>	MDT Co-ordinator	MTW
Mathilda Cominos	<b>MC</b>	Consultant Clinical Oncologist	MTW
Richard Vazzoler	<b>RV</b>	Clinical Nurse Specialist	GSTT
Louise Barrett	<b>LB</b>	Cancer Improvement Manager	GSTT
Sophia Holden	<b>SHo</b>	Clinical Nurse Specialist	GSTT
Helen Graham	<b>HG</b>	Research Delivery Manager	NIHR

Item		Discussion	Action
1.	TSSG Meeting	<p><b><u>Apologies</u></b></p> <ul style="list-style-type: none"> <li>The formal apologies are listed above.</li> </ul> <p><b><u>Introductions</u></b></p> <ul style="list-style-type: none"> <li>TKL welcomed the members to today's meeting.</li> <li>If you attended the meeting and have not been captured within the attendance log above please contact <a href="mailto:samantha.williams23@nhs.net">samantha.williams23@nhs.net</a> directly.</li> </ul> <p><b><u>Action Log Review</u></b></p> <ul style="list-style-type: none"> <li>The Action Log was not reviewed, but some updates were discussed at the meeting. The Action Log will be circulated to the members along with the final minutes from today's</li> </ul>	

		<p>meeting.</p> <p><b><u>Review Previous Minutes</u></b></p> <ul style="list-style-type: none"> <li>The final minutes from the previous meeting which took place on the 16<sup>th</sup> October 2025 were reviewed and agreed as a true and accurate record.</li> </ul>	
<p>2.</p>	<p><b>Clinical Reference Group Update &amp; Action Log</b></p>	<p><b><u>Update provided by Tuck-Kay Loke</u></b></p> <ul style="list-style-type: none"> <li>TKL outlined the members of the CRG, consisting of Jenny Pang, Jonathan Bryant, Karen Harrison-Phipps, Neil Crundwell, Riyaz Shah, Dominic Chambers and Toni Fleming. The CRG is the operational arm of the Lung TSSG and the team meet monthly.</li> <li>TsA highlighted that the CRG membership appears MTW heavy. Tuck explained this is only due to those who expressed interest even though the advert went out numerous times.</li> <li>TKL went through the following CRG Work Plan : -             <ol style="list-style-type: none"> <li>Harmonise and adapt local Lung MDT processes to align closely to the National Optimal Lung Cancer Pathway using diagnostic bundles and sharing best practice across sites. Work is currently ongoing through the joint initiative between MSD and KMCA (initial phase completion June 2025).</li> <li>Support local MDT working to minimise diagnostic delays early in the lung cancer pathway, using pathway mapping and enforcement of local governance procedures.</li> <li>Reduce variation in outcomes by doing a deep dive into patients referred for curative surgery and those referred for SACT.</li> <li>Review local lung cancer guidelines (2025) and SACT and radiotherapy target benchmarks (in conjunction with NOG).</li> </ol> </li> <li>Three Year Work Programme for Lung :-             <ol style="list-style-type: none"> <li>Develop a regional Mesothelioma MDT for Kent and Medway.</li> </ol> </li> </ul>	

		<p>2. Establish the early lung cancer screening programme across Kent and Medway and measure outcomes</p> <p>3. Commission a regional EBUS staging service, supported by a robust IT infrastructure for monitoring outcomes.</p> <ul style="list-style-type: none"> <li>TKL went through the following actions and progress on the CRG Action Log :-</li> </ul> <p><b><u>Action 1</u></b></p> <ul style="list-style-type: none"> <li>Provide any ideas or suggestions for improvements in lung cancer services, such as staging, curative and palliative care, to be included in the Cancer Alliance Planning Guidance. Progress – Navigational bronchoscopy for peripheral nodules, lung cancer screening, stratified pathways for surgical follow-up and streamlining MDTs.</li> </ul> <p><b><u>Action 2</u></b></p> <ul style="list-style-type: none"> <li>Explore the possibility of inviting a representative from the Guy's and St Thomas' robotic bronchoscopy service to present at the TSSG meeting. SF presented this at today's meeting.</li> </ul> <p><b><u>Action 3</u></b></p> <ul style="list-style-type: none"> <li>Follow up with the GP LNC or other relevant forums to discuss the need for GPs to include a CT scan request alongside the two-week wait referral. Progress - QIP development of new TWW referral for East Kent pilot, Task and Finish group to update current form.</li> </ul> <p><b><u>Action 4</u></b></p> <ul style="list-style-type: none"> <li>Provide an update on the progress of developing a robust follow-up protocol for surgical lung cancer patients, including the potential for a business case to support a dedicated surgical CNS role. Progress - Need to update Regional Cancer Guidelines KMCA.</li> </ul> <p><b><u>Action 5</u></b></p> <ul style="list-style-type: none"> <li>Arrange a separate meeting with Toni, Riyaz, and Lou to discuss the data and funding requirements for the Mesothelioma MDT. Progress - Grant application to Meso UK submitted</li> </ul>	
--	--	--	--

