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

**Meeting of the SWAG Network Oesophago-Gastric Cancer Clinical Advisory Group (CAG)**

***Friday 21st January 2022, via MS Teams***

**Chair: Mr Paul Wilkerson (PW)**

**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 SWAG website here.

**2. Research**

**2.1 West of England Clinical Research Network (CRN) Update**

**Please see the presentation uploaded on to the SWCN website**

**Presented by S Gangadhara / C Matthews**

C Matthews is the Research Delivery Manager for the West of England CRN, and manages the cancer portfolio.

The geography of West of England CRN differs from the SWAG region; data from SFT and YDH will be sourced from the Peninsula CRN for future meetings.

National data (combined oesophago-gastric and hepatobiliary) from the start of the pandemic to date shows that there has been recruitment to 144 trials, the majority of which are non-commercial and non-randomised. There has been an increase in trial recruitment when compared with pre-pandemic recruitment data (2019/20). This is not reflected in SWAG at present.

There are many studies currently open, as documented in the presentation. These have been divided into early and advanced to make it easier to navigate.

SCOPE 2 is for earlier Stage disease and is open in Bristol and Cheltenham. It is a Randomised Controlled Phase 2 Trial of radiotherapy dose escalation in patients with oesophageal cancer treated with chemo-radiation, using PET as a metabolic scan to stratify patients as responders or non-responders. It is looking at standard chemotherapy versus slightly different chemotherapy plus escalating the RT dose.

Evidence of improved outcomes following dose escalation trials has been seen in some other cancer sites. Recruitment is going well at present across the network. Feedback on any barriers to recruitment from other centres would be welcomed. Closure date is 1st December 2022.

It is reassuring to see more trials opening in the advanced setting, where outcomes require improvement.

DESTINY-Gastric 03 for gastric cancer is a Phase 1B/2 study to look at the efficacy of trastuzumab deruxtecan alone or in combination with chemotherapy and/or immunotherapy in HER2-positive patients. The study consists of two phases: Phase 1B , which is a dose escalation study, and Phase 2 for HER2 expressing patients who have not received prior treatment for metastatic cancer.

WAKING: Wnt and checKpoint INhibition in Gastric cancer, is a multi-centre open label non-randomised study, Phase 2 clinical trial for Wnt inhibitor plus Atezolizumab for patients with advance unresectable or metastatic gastric cancer who have progressed on chemotherapy.

The two trials are slightly running behind with recruitment; cross referrals from other centres or information of barriers to recruitment would be welcomed as the trials are imminently due to close.

Glow - A Study of Zolbetuximab (IMAB362) Plus CAPOX Compared With Placebo Plus CAPOX as First-line Treatment of Subjects With Claudin (CLDN) 18.2-Positive, HER2-Negative Locally Advanced Unresectable or Metastatic Gastric or Gastroesophageal Junction (GEJ) Adenocarcinoma, looking at progression free and overall survival. Zolbetuximab is an experimental monoclonal antibody.

EMERGE-Epigenetic Modulation of the immunE Response in GastrointEstinal Cancers, is a Phase 2 non-randomised trial assessing efficacy of domatinostat, a selective Class 1 histone deacetylase inhibitor in combination with avelumab, an anti-PD-L1 monoclonal antibody in patients with previously treated, inoperable or metastatic MMRp OG and CRC.

PLATFORM-Planning Treatment for Oesophago-gastric Cancer: a Maintenance Therapy Trial, has been open for a while across the region. HER2 patients will be randomised to single agent trastuzumab after finishing the standard 3-4 month course of chemotherapy, then continue maintenance trastuzumab. HER2 negative patients will be randomised between surveillance only, maintenance capecitabine, or maintenance with immuno-monoclonal therapy and anti-pdL1 antibody. Recruitment has been going well, The Chief Investigator is based in the Royal Marsden.

