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

Meeting of the SWAG Soft Tissue Sarcoma Clinical Advisory Group (CAG)

Tuesday, 20th October 2020, 14:00-15:30 via MS Teams

Chair: Gareth Ayre

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 (SWCN) website.

2. Review of previous notes and actions

As there were no amendments or comments following distribution of the minutes from the meeting on Tuesday 26th November 2019, the notes were accepted.

Actions

Many of the open actions are on the agenda. Actions discussed:

Action 014/15: National Lipoma Pathway:

The guidance has been ratified by the British Sarcoma Group (BSG); E Walton confirmed that all radiology departments have been made aware of the guidance. Action closed.

Action 003/16: Funding for a dedicated Sarcoma Physiotherapist:

A temporary extension of funding for Physiotherapist J Master's post has been agreed. NBT Cancer Manager T Agnew, is waiting to hear from BNSSG about the future funding commitment for all posts recruited using the Living With and Beyond Cancer funds. A business case is underway for the staff to be taken on substantively by the relevant divisions.

Action 010/17: Thoracic Surgeons to join Sarcoma MDT meetings:

E Internullo (EI) and D West plan to build time into their job plans to join the MDT meeting for relevant discussions. Action closed.

Action 013/17: Patient Experience Information for Circulation by Ward Staff:

To remain an open action.

Action 014/17: Systemic Anti-Cancer Therapy Protocols:

The protocols are underway and, once ratified, will be uploaded on to the SWCN website. Action closed.

Directory of Imaging Centres:

On compiling the Directory, which has some information still pending, it was found that GPs in Somerset are unable to refer patients for a local MRI when flagged as required after initial assessment of a suspicious lesion via ultrasound. Access to MRI for Weston GPs is also erratic as some practices are only commissioned to request MRI in NBT. Some GP practices in Gloucestershire and Stroud also do not have local access. This was raised with the Cancer Alliance Early Diagnosis Group but could not be prioritised at present, as the CA needs to prioritise direct access to scans as per NG12 guidance.

The number of patients that need to travel from other regions for MRIs is not currently tracked by radiology, but this may be arranged in the near future.

Action 001/19: The need for equity of access to booking of MRI scans across the region will be raised again with the CA Team. — **H Dunderdale / G Ayre**

MDT Service – promotion of Retroperitoneal Service:

The Consultant Retroperitoneal Surgeons are not available to attend at today's meeting to give an update. The National Service Specification states that services should treat 24 or more cases per year to be considered viable, and numbers need to be bolstered in NBT to secure the future of the service.

Action 005/19: A prospective audit of outcomes will be added to the list of audits for completion by a Registrar/Fellow, to demonstrate the quality of the service, and links will be formed with hospitals regionally and inter-regionally that could make referrals to the service. — **Retroperitoneal Surgical Team**

End Of Treatment Summaries (EOT) for Surgery and SACT:

The surgical EOT summary is still under development. Consultant Thoracic Surgeon E Internullo uses a prefilled template for lung cancer patients that is added to the end of clinic letters. Standard low grade and high grade sarcoma templates could be created. SACT EOT summaries will be automated using the Medway system. These are more appropriate to send these out at the beginning of the pathway as the definition of end of treatment is difficult to define.

Action 006/19: A copy of the Lung EOT summary will be shared and adapted for sarcoma by Consultant Plastic Surgeons R Khundkar P Wilson and T Wright, and the Plastics Secretaries who are aiming to ratify this prior to the next Sarcoma CAG meeting. — **E Internullo / R Khundkar**

Paediatric Shared Care Pathway:

The Paediatric Shared Care Pathway has been ratified.

Action 009/19: The Paediatric Oncology team are to arrange for a second opinion on sarcoma pathology samples to be sent to NBT Pathologist F Maggiani. — **H Rees**

Consultant Plastic Surgeons P Wilson, T Chapman and R Khundkar will share the responsibility of attending relevant Paediatric Oncology Solid Tumour MDT meetings, which are held on Mondays at lunchtime; this has become possible now that the meeting is held on a virtual platform.

