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

Cancer of Unknown Primary (CUP)

Clinical Advisory Group

Constitution

June 2022

Revision due: April 2024

VERSION CONTROL

THIS IS A CONTROLLED DOCUMENT. PLEASE DESTROY ALL PREVIOUS VERSIONS ON RECEIPT OF A NEW VERSION.

Please check the SWAG website for the latest version available here.

VERSION	DATE ISSUED	SUMMARY OF CHANGE	OWNER'S NAME
Draft 0.1	30th June 2015	First draft	SWAG CUP SSG
1.0	30th June 2015	Finalised	SWAG CUP SSG
1.1	22nd February 2016	Amendments to UH Bristol contact details. Addition of Gloucestershire MDT details.	H Dunderdale
1.2	25th February 2016	Addition of treatable syndrome and patient pathway guidance plus flow chart.	T Tillett, H Dunderdale
1.3	29th February 2016	Addition of site specific MDT contacts	H Dunderdale
1.4	April 2017	Biennial review	SWAG CUP SSG
1.5	30th June 2017	Amendment of site specific MDT coordinator details	H Dunderdale
1.5	6th July 2017	Update of RUH MDT contact details	E Nicolle
1.6	April 2019	Biennial review	SWAG CUP Clinical Advisory Group (CAG, formerly SSG)
1.7	28th June 2019	Finalised	H Dunderdale
1.8	23rd September 2021	Biennial update	H Dunderdale
1.9	November 2021	Amendment of Table 1 and Sections 3.2.1, 3.2.3, 3.2.4, 3.2.5, 3.3.1	T Tillett

This constitution was prepared by:

Tania Tillett, Chair of the SWAG CUP CAG, Consultant Medical Oncologist, Royal United Hospital Bath NHS Foundation Trust

Helen Dunderdale, SWAG Cancer Network CAG Support Manager

This constitution has been agreed by:

Name	Position	Trust	Date agreed
James Bennett	Consultant Medical Oncologist	Royal United Hospital Bath NHS Foundation Trust (RUH)	June 2022
Emma Cattell	Consultant Clinical Oncologist	Taunton and Somerset NHS Foundation Trust (TST)	June 2022
David Farrugia	Consultant Medical Oncologist	Gloucestershire Hospitals NHS Foundation Trust (GLOS)	June 2022
Thomas Wells	Consultant Medical Oncologist	Weston Area NHS Health Trust (WAHT)	June 2022
Vivek Mohan	Consultant Medical Oncologist	University Hospitals Bristol NHS Foundation Trust (UH Bristol)	June 2022

CUP CAG Constitution Contents

1. Statement of Purpose

The Somerset, Wiltshire, Avon and Gloucestershire Cancer Network CUP Clinical Advisory Group (CAG) endeavours to deliver equity of access to the best medical practice for our patient population. The essential priorities of the CAG are to provide a service that is safe, high quality, efficient and promotes positive patient experiences.

To ensure that this statement of purpose is actively supported, the consensually agreed constitution will demonstrate the following:

- The structure and function of the service is conducted, wherever possible, in accordance with the most up to date recommended best practice, as specified in the Manual of Cancer Services, CUP Measures[1]

- A CAG consisting of multidisciplinary professionals from across the Somerset, Wiltshire, Avon and Gloucestershire cancer services has been established and meets on a regular basis

- Network wide systems and care pathways for providing coordinated care to individual patients are in place. This includes the process by which network groups link to individual MDTs

- A process for ensuring that the CAG clinical decision making is in accordance with the most up to date NICE Quality Standards[2] (December 2014) is in place, as are local clinical guidelines that support the standards

- There is a process by which patients and carers can evaluate and influence service improvements that supports the principle '*No decision about me without me*'[3]

- Internal and externally driven routine risk related clinical governance processes are in place for evaluating services across the network, and identifying priorities for improvement

- The CAG have a coordinated approach to ensure that, wherever possible, clinical research trials are accessible to all eligible cancer patients

[1] Manual for Cancer Services

2 Improving Outcomes – A Strategy for Cancer (2011)
3 NICE guidelines

- Examples of best practice are sought out and brought to the CAG to inform service development

- Educational opportunities that consolidate current practice and introduce the most up to date practices are offered whenever resources allow

- Provision of advice to influence the funding decisions of the Cancer Alliance Board.

2. STRUCTURE AND FUNCTION

The Multi-Disciplinary Teams (MDTs) within the CUP CAG consist of consultant clinical and medical oncologists, pathologists, imaging specialists and other health care professionals. They meet regularly to discuss and manage each individual patient's care.