		<p>by end of March.</p> <p><b>Action 6</b></p> <ul style="list-style-type: none"> <li>Staging EBUS. Progress - All provider Trusts to submit data for National EBUS audit from April 2026.</li> </ul>	
<p>3.</p>	<p><b>Lung Dashboard</b></p>	<p><b>Update provided by Tuck-Kay Loke</b></p> <p>TKL went through the Lung Cancer Data Pack Slide Presentation.</p> <ul style="list-style-type: none"> <li>FDS Performance has declined substantially from 74.6% to 67.1% at Kent &amp; Medway in the last 6 months and 62 Day Performance is at 73.2%.</li> <li>MTW and MFT are doing well in FDS Performance and are above the quartile. DGT and EKHUFT are performing below the quartile. There is a trend that is going down from the 28 day standard.</li> <li>FDS Performance at MTW is 83.3%, MFT at 77.9%, EKHUFT at 53.0% and DGT at 50.0%.</li> <li>62 day Performance at DGT is 93.5%, MTW at 85.5%, MFT at 67.6% and EKHUFT at 63.2%.</li> <li>62 day standard – doing better than FDS. MTW is consistent but there is a concerning trend.</li> </ul> <p>Radiology recruitment is a national issue.</p> <ul style="list-style-type: none"> <li>Performing consistently on FDS Data completeness, but only 24.1% Data completeness – CNS Indicator.</li> </ul> <p>There is a need to look at the data being recorded. TKL expressed a need to respond to the data that is being collected.</p> <p>Chemotherapy by day 31 after DTT – all trusts are doing well and above the England standard.</p> <p>TKL went though his Observation Slides.</p> <ul style="list-style-type: none"> <li>FDS - MTW and MFT have consistently faster, more reliable movement from referral to key</li> </ul>	<p><b>Data Pack circulated to the group on 13/3/26 &amp; Data Observation Presentation circulated on 27/3/26.</b></p>

		<p>diagnostics (CT, PET-CT, bronchoscopy) and MDT, so far fewer patients tip past 28 days or 62 days and breach the standards.</p> <ul style="list-style-type: none"> <li>• DGT, EKHUFT and MFT show more volatile SPC patterns with occasional very low months, suggesting fragile diagnostic and treatment capacity, when CT lists, reporting, MDTs or treatment slots slip, waits lengthen sharply and performance drops.</li> <li>• Overall MTW look to have better-protected diagnostic capacity, more predictable MDT and treatment scheduling and stronger oversight of long-waiters, whereas MFT, EKHUFT and DGT are more exposed to bottlenecks and operational shocks at individual steps in the pathway.</li> </ul> <p>TKL asked everybody to digest this Dashboard information and make changes to their Pathways.</p> <p><b><u>How to sign up to the Cancer Pathways and Cancer in Primary Care Dashboards</u></b></p> <ul style="list-style-type: none"> <li>• Register for access to Kent and Medway ICB Power BI reports by completing the form at <a href="https://forms.office.com/r/svyPSvktHw">https://forms.office.com/r/svyPSvktHw</a>.</li> <li>• Email <a href="mailto:David.Osborne11@nhs.net">David.Osborne11@nhs.net</a> to inform him that you have completed the form for access to the dashboard. It can take up to a week for the ICB to grant access.</li> </ul> <p>Once access has been granted, you can access the dashboard at <a href="https://app.powerbi.com/home?ctid=4cfbd3c4-a42e-48a1-b841-31ff989d016e">https://app.powerbi.com/home?ctid=4cfbd3c4-a42e-48a1-b841-31ff989d016e</a>. Click on the <b>KM ICB Main</b> app and you will see <b>Cancer in Primary Care</b> and <b>Cancer Pathways</b> listed on the left-hand menu.</p>	
<p>4.</p>	<p><b>LCNS Update</b></p>	<p><b><u>Presentation provided on behalf of the LCNS team by Hateme Haxha</u></b></p> <ul style="list-style-type: none"> <li>• HH provided an LCNS update for all Trusts on behalf of all the Lung CNS's at DVH. This was not discussed due to time constraints.</li> <li>• EKHUFT - TS stated they have two CNS's on a 12-month contract. A Business Case has been sent to Alexis Warman. They do not have CNS's to carry out Stratified Pathways for surgical patients. EKHUFT currently have a recruitment freeze and TF does not want to lose the nurse she has. There is a need to look at LCNS workforce as a whole.</li> </ul>	<p><b>Presentation circulated to the group on 27/3/26</b></p>

