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

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

Friday 14th June 2019, 14:00-18:30
Board Room, Trust Headquarters, Bristol Royal Infirmary, Bristol, BS1 3NU

THIS MEETING WAS SUPPORTED BY ASTRAZENECA

Chair: Philip Rolland (PR)

NOTES **ACTIONS**

(To be agreed at the next CAG Meeting)

1. National Conference Planning

The next British Gynaecological Cancer Society (BGCS) Annual Conference will be held over three days from Wednesday 8th to Friday 10th July 2020 at Cheltenham Racecourse conferencing facilities.

Delegates will have the option to purchase a day rate ticket; the conference will be split into specialist workshops.

Commercial Sponsorship has been obtained, and network opportunities will be optimised to ensure continued interest in supporting future conferences.

One charity will be invited to provide a presentation each year on a rotational basis, decided either by straw poll or by invitation after review of a presentation extract. It was noted that the regional charities have previously collaborated to develop a poster for primary care clinics, and may be able to showcase different campaigns in a similar fashion.

The following format is proposed for the conference:

- Wednesday: Clinical Oncologist Technical Workshop (potential guest speaker: Alex Taylor) and Medical Oncologist Workshop (potential guest speaker: Rebecca Bowen)
- Thursday: Multi-disciplinary team day, including MDT reforms, genetic services (potential guest speaker: Dame Sue Hill) and tailored treatments, review of clinical research trials, follow up guidelines (which could include a patient versus clinician debate on the preferred format and use of online voting systems), advances in Artificial Intelligence healthcare systems (potential guest speaker from DeepMind), charity involvement, Cancer Waiting Times Guidance and NHS news round-up
- Friday: Surgical breakout meeting with guest speakers on the management of cervical and ovarian cancer, intraperitoneal chemotherapy, and radiological services (potential guest speaker from UH Bristol).

Guest speakers will be invited and a draft agenda circulated in the near future for the opinions of the group. **PR**

CAG Agenda

2. Welcome and apologies

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

3. Review of previous notes and actions

Discussion of the Cancer Exclusion Clinics held in Gloucestershire, for rapid access and discharge of patients referred via the two week wait pathway, generated an action to develop Patient Information Leaflets (PILs) to ensure that the purpose of the clinic was appropriately communicated to patients; the PIL has now been drafted.

In the last meeting, it was announced that it was no longer possible to use the Gynae Oncology database that had been developed in-house to streamline MDT processes. This was still the case but, as there was still a gap in the provision of such software, development will continue independently should there be an opportunity to reintroduce the system in the future.

End of Treatment Summary Templates had been distributed for comments, and an update from Living With and Beyond Cancer Manager Catherine Neck has been provided and will be circulated with the notes.

The SWAG Gynae Constitution and Clinical Guidelines have been updated to include updated membership lists and links to the latest national guidelines, and will be published on the SWCN website by the end of June to comply with Quality Surveillance deadlines.

As there were no amendments or comments following distribution of the minutes from the meeting on Friday 15th June 2018, the notes were accepted.

4. Network issues/service changes

4.1 SWAGGER Programme

Results from the LACC trial presented at the October SWAGGER meeting, which had shown disease-free survival at 4.5 years for minimally invasive radical hysterectomy (for early stage cervix ca) as inferior in comparison with the open approach, and associated with higher rates of loco/regional recurrences, has changed surgical practice in the region. The open approach is now offered, although it is recognised that this is associated with inferior surgical outcomes in terms of morbidity, pain and infection rate; the laparoscopic approach is still an option in some centres for lesions under 2cm. The reason for the difference in oncological outcomes is still unknown.

The management of trachelectomy cases will be revisited by the surgical SWAGGER team to agree a unified view on where the procedures should be undertaken, and by whom. Addressing this as a South West group will ensure all cases are managed within the region, so that the service can be maintained, and excessive travel for patients can be prevented. Support will be sought from the relevant CCGs and the meeting will be coordinated by Consultant Gynae-Oncology Surgeon Amit Patel. **AP**

The Clinical Oncologists are centralising the management of brachytherapy cases for similar reasons, and also to ensure network agreed protocols mitigate the risk of unwanted variation in practice.

4.2 Multi-Disciplinary Team Meeting Reforms

Please see the presentation uploaded on to the SWCN website

Presented by Stephen Falk (SF)

MDTM reforms are underway in recognition that the current system is overloaded. There is great enthusiasm among MDT Leads across the region to implement appropriate changes, which are supported by the National Cancer Board and SWAG Cancer Alliance. A number of teams are already trialling triaging processes for cases that meet specific clinical criteria (as defined in network wide protocols) that can safely progress to the next treatment stage without the need for full discussion within the MDT meeting. This allows additional time to concentrate on quality discussion of complex cases. Concerns have been allayed by continuing to list triaged patients for information, with the option to discuss at any time if there is a particular cause for concern; processes will be continually audited.