2.1 Network Configuration (measure 14-1C-101m)

The SWAG CUP CAG complies with Peer Review ground rules for networking by meeting the following criteria:

- The SWAG CUP network group is the only network group for the CUP MDTs associated with it
- All hospitals in the network are associated with a CUP MDT
- Relevant hospitals are associated with only one named CUP MDT
- The CUP MDTs within the network are the only MDT with this role in its host hospital
- The CUP MDTs are associated solely with the SWAG CUP CAG

The SWAG CUP CAG Multi-Disciplinary Teams

Table 1.

Trust	CUP MDT	CUP MDT Day / Time	MDT referral deadline	Lead clinician and contact details for advice and rapid referrals
Royal United Hospital Bath NHS Foundation Trust (RUH)	RUH	Thursday 08:30 – 9:00	Tuesday 09:30	Tania Tillett, James Bennett ruh.tr.cancerservicesruh@nhs.net 01225 825207. MDT Coordinator, Tracey Earwaker
Somerset NHS Foundation Trust (SFT) and Yeovil District Hospital NHS Foundation Trust (YDH)	SFT	Thursday 08:30 – 09:30	No specific deadline	Emma Cattell cupmdt@tst.nhs.uk (MDT Coordinator – Emma Pugh)
University Hospitals Bristol and Weston NHS Foundation trust: Weston site	UH Bristol	Thursday morning 8.30	Tuesday 08:00	Thomas Wells Thomas.wells@nhs.net 01934636363, ext. 3990,
North Bristol NHS Trust	UH Bristol	Thursday morning 8.30	Tuesday 08:00	Vivek Mahon, 01173423336, ubh-tr.CUPTeam@nhs.net
University Hospitals Bristol and Weston NHS Foundation Trust: Bristol site	UH Bristol	Thursday morning 8.30	Tuesday 08:00	Vivek Mahon 01173423336, ubh-tr.CUPTeam@nhs.net
Gloucestershire Hospitals NHS Trust (Glos)	Glos	Second and fourth Friday of the month, 12.00 – 13.00	No specific deadline	David Farrugia, 03004223830, Acute.Oncologyteam@glos.nhs.uk

2.2 Network Group Membership (measure 14-1C-102m)

All participants at MDTs are welcome to attend the CAG meetings.

The SWAG CUP CAG consists of the following core members:

Table 2:

Trust	Name	Title
YDH	Abbey Evenett	CUP Clinical Nurse Specialist / Lead Acute Oncology
RUH	Allison Rossiter	CUP Clinical Nurse Specialist
Somerset FT	Andrzej Karmolinski	Consultant Pathologist
RUH	Andrea Fensome	CUP Clinical Nurse Specialist
UHBW	Amy Hadley	Senior Nursing Practitioner
Glos	Amy Skelton	Acute Oncology Nurse Practitioner
SWAG	Amy Smith	Cancer Alliance CAG Administrative Coordinator
Weston UHBW	Ceri Tucker	CUP Clinical Nurse Specialist / Acute Oncology Sister
Glos	Colin Binks	Oncology Specialist Doctor
Glos	David Farrugia	Consultant Medical Oncologist
UHBW	David Wilson	Consultant Radiologist
YDH	Ed Cooper	Consultant Pathologist
RUH	Eleni Toumazou	Consultant Pathologist
UHBW	Emily Aston	CUP Clinical Nurse Specialist
Somerset FT	Emma Cattell	Consultant Oncologist
UHBW	Esme Merryfield	MDT Coordinator
UHBW	Hannah Taylor	Oncology Registrar
SWAG	Helen Dunderdale	SWAG Cancer Clinical Advisory Group Manager
SWAG/UHBW	Helen Winter	SWAG Cancer Alliance Clinical Director / Consultant Oncologist
RUH	James Bennett	Consultant Medical Oncologist
Somerset FT	Jo Botton	Associate Specialist
Glos	Jo Cheetham	CUP Clinical Nurse Specialist
Glos	Kathryn Falconer	Registrar/STR7
YDH	Kerry Youe	CUP MDT Coordinator
Somerset FT	Laura Pope	Upper GI Clinical Nurse Specialist
RUH	Leigh Biddlestone	Consultant Pathologist
NBT	Lucy Henderson	Clinical Nurse Specialist Acute Oncology and Haematology
UHBW	Lucy Lipinski	MDT Coordinator
UHBW	Maggie O'Donnell	CUP Clinical Nurse Specialist
YDH	Maung Moe	Consultant Oncologist
Glos	Michael Thomas	Consultant Pathologist
UHBW	Miranda Flory	Consultant in Palliative Medicine