		<p><b>ACTION – RC and TF to discuss the EKHUFT CNS’s outside of this meeting.</b></p> <ul style="list-style-type: none"> <li>• Callum Branch had sent through an EKHUFT LCSP Figures update, but due to time constraints this was not discussed. This presentation was sent to all members after the meeting.</li> <li>• MTW – KC reported that they have no MDT Co-ordinator for Lung. They have a navigator in place currently but this needs to be picked up separately as not sustainable.</li> <li>• CW added that Lung Cancer Screening needs to be promoted wider on TV and Radio and knows a journalist at the BBC that can help with this.</li> </ul>	<p><b>RC &amp; TF</b></p>
<p><b>5.</b></p>	<p><b>Robotic Navigational Bronchoscopy</b></p>	<p><b><u>Presentation provided by Stephanie Fraser</u></b></p> <ul style="list-style-type: none"> <li>• The Accelerating Lung Cancer Diagnosis through Navigation Bronchoscopy Presentation provided an overview of the following :-</li> <li>• Lung Cancer Screening programme at SELCA is hosted by Guy’s and St Thomas’s Trust and commenced in October 2022 with a target population of 175,000. 80,000 have been invited to date, with a 46% population roll out and will achieve 100% roll out by 2028. Boroughs with highest deprivation have been prioritised.</li> <li>• To date (October 2022 to November 2025) 30,292 Lung Health Checks have been completed, with 10,960 patients scanned and 128 lung cancers diagnosed with 75% at an early stage.</li> <li>• Current Lung Cancer Diagnostic Pathway are associated with a complex, multi-step process which involves CT, PET-CT/MRI, Biopsy, Bronchoscopy/EBUS and Decision. This leads to delays, high resource use and uncertainty.</li> <li>• Challenges include: limited biopsy/surgical capacity, sometimes surgery without confirmed diagnosis, and difficulty accessing early-stage diagnostics.</li> <li>• Implementation of Robotic Bronchoscopy - the future potential is :-</li> </ul>	<p><b>Presentation circulated to the group on 27/3/26</b></p>

		<ol style="list-style-type: none"> <li>1. More patients diagnosed in early stage.</li> <li>2. Vulnerable patients are given personalised support.</li> <li>3. Fewer patients are lost on the diagnostic pathway.</li> <li>4. Better utilisation of diagnostic and imaging resources.</li> <li>5. Shorter waiting times for treatment.</li> <li>6. Better patient experience.</li> </ol> <ul style="list-style-type: none"> <li>• Opportunity for Re-design across the whole pathway. GSTT is leading the delivery of the project with the support of stakeholders at local, regional and national level. There is now day and weekend operating with extended lists. They are looking at barriers and focusing on cohorts.</li> <li>• A proposed solution (robotic bronchoscopy) introduces earlier, more accurate diagnosis with higher diagnostic yield and lower complication rates. This enables faster decisions, better use of surgical capacity and improved access to targeted therapies.</li> <li>• A redesigned pathway (nurse-led) has resulted in some key improvements, including: early malignancy scoring, faster decision-making, robotic bronchoscopy (+/- EBUS) earlier in pathway and an integrated optimisation plan before treatment. This approach shifts from a reactive approach to anticipatory care.</li> <li>• The framework emphasises addressing system-level barriers, not blaming individuals and supporting socio-economic challenges, multi-morbidity and cultural and psychological barriers. The goal is to achieve equitable access for all communities.</li> <li>• With regard to implementation progress at the Guy's site, successes include, strong leadership &amp; project management, staff training across multiple disciplines, safe early rollout of robotic system, positive patient feedback and collaboration across multiple hospitals.</li> <li>• Initial Pilot – 74 cases with further data being analysed.</li> <li>• Challenges include: IT/PACS integration, theatre upgrades (lead lining delays), procurement processes and data capture and evaluation setup.</li> </ul>	
--	--	--	--