Action 001/20: To arrange for the Paediatric Solid Tumour MDT meeting invite to be forwarded. H Dunderdale

Recommendation to exclude Atypical Lipomatous Tumours (ALT) from CWT timed pathway, but continue to track in a similar way to Skin BCC cases:

Action 013/19: Consultant Oncologist G Ayre will discuss further with the Cancer Management Team G Ayre

3. Management of Services during the COVID-19 Pandemic

3.1 2WW Referrals

Historically, it has always been difficult for the Sarcoma Service to achieve the Two Week Cancer Waiting Times target, but this has now greatly improved due to the Clinical Nurse Specialist Lead triage system, organised by C Millman and B Peach.

3.2 Challenges to Surgical Operating Lists

Since lockdown, the Theatre Lists on Thursday and Saturday are no longer available to the plastics team. The lists on Monday and Wednesday are back to capacity, and the team have organised additional lists on Wednesday evenings to try and keep up with the workload, prioritising Grade 2 and 3 sarcomas. Additional slots are still required to manage the Grade 1 backlog but there is no indication from the Surgical Directorate on when this will be resolved; the expected surge in COVID-19 cases is likely to cause further restrictions and inundate Critical Care.

The 'See and Treat' service organised by R Khundkar is working well for appropriate cases.

At a recent Cancer Service meeting, data was shared showing that the service was breaching CWT targets, although the reason for the breaches was not included and the data seemed inaccurate as only 4 new cases were recorded over a 2 month period. This differs from the activity stored on the database which is used for triaging all new referrals from all sources.

Action 002/20: G Ayre will discuss data accuracy with Plastics Manager S Vaithianathan and put review of CWT data on the agenda for a future CAG meeting. G Ayre

3.3 MDT Meetings

The Sarcoma MDT meeting is held remotely at present. The possibility of running a hybrid MDT, with a few key members meeting face to face, will be considered, which would be the preference for some to ensure cohesion of the team. For the moment, this will not be pursued in view of current difficulties such as the capacity of the room, social distancing, and rising COVID-19 cases.

Action 003/20: G Ayre will discuss how the MDT is working with the MDT G Ayre

Coordinator

3.4 Returning to Normal

Follow up had been paused during the first wave of the pandemic, and has now resumed, with everyone who needs to be seen face to face being booked into clinic, or where appropriate, followed up via telephone clinic. This is preferable for some patients, for example, young patients with fibromatosis, has reduced the Did Not Attend (DNA) rate, and would be beneficial to continue.

The remote clinic held on Friday mornings gives patients the option of holding the clinic via video link or telephone.

Action 004/20: The preferred format of the patient's next appointment (face to face or virtual) can be recorded in the clinic outcomes, and the information then needs to be transferred to the clinic list to ensure that the appropriate appointment is booked. This will be discussed further with S Vaithianathan and the Clinic Working Group. **G Ayre**

3.5 Changes in Practice

It was decided to avoid pre-operative radiotherapy (RT) and go straight to surgery for some cases requiring complex reconstruction during the first phase of the pandemic. The decisions were made on a case by case basis, taking into consideration if the lesion was growing rapidly or if the patient was particularly frail. Pre-operative RT remains gold standard care for the majority of patients and will be provided for all appropriate cases, as determined in each MDT discussion. Speed of access to RT at the Bristol Haematology Oncology Centre (BHOC), and Critical Care bed availability may inform decision making over the second wave, but has continued throughout the pandemic to date.

3.6 Examples of Potential Harm / Learning Points

There were no examples of potential harm raised during the meeting.

3.7 Support Required from the Cancer Alliance

Straight to biopsy patient pathways need to be refined for those patients who are referred to the service and diagnosed with an alternative malignancy, for example, lymphoma. There is concern over delays to the patient pathway as, currently, the diagnosis is delivered by the Consultant Plastic Surgeon in NBT, which also may involve lengthy travel, rather than be delivered by the Consultant in the local centre to which the Sarcoma MDT will refer the patient for treatment.

Alternative options may be asking the patient's GP to deliver the diagnosis, or delivering the diagnosis by telephone. The cancer specialty to which the patient will be referred will always be made aware of the cross-MDT referral before informing the patient.

Patient Representative Michael Fowle is of the opinion that patients will want to know their diagnosis at the earliest opportunity, and how this will be managed by the appropriate specialist. A telephone call from the Clinical Nurse Specialist Team who are going to support their care could be an adequate solution. The patient information leaflet for the direct to biopsy service could be developed to set expectations that this may be experienced, although face to face communication of a malignant diagnosis is ideal, and the GP will usually be the last person that the patient will have met, as they will not have been seen by the NBT team at the point of biopsy.