UHBW	Rachel Booth	Clinical Nurse Specialist Acute Oncology and CUP
NBT	Rachel Royston	Consultant in Palliative Medicine
Glos	Rahul Fulmali	Consultant Pathologist
NBT	Richard Daly	Consultant Pathologist
UHBW	Samantha Wells	CUP Clinical Nurse Specialist
UHBW	Stephanie Jones	CUP Clinical Nurse Specialist
RUH	Tania Tillett	Consultant Medical Oncologist
Weston UHBW	Thomas Wells	Consultant Medical Oncologist
UHBW	Vanessa Fountain	AOS Sister
UHBW	Vivek Mohan	Consultant Medical Oncologist
NBT	Zainab Abdul-Rahman	Consultant Histopathologist

2.3 Network Group Meetings (measure 14-1C-103m)

The SWAG CAG will meet twice yearly. Agendas, notes and actions, and attendance records will be uploaded onto the SWAG website here:

Appendix 1 is the Template Agenda for the CUP CAG meetings, which is circulated prior to each meeting to ensure that all members are aware of who is required to attend and that all subject matters requiring discussion are identified.

Terms of reference are agreed in accordance with the paper *Recurrent Arrangements for Cancer Alliance Clinical Advisory Groups (2019),* which is available on the SWAG website here.

The CAG meetings are also conducted in line with the Manual for Cancer Services, CUP Measures (Version1.1).

2.4 Work Programme and Annual Report (measure 14-1C-104m)

The SWAG CAG will produce a Work Programme and Annual Report in discussion with the SWAG Cancer Alliance Board.

3. COORDINATION OF CARE / PATIENT PATHWAYS

3.1 Clinical Guidelines (NS/CUP-17-004)

The CAG refers to the NICE Guidelines for clinical management of CUP cancer. Further details of the local provision of the Guidelines are within the separate document as above. This is reviewed annually to ensure that any amendments to imaging, surgery, pathology, chemotherapy and radiotherapy practices are up to date.

3.2 Network CUP Guidelines and Algorithms on the Systemic Therapy of Treatable Syndromes (measure 14-1C-106m)

3.2.1 Poorly Differentiated Carcinoma with midline distribution

It is important not to miss the highly treatable extra-gonadal germ cell tumour. Patients with the following characteristics should be treated with the same chemotherapy protocol as a poor prognostic germ cell tumour after discussion with the Germ Cell MDT:

- ✓ Young age
- ✓ Male gender
- ✓ Predominant tumour location in the mediastinum or retroperitoneum
- ✓ Marked elevation of the serum human chorionic gonadotropin (hCG) or alpha-fetoprotein (AFP) levels
- ✓ Immunohistochemical staining for octamer-binding transcription Factor 4 (also called POU domain Class 5 transcription Factor 1).

Patients with a midline distribution of poorly differentiated carcinoma without the above features should still have a trial of chemotherapy with a platinum-containing regime, after careful immunohistological investigation to exclude melanoma and sarcoma.

Oncologists specialising in Germ Cell Tumours should treat these patients.

3.2.2 Women with predominantly peritoneal adenocarcinoma

Peritoneal carcinomatosis occurs more frequently in women with a BRAC1 mutation and so a careful family history should be sought. The tumour marker Ca125 can be helpful in this scenario. These patients should be treated as if they have Stage III ovarian cancer with a combination of systemic therapy and debulking surgery if appropriate.

Oncologists specialising in Ovarian Cancer should treat these patients.

3.2.3 Patients with adenocarcinoma involving the axillary lymph nodes

Investigations should be targeted at identifying an occult breast primary, including clinical examination, mammography and MRI if appropriate. These patients are a potentially

curable subset of CUP and should be treated as if they have Stage II or Stage III breast cancer. They should be treated with radical breast cancer treatment options such as surgery and radiotherapy. Systemic anti-cancer treatments should be given in accordance with Guidelines for Early Stage Breast Cancer.

Oncologists specialising in Breast Cancer should treat these patients.

3.2.4 Squamous cell carcinoma of the lymph nodes in the neck

There should be an initial comprehensive work-up to try to identify a Head and Neck primary including CT-PET and targeted panendoscopy under a specialist team, with consideration of radical Head and Neck treatment options such as surgery and radiotherapy for patients with an unknown primary tumour.