		<ul style="list-style-type: none"> <li>• With regard to impact so far, there has been a higher diagnostic yield, lower complication rates vs other UK centres and growing referral numbers.</li> <li>• Patient Engagement, National Awareness Campaigns and Recent Media Campaign have received good engagement.</li> <li>• Next steps include: NICE guidance and tariff agreements, economic evaluation, expansion across more sites, continued focus on equity and access and positioning as a disruptive technology for faster cancer pathways.</li> <li>• This project aims to transform lung cancer diagnosis by reducing delays, diagnosing earlier, improving patient outcomes and making the system more efficient and equitable.</li> </ul> <p>SF added that CT guided biopsy is taking 6 weeks and there are long waits for carrying these out. Going straight to surgery is becoming less of an option. GSTT is one of the busiest robotic sites in the country. 19 referral hospitals come to GSTT and they see more referrals from SE London hospitals than other areas including Kent. Patients face delays at every step of the pathway – patients are often referred after day 90.</p> <p>They have an issue with surgical waits and surgical capacity and have been doing extended lists and HIT lists. They work closely with the Cancer Alliances, referral trusts, GP’s and Roy Castle Foundation and are engaging with these stakeholders to look at local and national adoption.</p> <p>650 cases of robotic navigational bronchoscopy have been carried out since starting a year ago. There are IT challenges and ongoing challenges with getting the St Thomas’s site set up to carry out the RNB as well.</p> <p>UCLH has a 9-week waiting list for RNB and Brompton has a 6 week waiting list. They are looking at having another site in Lewisham but need to scale up to be able to provide this service for the South East of England.</p> <p>ICB’s need to agree to operational costs and there is need to model in order to match demand.</p>	
--	--	---	--

<p>6.</p>	<p><b>Breaking Bad News</b></p>	<p><b><u>Presentation provided by Deepa Doshi</u></b></p> <ul style="list-style-type: none"> <li>• DD explained that more patients are being diagnosed younger and how to explain this news to families/providing the required support. 46,300 children become newly bereaved on a yearly basis – Ruth Strauss Foundation will support these children and have trained professionals for all diagnosed cancers.</li> <li>• DD went through the Ruth Strauss Foundation Presentation which provided an overview of the following :-</li> <li>• Non-Smoking Lung Cancer Mission – to advocate for and invest in non-smoking lung cancer research and awareness, collaborating with patient-led organisations and healthcare professionals so that patient outcomes are improved.</li> <li>• Family Mission – to ensure that every family where a parent has incurable cancer has access to specialist, comprehensive and accessible support, so that parents feel confident and equipped to maintain open communication with their children, helping them build resilience now and in the future.</li> <li>• There is an RSF Scientific Advisory Group and DD listed all members.</li> <li>• Three video animations – Why do non-smokers get lung cancer? Why should I have my cancer tested? What might my test results mean for me?</li> <li>• Two campaigns – with two different objectives were run yearly. ‘See through the symptoms’ and ‘All you need is Lungs’ – this campaign is aimed at the public to reassure them that Lung Cancer is not always a death sentence.</li> <li>• Current Picture – Each year in the UK, 167,000 people die from cancer. Cancer diagnoses rising in those aged 25-50. Rates are projected to continue increasing until 2040.</li> <li>• No conversation is too tough – CPD Accredited training is available for cancer and palliative care professionals which can be through e-learning and in person – NCTT. Training days are</li> </ul>	<p><b>Presentation circulated to the group on 27/3/26</b></p>
-----------	---------------------------------	--	---

