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

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

Tuesday, 24th November 2020, 10:00–12:20, Virtual MS Teams Meeting

Chair: Dr Adam Dangoor

NOTES **ACTIONS**

(To be agreed at the next CAG Meeting)

1. Welcome and apologies

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

2. Genomic Analysis for Non-Small Cell Lung Cancer (NSCLC)

Please see the presentation uploaded on to the SWCN website

Presented by R Butler

The South West Genomics Laboratory Hub (GLH), based in Severn Laboratory for cancer tests, and Royal Devon and Exeter for rare disease tests, continues to evolve, with processes moving progressively faster. The GLH is one of seven in England, providing a service for the geographical region from Cheltenham down to the Peninsula. All GLHs are expected to provide the same tests, although there is some freedom to use different technological processes.

The National Genomic Test Directory for cancer is updated annually, with appropriate tests being added or removed by scientists and clinicians. It currently contains tests for over 180 tumour types.

For NSCLC, genetic testing has developed considerably over the last 10 years, with many different gene variants from many different genes now identified.

EGFR was the poster child test, with eligible patients then able to receive Tyrosine Kinase inhibitors resulting in significant responses to disease.

The range of targeted therapies is now on the increase, with the list of biomarkers and therapies available documented in the presentation. These have been approved either by the US and/or by Europe, and many others are expected in the future.

The NSCLC essential gene targets in the test directory are associated with NICE approved drugs. This includes KRAS, as a novel KRAS inhibitor is expected to be approved in the next 12 to 18 months.

The desirable gene targets in the test directory are associated with research trials, and may help patients get access to trials such as Matrix SMP2.

The gene panel processing strategy for extracting DNA and RNA from biopsies results in a bioinformatics analysis of all variants found so that it is possible to investigate if a relevant trial is available.

Gene panel turnaround time needs to take place within 10 days to comply with the National Optimal Lung Cancer Pathway (NOLCP), which the GLH is currently achieving for DNA results; for RNA results, turnaround time is currently 20 days

due to capacity issues, but this is expected to be processed in 10 days within the next month.

NHS England are going to change the turnaround time to 7 days at some point in mid-2021, which will only be achievable if the laboratory moves to a 7 day working week; this is currently under consultation.

It is recognised that, for some patients, these turnaround times are not quick enough, and some biopsies are too scanty and of unsuitable quality. Therefore a combination strategy has been developed where urgent or scanty samples can go for single targeted assays or circulating tumour DNA, depending on the clinician's request. Although this is a quicker process, it will be at the expense of using most of the tissue available, and it may not be possible to go back and do the larger gene panel.

Action: CAG is to agree the prioritised set of tests for the combination strategy scenario, which would probably include EGFR first and ALK second. **CAG Oncologists**

It is possible for pathology to assess the adequacy of samples on Day 1 that the sample is received and inform the MDT who decide which strategy to take.

Action: Rolling network audit of the adequacy of biopsy samples. **SW GLH**

Future access to the wider panel of test results was welcomed by CAG.

3. Quality Indicators, Audits and Data Collection

3.1 Lung Cancer Pathway Tool

Please see the presentation uploaded on to the SWCN website

Presented by J Hutchinson

The MSD pharmaceutical company has employees dedicated to providing non-promotional assistance to support the NHS with implementation of the NOLCP by utilising Prince2 Project Management principles. J Hutchinson has been working with Cancer Alliance Project Manager N Gowen to develop a SWAG pathway analyser report that will provide insights into the relevant service improvements required.

Details on 5 patient pathways have been requested from each provider Trust at the end of each month. Three months of data is available at present which is not enough to draw any conclusions. The main aim now is to ensure that the data collection is providing answers to the right questions and from hard marker data points that will allow accurate comparison. For example, from Gloucestershire, it appears that data on Out Patients Appointments (OPA) is inaccurate as the in-house process is to call relevant patients to arrange a PET prior to the OPA, which is not reflected in the dataset.

There is also missing data on referral dates where referrals are faxed and there is no e-record of the date.