OCCAMS: Multicentre Study Determining Predictive Biomarkers & Targets for Oesophageal Adenocarcinoma. There is a network of clinical centres recruiting patients for tissue collection. The aims are to better characterise clinical and demographic risk factures, characterise molecular genetic landscape through DNA and RNA analysis, and determine sub-types that would help to personalise medicine and improve clinical staging, prognostic and predictive algorithms.

There is also a trial open in GRH using spectroscopy for cancer and pre-cancer detection.

There are also five studies currently in set up. Further details are within the presentation.

**Action: CAG members are to share any trial recruitment barriers or examples of good practice** **CAG members**

Some of the epidemic and epigenetic studies where you are recruiting to gather information or pathological criteria may be the ones that help drive recruitment numbers.

New high-level objectives for the CRN are to be announced this year, most likely looking at recruitment to time and target. The Managed Recovery process, put in place after the pause caused by the pandemic is still underway, which includes the studies that have been selected by funders as of high importance to complete. There is only 1 OG study included – ROLo: Phase II study of ROS1 targeting with crizotinib in advanced E-cadherin negative, ER positive lobular breast cancer or diffuse gastric cancer. This is not open within the SWAG region.

The Participant in Research Experience Survey (PRES) target for responses has been met, with a good spread of information coming back from the SWAG Trusts, in particular from UHBW and NBT.

Responses show that the vast majority of patients would participate in research again. Comments are also included; the information will be collated and shared with Trusts by the end of the year to identify any areas for improvements and to share good practice across the region.

There is a new Research Scholars programme, which is a scheme that aims to develop and support staff looking to become involved in research as part of their future career. It is open to applicants at the moment and due to close on the 7th February 2022. It is funded at 2 PAs per week until March 2024. Further details are available on the website: CRN WE Research Scholars' Programme 2022-2024 (nihr.ac.uk).

CRN links and staff contact details for further information about this or any studies are included in the presentation.

**Discussion:**

A lot of the trials seem to be looking for potential candidates from a similar limited pool of metastatic patients and it becomes difficult to know which trial would best fit the patient.

The upfront testing puts pathology under a lot of pressure; at present there are problems with managing the workload with existing resources. The plan is for the Genomic Laboratory Hub to streamline all of the upfront testing in the future.

OCCAMS was not opened in UHBW because of concern that the request for fresh tissue to be harvested from oesophagectomies could compromise the ability to complete pathological staging.

**3. Patient Experience**

**3.1 National Quality of Life Survey**

**Please see the presentation uploaded on to the SWCN website**

**Presented by J Chambers**

As well as the regional SWAG Cancer Alliance Patient Representative, J Chambers is also a Patient Representative within the National Cancer Programme that has developed a National Quality of Life (QoL) survey and attends today to explain why this has been developed, who will be surveyed when, how it works and how the evidence gathered can be used to inform service improvements.

One of the ambitions from the NHS Long Term Plan is to give every patient diagnosed with cancer the opportunity to complete a survey to identify long term QoL issues.

Although long term effects of cancer treatments are well recognised, it is hoped that the survey will provide an individualised record that will help facilitate conversations between patients and clinicians on management of long-term symptoms and inform improvements in Living With and Beyond Cancer Work Programmes.

Based on her personal experience, the importance of understanding the benefits of treatment versus the wide range of physical and psychological effects post treatment from an individual perspective of their lifestyle priorities was demonstrated. For example, infertility, peripheral neuropathy, chemo brain, fatigue post chemotherapy versus a percentage improvement in survival outcome. The difficulty at the end of treatment, when everyone celebrates this success while patients are still undergoing the consequences, was also emphasised.

The survey will be sent to patients 18 months post-diagnosis to ensure that the majority of patients, including those with metastatic disease, are included.

An initial pilot survey was rolled out to 100% of breast, prostate and colorectal patients in September 2020 and rolled out to all disease sites in October 2021.

People will be sent an invite to complete the survey online, although this includes a paper copy for those patients who would rather not complete the digital version. It has been translated into many different languages and a support line is available to get as wide and diverse a response as possible. The response rate in SWAG and the Peninsula has been the highest in the country to date.

