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

Meeting of the SWAG Network Lung Cancer Clinical Advisory Group (CAG, formerly SSG)

10:00–15:00, Tuesday, 21st May 2019, Engineers House, The Promenade, Bristol, BS8 3NB

THIS MEETING WAS SPONSORED BY AMGEN, ASTRAZENECA, BRISTOL MYERS-SQUIBB, BOEHRINGER-INGELHEIM, MERCK, PFIZER AND ROCHE

Chair: Dr Adam Dangoor (AD)

	NOTES (To be agreed at the next CAG Meeting)	**ACTIONS**

1. Welcome and apologies

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

2. Review of last meeting's notes and actions

Notes:

As there were no amendments or comments following distribution of the notes from the meeting on the 27th November 2018, the notes were accepted.

Actions:

Multidisciplinary Team (MDT) service - surgical representation at 95% of MDT meetings: The Cheltenham and Gloucestershire combined MDTM is moving to a different day from July 2019. This will allow surgical representation at MDTMs to move towards meeting the 95% target across the region. Processes for streamlining MDTM discussions are being explored.

Coordination of patient pathways – implementation of the National Optimal Lung Cancer Pathway (NOLCP): Consultant Respiratory Physician Henry Steer has been appointed to the role of Cancer Alliance Clinical Lead to coordinate regional implementation of the pathway with assistance from Transformation Project Manager Nicola Gowen.

Rapid diagnostic pathways: The national lung cancer diagnostic algorithms have been adapted and are in use in RUH Bath.

Management of lung nodules: A session on management of lung nodules and development of a SWAG standardised Patient Information Leaflet (PIL) will be planned for the next meeting. **AD**

Development of information on managing pain and complex complaints, plus ways to access the surgical service for advice: A new PIL has been developed and is due to be authorised by the Communications Team in the near future.

Relabelling of patient information to match the wording in the National Cancer Patient Experience Survey (NCPES): After the review of the most recent survey, it was recommended that patient information is designed to match the wording used in the NCPES.

Organisation of a South West wide conference for education and research: The Autumn meeting will remain in the normal format. The aim will be to organise a larger event next May and invite teams from the Peninsula and South Wales. **AD/HD**

3. Living With & Beyond Cancer (LWBC)

3.1 Implementation of the Recovery Package

Please see the presentation uploaded on to the SWCN website

Presented by Catherine Neck (CN)

The majority of the elements of the Recovery Package are being provided to patients by Cancer Support Workers (CSWs), currently funded by the National Cancer Transformation Fund. Rehabilitation roles have also been supported from the fund, which stops in March 2020. A sustainable solution to continue the funding is currently being negotiated with the regions Clinical Commissioning Groups. It is essential to document all related activity to provide an accurate evaluation of the service provision.

The revolutionary CSW role delivers care alongside and supported by the Clinical Nurse Specialist teams. The most common outputs are assistance with access to financial benefits, psychological support, dietary and other health promotion advice and fatigue management.

Health and Wellbeing Events in the Bristol, North Somerset, South Gloucestershire region (there are different iterations across the SWAG region) have evolved from a 'next steps' event at the end of treatment, to also include a 'first steps' event at the time of diagnosis. A similar event for patients with a poorer prognosis of approximately 6 t 36 months (the Adjust, Adapt and Plan event) will be held, with input from the palliative care team. The team in RUH Bath are also holding 'first steps' and 'next steps' events, and are setting up a palliative support group based in the community. Positive patient feedback is routinely reported from the events.

End of treatment summaries have been drafted in collaboration with GP colleagues. The radiotherapy summary is routinely completed by the radiographers. It is not straight forward to achieve this for systemic treatment which often continues for a significant period of time, and changes from one treatment to another. General Practitioners need additional information on these treatments, especially on immunotherapies and long term effects. It would be difficult to keep such information up to date.