Recording the date that a test result is reported is recommended as it is far easier and more accurate to collect than the date that a test is requested, although, if tests are being ordered as a bundle, this information would not be picked up. **CAG Recommendation**

There are some concerns about the time it would take to complete the data collection. It has been found to take approximately 5 minutes per patient when completed from the Somerset Cancer Registry (SCR), but then the data needs to be reviewed and signed off by a clinician, extending the time period. The centres that have Navigators in post may already have the majority of the data available.

Ultimately, getting the report right will benefit the Trusts as it will provide MDT Leads with the evidence for service improvements.

A useful marker point would be the date that a biopsy is taken, and the date that it is reported. Biopsies from Salisbury are processed in Birmingham, where there is currently a two week turnaround time. It would be useful to demonstrate if the service was an outlier in SWAG to use as leverage to invest in this area.

There is a need to understand how each data field is populated to see if the process can be automated. The data fields need to be clearly defined so that all are collecting the same information. Ideally, data would be collected on as many patients as possible.

Action: NOLCP Pathway analyser tool will be reviewed and restructured by J Hutchinson. **J Hutchinson**

Action: NOLCP Pathway analyser tool v.2 will be circulated for March submission of last 5 patients treated during January 2021 **N Gowen**

3.2 National Lung Cancer Audit (NLCA) Annual Report 2018

Please see the presentation uploaded on to the SWCN website

Presented by J Hutchinson and H Steer

SWAG Trust Level Results from the NLCA had been examined, in particular to look at surgical resection rates in comparison with England, as previous reports looked as if resection rates may be lower in some areas of the SWAG region.

In response, to ensure that appropriate treatment decisions had been made, an audit was undertaken in GRH to review the management of patients with early stage lung cancer and a Performance Status between 0-2 who did not receive radical treatment. This involved examining 36 patient records to establish who made each decision and the reasons why these were made.

Results found that the majority but not all of the decision making was made by the Lung MDT after seeing a respiratory physician, and were worked up appropriately.

Half of the patients were referred on for radical oncological treatment, including SABR, SACT, or palliative radiotherapy.

There were 2 patients who were not coded correctly, 3 who declined treatment and the following for these other reasons:

- COPD 56%
- Cardiac Comorbidities 15%
- Frailty 15%
- Inoperable 3%.

There were no patients identified that could have had surgery that were not offered this treatment option; it was possible for surgical presence at all SWAG Lung MDTs via virtual platforms.

All patients who have been assessed as borderline for surgery should have access to prehabilitation services.

Surgical resection rates have now returned to being comparable with other centres; it is considered a valuable exercise for each centre to do the same audit and discuss as a network group.

Action: H Steer will share the surgical resection rate dataset with MDT Leads so that a network-wide audit can be coordinated. **H Steer**

4. Patient Experience / Service Development

4.1 Videoconferencing and Informatics

Presented by A Dangoor

Funding is available from NHS England via the Cancer Alliance for digital improvement projects for 1 year. After this time, provider Trusts will be lobbied to continue to provide the ongoing costs. One project, due to commence in the near future, is to pilot a Picture Archiving and Communications (PACs) system that can be logged into via a browser to see all PACs wherever performed across the region. Images can be viewed immediately, or be imported to Trust systems in approximately 10-15 minutes.

At present, different systems are used in each organisation; this will be an opportunity for a procurement process that will harmonise software solutions across the patch, with many contracts with existing systems due to end in the near future.

Some examples of software currently in use or under consideration include Insignia, Consultant Connect, Synapsis, EPR, and Carestream. Advantages and disadvantages will be compared to ensure that the one chosen enables maximum integration of systems. It will be used for all imaging requirements - not just for cancer.

Ideally there will also be an advice and guidance function that can integrate with GP systems and EMIS. The software currently used in Gloucestershire allows for this, which can help to avoid unnecessary admissions in an appropriate way.

The provision of an Advice and Guidance function does have workload implications and has to be properly job planned.