3.2.5 Poorly differentiated neuroendocrine carcinoma (NEC)

Octreotide scans are usually not helpful for patients with poorly differentiated Neuroendocrine tumour, but should still be considered for Neuroendocrine Tumours (NET). It should be noted that treatment of metastatic disease does not differ between primary sites and so an exhaustive investigation for the primary should not be undertaken e.g. CT PET and endoscopies etc. These patients should be treated with a small cell carcinoma regime, for example Carboplatin and Etoposide.

These patients can be treated either by a CUP Oncologist or an Oncologist specialising in Lung Cancer. Patients with a well differentiated neuroendocrine tumour (NET) should be referred to a NET specialist Oncologist and NET MDT.

3.2.6 Inguinal lymph nodes involved with squamous cell carcinoma

These patients should still be considered for radical treatments, including surgery and/or radiotherapy, and should be referred either through the Anal Cancer pathway to the Lower GI specialist team or women with this diagnosis can also be referred through the Gynaecology Cancer pathways.

The protocols will be distributed to the relevant cancer site-specific MDTs in the network.

3.3 Patient Pathways (NS/CUP-17-005)

3.3.1 The SWAG network group agreed network-wide patient pathways

These provide clear indications for the lines of responsibility to be followed by teams and services for the referral of patients with an initial diagnosis of a malignancy of unknown origin, and include the particular aspects of investigation and subsequent management that should be assigned to a specific team:

- Patients identified by the accident and emergency departments, hospital consultants, acute oncology services (AO) or a site specific MDT within the hospital, who meet the definition of an MUO / pCUP and require hospital admission, are to be rapidly referred to a member of the hospital CUP team (see Table 1 for rapid referral contact details)
- Patients identified in accident and emergency departments, who meet the definition of an MUO / pCUP and do not require hospital admission, are to be referred by the two week wait / urgent outpatient referral process to the hospital CUP team
- Patients identified in other outpatient hospital settings, such as routine clinics, who do not require hospital admission, are to be referred to the hospitals CUP MDT
- In-patient referrals will be reviewed in person by a core member of the CUP team by the end of the following working day
- Out-patient referrals will be reviewed in person by a core member of the CUP team within 2 weeks of the date of referral
- If a patient with an MUO is referred in the first instance to a site-specific team, that team will refer him on to the CUP MDT
- Patients with pCUP will be discussed at the next relevant hospital CUP MDT to decide if further investigations are required to either confirm the diagnosis of CUP or a primary site malignancy, if active treatment is appropriate, and make relevant treatment planning decisions
- When the CUP MDT recommends that a patient should not undergo further investigation and / or treatment, in accordance with the Patient Investigation and Management Policy (measure 14-1C-108m), a core member of the CUP team will discuss and agree this with the patient, and the patient should be offered referral to a Palliative Care specialist team
- Emotional and psychological support will be provided by the CUP CNS team in collaboration with palliative care teams, where appropriate. The responsibility will be transferred to a site specific CNS in the event that a primary malignancy is diagnosed
- Additional guidelines to those agreed in measure 14-1C-106m will be drafted for agreement for cases where CUP patients with certain special scenarios imply a specific but occult primary site and a site specific treatment.