Examples of questions are within the presentation; these have been sourced from EQ-5D and EORTC questionnaires. It takes approximately 10 minutes to complete. Results can be used to share best practice and also provide the patient with a patient summary, which acts as a prompt for patients to go back to their clinical team to ask QoL related questions.

Data is accessible on a public facing website and will also be on Cancer Stats from March 2022. The survey will be ongoing with data releases refreshed every 6 months.
Findings from the data are documented in the presentation.

Below are suggestions of things that could help, if possible, manage low-level effects:

- Normalise the psychological after-effects of post cancer treatment
- Provide low level psychological support
- Educate people about fear of recurrence and what to look out for and why
- Signpost to existing resources
- Advise that making lists can help to manage chemo brain
- Advise that planning each day's activities can help to manage fatigue
- Advise when a patient should contact the team with concerns and who they should contact
- Reduce 'scanxiety' by getting results to patients as soon as possible
- Provide continuity of care where possible
- Ask the patient what is the most important priority for them.

Every contact counts to imbed QoL discussions right from the start.

The SWAG Cancer Alliance point of contact for the project is Personalised Care and Support Lead H Shallcross.

**Discussion:**

The generic format of the survey will not pick up the QoL issues that are specific to the patient population with OG cancer. These are however identified in the Holistic Needs Assessments (HNAs) completed by the CNS team in follow up clinics.

The importance of having QoL discussions was a well-known issue; workload pressures make it challenging to have in depth QoL discussion in the current climate. The survey which is sent out 18 months post diagnosis will exclude a significant number of OG cancer patients.

Data should drive service provision in terms of further investment into Cancer Support Workers so that teams have the resources to improve provision of QoL discussions.

**4. Service Developments**

**4.1 Enhanced Supportive Care (ESC)**

**Presented by M Flory**

ESC was on the agenda approximately 3 years ago, with work undertaken for over a year until this was put on pause due to the COVID-19 pandemic and changes to availability of funding for the service. This is now being relaunched by South West NHS England; at present, UHBW is an outlier by not providing the service.

The original model, developed by the Christie, showed that early supportive care increases completion of oncology therapy, reduces admissions and length of stay

and improves symptom control and advance care planning. This has been repeated elsewhere, with other areas running it for 3-4 years; Gloucestershire and RD&E have well established services.

The model will be similar to that discussed at the November 2019 CAG meeting, with some slight changes. It is still at an early stage, but access to funding is thought to be imminent. NHS England has said there will be two years of funding to set up a multi-disciplinary service. Key performance indicators have been refined over the last few years; formal agreements around staffing levels are pending although it is hoped that now there are more palliative care staff, a plan to support patients with incurable cancer and candidates for disease targeted therapy can shortly commence.

Patients will be identified via the MDT.

The pilot will commence in phases, starting firstly with HPB, then rolling out to OG three months later after the patient pathway/processes have all been established, and eventually roll out to all relevant cancer sites in the future.

Next steps include recruitment of staff, business intelligence mapping, formation of a steering group, and defining the patient pathways.

It is anticipated that there will be hybrid options for multi-disciplinary clinics.

**Discussion:**

CAG are very pleased that the service improvement is back on track and agree that it seems most appropriate to start with HPB, where it is particularly important to optimise nutrition.

GRH report that the ESC service has been transformative. Established in 2018, it has demonstrated significant financial savings, for example, £100,000 in the last six months. The number of patients dying in hospital has reduced by half. Length of stay has been reduced as have non-elective admissions. It has made a huge difference to the patient experience and also to service in the broadest sense.

GRH team offer assistance to the UHBW team if advice is required during the set-up period.

**4.2 South West Genomic Laboratory Hub (GLH)**

**Presented by N Wong**

Consultant Pathologist N Wong will be ending his tenure as Pathology Lead for the GLH at the end of March 2022. CAG are invited to send any GLH queries to him prior to that date.

