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

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

Tuesday, 19th November 2019, Engineers' House, The Promenade, Bristol, BS8 3NB, 10:00–15:00,

THIS MEETING WAS SPONSORED BY AMGEN, ASTRAZENECA, ROCHE PRODUCTS LIMITED, MERCK, BOEHRINGER-INGELHEIM AND PFIZER

Chair: Dr Adam Dangoor (AD)

NOTES **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 21st May 2019, the notes were accepted.

Actions:

Living With and Beyond Cancer – Systemic Anti-Cancer Treatment Summaries: The process is already underway in UH Bristol; further optimisation is required locally, but will be removed from the CAG Work Programme.

Bristol Clinical Nurse Specialist Diagnosis Clinic: The clinic is working well. CAG Manager HD will draft a patient experience questionnaire to send out on behalf of the team for review at a future meeting.

National Lung Cancer Audit: Analysis of results on Stage 1-2 cases is ongoing; action closed.

Gloucestershire Hospitals Multi-Disciplinary Team Meeting (MDTM): The meeting has now moved to Wednesday which has improved the capacity for the surgical team to attend regional MDTMs; action closed.

Lung Cancer Diagnostic Algorithms: The RUH Bath team routinely follow the algorithms, although the pathway can be delayed due to limited radiological resources. Categorising patients into groups 1 and 5 is straightforward; use of categories 2-4 is more complicated. As RUH do not have a diagnostic MDT, this step is managed via email.

The algorithms work successfully in the Wythenshawe centre where they were developed. This is possible due to the availability of resources at the centre. Local implementation will continue with an ongoing review of the resources required

before complete adoption can be achieved.

Commissioning of General Practitioner (GP) Direct Access to CT in Somerset: The Somerset Clinical Commissioning Group Head of Long Term Conditions, Rachael Rowe, has confirmed that funding has been provided for Trusts to make changes to direct access possible; contracts now need to be reworded to ensure implementation of the change.

There are problems with radiology resource in Somerset, and a new CT scanner is required before the pathway can be implemented. There is concern that the Chest X-ray to CT pathway will dramatically increase the number of CTs required. This has not been found to be the case elsewhere, with GPs generally being more judicious than hospital staff when requesting tests.

Use of a risk assessment tool may help GPs make appropriate referrals.

The National Optimal Lung Cancer Pathway (NOLCP) Clinical Project Lead, Henry Steer (HS) will notify the Cancer Alliance that there is currently an inequitable diagnostic service in the region. **HS**

It is hoped that the new Rapid Diagnostic Service will alleviate service pressures.

Funding for Preventative Initiatives including Smoking Cessation: To be revisited at a future meeting. **HD**

3. Patient Experience

3.1 Adjust, Adapt and Plan Event: Patient Feedback

Please see the presentation uploaded on to the SWCN website

Presented by Mia Foxhall (MF)

The AAP event, held in UH Bristol as an alternative to Living Well events for patients with advanced cancer, has been evaluated by Clinical Psychologist Mia Foxhall. The event programme consists of 5 elements: nutritional needs, support from palliative medicine, psychological considerations, community support and managing fatigue. Long breaks are included to ensure that there are plenty of opportunities to ask questions and share experiences. There is a significant attrition rate which needs to be investigated; 55 patients have been invited to 4 events, with 32 patients (the majority having lung or haematological malignancies) and family members attending to date.

The evaluation, which people consented to at the event, involved semi-structured telephone interviews 3-5 days after the event for approximately 25 minutes with each of the 13 attendees. Thematic analysis revealed that the process was as valuable as the content of the event, with the main benefit being to help people to share their experiences, give them permission to start conversations on future wishes and adjust to their prognosis.

There is a critical period when the event is most useful to patients who are still

well enough to engage in the process.

The structure of the event will be continually reviewed and amended in response to feedback, as will the process for inviting people to attend. The evaluation was undertaken due to concern about how people would feel about being invited; every person that attended said that they would recommend it, and relevant patients should be given the opportunity to attend.

It is felt that the event will help address the cultural misconceptions about the meaning of palliative care. Further information is required on the patients that did not attend. There were a few attendees who were initially shocked to be invited and a few who did not attend as they already had sufficient information from St. Peter's Hospice.