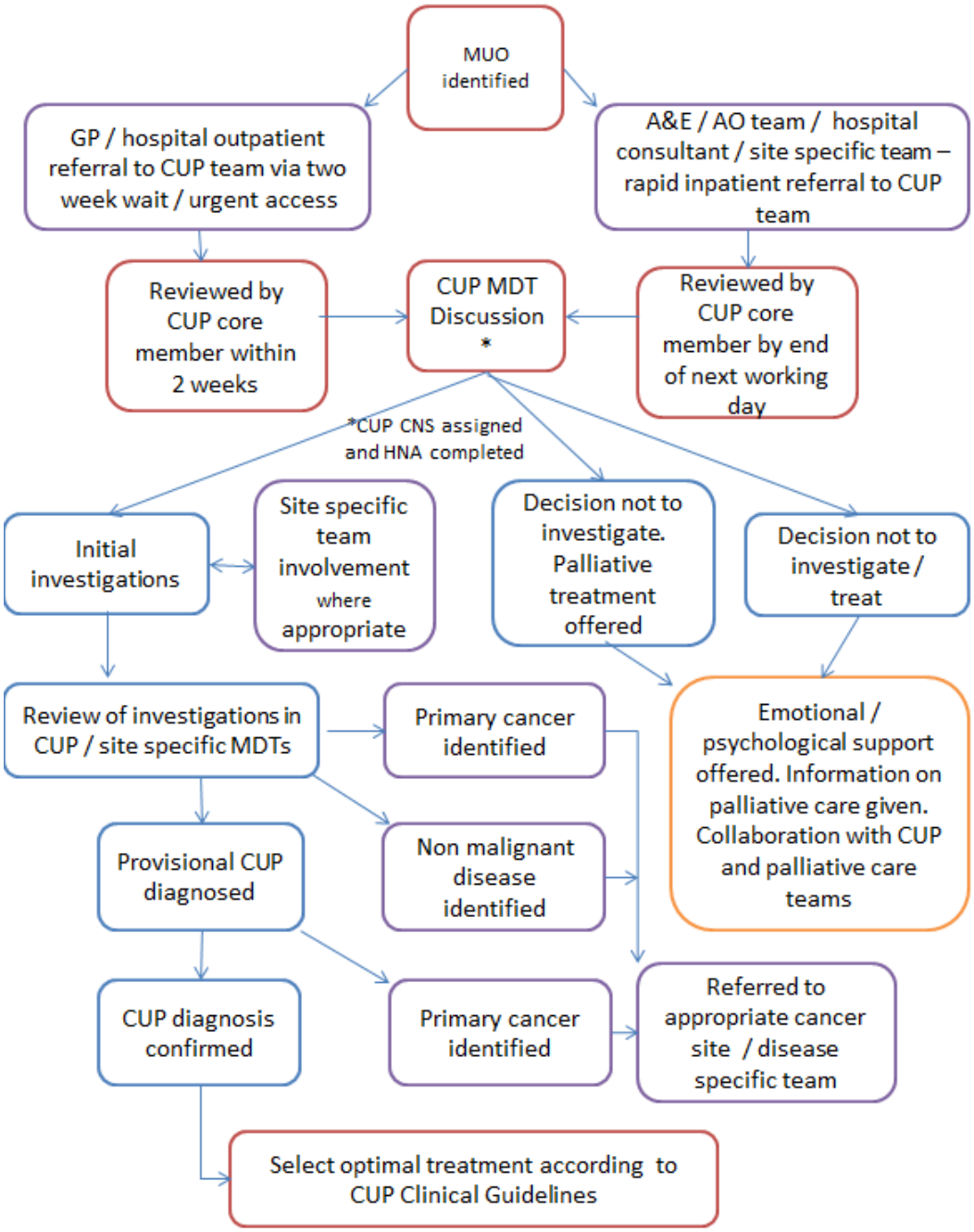
Initial investigations that are the responsibility of the CUP service, when clinically appropriate:

- Comprehensive history and physical examination including breast, nodal areas, skin, genital, rectal and pelvic examination
- Full blood count; urea, electrolytes and creatinine; liver function tests; calcium; lactate dehydrogenase
- Myeloma screen (when there are isolated or multiple lytic bone lesions)
- Symptom-directed endoscopy
- CT scan of the chest, abdomen and pelvis
- Tumour markers: PSA in men, CA125 in women with peritoneal malignancy or ascites, AFP and hCG (particularly if midline nodal disease is present; see special diagnostic tests below)
- Testicular ultrasound in men with presentations compatible with germ-cell tumours
- Biopsy and standard histological examination, with immunohistochemistry if necessary, to distinguish carcinoma from other malignant diagnoses.

In the event that a surgical or investigational procedure is deemed clinically appropriate to be performed by a site specific team, there will be collaborative responsibility for the patient between the two teams. The patient will continue to have emotional and psychological support provided by the CUP CNS until the primary diagnosis has been confirmed, after which, the site specific CNS will take full responsibility for the patient. The pathways have been distributed to the cancer site specific MDTs.

3.3.2

SWAG CUP Patient Pathway Flow Diagram



3.3.3 Site Specific MDT referral contacts

Table 3.