It would be ideal to create a template containing links to relevant websites in hospital information systems, so that this could be quickly added to clinic letters. The Systemic Anti-Cancer Therapy template will be amended and recirculated for

comments. **CN**

Cancer education events are being held for GPs across Sustainable Transformation Partnership areas.

4. Coordination of patient care pathways

4.1 28 day faster diagnostic standard

Please see the presentation uploaded on to the SWCN website

Presented by Ed Nicolle (EN)

The new 28 day faster diagnostic standard applies to all patients referred via the two week wait system and aims to improve the time between symptoms to treatment for those diagnosed with cancer, and improve the time to rule out cancer and put people's minds at rest. The two week wait target may begin to be phased out.

The associated dataset includes 9 data fields that will be collected on the Somerset Cancer Register or Infoflex from April 2019 onwards. Performance will be measured from 2020; the target has yet to be defined.

Evidence will be gathered from clinic letters, which may drive improvements in typing turnaround time.

It is thought that this will be superseded by implementing the optimal lung cancer pathway.

The target could be used to drive improvements in CT capacity.

4.2 Implementation of the National Optimal Lung Cancer Pathway (NOLCP)

Please see the presentation uploaded on to the SWCN website

Presented by Henry Steer (HS)

The Cancer Alliance Clinical Lead role for implementing NOLCP will provide seamless communication between the Cancer Alliance and the Clinical Advisory Group. Information on progress within each Trust is being mapped to assess where additional resources are required and to identify and share best practice. The biggest resource for enabling this to occur is via the expertise of CAG members. It is recognised that problems and solutions will vary according to the particular needs of each organisation. Many of the issues are related to waiting times.

A limited amount of funding has been allocated to lung cancer in recognition of the need to shorten patient pathways. This can be spent on improving CT scan reporting times and to support sending 90% of patients for curative treatment with all relevant tests completed.

Site visits are being arranged with each centre, some of which have already taken place. To date, it has been established that elements of the pathway are in place in some form in each Trust.

All Trusts have access to PILs developed to explain that a chest x-ray might automatically result in a referral for a CT scan. Patients referred to RUH Bath are given this either by their GP or by the x-ray department. The leaflet is also provided in UH Bristol and in Taunton, it is pasted into the appointment letter and given out by the x-ray department. Gloucestershire will set up a similar system. **HS**

The majority of Trusts are only coding those x-rays classified as CX3 – highly suspicious of cancer. Gloucestershire have adapted the CX2 code definition to allow it to be used for urgent non cancer CT referrals.

In some centres, the radiologist asks the GP to make the CT scan request. This process is not possible in Taunton. The Clinical Commissioning Groups will be required to commission the service with parity across the region by April 2020. **Somerset CCG**
CT requests are made by the Consultant Thoracic Radiologists in some Trusts, and by the respiratory team in others.

UH Bristol now have pre-allocated CT slots in the morning which are 'hot reported' within an hour, and the patient is seen in clinic the same day. This works well, although there is no time to triage patients after the CT scan so that many patients are seen in clinic who do not have cancer.

Taunton holds a twice weekly MDT to review the CT scans and can filter out approximately 75% of patients who do not need to come back to clinic. RUH Bath also only sees patients in their new fast-track clinic, called 'LIFT', when there is a suspicion of cancer.

RUH Bath has recently introduced diagnostic bundles; this is in progress in the other centres.

The RUH Bath team have two Lung Cancer Navigators in post that work closely with the respiratory team, Clinical Nurse Specialists, and Cancer Lead, to track all of a patient's progress through the pathway. Gloucestershire are changing the role of an administrative support worker to adopt a similar model; colleagues are recommended to visit the service to see how it works. Currently the Clinical Nurse Specialists in NBT, UH Bristol and TST track the patients. Other initiatives and details from site visits are documented within the presentation.

There are delays with the turnaround time of molecular test results; all Trusts except Taunton now reflex test, which does speed up the process. Tests are currently sent to a variety of centres; it is hoped that the NBT Genomic Centre will be able to resolve this when they are established.