CAG recommends producing 10 minute online videos for those patients that did not want to attend. It would also be helpful to hold an event in Weston as travel to UH Bristol could explain why some people did not attend. **MF to consider**

CAG can send any further questions about the event to HD to send on to MF.

The majority of referrals have been made by the patient's CNS; some patients have self-referred after seeing the event advertised.

Patient Representative Joe Norman welcomed the initiative, commenting on the amount of information required after receiving a palliative diagnosis, and the key being to ensure that the process for issuing invitations is handled in a sensitive manner.

The average time from diagnosis to attendance varied, with some patients on long term palliative support and others within months of diagnosis; the most recent patients will be invited as the events continue.

3.2 National Cancer Patient Experience Survey (NCPES) 2018

Please see the presentation uploaded on to the SWCN website

Presented by Belinda Ockrim (BO)

Survey results were collected over three months (April to June 2018) and include any inpatient (including day cases) aged 16 or over with a cancer diagnosis. Patients who received systemic anti-cancer treatment as an outpatient were not included. Outpatients will be included in a future iteration but not in the 2019 cohort.

Results, highlighted in green if higher than the national average and red if lower, are documented within the presentation, and are generally good across the board. They are only available for UH Bristol, Gloucestershire and Taunton, as greater than 21 responses are required for results to be published; other centres are recommended to read free text comments to formulate action plans.

National results and considerations are also documented within the presentation.

The low response rate from RUH Bath will be investigated to see how this might be improved.

HD to contact Cancer Manager

4. Coordination of patient care pathways

4.1 NOLCP Project Update / MDT Pathway Tool Review

Please see the presentation uploaded on to the SWCN website

Presented by Nicola Gowen (NG)

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.

South Central and West Commissioning Support Unit supplied a report for the South West Lung Cancer Services using data from NLCA, NHS England Statistics, and data sent from local centres. The teams were thanked for submitting the data. This provides each centre with details of compliance with national guidance, including workforce and testing turnaround times, and can be used as a lever to substantiate service requirements. Results are noted to be in calendar days rather than working days. The report will be recirculated to all and will be updated every 2 years.

HD

MDT Leads / CAG members will discuss the bottlenecks identified in the pathway with Cancer Managers.

CAG

An additional pathway analyser tool has been developed to capture information from referral to diagnostic MDT; the data shows 5 patients per month continuing through to treatment. Ideally, automated systems would be available to capture this information, as the process is complicated. When a quarter of data has been collected, the tool will be very useful to feedback pathway issues to management teams. The ambition would be to operate it as a live quality dashboard.

5. Clinical Guidelines

5.1 Management of Lung Nodules

Presented by Andy Low (AL)

Management of lung nodules will be standardised across SWAG MDTs to mitigate the risk of potential clinical incidents and streamline the associated workload.

Previous management in UH Bristol involved an initial 2 week wait clinic to inform patients that a nodule has been identified, repeat CT in between 3 to 12 months depending on past medical history, re-discussion in the MDT meeting followed by an additional clinic appointment.

Streamlining the process had initially been obstructed by a lack of available funding to support virtual follow up appointments. Following further discussion at divisional board level, it was agreed to fund consultant time for AL, and for Jemima Robinson's (JR) time when booking patients into virtual follow up clinics.

Patients will receive a lung nodule leaflet, which will be circulated to the group, and will continue to be tracked on the MDT list via close liaison with the MDT Coordinator, but will not be brought back for discussion or to clinic unless a relevant change in condition requires MDT input. It is hoped that this will facilitate management of the MDTM list, which is due to increase after the Weston merger. **HD**

Radiology reports for those nodules not for discussion should state 'no change in diameter and/or volume' however; the current problems with scanner equipment and reporting volume need to be addressed.

The process will be continually audited and results presented at a future meeting. **AL**

RUH Bath have triaged discussion of lung nodules from the MDTM for some time and see patients for one appointment to take family history, arrange CT follow up, and manage the rest of follow up via email, with the navigators tracking the patients; lung nodule leaflets will now be provided.

There is a lack of trust in outsourcing reporting of images, and a preference for all scans to be reported by the Thoracic Radiologists.

It was acknowledged that there are nodules with certain clinical features that do require MDT discussion to consider surgical options.

