Somerset, Wiltshire, Avon and Gloucestershire (SWAG) Cancer Alliance

Meeting of the SWAG Network Gynae SSG

Friday 15th June 2018, 15:30-18:30,
Board Room, Trust Headquarters, Bristol Royal Infirmary, Bristol, BS1 3NU

THIS MEETING WAS SUPPORTED BY ASTRAZENECA AND STRYKER

Chair: Philip Rolland (PR)

NOTES **ACTIONS**

(To be agreed at the next SSG Meeting)

1. Welcome and apologies

Please see the separate list of attendees and apologies uploaded on to the SWCN website here.

2. The Role of Somatic Testing in Ovarian Cancer

There have been many changes to the landscape of genetic testing for ovarian cancer in recent months; an update on the role of somatic testing had been requested.

Approximately a third of women diagnosed with ovarian cancer have a BRCA gene mutation (BRCAm). The majority are germline (inherited), combined with somatic variations; literature also shows that 8-10% of patients have a purely somatic mutation. At present, PARP inhibitor Niraparib is available from the Cancer Drug Fund (CDF) for second line treatment if the patient has a documented BRCA germline mutation, or for third line treatment if the patient has had a BRCA germline test, but does not have a germline mutation. The take home message is to ensure that a BRCA test is reported.

Olaparib is available from the CDF after second line for patients with a documented BRCAm. It is hoped that this will be licenced for use in the second line setting in tablet form in January 2019.

It was recognised that some patients will choose not to take Niraparib due to the weekly blood tests required.

At present, there are some problems with processing BRCA tests in a timely manner, and it is not always possible to obtain a tumour sample of sufficient size. In the event that a result is required urgently, a blood test for somatic mutations, which have been shown to respond in a similar manner to germline mutations, can be processed within 10 days by the laboratories in Manchester and Cardiff. A form is available online. Any related correspondences must be sent via nhs.net accounts. SSG members can contact steven.walton@astrazeneca.com for further details.

The service is currently funded until April 2019 by local Clinical Commissioning Groups rather than by Specialist Commissioning.

A recent trial has shown that maintenance Olaparib can extend progression free survival in platinum sensitive ovarian cancer regardless of BRCA status, with an 82% reduced risk of progression /death reduction in BRCAm patients and a 46% reduced risk in non-BRCAm patients.

3. Service Development

3.1 Genomic medicine service

Please see the presentation uploaded on to the SWCN website

Presented by Tracie Miles and Catherine Carpenter-Clawson (TM and CC-C)

The West of England GMC received their first results for cancer patients over the last few months, including a BRCA somatic gene variation. Many interesting results have been returned for patients in the rare disease arm of the project, which is closing to recruitment in the near future. At a meeting in December 2017, an update was provided on national recruitment to date, as documented in the presentation. The recruitment of cancer patients is currently under target due to the complexities involved in processing fresh tissue. Ultimately, the aim would be to open the pathway in all hospital sites for each disease type.

National results have shown that 65% of cases processed to date have gene variations with actionable significance.

A process of re-procurement commenced in December 2017 aiming to establish seven nationally commissioned Genetic Laboratory Hubs (GLH) by October 2018, when it is planned to transition whole genome testing from a project to standard care in the next 5-10 years.

A tailored directory of molecular markers that can be used to inform diagnosis, prognosis, and treatment decisions, will be developed and opportunities for clinical trials will be explored. It is thought that BRCA and Lynch syndrome will be included. Areas where further evidence on whole gene sequencing is required will be identified and patients consented accordingly. It is hoped to reduce the turnaround time for results to 20 days.

Recruitment of gynaecological cancer patients in Gloucestershire and RUH Bath has been progressing well. Clinical Nurse Specialist Tracie Miles (TM) decided to commit her time to the project to help mainstream genetic testing, and set up the complex pathway in Bath by engaging multiple staff members at every step required in the pathway. The project will remain open to recruitment until September 2018. A return of results pathway is now being developed. Input from any interested parties is welcomed. The service model in Bath will be shared. **TM**

Online training is available; for more information on this and any other queries, please contact CC-C: 07732 561067, Ubh-tr.wegmc@nhs.net, or Tracie.Miles@nhs.net .

4. Network Issues/Service Changes

4.1 Review of previous notes and actions

As there were no amendments or comments following distribution of the minutes from the meeting on the 13th October 2018, the notes were accepted.