Gloucestershire now call patients to inform them that a PET scan appointment will be booked to reduce the need to bring patients back to clinic. Patient feedback on the process has been positive.

The National Lung Cancer Audit (NLCA) are organising a national organisational survey. An online portal is now open for submissions until Wednesday 19th June 2019.

NLCA is also collaborating with the national programme Getting it Right First Time (GIRFT), designed to identify changes led by frontline clinicians, to improve the quality of care within the NHS by reducing unwarranted variations. The GIRFT team will visit every lung cancer centre, providing an opportunity for centre to identify their needs.

CAG members could undergo a workload analysis, looking at the number of patients and the Programmed Activity, Respiratory clinics and CNS posts required to manage the workload.

CAG will continue to share practice across centres to make NOLCP achievable.

5. Network issues/MDT service

5.1 Multi-Disciplinary Team Meeting Reforms

Presented by Vidan Masani (VM)

The national MDT streamlining pilot (2018), organised by NHS England on behalf of the late Professor Gore, has produced guidance that was presented at a recent meeting. The guidance should be considered with a degree of caution. The application of pre-determined standards of care works well for some cancer sites, such as prostate, but not for all; overall the evidence from the pilot was limited.

The main messages were to triage where appropriate, for example by triaging lung nodules in accordance with British Thoracic Society lung nodule guidance, audit MDT outcomes, nominate people responsible for data quality, and rationalise attendance numbers. Robust administrative processes are required to facilitate reforms. There is a non-funded version currently held in RUH Bath to discuss nodules and follow up. Non face to face tariffs need to be negotiated to enable patients to be managed in a virtual way rather than via outpatient appointments.

It was noted that radiology reports should always be referred to a named clinician rather than referred to an MDT.

6. Research

6.1 Clinical trials update

Please see the presentation uploaded on to the SWCN website

Presented by David Rea (DR)

The National Institute for Health Research (NIHR) has revised the high level objectives from 2019/20 to allow increased focus on smaller recruiting trials. The 30 day and 40 day set up targets have been replaced with a new median study set-up time. The former 30 objectives have now been replaced with 5 harmonised objectives.

New Principal Investigators will be sought for areas of research that are currently under-represented.

Two West of England Clinical Research Specialty Leads have been appointed: Consultant Oncologist Helen Winters and Consultant Gynae-Oncologist Claire Newton.

Recruitment figures (sourced from EDGE), open trials and trials in set up are documented within the presentation. The recruitment target per 100,000 population for Lung Cancer is 4, which had been exceeded in 2018/19.

CanopyA, a Phase III, multicentre, randomized, double blind, placebo controlled study, evaluating the efficacy and safety of canakinumab for completely resected (R0) non-small cell lung cancer (NSCLC) is struggling to recruit due to concerns over the increased risk of infection and lack of suitable patient numbers. Inclusion and exclusion criteria are documented in the presentation.

ADSCaN, A Randomised Phase II study of Accelerated, Dose escalated, Sequential Chemo-radiotherapy in Non-Small Cell Lung Cancer, is also struggling to recruit due to a lack of suitable patients

CAG members are asked to promote the trials and share ideas to improve recruitment numbers.

Although not part of the West of England Research Network, Taunton and Yeovil Centres should be included in correspondences about research, as the patient pathways map to the SWAG area.

Gloucestershire is recommended to open more experimental arms in the ADSCaN trial.

7. Quality indicators, audits and data collection

7.1 Lung Cancer Clinical Outcomes Publication (2018)

Please see the presentation uploaded on to the SWCN website

Presented by Doug West

The quality outcomes were based on surgical operations performed in 2016.

Centres identified as outliers based on survival data will receive a letter mandating that an improvement plan is submitted.

Optimum median length of stay and resection rates has yet to be defined.

Surgical resection rates have been increasing year on year.

Further details are documented within the presentation.

