

**Meeting of the SWAG Network Upper Gastro Intestinal / Hepatobiliary and Pancreatic
Clinical Advisory Group (CAG)**

**Friday 29th November 2019 12:30-17:00, Holiday Inn, Bristol City Centre, Bond Street,
Bristol, BS1 3LE**

THIS MEETING WAS SPONSORED BY KYOWA KIRIN AND MYLAN

Chair: Mr Richard Krzysztopik (RK)

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 South West Clinical Network website [here](#).

2. Review of previous notes and Work Programme

As there were no amendments or comments following distribution of the notes from the CAG meeting on Friday 10th May 2019, the notes were accepted.

The majority of actions on the Work Programme from previous meetings are on the agenda. Actions discussed:

Living With and Beyond Cancer (LWBC) - implementation of the recovery package: Patients frequently feedback that they can feel abandoned after the intense period of treatment has ended, and LWBC initiatives to improve this are welcomed.

End of treatment summaries have been drafted for patients and GPs that detail potential side effects and the alert symptoms to trigger referral back into specialist services. These will be circulated for the opinions of the group after the meeting.

HD

Prehabilitation: Prehab initiatives aim to improve patient's cardiovascular and nutritional health prior to undergoing surgery. Representatives from the WesFit trial, which focuses on prehab, will be invited to provide a presentation on the trial at the next meeting, with the aim to open to recruitment in regional centres.

Multi-Disciplinary Team Meeting (MDTM) reforms: The MDTMs, which provide a vital opportunity for patient discussions, are being reviewed. Participants have been asked to provide feedback via survey monkey on processes that work well, and processes that require improvements. The Upper GI MDTM is working efficiently, whereas the HPB MDT list is recognised to be overloaded, and needs to be streamlined to ensure that adequate time is available for discussion of complex cases. MDT Assessments are due to commence in December 2019 to identify where interventions might be implemented to assist with the process. Any ideas from attendees would be welcomed; the survey remains open for further comments.

All

National Oesophago Gastric Cancer Audit (NOGCA); regional audit of

discrepancies: A UH Bristol audit of proximal margins and a regional audit of emergency presentations will be undertaken in light of the most recent NOGCA data. The Taunton team are concerned that emergency presentations are currently documented inaccurately. Data will be accessed directly from NOGCA for this purpose.

HD

3. Research

3.1 Clinical Research Trials

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 as detailed in the presentation. There is an 80% patient recruitment target for both commercial and non-commercial trials. Set up targets are now 80 days for commercial studies and 62 days for non-commercial. The former 30 objectives have now been replaced with 5 harmonised objectives.

HD

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

Specific areas of focus for the NIHR are surgical trials, which are inherently difficult to recruit to, radiotherapy, rare cancers and Teenage and Young Adult (TYA) trials. A TYA Research Nurse has recently been appointed; the role will be based in the Bristol Haematology Oncology Centre, but will have a network-wide remit.

Recruitment figures (sourced from EDGE), open trials, trials in set up, and open to new sites, are documented within the spreadsheet and presentation, which also includes a list of useful links for people to check for trial availability; these will be circulated and uploaded on to the SWCN website. CAG members are invited to contact the research team for further information on trials that they might wish to open.

HD

The WesFit trial is for cancer surgery only, specifically UGI, HPB and Colorectal, but could be opened in other cancer sites. DR will liaise with the trial team.

DR

Discussion of trial eligibility during MDT meetings has been found to be poor. Data from the Somerset Cancer Register showed that, out of 7000 outcomes across the SWAG region, approximately 5% had a documented discussion about research. This was echoed in the results from the National Cancer Patient Experience Survey. A project is currently being planned to see how this might be addressed as part of the wider work on MDT reforms.

4. Patient Experience

4.1 Enhanced Supportive Care (ESC)

Please see the presentation uploaded on to the SWCN website

Presented by Miranda Flory

A new Enhanced Supportive Care service for the Bristol, North Somerset, South Gloucestershire (BNSSG) Clinical Commissioning Group (CCG) region (NBT, UH

Bristol and Weston) is due to be piloted from March 2020-21.

The service will ideally provide 2 multidisciplinary clinics, including Palliative Care, Dietetics, Occupational Therapy and Physiotherapy, per week, on a Friday afternoon, initially for patients with oesophageal, stomach, pancreas, cholangio-sarcoma, HCC and lung cancer. Data on relevant patients will be collected in the MDT meetings and recorded on the Somerset Cancer Register.

Site specific CNSs will continue as the patient's keyworker.