Somerset Cancer Register (SCR): Development of the SCR is now on the agenda of the National Cancer Transformation Board. Consultant Gynaecological Oncologist Claire Newton (CN) will be put in contact with SCR Senior Analyst Catherine Donnelly (CD) to arrange for her involvement in any developments to the Gynae Oncology section of the register. **HD**

Cancer Research UK Multi-Disciplinary Team (MDT) Effectiveness / MDT meeting reforms : Details of a webinar hosted by Professor Martin Gore, to discuss MDT reforms, is available via this link: https://attendee.gotowebinar.com/recording/5671196705207718915 (this may need to be forwarded to a non-NHS computer login for it to open).
A meeting of the regional Cancer Clinical Leads will be held on Monday 16th July 2018 to discuss a loco-regional approach to the proposed reforms.

4.2 South West Academic Gynae-oncology Group for Education and Research (SWAGGER) programme

Presented by Claire Newton (CN)

The data collected from the previous SWAGGER meeting on malignant melanoma has been submitted as a poster to the British Gynaecological Cancer Society (BGCS), and a draft paper is nearing completion; this will be circulated in the near future for the group's opinions. **CN**

Consultant Gynaecological Consultant Jo Morrison from Taunton has asked that the group conduct a service evaluation of laparoscopic versus open hysterectomy outcomes, as there was a lack of information in this area. A concise spreadsheet will be put together for this purpose, to provide detail of the relevant operations performed over the last 10 years. Data will be completely anonymised to comply with General Data Protection Regulation (GDPR 2018). Links to patient identifiers will be stored locally.

As a paper is due to be published relating to this subject, any decisions on the dataset should be delayed until this is available to avoid having to repeat the data collection, should an additional data field be identified as necessary at a later date.

Pathology colleagues will be consulted on the appropriate definitions to use for parametrial margins. It is hoped that data can be gathered on approximately 70 patients for the next SWAGGER collaborative publication, which should help to raise the profile of South West services. The dataset will be circulated when available.

CN

Research funding may be available to pay pathologists to collect data on margins.

4.3 Configuration of Cancer Exclusion Clinics

Please see the presentation uploaded on to the SWCN website

Presented by Phil Rolland (PR)

The volume of two week wait referrals in Gloucestershire has risen dramatically, doubling over the past few years, while the workforce has remained static, resulting in a detrimental impact on performance. An audit of referrals showed that the majority did not meet the referral criteria; there was pressure on GPs not to miss the signs of cancer and it was recognised that national policy is to increase access to cancer services. In response, the team have rebranded their outpatient appointments as a Cancer Exclusion Clinic (CEC) and have removed barriers to access cancer exclusion tests, the results of which all come back to the clinic for action. The first outpatient appointment includes an ultrasound, hysteroscopy and biopsy if needed. Patients found to be benign are discharged back to their GP to refer on to an 18 week pathway where appropriate; this has been approved by the Gloucestershire Clinical Commissioning Group.

The clinic, held on a Friday afternoon to fit in with laboratory workloads, is manned by 3-4 Consultants, each seeing approximately 10 patients. A meeting is held before the clinic starts to review notes and results. The new process has dramatically improved 14 and 62 day performance. It is reliant on Consultants being willing to commit to the required changes, dedicated documentation and a dedicated administrator to action the clinic outcomes over the weekend. There are still capacity problems to address and processes to streamline in the future, as documented in the presentation.

Consultant Gynaecological Oncologist Jonathan Frost (JF) will develop a patient information leaflet to explain the function of the clinic.

5. Research **JF**

5.1 Clinical trials update

Please see the presentation uploaded on to the SWCN website

Presented by David Rea (DR)

Recruitment figures (sourced from EDGE), open trials, and trials in set up are documented within the presentation. The national recruitment target for gynaecological cancer is currently 3 per 100,000 of the population served.

Recruitment to time and target for cancer studies has improved, resulting in a slight increase in income to the network from the National Institute for Health Research (NIHR).

The metrics for measuring performance are being revised and may provide ways to recompense research activity according to the burden of disease type.

Principal Investigators will be invited to use the research section of the SSG meetings to launch new trials. Information on open trials and those in set-up is available on the SWCN website to view within MDT meetings. In addition, there is a list of trials available to open in new sites documented within the presentation. SSG members are to contact Portfolio Facilitator Jessica Bartlett if they are interested in opening any of these trials, who will make enquiries on their behalf: jessica.bartlett@nihr.ac.uk

It was noted that GMC activity has now been included in the portfolio.

The MROC trial is comparing surgical decision making after CT scans for ovarian cancer with multi parametric MRI scans. Decision made after CT review, and the MRI results are sent to the trial team in UCL. If the trials team add any information in addition to that decided using the CT alone, the patient is discussed again prior to surgery. It is understood that salient findings have been reported that otherwise would not have been identified.