Gastric HER2 has been routine for some time now, and MMR/MSI testing is starting up. The newest test to be offered is PDL1 staining, which is set up in RD&E at present, but not in SWAG. The GLH currently outsource this to the Poundbury Cancer Institute which has a molecular laboratory, as there are not the resources to perform this locally, and probably won't be for a while. This may result in delayed turnaround times. Pathology colleagues have been contacted across the SWAG region to request that the test is sent directly to Poundbury to avoid delays as much as possible.

There are no other genetic tests available for OG at present.

**Discussion:**

SFT are increasingly sending genetics and molecular tests to multiple centres other than the SW GLH, which presents difficulties when you are working with a limited amount of tissue that must be split to go for MMR locally, then for HER2 and PDL1. It is difficult to monitor when each result might be returned.

It would be ideal if every single test could be performed in the same location with a streamlined turnaround time; this is the aim of the SW GLH. NHS E's aim for everything to be centralised immediately is not feasible to achieve with existing resources (shortages of pathologists and funding).

The problem needs to be escalated to the network as an issue that affects decision making for patients on treatment.

**Action: H Dunderdale to highlight the problem with genetic/molecular turnaround times to the Cancer Operational Group.** **H Dunderdale**

It may help ease pressures on Severn Pathology if Poundbury Laboratory can be requested to test for HER2 at the same time as PDL1; this will also save tissue.

**5. Multi-Disciplinary Team (MDT) membership changes/service**

**5.1 Clinical Nurse Specialist Update**

**Presented by CNS Team**

The UHBW CNS Team continue to provide a prehabilitation service to HPB patients. There is a planning meeting held every Monday where relevant patients are identified. A comprehensive spreadsheet has been developed that allows the patient to be tracked throughout their pathway to ensure every stage / test is arranged in as timely a way as possible, and to assess suitability for prehab.

The Trust has now funded additional help from physio, which has been very helpful.

Tracking work will now expand to cover OG patients. The prehabilitation pathway will be slightly different due to the neoadjuvant treatment. The focus will be on keeping people active during their chemotherapy; this is Phase 1 of the process.

When identifying patients who are candidates for radical treatment, an initial conversation is had about optimising health with high protein calories while preventing weight gain and doing enough activity to get short of breath. Once neoadjuvant treatment is completed, further prehab activity is encouraged prior to their surgery (Phase 2).

**Discussion:**

There are some patients from peripheral centres who may not come up to UHBW until after their neoadjuvant treatment who will need the information on

prehabilitation. However, the aim is for all relevant patients to have that initial conversation with the UHBW CNS team.

The information given at Phase 1 is to undertake 30 minutes of activity 5 days a week.

The Lead Cancer Nurse in Gloucestershire works closely with Allied Health Professional Juliette Sheridan who has set up a prehabilitation service with psychologist, physiotherapy and dietician, which is a funded specialised team. It may be of interest to the UGI nurses to forge links with the service as there are initiatives and assessments that could be useful to share.

There is approximately a 75% reduction in anaesthetic risk due to the impact of prehabilitation. A multi-disciplinary approach is felt to be the most beneficial model, including the valuable support provided by Cancer Support Workers.

The reason why the service is working well is because the CNS team is trained to provide some psychological support, such as motivational interviewing, pick up on any other problems that patients need help with, arrange interventions at the earliest opportunity, and liaise with other AHPs where required to optimise care.

No issues with completing HNAs were flagged. The NBT CNS team complete them regularly in a Tuesday clinic.

**5.2 Workforce Review**

YDH: A new Cancer Support Worker has been appointed, and funding has just been secured for 2 years to advert for a Band 5 Cancer Support Nurse. It will be a developmental role which will enable the current CNS to train other team members to run nurse-led clinics. A Medical Oncologist is also in post.

Somerset FT: There is a completely new UGICNS team.  D Shackleton has been in post since October 2021 and is joined by K Willis and S Smith, although a CNS will be leaving in the near future. An advert is currently out to appoint a Cancer Support Worker. There is also a new pathway navigator postholder who works closely with the MDT Coordinator. An additional Clinical Oncologist has recently been appointed who can provide some cover should E Cattell be away from work, and there is also one other Medical Oncologist.