Similar pilots have been shown to reduce admissions and length of stay, improve tolerance with completing systemic anti-cancer therapy, and improve symptoms, quality of life, and length of overall survival.

ESC is a proactive, earlier 'positive' supportive care process that is very much aligned with the palliative care process, but 'rebranding' palliative care. The aim is to identify disease / treatment side effects early on to provide interventions before symptoms become too exacerbated to manage.

It is possible to refer patients for psychological support, but there is not a specific psychologist assigned to the pilot.

A patient information leaflet is currently being developed.

Patients that are not well enough to attend clinics will follow the normal triage process to community palliative services.

Key Performance Indicators will be identified to measure the cost benefit of the service.

Somerset CCG has been allocated £500k to run a similar service, which will cover Yeovil and Taunton Hospitals.

It is unclear whether a similar plan for a service in RUH Bath is in progress.

CAG recommend that the clinic is moved to a different day of the week (Monday, Tuesday or Wednesday) due to the logistical problems with managing patients with dysphasia over the weekend. If these patients could be identified during the week by the ESC clinic, this could help to manage the significant associated emergency workload, which is meant to be a 7 day service; current workforce shortages and limited theatre time are making this increasingly difficult to manage.

Increased use of brachytherapy may reduce the stenting workload.

4.2 Patient Information when Surgery is Cancelled

Presented by All/CNS Team

The detrimental psychological impact that cancellation of surgery has on patients, relatives and the surgical team, has been escalated to Psychology Services for advice on how this might best be managed. A potential patient information sheet was drafted for the opinions of the group, and will be amended according to feedback in the meeting today.

The BRI surgical team have applied a cut-off time of 09:30 for Intensive Care bed availability to be confirmed. This will reduce anxiety caused by patients waiting for hours before they know if their surgery will go ahead or not.

**CAG
members/HD**

Ideally, a new date for surgery is offered before the patient leaves, and cancellations result in a follow up phone call from the CNS.

5. Clinical Guidelines

5.1 Genomic Laboratory Hub (GLH) Update

Presented by Newton Wong (NW)

The provision of genetic and genomic test panels is now transitioning from a project to a standard NHS service. The number of laboratories has been consolidated from 25 to a network of 7 Genomic Laboratory Hubs (GLHs), all processing a core set of samples according to the same standards. North Bristol Trust (NBT) was successful in the bidding process to become one of the GLHs in partnership with Royal Devon and Exeter Trust. Each hub has been given the responsibility for processing a number of additional specialist tests, which are divided so it is clear who is doing what for each indication / disease; all cancer samples will be processed in NBT. The Director of the laboratory is Genetic Scientist Rachel Butler (RB).

National genomic test directories for rare diseases and cancer have been published [here](#) to give equity of access across the country. These define the tests that will be made available via NHS England at some point in the near future (potentially April 2020); directories will be reviewed by a panel of experts on an annual basis. This includes access to tests for inherited cancer, whole genome testing for all patients with sarcoma, leukaemia and paediatric cancers (which will include patients up to 24-years-old), and genetic panels for other tumours.

Whole genome sequencing and gene panel tests are currently not available for oesophageal cancer, however gene panel tests are available for gastrointestinal stromal tumours; the plan will be to include more cancers in the future. Results from the Oesophageal Cancer Clinical and Molecular Stratification (OCCAMS) trial may well be incorporated.

The South West GLH is proposing a gene panel that includes 500 genes in the hope that further relevant gene alterations and targeted therapies can be identified in the future.

Transport methods are in the process of being clarified to ensure timely receipt of samples to the laboratory.

Tests will be requested on a paper referral form until an online requesting system has been developed.

Consent is required as results are stored on a research database and will be facilitated by a standardised record of discussion forms.

A list of agreed variants will be discussed by the Genomic Tumour Assessment Boards before reporting back to the requesting MDT; patients with germline variants will be referred to the genetic counselling service and guidance for delivering initial results will be provided by GLH representatives to the clinical team.

National guidelines are being developed on the reporting of relevant variants.

A Genomic Medicine Service Cancer Education Event will be held in Taunton on

Wednesday 29th January 2020.

6. Coordination of Patient Care Pathways

6.1 Cancer Alliance: Rapid Diagnosis Service (RDS)

Please see the presentation uploaded on to the SWCN website

Presented by Nicola Gowen (NG)

Progress has been made on the development of an RDS pilot to coordinate a series of tests to streamline the time to diagnosis for patients with serious non-specific symptoms (please see the presentation for referral criteria) who would otherwise be referred via the suspected cancer pathway. This aims to improve communications between primary and secondary care and prevent the delays which occur when patients are transferred from one specialist to another; the RDS will retain responsibility for the patient until an appropriate referral onwards has been identified.