Site Specific MDT	UHBW	RUH	GlOS	SFT	WAHT	NBT	YDH
Generic central email:	ubh-tr.cancerreferrals@nhs.net (Bristol) wnt-tr.CancerServiceswaht@nhs.net (Weston)	ruh-tr.cancerservicesruh@nhs.net	ghn-tr.GNHSFTcancerdatatransfer@nhs.net	canceradminservices@somersetft.nhs.uk	wnt-tr.CancerServiceswaht@nhs.net	cancerservices@nhs.net	YDH-MDT@ydh.nhs.uk
Brain	http://www.nbt.nhs.uk/bnog/, (NBT Service) 01173403154	http://www.nbt.nhs.uk/bnog/, (NBT Service) 01173403154	http://www.nbt.nhs.uk/bnog/, (NBT Service) 01173403154	http://www.nbt.nhs.uk/bnog/, (NBT Service) 01173403154	http://www.nbt.nhs.uk/bnog/, (NBT Service) 01173403154	http://www.nbt.nhs.uk/bnog/, (NBT Service) 01173403154	http://www.nbt.nhs.uk/bnog/, (NBT Service) 01173403154
Skull base	http://www.nbt.nhs.uk/bnog/, (NBT Service) 01173403154	http://www.nbt.nhs.uk/bnog/, (NBT Service) 01173403154	http://www.nbt.nhs.uk/bnog/, (NBT Service) 01173403154	http://www.nbt.nhs.uk/bnog/, (NBT Service) 01173403154	http://www.nbt.nhs.uk/bnog/, (NBT Service) 01173403154	http://www.nbt.nhs.uk/bnog/, (NBT Service) 01173403154	http://www.nbt.nhs.uk/bnog/, (NBT Service) 01173403154
Breast	Breastmdt.referrals@nhs.net, (NBT Service) 0117 3237008	ruh-tr.cancerservicesruh@nhs.net 01225 826452	ghn-tr.GNHSFTcancerdatatransfer@nhs.net	breastmdtreferrals@somersetft.nhs.uk	wnt-tr.CancerServiceswaht@nhs.net FAO Suzannah Dyer 01934 881117	Breastmdt.referrals@nhs.net, 0117 3237008	Natacha.blake@YDH.NHS.UK 01935 384290
Colorectal	ubh-tr.cancerreferrals@nhs.net (Bristol) wnt-tr.CancerServiceswaht@nhs.net (Weston)	ruh-tr.cancerservicesruh@nhs.net 01225 825207	ghn-tr.GNHSFTcancerdatatransfer@nhs.net	colorectalmdtreferrals@somersetft.nhs.uk	wnt-tr.CancerServiceswaht@nhs.net FAO Jolanda Bennett 01934 881117	https://www.nbt.nhs.uk/clinicians/services-referral/colorectal-cancer-clinicians/2-week-wait-colorectal-pathway	ColorectalMDT@YDH.NHS.UK Claire-Louise.Barnes@YDH.NHS.UK claire-louise.barnes@nhs.net 01935 383486
Gynaecology	ubh-tr.cancerreferrals@nhs.net	ruh-tr.cancerservicesruh@nhs.net 01225 825207	ghn-tr.GNHSFTcancerdatatransfer@nhs.net	gynaemdtreferrals@somersetft.nhs.uk	wnt-tr.CancerServiceswaht@nhs.net FAO Suzannah Dyer 01934 881117	cancerservices@nhs.net,	tracey.mcewan@YDH.NHS.UK 01935 383486
Haematology	ubh-tr.cancerreferrals@nhs.net	ruh-tr.cancerservicesruh@nhs.net 01225 821314	ghn-tr.GNHSFTcancerdatatransfer@nhs.net	haematologymdtreferrals@somersetft.nhs.uk	wnt-tr.CancerServiceswaht@nhs.net FAO Leah Johnston 01934 881117	cancerservices@nhs.net,	tracey.mcewan@YDH.NHS.UK 01935 383486
Head and Neck	ubh-	ruh-	ghn-	headandneckM	ubh-	ubh-	Kerry.Youe@YD