Another initiative under consideration is the provision of a digital patient portal where patients can view their Outpatient Appointments, request changes, and access clinic letters, which could significantly reduce postage related costs. It could also be used for Patient Reported Outcome Measures (PROMS); two different companies are in the process of bidding to provide the portal.

Video consultations are being held as an alternative to face to face patient clinics, more extensively by Mental Health and Allied Health Professional services, and could be used more extensively by cancer services. This enables discussions to include multiple family members, removes the communication barrier of having to wear masks, and the need for patients to leave their homes. The CNS team can also join at the same time.

At the most recent meeting of the Cancer Clinical Leads, a patient representative gave feedback that video consultations were not personally suited to their particular situation, and has resulted in the patient seeing many different Consultants with no continuity of care. This highlighted the need to cater to individuals' preferences and provide options when planning consultations.

The Attend Anywhere and Visionable systems are used in varying amounts in some Trusts; GPs have access to accuRX which apparently works better on mobile devices and may be an alternative for consideration. The majority of virtual consultations in Gloucestershire are held via telephone.

CAG recommend the continued provision of video consultations as an appointment option post-pandemic due to the time saving benefit to patients, negating the need to travel and find parking close to the hospital.

CAG recommendation

4.2 National Cancer Patient Experience Survey (NCPES) 2019

Please see the presentation uploaded on to the SWCN website

Presented by B Ockrim

The 2019 NCPES results, published in July 2020, were collected between April and June 2019 from day cases or inpatients aged 16 or over.

SWAG Lung Cancer Services received 220 responses. The main response group was aged 65-74 years, followed by 75-84 years and 55-64 years. Women are more likely to rate their experience more negatively than men.

Only absolute responses are recorded, with mid-range responses, such as 'yes to some extent' excluded.

There will be no 2020 survey due to COVID-19, but NCPES are working on a snapshot survey of patient experience during the pandemic, and it could be useful for each centre to do the same – simply asking the questions what went well, and what could have gone better.

Potential in-house patient experience survey

SWAG responses were extremely positive and above the national average, for

example, the question 'beforehand, did you receive all the information about your operation' was rated 100% positive, and 'were you given the name of a CNS who would support you throughout your treatment' was rated 98% positive.

Results on the provision of financial help were also high which, along with other related questions, has helped to build the Business Cases to support ongoing funding of support staff, who were initially appointed with Personalised Care and Support (formally known as Living With and Beyond Cancer) funding.

The majority of lower scores were about the same as the national average, with the lowest being on the question on patients being told that they could bring a family member to their appointment, and the question on patients understanding the medical explanation of what is wrong with them.

Lead Cancer Nurse R Hendy is joining the NCPES Advisory Board which is reviewing the survey, and can share any suggestions for its redesign.

Feedback from the survey was positive news, and it is unfortunate that the patient experience will be impacted by the pandemic; it is important not to overpromise and to manage patients' expectations over the next few months.

5. Research

5.1 West of England Clinical Research Network

Please see the presentation uploaded on to the SWCN website

Presented by C Matthews

Research Delivery Manager for Cancer, C Matthews, undertook the role 1 week following D Rea's move to work on the COVID-19 trials.

Update since March 2020:

All NIHR research activity has been paused and is now focused on Urgent Public Health (UPH) Research to develop vaccines and therapies for coronavirus since the pandemic began. Set up and delivery has been expedited across all research systems. There are currently 67 UPH trials open; of these 47 opened in the West of England Clinical Research Network.

Many research staff were also redeployed to clinical duties from March 2020.

In May, a restart framework was introduced aiming to restore the full portfolio while continuing to support COVID-19 research. However, 35% of Lung Cancer Trials did manage to continue throughout the pandemic.

NIHR Guidance has been issued on how to protect research activity during the second wave, including that research staff funded by the NIHR will not be deployed to clinic duties except in exceptional circumstances.

The original high level objectives for research during 2020/21 have been suspended and replaced with objectives related to the UPH trials.