Results of a national pilot of multi-diagnostic centre models, held in 10 sites across the UK, are detailed in the presentation.

Phase 1 of the RDS pilot will commence in the Primary Care Networks in Mendip and Devizes in the week starting Monday 6th January 2020, and feed in to RUH Bath.

It is hoped that expressions of interest to take part in Phase 2, which has been sent to the STP Leads in each Trust, will allow the pilot area to be widened.

GPs with an extended scope will deliver the service, with agreed points of contact for advice and guidance from specialist MDTs. There is agreement for this patient cohort to be referred to CT within 7 days, which is faster than the current cancer pathway.

Radiology colleagues expressed concern regarding the impact that the new service will have on imaging departments that are already struggling to manage significant workload pressures. Communication with the department is required in order to work through the logistics; CT turnaround time of 1 week for the expected number patients was not felt to be feasible with existing resources.

It is hoped that the demand for CT will not increase, as these patients would already be referred via other routes.

The pilot will be evaluated and adjusted according to local and national findings.

E-Learning will be developed to support the services.

The project was felt to be a worthy initiative, and an opportunity to obtain diagnoses in a more efficient way; feedback on progress would be of interest at a future meeting.

6.2 Implementing a Timed Oesophago-gastric pathway

Please see the presentation uploaded on to the SWCN website

Presented by Dipankar Mukherjee (DM)

Oesophageal Surgeon and North Central and East London Alliance (NCELA) Pathway Director, DM, shared learning from the project to implement the timed pathway in the London service. It is recognised as a complicated pathway which will require different solutions for different organisations.

The reason for implementing timed pathways is to support the national aim to diagnose cancer within a faster timescale, with the Cancer Waiting Time 28 day faster diagnostic standard (to inform a patient if they have been diagnosed or cleared of cancer from that particular investigation within 28 days) being introduced in April 2020.

For the pathway to be achieved, the whole team from treaters to managers and administrative support, including support from project management, need to be engaged. The importance of involving the CNS team and MDT Coordinators needs to be recognised.

Ideally, a small coalition will then be formed to start the change process, initially by measuring the current service provision (conducting a gap analysis), and then by making small incremental improvements, as advised by the clinical team, with the support, rather than instruction of the Cancer Alliance, in recognition that the solutions come from the teams in local centres and not via NHS England. Involving patient partners to understand patient experience, for example how to managing 'did not attend' numbers, is also recommended. The change process needs to allow for failure as part of the way to progress refining the pathway.

Once the London team had produced a Project Initiation Document (PID) that detailed an agreed plan, signed off by the Chief Executives, an engagement event was held that focussed on diagnosis, communications and data management. Roles and responsibilities were allocated.

The need to create job variety and avoid repetition for staff health and wellbeing is recognised. At first, it was thought that developing a nurse endoscopist role would be well received, but now the nursing team rotate responsibilities and the variety helps with staff retention.

It is felt to be vital for Upper GI and Lower GI endoscopists to pool into one team to support implementation of timed pathways.

It is vital to share information on service developments during delivery. The implementation group meet regularly via video-conference every 4-6 weeks to track progress and troubleshoot any issues. Workload pressures for radiology and in particular pathology have been raised as the main problems; sample processing is often outsourced in London, and governance of outsourcing tests is an area of concern.

Data capture of the full system is required but is not available at present. However, the SWAG Cancer Alliance will have a dataset on the 28 day Faster Diagnostic Standard available to analyse, as this is already being collected by Cancer Management Services.

Further recommendations for implementing the pathway are documented within the presentation.

There have been continual efforts to streamline the OG pathway in the SWAG region over the past decade, with support from management teams, but obstacles arise that are not within the surgical centre's control to resolve, mostly with CT capacity in other centres, and similarly with PET-CT capacity in Southmead. Actual breaches in OG surgery are rare, and MDT meeting decisions are progressed outside the MDT meeting environment, yet the demand outweighs capacity. Significant investment is required, for example, PET-CT availability in the surgical centre.

When it is not possible to meet other targets, priority should be given to maintaining the positive patient experience. Hopefully, political support will come through to implement these changes, which may bring further investment.

Staff health and wellbeing also need to be prioritised, as the current pressures could affect workforce retention.

Future innovations, such as the potential for cancer screening breath tests are required.

Consultant Gastroenterologist Javaid Subhani has coordinated an excellent straight to test service in the Basildon; details of the service will be requested.

HD

Date of next meeting: To be confirmed

-END-