Reducing disparities in median length of stay and reducing readmission rates have been identified as national targets for quality improvements.

Surgical resection rates may increase when the surgical service can provide more cover to the peripheral centres, although it is recognised that surgery is often declined due to patient choice when there is a requirement to travel from a rural region to a specialised centre.

From the NLCA audit, 1 year survival has risen by 37 percent, and provision of anti-cancer surgery and other therapies, including chemotherapy for small cell, has increased. There is a continued need to look into the regions' surgical resection rates for patients with Stage 1 and 2 lung cancer with a Performance Status (PS) between 0-2, as numbers are still low in comparison with the national average. Consultant Respiratory Physician Andy Low (AL) will conduct another audit. An audit was recently completed in Yeovil, which again found that the burden associated with travel and finances were the main reasons why patients had declined surgery. The aspiration would be to offer a hospital transport system comparable to the service provided in Sweden. **AL**

Complex comorbidities have been found to be the other reason why surgery had not been offered; for example a patient with a PS of 1 but severe emphysema, and a patient with a second metastatic cancer. It would be helpful to document these details in the audit.

The audit data should be validated on a regular basis and a monthly report issued. As this had not been received recently it will be investigated. **AL**

In the event that a patient is seen by an Acute Oncology or Palliative CNS rather than the Lung Cancer CNS team, this should still be recorded as 'seen by CNS' in the Somerset Cancer Register.

The audit is out to tender this year. This could be an opportunity to provide feedback about the accuracy of data.

7.2 Surgical resection review

Please see the presentation uploaded on to the SWCN website

Presented by Eveline Internullo (EI)

Further details from the NLCA are documented within the presentation. The Royal Devon and Exeter service was noted to have ceased during the last audit period. UH Bristol has submitted data on 240 surgical resections in 2017.

There has been a significant increase in the number of operations for carcinoid lung tumours (82% in 2 years).

Pulmonary rehabilitation and smoking cessation guidance should be made available to all patients as it is possible to help patients who are considered borderline for tolerating surgery to get fit for surgery within a short period of time. Optimisation should also include COPD management, CPET, cardiology review and a surgical second opinion. A complex case review meeting is held each week with 2 anaesthetists and 2 thoracic surgeons; this changes the management of approximately 50 percent of patients.

A pre-assessment video to observe a patient walking the length of the ward, sitting and standing, is a good source of information to help with clinical decision making.

The patient pathway can be further optimised by minimising administrative 'dead times' by wider use of the fast referral form and ensuring the patient is booked into clinic with all diagnostic test results available.

There are a number of ways that pulmonary rehabilitation can be delivered, including a DVD that can be watched at home, various applications that can be downloaded, or pedometers that are available on Amazon for approximately £4.00.

CAG will link with the Cancer Alliance Prevention and Early Diagnosis Group to determine if there is a way to fund Prehabilitation initiatives to include help with smoking cessation; this will be added to the agenda of the next meeting. **HD**

7.3 Lung Cancer Screening: The Nelson Trial

Please see the presentation uploaded on to the SWCN website

Presented by Eveline Internullo (EI)

Results from the Nelson Trial, published in September 2018, proved that Computed Tomography (CT) screening can reduce lung cancer deaths, with an overall reduction of 26% after 10 years follow up.

The randomised controlled trial compared usual care versus CT scan at baseline, 1, 2 and 5 years. 67% of lung cancer detected was diagnosed at Stage Ia to II. This could lead to a shift from mainly palliative to curative treatments and less invasive surgery. Fast growing tumours would still be missed.

The cost implication for implementing screening is significant, and money may be better spent on smoking cessation; the 10 pilots underway in the UK (the locations of which are based on prevalence of lung cancer) are set up as lung health checks. The number of CT slots and reporting radiologists required needs to be estimated by calculating the screening population from GP databases. The pilot in Manchester, which is based in a couple of lorries in a supermarket car park, has successfully engaged with the general public, and has shown that screening people stops them smoking.