As discussed in a previous meeting of the Cancer Clinical Leads, the quality of decision making has been shown to drop dramatically after discussion of 20 patients /after 1 hour, and the introduction of a 10 minute break has been shown to balance the quality of decision making and reduce the overall time of the meeting.

It is recognised that MDT streamlining should work around the needs of radiology and pathology colleagues. Details of the current pathology workload are within the presentation; a process for removing a step in the pathology pathway has been implemented by Consultant Pathologist Jonathan Oxley.

The Cancer Alliance has agreed to support changes to job plans to facilitate triaging processes. It is hoped to drive forward local solutions before national instructions are mandated.

The Colorectal Cancer MDT has started by triaging straightforward cases requiring a right hemicolectomy straight to surgery. This has greatly improved the quality of the North Bristol Trust MDT, reducing patient discussions by 30%. The key is to start with a simple, effective process that does not increase bureaucracy, and

allow some time for this to become an embedded, audited routine before considering further changes.

MDT function could be monitored by looking at the rate and reasons why discussions are rolled over to the next meeting. This data is available from Trust Cancer Managers, and will be circulated to help inform the requirements for MDT reforms. **HD**

Early stage endometrial cancer cases were considered the most logical ones to triage. These most commonly fall into three categories:

1. Protocolised endometrial cancer management
2. A single core MDT member is required to make a management decision
3. A more complex face to face discussion is required.

MDT reforms will be considered by the group. **MDT Leads**

4.3 Clinical review of Cancer Waiting Times Standards

The NHS National Cancer Programme has asked for a clinically-led review of NHS Access Standards. For cancer, it is proposed that a new 28 day Faster Diagnostic Standard (FDS) to communicate a definitive cancer / not cancer diagnosis for patients referred urgently, will replace the current two week wait referral standard.

There are certain scenarios where pathology and radiology turnaround for diagnosis would not be possible within the 28 day time frame. Details will be shared with the national team. **PR**

4.4 SWAG Rapid Diagnostic Services

Please see the presentation uploaded on to the SWCN website

Presented by Amelia Randle

Cancer Alliances have been instructed by the National Cancer Board to spend 15% of 2019/20 funding (£900,000 for SWAG) on the development of a Rapid Diagnostic Service. The purpose of the service is to coordinate a series of tests to streamline the time to diagnosis for those patients with serious non-specific symptoms (approximately 80 per 100,000 population per annum) who otherwise would have been referred via the suspected cancer pathway. It is hoped that this will evolve over time into a single point of access to support delivery of the 28 day faster diagnostic target, and increase the number of appropriate referrals sent to site specific centres.

A national service specification has yet to be defined and, due to the rural geography of the South West, one RDC has not been proposed by the SWAG CA team.

SWAG CA proposes a pilot model based in several areas in the primary care network, so the need for patients to travel is reduced. Referrals will be sent for a 45 minute holistic clinical assessment and test bundle before referring on to diagnostic imaging, if deemed appropriate, after liaison with relevant secondary care teams. Examples of how this might be achieved are detailed in the draft plan, which could be led by a General Practitioner (GP) or secondary care clinician.

The service would retain ownership of the patient in the event that an initial diagnostic test was shown to be negative, but the non-specific symptoms remain unresolved.

Members of the team are invited to express an interest in establishing the service, and send any ideas to their associated Sustainability and Transformation Partnerships (STPs).

There has been a huge influx of suspected cancer referrals to gynae-oncology services in Gloucestershire since publication of the NICE suspected cancer guidance. GPs have started to use the two week wait referral pathway for routine referrals as the influx caused the 18 week referral pathway to fail. As a result, the team implemented the Friday afternoon Cancer Exclusion Clinic; plans to move some of this workload back into the community are currently being negotiated, but it is thought that GPs were not always comfortable with interpreting ultrasound scans and performing the necessary clinical examinations. An alternative service to manage these referrals was considered to be a beneficial move, but caution was raised over the potential for the service to be inundated with inappropriate suspected cancer referrals.

New technologies to detect cancer at earlier stages are being developed; studies are required to validate biomarkers, and the potential to run such a study with the cohort of patients attending these one stop clinics will be considered.