6. Quality indicators, audits and data collection

6.1 Minimum information output from Gynae-Oncology MDTs

Please see the presentation uploaded on to the SWCN website

Presented by Amit Patel (AP)

Dichotomies were present in MDT working: differences in managerial and clinical approaches, such as increased access to services for the worried well versus delayed diagnosis of cancer – quantity versus quality. The right tools were required to ensure that the purpose of MDTs, to ensure patient safety, was maintained. MDTs require streamlining wherever possible to manage the ever increasing workload.

MDT activity can be divided into three sections:

- Before: How the patient is referred can be improved by the implementation of a referral proforma with mandatory data fields, reducing the number of patients rolled over to the next meeting
- During: The round table discussion can be improved by the use of appropriate audio visual facilities. Leadership can also assist with streamlining, to ensure that discussion of the same issues is not repeated, by protocolising the care of certain patient groups where deemed safe to do so, and by checking that MDT outcomes are recorded using precise language so that there is no need for further clarification. It is useful for MDT members to look at Belbin's team roles to establish how their individual traits can best complement team work, and encourage contributions from those more reluctant to speak

- After: Systems that support the MDTs' duties of record keeping will assist MDT Coordinators with immediate distribution of MDT outcomes and referral on to other MDTs where relevant.

Work can be halved if the appropriate tools are in place. The capacity to audit efficiency, morbidity and patient outcomes, to identify areas for improvements and give patients accurate expectations is also required. For example, the previously used gynae-oncology database, developed to support MDT function, had been used to supply management with data to show that the number of patients rolled over to later MDT meetings was due to reduced radiology capacity.

The Information Management and Technology (IM&T) Department in UH Bristol has recently announced that it is no longer viable to support the gynae-oncology MDT database. This is felt to be a backwards step, as other Trusts are in the process of considering purchase of the software.

6.2 Review of COSD data completeness

The COSD data review will be deferred to the next meeting due to time constraints.

7. Patient experience

7.1 Clinical Nurse Specialist (CNS) update

The CNS workforce in University Hospitals Bristol is due to be increased in the near future. CNS Katie Horton-Fawkes has been seconded for 2 days per week to work on Patient and Public Involvement for the SWAG Cancer Alliance.

7. Living With and Beyond Cancer

7.1 Ovarian cancer Wellbeing Days

The update on ovarian cancer Wellbeing Days will be deferred to the next meeting due to time constraints.

7.2 Cancer Transformation Fund/Patient initiated Follow-Up (PIFU)

Please see the presentation uploaded on to the SWCN website

Presented by Catherine Neck (CaN) and Katy Hawton-Fawkes (KH-F)

The National Cancer Transformation Board has notified the South West Cancer Alliance that Transformation Funding will be reduced to 75% for Quarters 1 and 2, due to the recent creation of a rule that links funding to 62 day Cancer Waiting Time (CWT) performance. Development of a patient information portal has been put on hold. Funding may be reduced again should there be a further decline in CWT 62 day performance.

Living With and Beyond Cancer (LWBC) activity is being measured for prostate, breast and colorectal cancer sites. This initiative (which involved implementation of the recovery package), will be made available for all cancer patients, with generic Living Well days being held as an alternative to site specific events.

Funding is being used to recruit 25 Cancer Support Workers across the region to support the CNS teams with LWBC activity. RUH will have 8, UH Bristol 5-6, and Gloucestershire 5-6. A Band 7 Allied Health Professional will be employed by each Trust to enhance cancer rehabilitation services, and a Consultant Clinical Psychologist has been appointed to supply Level 2 psychological training programmes for staff across the region. The work is also supported by Project Managers in the Trusts and CCGs.

Treatment Summary Templates have been drafted and will be circulated for input from the clinical team. **CaN/HD**

PIFU has commenced in UH Bristol for those patients that are deemed safe to discharge. Each relevant patient is given a PIFU business card containing contact information for the CNS team on one side and alert symptoms on the reverse and a standardised discharge letter is sent to the patient's GP. It is hoped that this process will significantly free up capacity in follow up clinics and could be adopted across the SWAG region. Claire Newton (CN) is working on a grant application for a PIFU survey to assess its safety and would welcome assistance from the CNS teams. CNS Tracie Miles has relevant data to contribute to the survey; a meeting will be arranged for further discussion about the project. **CN/TM**

9. Clinical Guidelines

9.1 Fluorescent imaging and its use in Gynae-Oncology Surgery

The laparoscopic stacks purchased by the UH Bristol gynae team allow use of indocyanine (ICG) which, in fluorescent mode, allows the surgeon to visualise the lymph channels and follow them to identify nodes. It is not for use in patients who are iodine sensitive. A demonstration of the imaging technique was provided.

10. Any other business

An update on the progress of mainstreaming genetic testing for ovarian cancer will be provided by TM at the next meeting.

Date of next meeting: Friday 12th October 2018 09:30-14:00, Exeter, venue to be confirmed.

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