RUH: A new CNS, K Birch, has been appointed to help cover both OG and HPB patients. Funding has been agreed for a Patient Navigator as well, and the post should go out to advert in the next few months. This is a significant improvement as the need for additional support has been repeatedly flagged for quite some time. The team has been further enhanced by increased involvement in the service by the gastroenterologist's.

One Oncologist has left, with T Tillett now providing cover for a different site. There are now two Medical Oncologists covering the service. Historically, the HPB and OG workload was split, but it is hoped that cross-cover can be arranged in future.

NBT: E Newbold joined the CNS team in August 2021 from Critical Care which brings the nursing workforce up to two Whole Time Equivalent (WTE). H Kitchen will be leaving to join the UHBW team in February 2022. The current Cancer Support Worker is leaving and there will be a period of time where there will be no cover while the team try to recruit to the post.

UHBW: J Wheat has joined the UHBW team as a locum increasing the surgical team to 5 WTE. Once H Kitchen has joined the CNS team, there will be just one further vacancy to fill. Since the expansion of the service, it has been challenging to provide cover for the inpatient work; these additional roles should address this gap.

The Cancer Support Workers in UHBW are shared across six sites and so input is somewhat limited. There is a part-time administrator who helps manage the service.

GRH: The workforce is reasonably stable. An additional surgeon has joined the team who is doing endoscopic resections. An additional Clinical Oncologist has joined the team and CNS numbers have increased to 5 WTE. A Macmillan funded Cancer Support Worker has also joined the team.

**6. Coordination of Patient Care Pathways**

**6.1 Rapid Diagnostic Service Project**

**Please see the presentation uploaded on to the SWAG website**

**Presented by B Hill**

SWAG Cancer Alliance Project Manager B Hill has been tasked with helping to implement the rapid diagnostic principles which are about to be introduced for UGI Cancer.

Further on from the discussions of workforce, funding from the RDS project can be used to support navigator roles, which could benefit NBT.

RDS services started off as a way to improve the pathway for patients with vague symptoms that do not fit a specific cancer pathway and is now being rolled out to all cancer pathways.

The seven RDS principles, which are part of the NHS E Long term plan to implement in all cancer pathways by 23/24, are intended to facilitate meeting the 28 day Faster Diagnosis Standard (FDS) Cancer Waiting Time Target (patient informed of diagnosis).

The principles include:

- Early identification
- Timely referral
- Broad assessment of symptoms
- Coordinated testing
- Timely diagnosis
- Appropriate onward referral
- Excellent patient coordination and support.

The National Cancer Board have said that key milestones on the best practice timed pathway that the team should focus on embedding are from Day 1-7 and Day 28.

Templates have been sent to all providers in October 2021 to establish what each Trust requires to implement the best practice timed pathway and what funding the Cancer Alliance can provide to help embed any changes.

Originally it was hoped that the templates would be returned in December 2021, but as the deadline was not feasible given the current pressures on the service and this was extended to the end of January 2022. Feedback has since been received by 4 out of 7 Trusts.

Support is offered by the Cancer Alliance to help implement upgrades to the service; CAG members are invited to contact B Hill with suggestions for improvements so that the Cancer Alliance can work with providers to get agreement for relevant changes to be adopted.

The Commissioning Support Unit (CSU) is going to help the Cancer Alliance to develop an UGI patient experience survey. Trusts will be asked to get consent from patients to share contact details with the CSU. It is hoped that this will provide helpful feedback to the Cancer Alliance and Trusts. Suggestions for questions would be welcomed.

The site specific RDS can be best described as a way to access national funding to upgrade existing two week wait pathways**.**

**Discussion:**

Consultant Radiologist A Phillips emphasised that same day or next day CT scans were not feasible due to radiology capacity, and every best practice timed pathway for cancer is requesting the same turnaround times. At present it was a struggle to scan two week wait referrals within 2 weeks. A compromise needs to be made, for example, that a staging scan is undertaken within a week before the MDT case discussion.