Details on the progress for restarting trial activity across cancer as a whole, and

specifically for Lung Cancer trials, are documented within the presentation. Further information is available on the NIHR website. If any CAG members have questions about trials, please contact claire.matthews@nihr.ac.uk

As discussed by the Oncologists present, set-up of new trial activity has commenced in UHBW, RUH and GRH. Matrix SMP2 is now open. Patients can be consented remotely into SMP2, and tumour samples sent to the nominated laboratory; 30% of patients are randomised to receive a targeted therapy, but the number of patients that can be recruited will be limited over the next 3-4 months due to capacity issues caused by COVID-19.

It had been hoped to open Atomic-Meso, but Research Governance Departments are not supporting this as it closes within a year.

There is an Institute of Cancer Research (ICR) study open in London for patients who have done well on immunotherapy who may be willing to travel.

6. Clinical Opinion on Network Issues

6.1 Management of Services during COVID-19

Please see the presentation uploaded on to the SWCN website

Presented by Henry Steer (HS)

There has been a dramatic drop in two week wait referrals at GRH since lockdown, with a shortfall of approximately 40 cases that would have been expected to be referred by Autumn 2020. Referrals have gradually increased since June, but have yet to return to normal levels. Lung cancers diagnosed after admission via an emergency route have risen; survival rates will be affected, with the number of patients diagnosed at a later stage increasing, and the number of patients detected at an early stage declining.

Patients have not been accessing health care due to the fear of contracting COVID, and not wishing to overburden GPs with fairly minor symptoms. GPs have also probably been less inclined to refer patients into Secondary Care during the first wave pandemic.

One benefit of COVID is that there have been fewer exacerbations of COPD, although this is normally a rich source of chest x-ray requests and incidental findings of lung cancer. It is also thought that less chest x-rays have been requested due to the reduced number of GP consultations held face to face, and loss of the walk-in access to chest x-rays. Reduced scanning capacity and less scanning for other indications will also affect pick up of incidental findings.

National and local public message campaigns have been undertaken to encourage the public to contact healthcare providers when they have symptoms. Cancer Research UK and the Roy Castle Lung Cancer Foundation have kick started this, and NHS England has planned a national lung cancer campaign in February 2021.

Locally, H Steer and GP Sadaf Haque created a video for Primary Care which is published on the GP information site G-Care.

A Primary Care Network Webinar was also held with approximately 50-60 GPs attending to spread the message to have a low threshold for referral for chest x-ray, as per NICE Suspected Cancer Referral Guidance (NG12).

Practice level data has been sourced from CCGs to send on to GPs and raise awareness of the drop in chest x-ray referrals.

Action: To request practice level data from the other CCGs within SWAG **H Dunderdale**

The pandemic has also provided some opportunities for innovations. Monthly meetings of the SWAG MDT Leads have been held during the pandemic for the purpose of sharing practice, such as any Standard Operating Procedures that teams develop, and also to provide peer support.

The document *Optimising Use of Radiology Resources During the COVID-19 Pandemic* which breaks scans into 4 different groups, was developed for the purpose of reassuring the team that it is reasonable to marginally deviate from National/International guidance for low risk patients during the pandemic.

For example, it could be appropriate for the current CT led surveillance to be moved to clinical assessment prior to organising a CT.

Adoption of NOLCP timeframes for CT has been accelerated with slots now saved for this purpose.

H Steer has worked with COBALT to implement contrast PET-CT to enable brain staging at time of the PET scan and also provide the mediastinal anatomy required by the surgeons.

Telephone and videoconferencing have been implemented to triage patients to the next step in the pathway.

UHBW are looking to introduce navigational bronchoscopy which would lead to a reduction in the number of patients needing inpatient surgery for diagnosis.

It was noted that the next few months are going to be very demanding.

6.2 Any Other Business

Lead Cancer Nurse B Ockrim raised the CAG / COG concerns about clear guidance for the bundle of investigations required prior to referral to the surgical team.

Action: The surgeons will be contacted for referral guidance to be clarified. **H Dunderdale**

Date of next meeting: To be confirmed

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