		<p>being held in London on 19<sup>th</sup> June 2026, 30<sup>th</sup> October 2026 and 29<sup>th</sup> January 2027. Training will be coming on line soon for HCP's and Support Staff.</p> <ul style="list-style-type: none"> <li>• Ruth Strauss Foundation Family Support Service offer a free counselling support which can provide 1:1's for children up to the age of 25 and provide family support. Free Resources are available.</li> <li>• Referring – There is a Referral Form to complete for any patients with incurable cancer, who have children or is a primary caregiver to under 25's, patient partner or co-parent. Health care professionals can complete with their consent. There is the ability to order resources on their behalf or they can be sent the link. An Information Sheet is available to share with them.</li> <li>• YouTube link is available for Education and Schools.</li> </ul> <p>DD added that research grants have been awarded and have materials available for the Cancer Alliance to use. November is Lung Cancer Awareness month.</p> <p>TF stated that the CNS's use the RSF service across Kent and Medway.</p> <p>CW mentioned that there needs to be better GP awareness, regarding young patients having lung cancer and also young patients being diagnosed that are non-smokers.</p> <p><b>Action - RC agreed to discuss this at the joint PC/SC forum.</b></p>	<p>RC</p>
<p>7.</p>	<p><b>Research Update</b></p> <p><b>TOURIST Platform Trial</b></p>	<p><b><u>Presentation provided by Nicky Downs</u></b></p> <ul style="list-style-type: none"> <li>• ND explained that the Tourist Platform Trial is a Thoracic Umbrella Radiotherapy Study in Stage IV NSCLC. This study is primarily funded by the National Institute for Health and Care Research (NIHR).</li> <li>• Current Candidate Specific Trials (CST) within the platform are <b>Prince</b> – prospective, randomized, multicenter trial of first line systemic treatment and radiotherapy in Stage IV non-small lung cancer. <b>Quartz Lung</b> – quality of life after radiotherapy treatment for patients with Stage IV non-small cell lung cancer.</li> </ul>	<p><b>Presentation circulated to the group on 27/3/2026.</b></p>

		<ul style="list-style-type: none"> <li>• Platform Trial Schema. Patients with confirmed Stage IV NSCLC, fit for thoracic RT without symptoms requiring immediate RT are eligible for the Tourist Platform Trial – Prince, Quartz Lung, CST 3 and CST 4.</li> <li>• Objectives – Prince Tourist Platform Trial – To determine the clinical effectiveness of early high-dose palliative thoracic radiotherapy on health utility in patients with Stage IV NSCLC receiving first line standard of care systemic therapy. 472 Recruited and closes in January 2028.</li> <li>• Objectives – Quartz Lung Tourist Platform Trial – To determine the clinical effectiveness of low dose palliative thoracic radiotherapy on health utility in patients with Stage IV, Stage IIIB and IIIC NSCLC not receiving systemic therapy. 448 Recruited and closes in March 2029.</li> <li>• NG outlined the Tourist Platform Flow Chart.</li> <li>• Ease of Trial Delivery in Clinical Practice. Minimal patient burden due to patients following standard of care pathways. Various site types- patients may continue to be managed between DGH and Radiotherapy sites. Trial visits undertaken during usual clinic appointments and where required, phone calls conducted.</li> <li>• Amendment in progress – Prince Trial – Inclusion of Stage III patients for whom curative treatment is not feasible. Quartz Lung Trial – Inclusion of Stage IIIa patients for whom curative treatment is not feasible.</li> <li>• NG highlighted the site map and current trust sites where the trials are taking place.</li> </ul> <p>ND reported that recruitment has been low on both studies, but can provide posters and is happy to present at MDT's.</p> <p>JP is interested but has research team capacity issues.</p> <p>JH is looking to open this but asked how they can deliver as a team? KOC is a radiotherapy centre (this also covers KCH) so patients would need to come via that route and they also have capacity issues. Keen to open but due to the radiotherapy site being limited, this will cause issues. JH requires more</p>	
--	--	---	--



		<p>PE has prepared the business case and is developing a secured research grant with Meso UK, which will only fund for the first two years. EKHUFT have carried out a 3-month data audit. Programmed Activities for Consultants have been included in the Business Case.</p> <p>The Cancer Alliance are happy to support, however the trusts would need to provide the funding after the 2-year Meso UK funding.</p> <p>RC added that streamlining would free up radiographers to do less clinical value reporting and suggested the governance sits with the KOC.</p> <p><b>ACTION – RC, TKL and TF to discuss the Meso Business Case and taking it the next level, as time is running out to apply for this grant.</b></p>	<p>RC, TKL &amp; TF</p>
<p>9.</p>	<p><b>Clinical Audit Update</b></p> <p><b>Staging EBUS</b></p>	<p><u>Presentation provided by Roisin Dunwoody</u></p> <ul style="list-style-type: none"> <li>• RD went through the Staging EBUS Presentation which provided an overview of the following :-</li> <li>• Staging EBUS – Importance of Staging, Systematic Staging EBUS, BTS EBUS Pilot and EBUS Training.</li> <li>• Staging and EBUS Matters - Prognosis, Determines curative vs non-curative treatment. Treatment Options – Peri-operative therapy and SABR. Eligibility for Clinical Trials. Tissue adequacy determines molecular testing and targeted therapies.</li> <li>• Accurate Staging Matters – TNM9. Proposed N Categories and Descriptors. Compared clinical vs pathological TNM in RCT's. 34% patients clinically under-staged. Mis-classified nodal disease in 38% of patients.</li> <li>• Accuracy of Clinical Staging for Stage III – Single-station N2 NSCLC. A multi-centre UK Study. 115 patients from 15 hospitals. Clinical Staging (PET-CT, EBUS, MDT Discussion) – Stage III – Single Station N2. Pathological Staging – multi-station N2 disease found in 33%.</li> <li>• SEISMIC – Systematic Endoscopic Staging of Mediastinum to guide radiation therapy planning</li> </ul>	<p><b>Presentation circulated to the group on 27/3/26</b></p>

