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

Meeting of the SWAG Network Upper Gastro Intestinal / Hepatobiliary and Pancreatic Site Specific Group (SSG)

Friday 19th October 2018 12:30-16:30, Hotel Du Vin, The Sugar House, Bristol BS1 2NU

This meeting was sponsored by Kyowa Kirin, Mylan and Stryker

Chair: Mr Richard Krysztopik

NOTES **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 last meeting's notes and actions

As there were no amendments or comments following distribution of the notes from the SSG meeting on 7th July 2017, the notes were accepted.

The meeting planned in Cheltenham in April 2018 had to be cancelled due to a clash with a national conference. It is hoped that the next meeting in 2019 will be held in Cheltenham instead.

Actions from previous meetings are on the agenda.

3. Research

3.1 Clinical trials update

Please see the presentation uploaded on to the SWCN website

Presented by David Rea (DR)

Recruitment figures (sourced from EDGE), open trials and trials in set up are documented within the presentation. The West of England Clinical Research Network (CRN) is currently struggling to meet cancer recruitment targets due to its size in comparison with other networks. The standard for recruitment to time and target was met for 2017/18, which meant that funding for the network remained stable.

The metrics for measuring performance are being revised and may provide ways to recompense research activity according to incidence and prevalence. Heat maps and different models to accurately calculate this are being developed. The recruitment target per 100,000 population for Upper GI is 3, and is currently on target and performing well in comparison with the percentage of cancer incidence in the region.

When comparing recruitment across clinical research networks, figures can be skewed by larger centres that open single site high recruiting observational studies.

A spreadsheet of open trials, trials in set up, and trials that are open to new sites is available on the SWCN website here. It is hoped that Principal Investigators (PIs) will use the research slot on the SSG agenda to boost recruitment by promoting new and existing trials.

The SUNFLOWER trial, a multicentre randomised controlled trial to compare expectant management (i.e. no imaging) versus pre-operative imaging with MRCP in patients with symptomatic gallstones undergoing laparoscopic cholecystectomy, is due to open in the near future. The study aims to recruit 13,680 participants in total (with one third randomised to MRCP and two thirds straight to laparoscopic cholecystectomy) from at least 50 centres across the UK. Consultant Hepatobiliary Surgeon Jonathan Rees is the PI.

Another large NIHR trial for thoracic patients is due to open in the near future, and there was concern that the surgical research nurse team might not have the resources to manage two large recruiters in addition to their current workload. DR will contact the PI Tim Batchelor to investigate this. **DR**

The next opportunity to apply for the CRN development and contingency funding bids will be January 2019.

A link to the spreadsheet of open trials can be added to the MDT meeting list so that it is available to view within the MDT and in clinic. The current list will be reviewed to ensure all relevant trials are included.

4. MDT membership changes / service

4.1 National Oesophago-Gastric Cancer Audit (NOGCA): High Grade Dysplasia (HGD) data

Please see the presentations uploaded on to the SWCN website

Presented by Dan Titcomb (DT)

NOGCA now provide pre-formed slides that can be populated with local audit results.

NOGCA has received data on 2059 patients diagnosed with HGD from April 2012 to March 2017. This constitutes the number of cases where, for the majority of patients, cancer is now being prevented. Details of demographics, indicators for care, the proportion of patients receiving active treatment, and recommendations are within the presentation.

The percentage of patients receiving active treatment within the SWAG region compares favourably with the other centres.

The percentage of HGD patients discussed by the MDT appeared to be lower than

the national average. This was not due to local data collection, which was routinely checked for completeness and accuracy, but due to a flaw in the way that NOGCA captured their data from the Hospital Episode Statistics (HES) dataset, which results in an overestimation of the number of cases admitted.

SWAG is a positive outlier for emergency admission numbers, with only 2.9% diagnosed via this route in comparison with a national average of 13%.

The lower uptake of patients having an initial CT scan has been investigated and was found to be due to patient choice.

The proportion of patients diagnosed with early stage cancer has remained stable over the past 5 years.

Pathology outcomes also compared favourably, although the indicators for this measure were being used for benchmarking at this time.

Nationally, only 56% of patients having palliative chemotherapy completed their treatment, and there was variation in the use of triplet regimens.

For further information, please visit the website: www.nogca.org.uk

An HGD regional roadshow is being organised by Consultant Oesophago-gastric Surgeon Paul Barham (PB) to engage with gastroenterologists, who is also drafting a record of dysplasia treatment booklet which will be circulated when complete. Ideally two CNS representatives in each centre could be identified to drive this initiative, although it was recognised that this is a pre-cancerous condition. **PB** **CNS Team**

A process for ensuring that every patient has a named consultant is currently underway.

Proximal resection margins are currently being reviewed.