5. Clinical guidelines

5.1 Introduction to the South West Genomic Laboratory Hub (GLH)

Please see the presentation uploaded on to the SWCN website

Presented by Rachel Butler (RB)

In December 2018, the UK reached its goal of sequencing 100,000 genomes. Over 3,550 samples, of which 2,643 were for rare diseases, were collected by the West of England Genomics Medical Centre (GMC, which consisted of a virtual body of champions who consented patients and coordinated the necessary pathways in collaboration with the clinical teams) across all the provider Trusts.

Results are now being returned for analysis en masse, resulting in the management of a significant initial workload. Transition from a project to a standard NHS service, with continued involvement from the GMC team, is now

underway by reducing the number of laboratories from 25 to a network of 7 Genomic Laboratory Hubs, all processing a core set of samples according to the same standards. North Bristol Trust 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.

National genomic test directories for rare diseases and cancer have been published here that define the genetic and genomic 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. A list of tests specific to gynaecological cancer is included.

Funding for the service needs to be informed by the number of tests currently undertaken, which have been found to be inconsistent across the region (as previously noted), and clear pathways for reflex testing need to be developed.

All sarcoma diagnoses are eligible to be referred for whole genome processing. The majority of uterine sarcomas are diagnosed retrospectively; it could become necessary for all high risk patients to have samples fresh frozen in theatre, and consent patients for genome sequencing once the histology has been confirmed. Guidance will be sought from the national team. **RB**

Endometrial cancer associated with lynch syndrome is currently under diagnosed. Results are required to tailor treatment. NICE are currently undertaking a related scoping exercise. Mismatch repair (MMR) mutations are thought to be more readily identified using Immuno-histo-chemistry (IHC) tests rather than microsatellite instability tests, and IHC reagents are becoming significantly less expensive. It is hoped that this will be picked up by the GLH.

The GLH can provide germline BRCA analysis for high grade serous ovarian cancer at the request of Clinical Genetics. Somatic BRCA analysis is available at Cardiff Genetics (funded by AstraZeneca) for 3rd line therapies; this is currently in set-up at Bristol Genetics Laboratory. From April 2020, both germline and tumour BRCA testing should be available through the national genomic test directory and be provided in Bristol.

A regional event for genetic consent training, which is required for germline but not somatic BRCA analysis, was recently provided by CNS Tracie Miles. It is important to clarify to patients that their sample will be kept for 30 years as part of the audit trail. Ideally patients will be consented prior to surgery.

Access to Olaporib and parp inhibitors is only available via the Cancer Drug Fund for second and third line treatment if the patient has a documented BRCA mutation, and it will probably be available for 1st line treatment in the near future after publication of the results of the SOLO-1 trial; clear pathways and a rapid turnaround time will need to be in place to make this feasible.

The surgical guidelines for tumour sample preparation will be circulated to the group, a process pathway will be mapped and ratified, and a PIL will be developed. **RB**

There is a significant backlog of patients on active surveillance that are still eligible for treatment and require BRCA analysis. Consultant Oncologist Axel Walther (AW) will compile the list in the hope that consent and tests can be arranged. This will also be coordinated for relevant patients in Gloucestershire by Consultant Oncologist Audrey Cook (AC), and both will liaise further with RB. **AW** **AC**

5.2 Oncology update

Presented by Hoda Booz (HB)

A network meeting of the oncology team was held in the morning to discuss the following:

- Vulva radiotherapy modality doses (Results from a Royal College of Radiotherapy audit will be available for a future presentation in the near future)
- Endometrial cancer updates
- Avastin in post Chemo RT metastatic disease
- Standardisation of imaging and FU for cervix across network
- Brachytherapy insertion options
- Clinical trial updates (all)
- Group discussions for protocol amendments.

A vulval cancer management workshop will be presented by Consultant Oncologist Hoda Booz at the next BGCS conference. **HB**

6. Research

6.1 Clinical trials update

Please see the presentation uploaded on to the SWCN website

Circulated on behalf of David Rea

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 Chief and 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 Gynae Cancer is 3; this had been comfortably exceeded in 2018/19. Recruiting expected numbers within the estimated time frame requires improvement in the coming year.

Inclusion of data from Yeovil and Taunton has not been possible on this occasion as the Peninsula Research Delivery Manager responsible for supplying the information was no longer in post. This will be addressed prior to the next meeting.

7. Any other business

Consultant Gynaecological Oncologist Phillip Rolland stood down as Chair of the Gynae CAG. An email will be circulated for expressions of interest in the role. **HD**

Date of next meeting: To be confirmed

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