The patient information leaflet was considered good quality by the Patient Representative. Information on follow up is included at the bottom of page 5.

5.2 Lung Cancer Diagnosis and Management: NICE Guidance 2019

Please see the presentation uploaded on to the SWCN website

Presented by Doug West (DW)

It was clarified that the wording in NICE guidance to 'offer' an intervention, means that provision is expected, whereas to 'consider' an intervention means that provision is optional.

Guidance needs to be regularly updated due to the pace of change brought about by evidence from numerous research trials, and should be reviewed alongside the most recent publications.

Guidance now includes the following:

- Specific advice on tobacco addiction
- Brain imaging for Stage II (CT) and Stage III (MRI) to avoid futile radical treatment
- Staging guidance that reduces the role of bronchoscopy
- Increased role of EBUS / reduced role of mediastinoscopy
- Addition of transfer factor in fitness assessment for surgery
- Preference for VATS versus open surgery has not been advised either way and is pending the results of the VIOLET study
- If unfit for lobectomy, consider sublobular excision or stereotactic radiotherapy (SABR)

- New guidance for operable Stage IIIA N2 patients fit enough to consider for multi-modal therapy should discuss risks versus benefits with those patients (progression free survival is thought to be 'probably' better, although there is no Quality of Life (QoL) versus survival evidence)
- Small cell guidance has not changed significantly and focuses on early chemotherapy and radiotherapy.

Due to the rapid changes in SACT, the NICE guidance should be used in conjunction with the most recent NICE technological appraisals.

Please see the presentation for further information.

Overarching themes of quality indicators in 2020 are smoking cessation initiatives, CNS provision, and providing tissue for genetic analysis.

There is no smoking cessation service in UH Bristol (this is currently out to tender) or TST at present. RUH, YDH and Glos can refer patients to relevant services. The most effective treatment, Varenicline, is not available on the secondary care formulary and the patient's GP has to be asked to prescribe it.

DW has been asked to remain a member of the NICE committee to review the quality standards next year.

5.3 VIOLET Study and Surgical Service Update

Please see the presentation uploaded on to the SWCN website

Presented by Eveline Internullo (EI)

There is a dearth of new trials at the moment. The Nelson lung cancer screening trial has now closed; similar trials are underway in the US and Japan.

Preliminary results of the Violet Study were presented at the World Conference on Lung Cancer in Barcelona in September 2019; which compared open lobectomy versus thorascopic lobectomy (VATS) procedures.

UH Bristol was the highest recruiter, responsible for 30% of enrolled cases.

Results:

Pain	Less (little difference)
Complications	32.8% VATS versus 44.3%
Length of stay	4 days VATS versus 5 days
Nodal upstaging	No difference
Completeness of resection (R0)	No difference

Conclusions:

- Increase in VATS lobectomy rates
- Proof that randomised controlled studies in surgery are feasible.

Follow up in the trial protocol is for 1 year but is likely to continue for 5 years.

Consultant Thoracic Surgeon Gianluca Casali is retiring in the near future; a locum replacement is due to start in post in January 2020. In the interim, this may result in some clinic cancellations in December 2019, but all Theatre lists will continue as planned.

The surgical team will agree the pre-operative tests that regional referral centres are required to perform prior to referral and the tests that will occur in the surgical centre, to prevent delays to the patient pathway. This will be documented and shared with UH Bristol Cancer Manager, Hannah Marder. **EI**

6. Service Development

6.1 South West Genomic Laboratory Hub

Please see the presentation uploaded on to the SWCN website

Presented by Daniel Nelmes (DN)

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 is currently not available for lung cancer, but the plan will be to include all cancers in the future.

The tests available to patients with lung cancer (all tests have an individual code) are listed in the presentation. 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; many biomarkers are emerging that could be eligible for Neurotropic Tyrosine Receptor Kinase (NTRK) gene alteration inhibitor drugs.

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.

7. Patient Experience

7.1 Complex Cancer Late Effects Rehabilitation Service (CCLERS)

Please see the presentation uploaded on to the SWCN website

Presented by Jane Cook (JC)

The CCLERS is a highly specialised national service, based at RUH Bath, for adults with persistent pain and reduced physical function following their cancer treatment.

