Kent & Medway Cancer Collaborative

Lung Tumour Site Specific Group meeting
Thursday 14th March 2024
Microsoft Teams
13:30-16:30

Final Meeting Notes

Present	Initials	Title	Organisation
Tuck-Kay Loke (Chair)	**TKL**	Consultant Respiratory & General Physician	MTW
Deborah Willcox	**DW**	Research Nurse	MTW
Victoria Harris	**VHar**	Trials Coordinator	MTW
Sophie Hurcomb	**SHu**	MDT Coordinator	MTW
Grace Gilbert	**GG**	Pathway Navigator	MTW
Gill Donald	**GD**	Clinical Scientist	MTW
Summer Herron	**SHe**	General Manager – Cancer Performance	MTW
Dominic Chambers	**DC**	Consultant Histopathologist	MTW
Melissa Cooke	**MC**	2ww Booking & ERS Navigator Team Lead	MTW
Deana Giles	**DG**	AGM for Respiratory	MTW
Simon Webster	**SWe**	Consultant Respiratory Physician	MTW
Neil Crundwell	**NC**	Consultant Radiologist	MTW
Nicola Davis	**ND**	Consultant Clinical Oncologist	MTW
Sandra Wakelin	**SWa**	Macmillan Lung Cancer ANP	MTW
Jennifer Pang	**JP**	Consultant Clinical Oncologist	MTW
Tim Sevitt	**TSe**	Consultant Clinical Oncologist	MTW
Katharine Clark	**KCl**	Macmillan Lung Cancer CNS	MTW
Hateme Haxha	**HH**	Macmillan Lung CNS	DVH
Simiat Ojo	**SO**	Early Diagnosis Lung CNS	DVH
Marie Payne	**MP**	Lead Cancer Nurse	DVH
Brett Pereira	**BP**	Respiratory Consultant	EKHUFT
Toni Fleming	**TF**	Macmillan Lead Lung Cancer CNS / TLHC Responsible Assessor	EKHUFT
Jacqueline Motta	**JM**	Macmillan Lung Cancer CNS	EKHUFT
Tracey Ryan	**TR**	Macmillan User Involvement Manager	KMCA
Ritchie Chalmers	**RC**	Medical Director	KMCA
Serena Gilbert	**SG**	Cancer Performance Manager	KMCA
Colin Chamberlain (Notes)	**CC**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Lead	KMCC
Annaselvi Nadar	**AN**	Faster Diagnosis Matron	MFT
Thomas Sanctuary	**TSa**	Respiratory Consultant	MFT
Heather Foreman	**HF**	Macmillan Lung and Mesothelioma Cancer CNS	MFT

Louise Black	**LB**	Macmillan Deputy Lead Cancer Nurse	MFT
Catherine Bodkin	**CB**	Macmillan Lung and Mesothelioma CNS	MFT
Kolera Chengappa	**KCh**	Respiratory Consultant	MFT
Suzanne Bodkin	**SB**	Cancer Service Manager	MFT
Sarah Paterson	**SP**	Faster Diagnosis Lung CNS	MFT
Hannah Stanford Weeks	**HSW**	Implementation Lead	MSD
Ann Courtness	**AC**	Macmillan Primary Care Nurse Facilitator	NHS Kent & Medway ICB
Caroline Wordsworth	**CW**	Patient Partner	
Apologies			
Chieh-Yin Huang	**CYH**	Consultant Radiologist	DVH
Bradley Smith	**BS**	Lead Radiology Manager for Cancer Services	DVH
Vicki Hatcher	**VHat**	Macmillan Upper GI Lead CNS	EKHUFT
Syed Hassan	**SHa**	Consultant Respiratory and General Medicine	EKHUFT
Pippa Enticknap	**PE**	Senior Service Manager	EKHUFT
Jonathan Bryant	**JB**	Primary Care Cancer Clinical Lead	KMCA
Karen Glass	**KG**	Administration & Support Officer	KMCA
Louise Gilham	**LG**	Mesothelioma UK CNS (Kent)	MTW
Riyaz Shah	**RS**	Consultant Medical Oncologist	MTW
Shona Sinha	**SS**	Consultant Histopathologist	MTW
Ravish Mankragod	**RM**	Consultant Respiratory Physician	MTW
Emma Forster	**EF**	Head of Service Improvement - NHS England (South East)	NHSE

Item		**Discussion**	**Action**
1	**TSSG Meeting**	**Apologies** • The apologies are listed above. **Introductions** • TKL welcomed the members to the meeting and asked them to introduce themselves. **Action log Review** • The action log was reviewed, updated and will be circulated to the members along with the final minutes from today's meeting. **Review previous minutes** • The final minutes from the previous meeting were reviewed and agreed as a true and accurate record. **Aims/Objectives** • The Lung TSSG is committed to improving the outcome of patients with lung cancer by: - Encouraging early referral from primary care of 'at risk' patients.	