		<p>inpatients with locally advanced non-small cell lung cancer (NSCLC) – Background and Aims of the study.</p> <ul style="list-style-type: none"> <li>• Staging matters – eligibility for peri-operative therapy. Neoadjuvant/perioperative therapy. Imperative to diagnose N1 and N2a/b disease.</li> <li>• Optimal diagnosis and staging - NOLCP. Diagnostic and Staging Tests.</li> <li>• Intrathoracic nodal staging of non-small lung cancer in patients being considered for radical treatment – Flow Chart.</li> <li>• Accurate Staging Matters – IASLC Lung Cancer Lymph Node Map and Systemic Staging.</li> <li>• There has been a transition to TNM9 from January 2026.</li> <li>• Global Survey on Current Practices of Endobronchial Ultrasound Approaches to N2 Staging in Non-Small Cell Lung Cancer following the ninth edition of the TNM classification.</li> <li>• 2022 GIRFT Report Recommendations were made in relation to EBUS.</li> <li>• BTS Pilot Audit was carried out to measure the quality of EBUS services across the UK, consistency of EBUS practice across centres and improving lung cancer pathways. The Audit period ran from 1<sup>st</sup> March 2024 to 30<sup>th</sup> June 2024. Data Collection – 1<sup>st</sup> October 2024 to 31<sup>st</sup> January 2025. 30 Hospitals were selected and 28 hospitals submitted data. In total 1,859 procedures submitted. Range of 7 to 186 per hospital. 57% were male and median age of 68.</li> <li>• EBUS Delivery – 96% used physician-led sedation. 86% used 21-22g TBNA needles. Rapid on-site cytology (ROSE) used in 4% of procedures. Staging EBUS – 26/28 Hospitals performed Staging EBUS-TBNA. Wait for Staging EBUS – Referral to procedure time, Median of 11 days (IQR 9-15). No Hospital met the audit standard of 5 days.</li> <li>• Graph outlined the proportion of Pet Scans performed before EBUS and Audit Results for Staging EBUS.</li> </ul>	
--	--	--	--

		<ul style="list-style-type: none"> <li>• Each site submitted their nodal staging results based on EBUS Pathology, Final Confirmation Staging and Verification of Final Staging. Sensitivity and NPV calculated based on the prevalence of nodal metastases in population under EBUS – 8 Hospitals excluded as &lt;10 submitted (n=18). Prevalence of nodal metastases - 53%. Only 39% of centers met the sensitivity standard and 56% met the NPV standard.</li> <li>• Diagnostic EBUS – Audit Standards Charts for Diagnostic EBUS in Suspected/Confirmed Lung Cancer.</li> <li>• Problems – EBUS is not a core curriculum item and not all Centre’s offer training. Those that do, trainees often have on-call commitments and a high volume of workload. There is no curriculum.</li> <li>• RD listed her pathway of posts held and received her best training via fellowships.</li> <li>• Conclusions – Accurate Staging is critical to optimal lung cancer care. Staging EBUS is central to this. Marked variation in the delivery of EBUS nationally. Training trainees is vital.</li> </ul> <p>HS has carried out EBUS for many years and did an Audit in West Midlands on Lymph nodes.</p> <p>RC added that staging EBUS should be a centralised service, depending on the centre. EBUS lists are under-utilised in the system.</p>	
<p><b>10.</b></p>	<p><b>AOB</b></p>	<ul style="list-style-type: none"> <li>• TKL requested MDT members to complete the BTOG Survey that had been sent from Yiwen Soo (Respiratory Clinical Fellow) from UCLH.</li> </ul>	
<p><b>11.</b></p>	<p><b>Next Meeting</b></p>	<ul style="list-style-type: none"> <li>• <b>September 2026 – Date and Venue TBC.</b></li> </ul>	