8. Clinical guidelines

8.1 Diagnostic algorithms

Please see the presentation uploaded on to the SWCN website

Presented by Vidan Masani (VM)

The lung cancer diagnostic algorithms, originally compiled by the team in Wythenshawe, include 5 different groups of patient characteristics at presentation, and the corresponding bundle of diagnostic tests to be requested at the first appointment.

Group 3 was looked at in detail. The RUH team has reviewed and created a local adaptation of the algorithms that is now in use in the LIFT clinic. Each team will aim to do the same in the next 6 months. There were some elements that were not available in all centres at present, for example Staging EBUS. **AGREED**

Physicians in RUH are working with surgeons and oncologists to develop a geriatric scoring system to roll out across cancer sites. Advanced Nurse Practitioners may be trained to provide the assessment.

Patients should not be overloaded with information after receiving their diagnosis; information on Prehabilitation can be given by Cancer Support Workers soon after but on another occasion. Similar information is also provided in 'First Steps' wellbeing days, held prior to treatment commencing.

8.2 Radiofrequency Ablation in the management of pulmonary tumours

Please see the presentation uploaded on to the SWCN website

Presented by John Hughes (JH)

Radiofrequency ablation has been replaced with microwave ablation, which provides better air penetration and heat sink effects, plus it reduces the time of treatment from 15 to 2 minutes.

Indications are for treatment of bronchogenic carcinoma with curative intent in patients not suitable for surgery or radical radiotherapy, and treatment of pulmonary metastases with curative intent, which, with the introduction of SABR, is rarely required.

Treatment is given via a standard biopsy technique as a day case under general anaesthetic. The 16 gauge microwave needles used have a cooling system to ensure that only diseased tissue is ablated. The area of the lung that is safe to ablate (1 cm distance from pleura / heart) is the same area that is ideal for treatment with SABR, although microwave ablation is possibly preferable for those patients with interstitial lung disease or previously treated with SABR. Complications are rare, with the most common risk being pneumothorax, and the treatment is relatively effective.

9. Patient experience

9.1 Clinical Nurse Specialist update

Presented by the CNS team

Yeovil District Hospital: A new respiratory department opened 2 months ago enabling the team to sit together which has notably improved communication between team members. It is planned to hold 2 dedicated cancer clinics per week, and a Cancer Support Worker is due to be appointed in the near future.

The importance of working in close proximity had become apparent in the oncology department; communication had deteriorated since the secretaries and management team had moved out of the BHOC.

Musgrove Park Hospital: A new Clinical Nurse Specialist (CNS), who previously worked in primary care, has recently joined the team. Cancer Support Workers are providing the team with support completing Holistic Needs Assessments and coordinating Wellbeing events. An event for patients that are newly diagnosed will be held in the next few months.

Weston General Hospital: A Band 6 CNS will be starting in July. Consultant Oncologist Waheeda Owadally has returned to the team.

RUH Bath Hospital: The possibility of the part time post of CNS to be changed to a full time post is being investigated. Work is underway with the 2 Lung Cancer

Navigators to optimise the initial part of the patient pathway via the LIFT clinic, and now work will commence on optimising the oncology part of the pathway. The CNS team are proactive at optimising patients prior to surgery wherever possible.

UH Bristol Hospital: The Cancer Support Worker roles are making a huge difference to patients, especially on providing support with seeking financial assistance.

10. Any other business / content of next meeting

User Representative Joe Norman emphasised the benefits of social prescribing to services outside the health service, such as walking clubs, that can help support Prehabilitation and Rehabilitation initiatives. CSWs are to make these links with the community.

The larger meeting in May will concentrate on research, audit, and education, and showcase initiatives from across the region.

A representative from the genomic medicine team will be invited to provide a presentation at the next meeting. There are currently issues with genetic test result turnaround times that need to be addressed as a network.

Date of next meeting: Tuesday 19th November 2019

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