		- Providing a rapid and comprehensive local pathway for the investigation and treatment of these patients. - Complying with the NICE guidelines for the management of lung cancer.	
2	**Kent-wide Mesothelioma MDT**	**<u>Update provided by Kolera Chengappa</u>** • The Kent-wide Mesothelioma Steering Group, which is in its infancy, has already met once and conversations there predominantly centred around: - The set-up of the forum. - The frequency of the MDT meetings (KCh believes they should be fortnightly). - The number of patients to be discussed at these meetings. - The funding aspect of supporting these meetings. - How the meetings are to be supported from an administrative perspective. - The need to assign names for membership. Ideally, the members should have 0.5 PA set aside for supporting the MDT. • TKL highlighted the need to be clear with commissioner colleagues around why there is a need for a regional Mesothelioma MDT now and to discuss the funding aspect of supporting the forum. • RC believes a written proposal outlining the following is needed: - Why the Mesothelioma MDT is needed. - Its benefits. - What the expectations are of the MDT. - Where the funding is needed from exactly to support the MDT. • In addition to the above points, RC believes a Terms of Reference needs to be formulated in order to support the written proposal.	
3	**TLHC**	**<u>Presentation provided by Toni Fleming</u>** • The presentation provided the group with an overview of: - The TLHC Patient Pathway Overview. - National programme data from the start of the programme to December 2023. - Incidental findings identified between April 2019 and December 2023. - The national programme's lung cancer diagnosis statistics to date (April 2019 to December 2023). 3332 lung cancers have been diagnosed throughout this period (62% at stage 1 and 13% at stage 2). - Cancer diagnosis and staging data for all Cancer Alliances (April 2019 to December 2023). During this period, KMCA have diagnosed 11 lung cancers (nine at stage 1 and two at stage 3). - The number of participants invited to the KMCA TLHC programme across 2023-2024, the number of LHCs attended and the number of CT scans completed. Uptake rate is currently at 44.9%, referral rate to CT scan from LHC is at 31.6% and the conversion rate from initial CT to cancer diagnosed is 0.6%. - The SKC TLHC data report (01.11.2022 to 17.01.2024) which shows: how many invite letters have been sent, how many patients accepted/declined/did not respond to the invite, how many telephone/face-to-face appointments have been booked, how many incorrect referrals were sent due to patients never having smoked, how many CT scans have been booked, and how many referrals have been sent to One You Kent.	

		- The findings of CT scans. - Patient feedback of the service. • In terms of moving forward: - The next phase of the rollout will be in November 2024 with Canterbury North and South. - The team are currently working with colleagues in the ICB as well as the Senior Strategic Projects Manager at EKHUFT to submit a bid for National Funding for a mobile CT scanner to access remote areas and provide more capacity for the second phase of the rollout across East Kent. - The service is awaiting the refurbishment of clinic areas in Buckland. - The team are awaiting training for spirometry as well as a safe area to practice in. - There has been an expansion of the team. A new Band 6 started with the service in December 2023 and a new Stop Smoking Advisor has also been recruited. - Medway will be the next Trust to go live with the programme and CDC development for MTW and DVH is underway. • TF stated Jonathan Bryant is currently undertaking some work with GP colleagues on the incidental findings piece. • **<u>Action</u>: TKL highlighted the importance of understanding how the ICB plan to support the expansion of the TLHC programme in terms of funding and resources. In response to this, RC mentioned this would be taken to the Elective Care Steering Group for discussion.** • It was also highlighted that further work needs to be done in order to work out how to better engage with difficult to reach groups e.g. the travelling community/prisoners. • RC emphasised the need to understand how much the programme is impacting on radiology turnaround times and who should fund what she described as 'unintended consequences'. • RC feels interventional radiology and biopsy capacity also need to be reviewed within the context of how it supports the TLHC programme.	**RC**
4	**Lung Pathway optimisation**	**<u>Update provided by Hannah Stafford Weeks (MSD UK)</u>** • HSW stated that MSD can work together in collaboration with the NHS to support pathway implementation and optimisation. • HSW is aware that NHS Trusts are currently facing a number of challenges in oncology departments, affecting parts of the patient pathway, from referral through to treatment. These challenges tend to be caused by: - An increasing number of patients compared with current demand. - New treatments becoming available. - Staff shortages. - The impact of the Covid-19 pandemic. • MSD understand the challenges Trusts face and have a dedicated team who can work with professionals to optimise and implement pathways, tailored to any changes they may be facing in their hospitals, to improve care and management for patients. • The MSD Pathway Development Programme (PDP) is conducted under a collaborative working agreement which aims to support NHS organisations and healthcare professionals in delivering improved care and management for their patients. • MSD's dedicated team will:	