	tr.cancerreferrals@nhs.net	tr.cancerservicesruh@nhs.net 01225 821450	tr.GNHSFTcancerdatatransfer@nhs.net	DTreferrals@tst.nhs	tr.cancerreferrals@nhs.net 01173420620	tr.cancerreferrals@nhs.net 01173420620	H.NHS.UK 01935 384627
Lung	ubh-tr.cancerreferrals@nhs.net	ruh-tr.cancerservicesruh@nhs.net 01225 821450	ghn-tr.GNHSFTcancerdatatransfer@nhs.net	lungmdtreferrals@somersetft.nhs.uk	wnt-tr.CancerServiceswaht@nhs.net FAO Leah Johnston 01934 881117	Carrie.trott@uhbristol.nhs.uk 01173420617	Corinne.Lock@YDH.NHS.UK Corinne.lock@nhs.net 01935 384290
Neuro-endocrine	ubh-tr.cancerreferrals@nhs.net	cancerservices@nhs.net, 01173232466	ghn-tr.GNHSFTcancerdatatransfer@nhs.net	ubh-tr.NETMDTBristol@nhs.net (UH Bristol Service)	n/a	cancerservices@nhs.net,	n/a
Sarcoma	cancerservices@nhs.net, (NBT Service) 01173232466	cancerservices@nhs.net 01173232466	Refer to midland cancer services	cancerservices@nhs.net, 01173232466 (NBT Service)	cancerservices@nhs.net, 01173232466	cancerservices@nhs.net, 01173232466	cancerservices@nhs.net, 01173232466
Skin	ubh-tr.cancerreferrals@nhs.net	ruh.tr.cancerservicesruh@nhs.net 01225 821405	ghn-tr.GNHSFTcancerdatatransfer@nhs.net	skinmdtreferrals@somersetft.nhs.uk	cancerservices@nhs.net, 01173232466	cancerservices@nhs.net, 01173232466	Emily.fox-williams@ydh.nhs.uk 01935 384290
TYA	ubh-tr.cancerreferrals@nhs.net	andrea.majai@uhbrisol.nhs.uk	ghn-tr.GNHSFTcancerdatatransfer@nhs.net	PaedOncMDT@uhbw.nhs.uk (UH Bristol Service)	andrea.majai@uhbrisol.nhs.uk	andrea.majai@uhbrisol.nhs.uk	andrea.majai@uhbrisol.nhs.uk
Testicular	ubh-tr.cancerreferrals@nhs.net 01173420618	ruh-tr.cancerservicesruh@nhs.net 01225 821017	ghn-tr.GNHSFTcancerdatatransfer@nhs.net	Tony-marie.harvey@uhbristol.nhs.uk (UH Bristol Service) 01173420618	Tony-marie.harvey@uhbristol.nhs.uk (UH Bristol Service) 01173420618	Tony-marie.harvey@uhbristol.nhs.uk (UH Bristol Service) 01173420618	Tony-marie.harvey@uhbristol.nhs.uk (UH Bristol Service) 01173420618
Upper GI	ubh-tr.cancerreferrals@nhs.net	ruh.tr.cancerservicesruh@nhs.net 01225 825207	ghn-tr.GNHSFTcancerdatatransfer@nhs.net	uppergimdtreferrals@somersetft.nhs.uk	wnt-tr.cancerserviceswaht@.nhs.net FAO Miriam Pople 01934 881117	cancerservices@nhs.net, 01173232466	YDH-ftr.UpperGIMDT@nhs.uk; Tracey.McEwan@YDH.NHS.UK 01935 38462
UGI – Hepato-Pancreato-Biliary	ubh-tr.cancerreferrals@nhs.net	ruh-tr.cancerservicesruh@nhs.net 01225 825207	Refer to Midlands Cancer Services	ubh-tr.hpbmdtbristol@nhs.net (UH Bristol Service)	Tracy.smart@uhbristol.nhs.uk 01173420625	Tracy.smart@uhbristol.nhs.uk 01173420625	Ubh-tr.hpbmdtbristol@nhs.net 01173420625
Urology	cancerservices@nhs.net (NBT Service – for patients living Bristol) wnt-tr.cancerserviceswaht@.nhs.net (for patients living Weston)	ruh-tr.cancerservicesruh@nhs.net 01225 821017	ghn-tr.GNHSFTcancerdatatransfer@nhs.net	urologymdtreferrals@somersetft.nhs.uk	cancerservices@nhs.net wnt-tr.cancerserviceswaht@.nhs.net FAO Judith Harvey 01934 881117	cancerservices@nhs.net	Corinne.lock@ydh.nhs.uk Corinne.lock@nhs.net 01935 384290

The SWAG CUP CAG also follows the patient pathways as recommended in the NICE Guidelines here.

Important Definitions:

Malignancy of undefined primary origin (MUO): this is metastatic malignancy identified after a limited number of tests, without an obvious primary site.

Provisional carcinoma of unknown primary (CUP): metastatic epithelial or neuro-endocrine malignancy on the basis of biopsy, with no primary site identified, despite initial investigations and before specialist review.

Confirmed CUP: as above, after specialist review and appropriate specialised investigations.

Patients referred to the CUP MDT will have usually undergone a CT of the chest, abdomen and pelvis.

Patients who are unfit for treatment (or who opt against investigation) who have had partial imaging will be discussed to advise on the merits of further investigation.

3.4 Patient Pathways for Teenagers and Young Adults (TYA)

Details of TYA patient pathways for the SWAG CAGs can be found on the SWAG website:

TYA

3.5 Patient Investigation and Management Policy (measure 14-1C-108m)

The network group agrees to the following network wide policy, which underpins the ongoing investigation and subsequent management of all patients presenting as cases of MUO.

Continuing investigations to find the primary should only be carried out if:

- The patient is fit for treatment if the primary is found
- The results are likely to affect a treatment decision
- The patient understands why the investigations are being performed and the potential risks and benefits of investigation and treatment
- The patient is prepared to accept eventual treatment.

