

Lung Tumour Site Specific Group Meeting

Wednesday 30th September 2026

Lecture Theatre, Postgraduate Centre, William Harvey Hospital, Kennington Road, Willesborough, Ashford. TN24 0LZ

09:30 – 12:30

Final Meeting Minutes

Present	Initials	Title	Organisation
Tuck-Kay Loke (Chair)	TKL	Consultant Respiratory & General Physician	MTW
Sylvia Amofa-Kra	SAK	Programme Manager – Lung Cancer Screening Programme	MTW
Michelle Crosbie	MC	Lung Cancer Screening Programme Manager	DVH
Hateme Haxha	HH	Lung Cancer Clinical Nurse Specialist	DVH
Claire Pearson	CP	Macmillan Lung Clinical Nurse Specialist	DVH
Shefa Jahan	SJ	Consultant Respiratory Physician	EKHUFT
Toni Fleming	TF	Lead Macmillan Lung Cancer Clinical Nurse Specialist/ Mesothelioma UK CNS	EKHUFT
Jennifer Santer	JS	Lung Cancer Clinical Nurse Specialist	EKHUFT
Ramin Baghai-Ravary	RBR	Consultant Respiratory Physician	EKHUFT
Jacqueline Motta	JM	Macmillan Lung Clinical Nurse Specialist	EKHUFT
Kawsar Ahmed	KA	Respiratory Consultant	EKHUFT
Laura Briant	LB	Cancer Research Nurse	EKHUFT
Adam Rashed	AR	Respiratory Consultant	EKHUFT
Saleheen Kadri	SK	Respiratory Consultant	EKHUFT
Sarah Ryan	SR	Project Lead	EKHUFT
Brett Pereira	BP	Respiratory Consultant	EKHUFT
Serena Gilbert	SG	Cancer Performance Lead	KMCA
Jonathan Bryant	JB	Primary Care Cancer Clinical Lead	KMCA
Karen Glass	KG	PA / Business Support Manager	KMCA / KMCC
Colin Chamberlain	CC	Administration & Support Officer	KMCC
Samantha Williams (Minutes)	SW	Administration & Support Officer	KMCC
Oluwafemi Familokun	OF	Lung Cancer Screening Programme Manager	MFT
Thomas Sanctuary	TS	Respiratory Consultant	MFT
Kolera Chengappa	KC	Respiratory Consultant	MFT
Rebekah Thomas	RT	Pathway Co-ordinator	MFT
Heather Foreman	HF	Macmillan Lung and Mesothelioma Cancer Clinical Nurse Specialist	MFT

Apologies			
Suraj Menon	SM	Consultant Radiologist & Clinical Director	DVH
Fay Fawke	FF	Deputy Lead Cancer Nurse	DVH
Charmaine Adeyemi-Walker	CAW	Cancer Services Operational Manager	DVH
Ritchie Chalmers	RC	Medical Director	KMCA
Chris Singleton	CS	Senior Programme Manager	KMCA
Emily Lloyd	EL	Cancer Pathways Improvement Project Manager	KMCA
Ann Courtness	AC	Macmillan Primary Care Nurse Facilitator	KMCA
Pippa Enticknapp	PE	Deputy General Manager – Lung Cancer Screening	EKHUFT
Bobbie Matthews	BM	Clinical Nurse Specialist	MFT
Sarah Paterson	SP	Faster Diagnosis Lung Clinical Nurse Specialist	MFT
Timothy Sevvitt	TSe	Consultant Clinical Oncologist	MTW
Riyaz Shah	RS	Consultant Medical Oncologist	MTW
Katharine Clark	KCI	Lung Cancer Clinical Nurse Specialist	MTW
Janice Christie	JC	Lung Clinical Nurse Specialist	MTW
Jennifer Pang	JP	Consultant Clinical Oncologist	MTW
Nicola Davis	ND	Consultant Clinical Oncologist	MTW
Neil Crundwell	NC	Consultant Radiologist	MTW
Grace Gilbert	GG	Lung Cancer Pathway Navigator	MTW
Dominic Chambers	DC	Consultant Histopathologist	MTW
Louise Gilham	LG	Mesothelioma UK Clinical Nurse Specialist (Kent)	MTW
Mathilda Cominos	MCo	Consultant Clinical Oncologist	MTW
Holly Groombridge	HG	Project Manager	GSTT

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 meeting.	