The same feedback has been given by radiology across all of the cancer sites.

It was noted that the SWAG UGI service was achieving the FDS standard target on >70% compliance, which is above the national target.

Pre-pandemic, Gloucestershire were close to managing to organise faster referrals for CT post endoscopy. This has been thwarted due to the COVID-19 pandemic but, fortunately, having the PET-CT service based in Cheltenham, the opportunity to streamline the pathway by having combined contrast CT and PET immediately after diagnosis as a single staging intervention has been offered since April 2020. This has reduced hospital admissions and, although it will mean that a few patients will get an unnecessary PET, it is increasingly being used to manage patients with palliative disease and guide oncological treatment.

A paper is due to be published on the service, which shows that it is also cost effective.

**Action: Consultant Surgeon S Higgs will send B Hill details of the service.** **S Higgs**

**7. Quality Indicators, Audits and Data Collection**

**7.1 National Oesophago-Gastric Cancer Audit**

**Please see the presentation uploaded on to the SWCN website**

**Presented by D Titcomb**

It is important to note that SWAG includes Gloucestershire, unlike the former Cancer Network, and also sits with Birmingham and Oxford.

High Grade Dysplasia (HGD) submissions had been low and were now one of the highest performing centres in the country.

OG cancer submissions from UHBW, which include data right up until the start of COVID, has improved.

Diagnosis of HGD patients that have had diagnosis confirmed by a 2nd pathologist and discussed at MDT show a discrepancy in the data that is thought to be due to the cohort of patients that are not referred to UHBW; the discrepancy has however got better in comparison with the previous data.

Initial primary treatment of HGD shows that SWAG are treating nearly the highest number of patients in the country, which is a huge positive for the group.

Site of cancer is much the same as for the rest of the country.

There was substantial variation in the number of patients diagnosed following emergency admission in Wales, but not in the rest of the country.

Staging CTs are not performed on those patients who are deemed appropriate for immediate palliation.

Data shows that only 52.1% of patients in UHBW on curative treatment had a PET-CT, which seems like a data collection error that will be investigated further.

Stage of disease at diagnoses shows that many patients are being diagnosed at an earlier stage.

SWAG are not an outlier when comparing Cancer Waiting Time targets.

Time to start non-curative oncological treatment is 67.5 days.

Data on nutritional support looks low as it is not recorded well. The number of feeding jejunostomies has been reduced unless the patient is not able to swallow, as they cause a lot of morbidity.

Mortality data is good; no SWAG surgeons are outliers.

Pathology outcome data is comparable with the national data.

Provision of chemotherapy, radiotherapy and immunotherapy is expected to significantly increase in the next audit report.

NOGCA want to increase the amount of information on palliative treatments in the future.

Over the past 5 years, data collection and treatment evidence is significantly better than it used to be. Further detail is required on long term outcomes as at present it concentrates on 30 day, 90 day and 1 year mortality.

Anyone with a cancer diagnosis will be included in the dataset. Only major surgery will be included.

There are problems with entering data to track HGD cases on to the SCR. A national approach is required to address this. Currently there are not sufficient resources to track pre-cancerous conditions in cancer services.

**Action: H Marder will investigate with NOGCA PET denominator data inclusions to see if this just includes those undertaking curative treatment or if it includes all cases** **H Marder**

**7.2 Service Delivery During the COVID-19 Pandemic**

It should be noted that every unit within the SWAG OG region is struggling with staffing issues during current pandemic circumstances.

**7.3 Any Other Business**

The action plan and progress report will be reviewed outside the meeting and relevant actions will be sent out to individuals.

**Action: P Wilkerson and H Dunderdale to arrange circulation to members** **P Wilkerson / H Dunderdale**

**Date of next meeting: To be agreed by Doodle Poll, 2022**

**-END-**