		1. Work with organisations to understand the current service pathway and the demands on the health service. 2. Help to identify gaps in the current pathway, and highlight potential areas to improve – and the risks involved with not optimising these areas. 3. Facilitate conversations around the changes needed for service improvements. 4. Support in the implementation and evaluation of the service improvement and then publish the outcomes. • In terms of supporting this project going forward, SWe highlighted the need to have buy-in from all four Trusts. • To make the most of this project, TKL highlighted the importance of having: - Good quality clinical leadership and for the MDT to sit under this. - Lead roles within the TSSG. - Project support to map out pathways. - Streamlining of MDTs. - Working Groups in order to take issues the teams have forward. • **<u>Action:</u> HSW will be in contact with the Lung Clinical Leads shortly to further elaborate on how she can support their respective services. TKL to bring this back to update the TSSG.**	**TKL**
5	**"Decision algorithms for limited biopsy material"**	• Nicola Chaston was unable to attend today's meeting so provided the TSSG with an emailed update as per below: - *"Please remind all clinicians that we are likely to need more viable tissue moving forward so we have sufficient tumour cells for all of the additional testing which we are doing reflexively. If we do not have sufficient tissue for all testing, it would be nice to have consensus on whether the oncologists would prefer NGS (which will give more info but take several weeks longer) or the more rapid testing undertaken at MTW which we will get back within a week but may not provide all possible information."*	
6	**Research update**	• This item was not discussed. There is still not a nominated Research Lead for the TSSG.	
7	**Clinical Audit updates**	• **<u>Action</u>: Abnormal chest x-ray to CT pathway DVH audit to be presented at the next meeting by MP and SO.** • **<u>Action</u>: Audit on tissue viability for EBUS to be presented at the next meeting.**	**MP / SO ALL**
8	**Performance data**	• Kent & Medway's performance relative to the England average is worse for lung than other tumour types. • Kent & Medway currently sit 14th out of 21 Cancer Alliances for the FDS performance metric. MFT (58.4%) and EKHUFT (73.9%) are below the England average for FDS whereas DVH and MTW are close to the England average. • Kent & Medway currently sit 1st out of 21 Cancer Alliances for the 62d performance metric. • Kent & Medway currently have the 12th lowest number of USC backlogs out of 21 Cancer Alliances. • Regarding lung cancer outcomes in Kent & Medway being worse than England: - The gap between Kent & Medway and England has not changed much over time. - The gap between Kent & Medway and England is seen across all patient demographic groups. • With regard to radical intent treatment commencing by day 49 of the overall NOLCP pathway, overall performance is currently around 26% (based on July 2022 to September 2023 data).	