		- If you attended the meeting and have not been captured within the attendance log above please contact samantha.williams23@nhs.net directly. <u>Action Log Review</u> - The Action Log was reviewed, updated and will be circulated to the members along with the final minutes from today's meeting. <u>Review Previous Minutes</u> - The final minutes from the previous meeting which took place on the 25th March 2026 were reviewed and agreed as a true and accurate record.	
2.	Clinical Reference Group Update & Action Log	<u>Update provided by Tuck-Kay Loke</u> - The CRG is the operational arm of the Lung TSSG and the team meet monthly. TKL highlighted that the CRG membership appears MTW heavy and would like more staff from other Trusts. - TKL went through the following CRG Work Plan : - - 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). - Support local MDT working to minimise diagnostic delays early in the lung cancer pathway, using pathway mapping and enforcement of local governance procedures. - Reduce variation in outcomes by doing a deep dive into patients referred for curative surgery and those referred for SACT. - Review local lung cancer guidelines (2025) and SACT and radiotherapy target benchmarks (in conjunction with NOG).	

		- Three Year Work Programme for Lung :- - Develop a regional Mesothelioma MDT for Kent and Medway. - Establish the early lung cancer screening programme across Kent and Medway and measure outcomes - Commission a regional EBUS staging service, supported by a robust IT infrastructure for monitoring outcomes. - TKL went through the following actions and progress on the CRG Action Log :- <u>Action 1</u> - SG to talk to Richie about arranging a slot with the acute provider collaborative to decide where the regional navigational bronchoscopy service should be located and then brief Tuck on the outcome. This Action is now closed. <u>Action 2</u> - Develop a business case for a hub and spoke model of navigational bronchoscopy based at GUY'S, co-located with the Kent and Medway cellular pathology hub, including proposed site and funding requirements. This Action is now closed. <u>Action 3</u> - SG to contact Stephanie Fraser to request the outline business case for the SATNAV / staging EBUS infrastructure so it can be reviewed and fleshed out with all relevant components. <u>Action 4</u> - Arrange for a visit to all lung MDTs to observe current practice, learn from best practice, draft a standard of care document, bring it back to this group for discussion and route it via the acute provider collaborative for chief executive sign-off. There is a tariff conversation ongoing and Business Case obtained.	
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		<u>Action 5</u> - 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. Progress has been made through the QIP development of a revised Two-Week Wait (TWW) referral form for the East Kent pilot. This work is being taken forward via a Task and Finish Group, which is currently reviewing and updating the existing referral form to support inclusion of CT scan requests at the point of referral. JB to provide updates as and when required. - Engagement with GP-facing forums (including LNC or equivalent) is being incorporated into this programme of work, with the intention that the revised process will be piloted in East Kent prior to wider rollout. <u>Action 6</u> - TF to contact Eve McGary regarding a Research Presentation at the TSSG. <u>Action 7</u> - Jenny to contact Mathilda Cominos about Research/Trials Presentation information at the TSSG. <u>Action 8</u> - SG and TKL to talk to Jasmine Turner and Louise Wilcox at MTW to find out the protocol for Radiology and share with EKHUFT. This has now been actioned. <u>Action 9</u> - Feedback from Direct Access Care Meeting trying to influence the above. Also reviewing the quality of acceptable referrals. Share new form for EKHUFT. This has now been actioned. <u>Action 10</u>	
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		SSRAB Service being looked at for Kent & Medway.	
3.	Lung Dashboard	<u>Presentation provided by Tuck-Kay Loke</u> TKL went through the Improving Lung Cancer Outcomes in Kent & Medway Presentation. Current Performance – The Gap. Kent & Medway lags on Early Diagnosis with FDS Performance at 68%, 62 Day Performance is at 67%. We are at the bottom in terms of performance, there is room for improvement and diagnostic delays are our weakness. Provider Variation- Trust Level Performance – there is significant variation between DGT, EKHUFT, MTW and MFT. MTW consistently have higher performance on diagnosis and treatment metrics. EKHUFT have volatility with prolonged periods below mean performance. DGT and MFT show intermediate results and have variable performance. Where patients get diagnosed influences their pathway experience and outcomes, indicating unwarranted variation. Treatment Variation – Stage I-II NSCLC (PS 0-2). Treatment Data was shared. Most patients receive curative treatment, but some do not. Every untreated patient with PS-02 requires documented clinical rationale, MDT Review and patient preference discussion. Treatment Variation – Stage IIIA NSCLC (PS -0-2). Treatment Data was shared. Curative intent treatment should be the default. MTW appears to deliver curative treatment more consistently. This requires investigation and potential replication across providers. Treatment Variation – Stage IIIB-IV NSCLC (PS 0-2). Treatment Data was shared. There is a huge variation in treatment. Root Causes – Four Linked Problems. Diagnostic Delay – 28-day standard substantially worse than 62-day standard. Provider Level Variation - Outcomes depend partly on where patients enter the system. Potential Under-treatment – concentrated in advanced NSCLC and selected providers. Data is not driving decisions – Dashboard exists but this is not yet embedded in clinical audit loops. These are system problems, not an individual clinical problem. Strategic Aim and Targets - Diagnose earlier, decide faster and ensure every potentially	Data Pack circulated to the group on 18th September & Presentation circulated on 30th September.