4.2 Multi-Disciplinary Team Meeting Reforms

Please see the presentation uploaded on to the SWCN website

Following review of the Cancer Research UK MDT Effectiveness Report by each SSG, and Professor Martin Gore's appointment by the National Cancer Transformation Board to reform MDTM working arrangements across the UK, an inaugural meeting of the SWAG Cancer Clinical Leads was held on Monday 16th July 2018 to define a loco-regional approach to MDT meeting reforms. Cancer Leads from all disciplines attended.

A presentation from Cognitive Scientist Tayana Soukup Acencao (TSA) gave details of 3 tools that can be used to improve MDT streamlining. It has been proven to be beneficial to have a 10 minute break in meetings after a period of 1 hour, or after 20 patient discussions, to prevent cognitive fatigue and the negative effect that this can have on the quality of decision making. Slides from the talk will be distributed. **HD**

It was also recommended that MDT Chairs visit alternative MDT meetings to compare styles. In addition, it is planned to address the varied quality of triage systems, including development of online referral proformas similar to the one used by the Bristol Neuro-Oncology Group (BNOG). The Cancer Alliance has allocated some funding to support the work.

The group will meet again in approximately 6 months to discuss progress.

Further suggestions for improvements are listed in the presentation, including improving the layout of the room, which is something that the Upper GI team could immediately improve by moving the seats into a u-shape rather than in a lecture theatre format. **MDT members**

A National MDT streamlining pilot is underway to develop predetermined standards of care (pSOC). SWAG Breast and Colorectal Cancer MDTs are participating in the pilot. It is hoped that reducing the number of MDT discussions using pSOCs will free up time for a more thorough discussion of complex cases.

4.3 Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland (AUGIS) HALO Poster

Please see the presentation uploaded on to the SWCN website

An audit of radiofrequency ablation (RFA) for the management of Dyplastic Barrett's Oesophagus (HALO therapy) was undertaken to assess rates of progression and regression. Data was collected on 85 patients from June 2011 to February 2018. When the procedure was first introduced, it was hoped that this would be successful for approximately 98% of patients, but clearly there is now a percentage of patients that don't respond to the treatment, with an actual regression percentage of just over 80%. Patients diagnosed with adenocarcinoma had a regression percentage of 93.3%. A few patients required a repeat procedure. The local outcomes correlate with national data.

The first pie chart in the poster refers to data gathered at the 6 week follow up, and the second pie chart refers to the patients' latest follow up appointment.

International data suggests that the procedure has a 10% risk of developing a stricture, and a few cases have been reported where it has caused a rupture.

4.4 Hepato-Pancreato-Biliary (HPB) Services Update

Presented by Jonathan Rees (JR)

The number of referrals to the HPB MDT has increased exponentially, and work is underway to see how this can best be managed.

A number of guideline documents have recently been produced and published on the SWCN website here. These include gall bladder polyp management guidance, based on the latest evidence published in the European guidance, which has proved controversial with a couple of referring Trusts in the region.

It was acknowledged that, although the guidance was based on the best evidence available to date, further evidence was required; prospective and retrospective data collection on relevant cases could provide this. The University of Bristol is willing to provide £500 funding per student (on the condition that it is spent by the end of the financial year) for departments to host 3rd year and 4th year medical students to assist with such projects. It would then be possible to look into developing local guidance.

A nutrition bundle for HPB has also been drafted with support from Dietician Tom Lander and Hepatology colleagues.

A process for patients to go straight to endoscopic ultrasound (EUS) prior to MDT discussion, and other similar streamlining strategies are being mapped.

The Bristol North Somerset and South Gloucestershire CCG has recently agreed funding per patient for a pancreatic cyst MDT, to be arranged with colleagues sometime in the next few months as a mini meeting outside the main MDT.

An nhs.net email address for referrals will be set up and ultimately an online referral system similar to the BNOG form.

Endoscopic retrograde cholangiopancreatography (ERCP) is being undertaken in Taunton and Bristol using the Spyglass technique. In the absence of Joint Advisory Group (JAG) guidelines, metrics on the procedure will be shared for quality control purposes.

A gastroenterologist based in NBT has expressed an interest in performing EUS for benign cases, reflecting the current move towards a shared approach to managing workloads; this will be explored further.

Significant problems have recently arisen when accessing critical care beds, and the matter has been entered on to the Trust risk register, as the wait for surgery can rapidly reduce surgery as a treatment option. Implementation of a process to ensure that there is oversight of the patients waiting on the pathway will be explored by Cancer Manager Hannah Marder who will liaise with JR. **HM/JR**

RK will convene a break-out meeting of interested parties who wish to explore the implementation of MDT reforms. **RK**

5. Clinical guidelines

5.1 Review of SWAG Clinical Guidelines

The Clinical Guidelines are currently being updated. RK will update the oesophago-gastric section. The HPB section has recently been updated. Other individuals will be nominated to check that the content is satisfactory. **RK/HD**

It may be relevant to look into intra-peritoneal oncology treatment for palliative patients which is surgically delivered via a port-a-cath; this will be discussed with the oncologists. **RK**

It may also be relevant to incorporate Spyglass into the guidelines. The guidelines on who is suitable to receive tri or bi modality need to be clarified after results of a related clinical trial have been published.