		• With regard to surgery, thermoablation or radiotherapy treatment commencing by day 16 after the decision to treat, overall performance is currently around 40% (based on July 2022 to September 2023 data). • The presentation provided the group with an overview of the median waiting times (in days) at each Trust from referral to: chest x-ray, CT recorded by GP, first seen, first OPA, CT chest, lung biopsy, endobronchial ultrasound, FDS: cancer ruled out, FDS: cancer diagnosed, MRI, DTT and Inter-provider transfer.	
9	**Patient Rep for TSSG**	• CW introduced herself to the members as the new Patient Representative for the Lung TSSG. • In 2018, CW was diagnosed with stage 4 lung cancer and had been to see her GP five times over the space of five months before she was referred for a chest x-ray. In view of this, she highlighted the importance of GP education. • CW stated she had received exemplary care following her diagnosis and thanked the teams involved in her care. TKL thanked CW on behalf of the TSSG for her involvement in supporting the group.	
10	**CNS Updates**	**<u>Presentation provided by Catherine Bodkin</u>** • CB provided the group with an overview of: - The number of referrals the Trusts had received in 2023 versus the number received in 2022. - The total number of diagnosed cancers in 2023 at each Trust versus the total number diagnosed in 2022. - The total number of lung cancer and mesothelioma diagnoses at each Trust in 2023 versus the total number of diagnoses in 2022. - The total number of mesothelioma diagnoses per hospital site in 2022 versus the total number in 2022. - The total number of CNS contacts at each Trust in 2023 versus the total number in 2022. **<u>DVH</u>** • The team comprises of 3.0 WTE Band 7 Lung CNS' and a 1.0 WTE Early Diagnosis Nurse who was promoted to Band 7 in July 2023). The Early Diagnosis Nurse manages the 2ww ERS referrals and the new Lung CT pathway (support is provided by the Lung CNS' if needed). The Early Diagnosis nurse also attends the 2ww rapid access clinics with the assistance of the Lung CNS'. • 2ww rapid access clinics vary depending on the Respiratory Consultants' rota but there can be up to five clinics a week. • The CNS team do daily triage with the Respiratory Consultant and this is split between the Lung CNS' and the Early Diagnosis Nurse. • The Physician Associate (0.4 WTE) attends the RAC, Lung MDT and pleural clinic on a Thursday. • The Band 4 Support Worker (0.2 WTE) helps with administrative work. • There are two nurse-led Breaking Bad News clinics and two nurse-led HNA clinics per week. • There are four oncology clinics per week supported by the Lung CNS'. • The CNS team provide lung MDM support and deal with post-MDM telephone calls and appointments. • The team deal with daily patient telephone calls/queries and undertake assessments and triage.	

		• The team also support with ward referrals and ward reviews. • There is psychological support in place for patients and families. • The team are involved in the weekly formal PTL meeting. • The team signpost and refer to other services. **EKHUFT** • There is a 1.0 WTE Band 8a who covers mesothelioma two days a week and spends three days dealing with management duties and being the Responsible Assessor for the TLHC post. • There are 3.7 WTE Band 7 CNS'. • There is a 1.0 WTE Band 4 Cancer Support Worker for all sites and they are undertaking HNAs. • There is a 1.0 WTE STT CNS (Band 6) who covers all sites. • The service covers three main hospital sites (QEQM/KCH/WHH) and 3 cottage hospitals (Dover/Deal/Folkestone). • There are two lung cancer MDMs each week (Wednesday at KCH/Friday at WHH). • The nursing team covers four NP Oncology Clinics (two at WHH and two at KCH), two surgical clinics (one at WHH and one at KCH), eight 2ww clinics (across QEQM/KCH/WHH/Folkestone) and five Lung CNS MDM/Breaking Bad News clinics at KCH/QEQM/WHH. • There is one mesothelioma support group which meets monthly in Canterbury. • The team deal with daily Cancer Care Line calls as well as MDM telephone clinics. • The team support Acute Oncology/Palliative Care with inpatient reviews for WHH/QEQM/KCH. • The CNS' also triage ERS 2ww referrals (predominantly the STT CNS but with cover by the Lung CNS team). • Psychological support for patients and families is provided as is signposting and referrals to other services. • There are daily PTL update reviews as well as a weekly formal PTL meeting. **MFT** • The team comprises of 2.0 WTE Lung CNS' (one CNS is Macmillan-funded and on sabbatical but is due to return in June 2024), a 1.0 WTE Band 4 Support Worker (Alliance-funded) and a 1.0 WTE STT Lung CNS. • There are seven oncology clinics per week and there is a CNS presence in face-to-face outpatient appointments only at present. CNS attendance on virtual OPAs is ad-hoc at the moment. • There are two to four Rapid Access Respiratory Clinics per week. These comprise of a mixture of 2ww/upgrade referrals, post-MDM and Breaking Bad News cases. • There is one nurse-led surgical follow-up clinic per week. • There is one Lung MDM and one Lung pre-MDM per week. • The service is in the process of setting up a nurse-led oncology clinic for new SCLC patients. This is on hold due to current workload.	