Please see the presentation for patient eligibility criteria and details of a case study that demonstrates the benefits that the service can provide during the 2 week residential programme with the multi-disciplinary team; any Health Care professional can refer in to the service, which is free to any patient registered with a GP in the UK.

The service is relatively new and must be promoted across the country to ensure all relevant patients can have access to rehabilitation. Patient numbers are currently 15-20 per annum and there is capacity to help more patients.

Patient outcomes pre and post treatment had significantly improved across a longer period of time due to continued contact after the 2 week residential programme; patients are contacted at 3, 6 and 12 months, and are also able to re-contact the service independently at any time.

Local services are available, such as pain clinics, but a pathway for addressing multiple late effects is not available in each locality.

CAG members are asked to identify and refer relevant patients, provide feedback on the content of the presentation, and suggest any other useful information that could be included.

8. Research

8.1 Clinical Trials Update

Please see the presentation uploaded on to the SWCN website

Presented by Ashley Cox (AC)

A list of open trials, trials in set up, and trials open to new sites, are documented in the presentation.

Keynote 867: Efficacy and Safety Study of Stereotactic Body Radiotherapy (SBRT) With or Without Pembrolizumab (MK-3475) in Adults With Medically Inoperable Stage I or IIA Non-Small Cell Lung Cancer (NSCLC). Open in BHOC (a biopsy is required) and to all eligible patients across the region. The trial sponsor will pay for taxis. Two patients have been recruited to date, one from Gloucestershire and one from Taunton. Although trial paperwork can only be provided by the UH Bristol Team, it is appropriate for referring centres to discuss this as an option, which involves 3 weekly infusions in the BHOC.

CANOPY-A: A Phase III study of Canakinumab as adjuvant therapy in patients with surgically resected non-small cell lung cancer (NSCLC). Open in BHOC and Cheltenham; eligible to patients that have had a minimum of 2 cycles of Cisplatin. Patients randomised to the trial arm would need to attend the BHOC or Cheltenham every three weeks for 1 year. Recruitment could be improved if patients were brought back to MDT post resection.

SARON: Stereotactic ablative radiotherapy for oligometastatic non-small cell lung cancer; a randomised Phase III trial. Eligibility criteria, patients with 1-3 metastases at least 6 months post first line treatment. Recruitment has been challenging, but the first patient has recently enrolled.

SMP2: A study looking at how to test the genes in lung cancer cells (Stratified Medicine Programme Two) is available in RD&E and NBT. Recruitment started well, but has now slowed down. It is hoped that CNS involvement might stimulate recruitment. Patients that have had first line treatment and a good quality biopsy can have samples sent for analysis, and may be offered a drug tailored to a particular gene variation. Consent needs to take place in NBT. Patients may still be eligible if disease progression occurs second line. Result turnaround time is currently within 2 months.

HALT: Phase II/III, multicentre, randomised controlled trial in patients with advanced non-small cell lung cancer (NSCLC). Patients will have a defined, actionable mutation responding to targeted tyrosine kinase inhibitor (TKI) therapy and 3 or fewer sites of oligo-progressive disease, which will have developed after becoming resistant to targeted TKI treatment. Randomisation is between standard care versus standard care plus SABR in BHOC. Systemic treatment can be given in local centres. CNS support to promote the trial would be appreciated.

Potential new trials might be ATOMIC for advance NSCLC and RET for RET-rearranged NSCLC. It was acknowledged that the BHOC trials unit was lacking the resources to open many more trials at present.

The list of trials will be circulated and uploaded on to the website. The Peninsula team will be contacted to compare trial details. **HD**

9. Quality Indicators, Audits and Data Collection

9.1 Audit of Surgical Resection Rates

Please see the presentation uploaded on to the SWCN website

Presented by Andy Low (AL)

In light of the difference in surgical resection rates reported nationally (18.4%) in comparison to SWAG (17.0%) in the National Lung Cancer Audit, a local audit of the data was undertaken, looking at every early stage case in detail as documented in the presentation. This concluded that decision making on the appropriateness of surgery was fitting for all cases identified.

Accurate recording of Performance Status in the MDT meeting is an important factor, as is validating data prior to submission. The audit could be submitted as a poster for the next British Thoracic Oncology Group Conference.

9.2 Any Other Business

Date of next meeting: To be confirmed – a South West conference will be arranged in April / May 2020.

-END-