6. Quality indicators, audits and data collection

6.1 COSD and Public Health England datasets

The Cancer Outcomes and Services Dataset (COSD) entered into the Somerset Cancer Register within the MDT and submitted to the National Cancer Registration and Analysis Team on a monthly basis, is available to view on NHS computers by registering on the Cancer Stats website:
https://cancerstats.ndrs.nhs.uk/cosdl3/alliance

Data completeness sent from Trusts can be viewed by selecting 'Level 2' from the COSD drop down menu. The dataset can then be filtered by tumour group, Trust and year to look at the monthly submissions in detail.

The registration team add missing information to the dataset by accessing a variety of information systems, including pathology, radiology, systemic anti-cancer therapy, cancer waiting times etc. Ideally the dataset would be completed in full prior to submission. This more complete dataset can be viewed by selecting 'Level 3' from the COSD drop down menu, filtered as above, and compared with other Trusts. The most recent data available to date is Quarter 1 and 2 for 2017.

An HPB dataset, previously combined with the Upper GI dataset, was introduced in September 2018, from which a specific report can be generated.

Requests for a more complex analysis of the data can be sent to the analytical team:
NCRASenquiries@phe.gov.uk

It would be ideal if real time data was available that could be analysed to inform clinical decision making. The information that would be required to achieve this needs to be defined.

6.2 28 day faster diagnosis standard

Presented by Hannah Marder

A new 28 day faster diagnosis standard is due to be introduced in April 2019, aiming to be compliant with the standard by April 2020. This will involve collecting an extra dataset on all patients referred via the Two Week Wait or screening pathway to confirm when and how a patient is told if they have been cleared or diagnosed with cancer. Cancer Managers are meeting next week to find a feasible way for the information to be collected from existing evidence; it is hoped that a method can be found that will not create additional work for the MDT coordinator.

It is only possible to state that cancer has not been found from the results of a particular site exclusion test, and not possible to confirm that a patient does not

have cancer.

7. Patient experience

7.1 Clinical Nurse Specialist (CNS) update

The National Cancer Patient Experience Survey will be discussed at the next meeting as publication of the results has been delayed.

CNS Ruth Harding from UH Bristol is the regional Allied Health Professional (AHP) Representative for AUGIS, and will attend an AHP Forum in November where regional issues and best practice can be shared. AHPs are encouraged to become members of AUGIS and attend the conference in Liverpool from 25th-27th September 2019 as this is an excellent networking opportunity.

Ward A800 has been shortlisted for UH Bristol's Recognising Success awards.

Dietician Tom Lander is involved with the Pancreatic Society which has a CNS and Dietician group that network, share resources, and undertake joint project work which could be a potential model for AUGIS to work towards.

The SSG due to be held in Cheltenham would be an opportunity for a more educational event to share best practice. SSG members are to send potential topics of interest to Helen Dunderdale (HD).

8. Living with and Beyond Cancer (LWBC)

8.1 Cancer Transformation Funding/LWBC Progress

National Transformation Funding has been awarded to providers within the SWAG region for the purpose of implementing the LWBC Recovery Package. The funding is dependent on delivering the activity, which is being measured for certain cancer sites. In North Bristol Trust this is Breast, Colorectal and Prostate, and in UH Bristol Colorectal, Gynae and Lung, although the initiative, which has funded Band 4 Cancer Support Workers (CSW) to assist the CNS team, is being made available to all cancer patients. Additional AHPs and LWBC Project Managers have also been appointed. UH Bristol is planning to provide Health and Wellbeing events earlier on in the patient pathway rather than at the end of treatment to match the model in NBT.

A 'next steps' day for patients with a poor prognosis has been recognised as an area of unmet need. A project to set up such events has been underway in UH Bristol over the past year. The first pilot event will be held on Monday 4th February 2019 in the Education and Research Centre, University Hospitals Bristol NHS Foundation Trust. Clinical Nurse Specialists can refer both male and female patients treated in UH Bristol who have a prognosis of between 6-36 months. It will have a similar format to the 'Living Well' events, with talks from a poor prognosis perspective on managing fatigue, finances, advanced care planning and Will writing.
It is hoped that it can be extended to patients across the Alliance on a regular basis once funding and an appropriate venue have been secured.

Teams are encouraged to complete End of Treatment summaries to provide GPs and Practice Nurses with the information they require to care for patients post discharge.

Level 2 Psychology Training for CNSs and AHPs will commence in the new year.

9. Any Other Business

Consultant Gastroenterologist Daniel Pearl has stepped down as joint MDT Lead for Taunton, and Consultant Clinical Oncologist Julie Walther is now the main contact.

Date of next meeting: March/April 2019, Cheltenham, further details to be confirmed

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