Action 005/20: A standardised letter to GPs will be drafted to see if this may be an acceptable solution; this will be shared with the Cancer Alliance and Macmillan GPs for feedback. **G Ayre / H Dunderdale**

4. Patient Experience

4.1 CNS Led Sarcoma Triaging Service

Please see the presentation uploaded on to the SWCN website

Presented by C Millman and B Peach

The triaging service was set up by C Millman in August 2019 in response to managing overbooked clinics, high volumes of MDT discussions, patients coming for multiple appointments, and to improve GP and patient communications. On return from maternity leave in April 2020, B Peach began a Band 6 developmental role, completed competencies to reach Band 7 triaging capacity; the two CNSs now provide a 5 day a week triaging service, having developed a triaging protocol in collaboration with the Consultant Radiologists, and patient / GP template letters.

A review of the service now that there is a full year of data, shows a significant reduction in 2WW breaches. When comparing data from July, there were 10 breaches in 2018, 5 in 2019, and 1 in July 2020. The reason for this breach will be investigated, aiming to ensure that no breaches occur next year. The process has also saved numerous full MDT discussions by having the pre-MDT radiology meeting.

Patients are now attending Out Patient Appointments (OPAs) with appropriate investigation already performed and a plan from MDT, resulting in a reduction in the number of OPAs per patient.

Positive feedback has been received from GPs and from patients on the improved communication, including giving the CNS contact details earlier in the pathway.

The service was shortlisted for the NBT Director of Nursing awards in the Team of the Year category. All consultants and surgeons present appreciate the impact that the service has had and the savings to clinic time and costs.

Concerns were raised about the CNS workload, and the appropriate level of financial tariff return for the service offered. Currently, virtual clinics generate a tariff of £30 per patient, and the telephone triaging service should be recognised as a similar process.

Action 017/17: C Millman and B Peach will discuss how the service will be recompensed with Finance; CAG will support the negotiations.

4.2 CNS Update **C Millman / B Peach**

A review of the triage dataset is underway, and once a full analysis of yearly data is completed, this can be circulated prior to the next CAG meeting. Review of follow ups, Holistic Needs Assessments and local Patient Experience Survey results are also underway.

4.3 National Cancer Patient Experience Survey (NCPES) Results, 2019

Please see the presentation uploaded on to the SWCN website

Presented by R Hendy (RH)

The survey, which included a 3 month cohort of patients seen as day cases or inpatients between April-June 2019, showed overall that the patient experience

results were improving. There were only 28 sarcoma specific responses included in the SWAG results, with minimal detail to be able to pick out any actions to prioritise, and so the highest and lowest SWAG scores from across the board have been drawn out and are documented in the presentation.

NCPES is currently being reviewed; R Hendy has volunteered to sit on the Clinical Advisory Group and can take any suggestions for improvements that the CAG may want to make, including how to capture sufficient information for rarer cancer sites.

4.4 Prehabilitation and Rehabilitation During COVID-19

Presented by J Masters

This item will be discussed at the next CAG meeting due to time constraints.

5. Clinical Guidelines

5.1 Genomic Laboratory Hub update

Presented by A Juett

Go live dates for the Whole Genome Sequencing (WGS) Service have been moved back due to the COVID-19 pandemic and its impact on laboratory resources and funding. However, the sarcoma pathway has been shown to be effective, with frozen samples ready to go, which will hopefully be sent in November 2020. The delay has given time to refine the consent process, which now takes approximately 5-10 minutes. Patients are generally willing to be involved. The appropriate blood form is available on ICE and the biopsy sample form is available to print out and should be sent to the GLH generic email address. The aim is to embed offering WGS to all sarcoma patients, particularly for those with high grade sarcoma who are most likely to relapse; this will be easier to prioritise once the clinic is optimised.

A Juett and Genetics Counsellor A Pichini are available to provide support to the team as and when required.

6. Any Other Business

Clinic Reconfiguration:

Action 012/17: An email will be sent to selected members of the group to arrange a time for a Clinic Working Group that will define the ideal format of the Tuesday morning clinic.

The British Sarcoma Group (BSG) virtual conference will take place on 24th and 25th February 2021; abstracts should be prepared for submission in October/November. C Millman and B Peach may want to produce a poster to share the triage work, and R Khundkar may want to produce a poster on the 'See and Treat' process. **G Ayre**

Date of the next meeting: Tuesday 2nd February 2021

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