		treatable patient receives an equitable evidence-based treatment offer. TKL outlined the three-year targets. • 28-day Faster Diagnosis – The target is for ≥74% within 12 months; ≥87% thereafter. • 62-day Treatment Standard – The target is to sustain ≥72%, progress toward ≥80%. • Stage I–II/IIIA untreated (PS 0–2) – The target is for 100% documented MDT rationale. • Stage IIIB–IV biomarker testing – The target is for 100% eligible patients assessed. • Data completeness – The target is for ≥95% for stage, PS, intent, molecular markers • Improvement Programme- • Five workstreams were proposed : - Rapid Access Diagnostic Pathway, Standardised Staging and Tissue Pathways, Reducing Treatment Variation through regional MDT review. More Actionable MDT processes. Equity, supportive care and patient navigation. • First 90 Days and Measurement – Immediate Actions - • Validate dashboard definitions and reconcile data sources. Case Note review of all untreated PS 0-2 patients (Stage 1-11, 111A, sample of 111B-IV). Map diagnostic pathway at each provider and identify top three delays. Agree common regional diagnostic and MDT Dataset. Launch weekly treatment readiness meeting. Share MTW practices with other providers. Report progress at 30, 60 and 90 days using run charts. ACTION – TKL asked for all Cancer Managers to share this Data. <u>How to access the Cancer Pathways and Cancer in Primary Care Dashboards</u> 1) Email David.Osborne11@nhs.net requesting access. The reports are hosted by the ICB. 2) Once access has been granted, you can access the dashboards here: • Cancer Pathways • Cancer in Primary Care	All Cancer Managers
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4.	LCNS Update	<u>Presentation provided on behalf of the LCNS team by Hateme Haxha</u> • HH provided an LCNS update for all Trusts on behalf of all the Lung CNS's at DVH. The full details have been circulated. • DVH, MTW and EKHUFT all have an STT Nurse apart from MTW. MTW have a 1 Stop Clinic instead, this has not impacted the FDS. • CNS's from all sites meet twice a year. • TKL would like to know the number of patients that are seen in the Trust vs the number of nurses, there is a need to know the lack of support. He would like to see in graphics the number of patients they see year on year. TKL suggested the CNS's produce an Annual Report. • EKHUFT - TF added that they are fighting to have 2 posts made permanent. There is a limited resource of CNS's and they do not have the capacity.	Presentation circulated to the group on 30th September.
5.	Lung Cancer Screening Programme Update	<u>Presentation provided by Toni Fleming</u> • TF provided an LCSP Update for all Trusts. The full details have been circulated. • EKHUFT are working on a Pathway for Aortic Valve Calcification. The programme's second phases went live at Estuary View on 3rd March 2026. • DVH - MC reported that the Scanner at the CDC is to stay in one place. They did have problems with the DPIA and carried out promoting and asking people to self-refer into the programme for the first month. A pharmacy pilot was held with 12 pharmacies on board. 550 Lung Health Checks were carried out in September, with a blip with invitations not being sent out for a week in September. The team consist of 1 Band 7 and 2 Band 6 Nurses with 4 full time admin staff. The programme is working well, but are having teething problems and ideally need 1 system of dealing with letters.	Presentation circulated to the group on 30th September.