		• Post-MDM telephone calls are in place. • The CNS team deal with daily patient telephone calls, queries, emails, assessments and triage. • There are two PTL reviews weekly. • There is a monthly support group for both Medway and Swale patients. • The team conduct inpatient reviews, supporting BBN clinics/Acute Oncology/Palliative Care. • Psychological support is provided for patients and families. • The team are involved in signposting and referrals to other services. • There is a TSSG Lung CNS Lead in place. **MTW** • The Lung Cancer CNS team comprises of 3.5 WTE CNS' across two sites and a 0.7 WTE ANP role under the oncology directorate. In addition, there is a 1.0 WTE CSW, a 0.6 WTE Regional Mesothelioma UK Nurse and a 1.0 WTE Band 6 rotational CNS post (split between breast, lung and colorectal) who started in January 2024 and is on a fixed-term contract for 18 months. • There is a 1.0 WTE Band 7 vacant post and a hybrid research nurse post is due to go out to advert next week. • There are currently six 2ww clinics across site and CNS' are present if required in these clinics. • The pilot Marsden 360 ctDNA test is being completed for suspected cancers. • There are an increased number of patients on treatment with increased survival on newer regimes which is therefore putting pressure on the service. • The CNS team are involved in: - MDM support. - Post-MDM telephone calls and arranging appointments. - Ward referrals to support BBN on the ward and reviewing lung patients. - Supporting two BBN clinics (one is consultant-led and one is nurse-led). - Supporting six oncology clinic sessions and one surgical clinic. - Running one post-surgical nurse-led clinic and four nurse-led oncology clinic sessions. - Nurse-led oncology clinics which have increased to incorporate the follow-up of patients who have completed immunotherapy, patients whose treatment is on hold and in the immune toxicity review clinic, TKI clinic and review of patients on SACT. - Supporting and reviewing patients on chemotherapy units with complex decision-making. - Telephone assessments and the triage of calls in to the Lung CNS team. - Close liaison with CT, MRI, Interventional Radiology, Acute Oncology and Palliative Care teams. - Psychological support for patients and families. - Signposting and referrals to other services.	

		<u>Action</u>: TKL believes it would be helpful for the CNS' to create annual reports (if they do not have them in place already) and for these to be shared with him by the end of May 2024.	**CNS'**
11	**Patient Satisfaction Survey**	**<u>Update provided by Heather Foreman</u>** • The Patient Satisfaction Survey presentation provided the group with an overview of: - Responses to the survey received by participating Trust. - The gender of the responder at each participating Trust. - The age range of the responder at each participating Trust. - How long the patient had experienced symptoms before seeing their GP. - What symptoms the patient had experienced. - Who first told the patient about their diagnosis. - How many weeks the patient had to wait in order to get test results to find out if they had cancer. - Whether the patient was expecting the diagnosis they received. - Whether the patient understood the explanation of their diagnosis and also whether this information was too much, the right amount, not enough or not understandable. - Whether the patient's diagnosis and subsequent care was discussed in the presence of a family member or friend. - Whether the patient felt their diagnosis was explained sensitively. - Whether the patient was given the name of someone they could contact for further support and advice. - Whether the patient had had contact with the Lung Cancer CNS and if so whether this was before diagnosis, at diagnosis or after diagnosis. If they had not had contact with the Lung Cancer CNS, whether the patient thought this would have been helpful. - What support the patient received from the Lung CNS. - Who the patient had been referred to. - Whether the patient felt they were getting enough support from their GP. - Whether the patient would like to attend a patient/carer support group in their area. - How the patient would rate the care given to them by staff. • The results to the questions asked in the survey can be found in the presentation circulated to the members on 15.03.2024. • EKHUFT have just commenced with the patient satisfaction survey.	
12	**AOB**	**<u>The oncology management of pulmonary NET tumours</u>** • It was mentioned that local pulmonary NET tumour cases are currently referred to the King's College Hospital MDM for review. • TKL asked the oncologists present at today's meeting whether, by show of hands, they had an interest in the management of pulmonary NET tumours locally. No hands were raised. In view of this, TKL stated this item should be discussed offline. • TKL and TR highlighted the importance of ensuring there is clarity and transparency in primary care when informing a patient they are being referred in to secondary care in order to rule out cancer.	

		Guardant360 • SWe thanked CNS' for their support with the Guardant360 CDx test which is FDA-approved for complete genomic testing across all solid cancers, providing doctors guideline-complete genomic results in seven days from a simple blood draw to inform treatment decisions. A blood test does not require tissue testing, enabling more patients to benefit from the growing number of FDA-approved targeted therapies. • SWe encouraged all Trusts to take part in this study if they are not already and highlighted the importance of clinical leadership in supporting this.	
	Next Meeting	• To be confirmed.	