		- Medway and Swale programme is set to go live in December 2026. A GP Meeting has been held to discuss incidental findings. - MTW – SAK have adopted a phased implementation approach, with a soft launch planned for 13th October 2026 with support from the Roy Castle Foundation. A target start date of 23rd October 2026 is planned. DIPA and DSA approval are their main challenge. They have learned from Dartford and will be using self-referral. Obtaining a Responsible Radiologist has also been a challenge and has been escalated in the Trust. The next four weeks is crucial to get everything in place for go live.	
6.	Summit Study	<u>Presentation provided by Tuck-Kay Loke</u> TKL went through the findings of the SUMMIT Trial Presentation. Background - LDCT screening detects early-stage lung cancer with survival benefit depending on timely treatment. Assessment requires imaging, biopsy and MDT Review. Delays may allow tumour progression. SUMMIT Study Context – Prospective UK Lung Screening Co-hort. High Risk adults aged 55 – 77 years. More than 12,700 participants were screened, with nearly 80% diagnosed at Stage I-II. Study Design - Screen-detected cancers staged cT1a–c at referral. Upstaging defined as increase in T stage between referral and treatment. Assessed treatment delays and mortality. Co-hort Characteristics – 390 Screen-detected Lung Cancers included, all initially cT1a-c, compared upstaged Vs non-upstaged tumours. Main Result – 43% of cancers were upstaged before treatment. 165 of 390 tumours progressed in T-Stage. Which Tumours progressed most - cT1a – 56% upstaged, cT1b – 38% upstaged, cT1c – 40% upstaged. Smallest tumours showed greatest progression risk. Treatment Delay Findings – Median referral-to-treatment time. Upstaged – 84 days, Not	Presentation circulated to the group on 30th September.

		upstaged – 72 days. Longer waits associated with higher upstaging rates. • Nodule Characteristics – Part-solid nodules – 27% in upstaged group and 21% in non-upstaged group. No significant difference identified. • Mortality Implications – Mortality assessed using Cox proportional hazard models. Adjusted for age, sex, smoking exposure and co-morbidity. Stage migration may reduce screening benefit. • Strengths and Limitations – Prospective real-world screening programme. High Clinical Relevance, observational design. Cannot prove delay directly caused progression. • Key Take Home Messages - 43% of cT1 cancers upstaged before treatment. Longer pathways associated with greater progression. Rapid assessment is essential. Early detection only helps if treatment is timely. TKL expressed the need to look at our Pathways and raise our concerns with NHSE being highlighted.	
7.	MESO UK Update	<u>Presentation provided by Toni Fleming</u> TF went through the Kent-Wide Regional Mesothelioma MDT Pilot – First year provisional results (October 2025 to date). • Move from a pilot dependent on goodwill to a commissioned county-wise clinical function and approve the Kent-wide Mesothelioma MDT as a permanent regional service. • A specialist regional MDT is needed as rare disease, dispersed expertise and material variation in care make a hub and spoke model appropriate. • Pilot Model and Referral Pathway - A second specialist review that complements rather than replaces, local Lung MDT discussion. • The pilot has demonstrated Kent can sustain a regular specialist forum for a rare cancer like Mesothelioma. Regional review added missing stage, performance status and molecular information. Repeat discussion provided a route to close diagnostic and treatment-planning	Presentation circulated to the group on 30th September.

		questions. The regional MDT complemented local MDTs rather than replacing them. • Clinical Impact – Decisions changed because of review – The pilot identified missing stage information, changed state and triggered additional testing. • Kent needs a Regional Mesothelioma MDT - The case for regionalisation rests on rarity and complexity. Local teams retain ownership and present the clinical question. The regional meeting pools expertise and case volume, reducing unwarranted variation while preserving local delivery and relationships. • National Guidance supports specialist regional review - The British Thoracic Society recommendation carries Grade D evidence, reflecting the difficulty of experimentally testing MDT organisation in a rare cancer. Its good-practice statement is stronger operationally: timely review, sufficient case volume, named mesothelioma CNS involvement and trial awareness. The pilot provides Kent-specific service evidence to add to this national rationale. • Proposed Operating Model was based on pilot activity, internal service context and specialist MDT best practice principles. • There is a case for permanent establishment as the pilot has moved beyond proof of concept and is now an identifiable safety and equity function. • Recommendation and next steps – Endorse now, formalise quickly and continue measuring. The pilot demonstrates need, activity and clinical impact. The remaining task is to make the service reliable, equitable and sustainable. Meso MDT Meeting has been running for the last year and is held every fortnight. RS is on the panel where specialist reviews are held. A bid has been submitted to MESO UK to obtain funding for 2 years and to find Radiology and Pathology Co-ordinators. KC expressed the need for an established process and require a provider Trust to take ownership. TF will find out on the 1st October 2026 if the bid has been successful. Action – SG will arrange for the Kent-Wide Regional Mesothelioma MDT to be presented at the KMCA Delivery Board.	SG
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8.	Research Update EKHUFT Lung Cancer Trials	<u>Presentation provided by Laura Briant</u> • ND explained that they have currently 2 open Lung Trials – KRASCENDO 2 and TROFUSE 007 and an academic Lung Study – REFINE-Lung. • Recruitment – MK2870 007 is planned to close the end of 2026. KRASCENDO 2 is recruiting quicker than expected. REFINE-Lung is planned to close end of February 2027 and has been hard to recruit to. • Challenges included only having up to 28 days to screen patients and have a strict eligibility criteria. • Team Successes included meeting targets for both commercial trials, excellent feedback from sponsors, pro-active investigators and receiving positive patient feedback on their experiences.	Presentation circulated to the group on 30th September.
9.	Clinical Audit Update	<u>Update provided by Jennifer Pang</u> • JP outside of the meeting previously gave an update on an audit to assess time to commencing chemo-radiotherapy treatment in the radical lung cancer patient pathway. • JP initially audited 2023-24 data from EKFT, MTW and Medway. It was realised that DVH had been omitted. This data has since been added. • The key findings were: • Triage to MDM missing target by about 3 weeks. • Referral to OPA – tight target of 3 days, but missing this by about a week. • Time from OPA to chemo was fairly good. • EAS (Electronic action sheet, i.e. document to signify referral for RT) to RTPCT – 8/39 more than 21 days, mean 15.7 days. • RTPCT to RT average around 18 days, leaving only 3 days between OPA and RTPCT. • From an oncology point of view, it was felt that the key part of the pathway that could be	

		shortened was EAS to RTPCT. If this could be brought to within 3 days, this could take around 1-2 weeks off the total pathway. RT management are trying to implement this. JP will try and find out more detail about how this is progressing and will update TKL. TKL asked for a Lead in Research if anyone is interested.	
10.	AOB	- TKL announced that he will sadly be stepping down as Chair for the Lung TSSG after six years in post. If anyone is interested in this role, please contact TKL or SG. - KC asked for wider attendance for this meeting.	
11.	Next Meeting	March 2027 – Date and Venue TBC (to be held in the afternoon preferably).	