Confirmed CUP Patients without a specific 'treatable syndrome' (measure 14-1C-106m) who are being considered for chemotherapy should:

- Have the balance between potential risks and benefits discussed with them
- If it is decided to proceed with chemotherapy, be offered entry into a clinical trial if available

- Confirmed CUP Patients with a 'treatable syndrome' and fit for treatment, should be offered chemotherapy according to the Network CUP Guidelines and Algorithms on the Systemic Therapy of Treatable Syndromes (measure 14-1C-106m).

This policy will be distributed to the relevant hospitals and cancer site specific MDTs in the network.

4. PATIENT AND PUBLIC INVOLVEMENT

4.1 User involvement

The NHS employed member of the CAG nominated as having specific responsibility for users' issues and information for patients and carers is the Cancer Clinical Advisory Group Manager. The CAG actively seeks to recruit user representatives. Appendix 2 contains the patient/user involvement brief that is circulated for this purpose.

4.2 Patient Experience (measure 14-1C-109m)

The results and actions generated from the National Cancer Patient Experience Survey within each Trust in the CAG will be reviewed in every CAG meeting, and the progress of the agreed improvement programme monitored. Progress will be published in the Annual Report.

4.3 Charity involvement

See Appendix 3

5. CLINICAL GOVERNANCE

5.1 Clinical Outcomes, Indicators and Audits (measure 14-1C- 110m)

The CAG regularly review the data from each MDT's clinical outcomes, quality indicators and audits. At least one network audit will be performed each year. The results of this are presented at the CAG meetings and distributed electronically to the group.

5.2 Data Collection

Patient data on diagnostics is uploaded to the Somerset Cancer Registry as part of a National initiative.

6. CLINICAL RESEARCH

6.1 Discussion of Clinical Trials (measure 14-1C-111m)

Members of the CAG discuss each MDT's report on clinical research trials within every CAG meeting. A list of all of the open trials on the CUP NIHR portfolio, and potential new trials is brought to each CAG meeting by the West of England Clinical Research Network (CRN) Cancer Research Delivery Manager.

Due to the CRNs mapping with the Academic Health Science Networks, Taunton and Yeovil are in South West Peninsula CRN. The Cancer Research Delivery Manager from the Peninsula CRN will provide the CAG with the data for these Trusts. Information on clinical trial recruitment will be published in the CAG Annual Report. Potential new trials to open and actions to improve recruitment will be documented in the CAG Work Programme. The trials available in each Trust will be updated on the South West Strategic Clinical Network website at regular intervals so that the CAG members can ensure, wherever possible, that clinical research trials are accessible to all eligible CUP oncology patients. The NHS staff member nominated as the Research Lead for the CAG is Consultant Oncologist Tania Tillett.

7. SERVICE DEVELOPMENT

Regular reviews of major service developments and changes in treatment pathways are conducted at the CAG meetings.

A regular review of Chemotherapy Protocols is conducted by the CAG.

7.1 Education

The CAG meetings will have an educational function. Continuous Professional Development (CPD) accreditation for meetings with multiple educational presentations will be sought by application to the Royal College of Physicians. This will involve uploading presentations and speaker profiles to the CPD approvals online application database. The approvals process takes approximately six weeks, and can be applied for retrospectively. The CAG members will be required to complete a Royal College of Physician's CPD evaluation form. Certificates of the CPD points that are allocated to the meeting will be distributed to the CAG members.

7.2 Sharing Best Practice

Where best practice in CUP oncology services outside the SWAG CAG has been identified, information on the function of these services will be gathered to provide a comparison and inform service improvements. Guest speakers from the identified services will be invited to provide a presentation at the CAG meetings.

Where best practice in CUP oncology services within the SWAG CAG has been identified, information on the function of SWAG services will be disseminated to the other cancer networks.

8. FUNDING

8.1 Clinical Commissioning Groups / Integrated Care Boards

In the event that an insufficiency in the CUP oncology services relating to funding is identified, the CAG will gather evidence of the insufficiency via audit and research, together with feedback about how the provider Trusts have tried to address them. The consequences of the insufficiencies for patients will be listed so that all key issues are documented and the required actions made clear. This information will then be fed back to the Cancer Alliance Delivery Group to determine what action needs to be taken and escalated to the SWAG Cancer Board if required.

8.2 Industry

The Government's paper *Improving Outcomes: A Strategy for Cancer* states that 'working together with other organisations and individuals, we can make an even bigger difference in the fight against cancer'. The CAG will forge relationships with pharmaceutical companies to seek commercial sponsorship for the meetings in order to make savings that can be fed back into the CAG cancer services. The CAG Support Manager will comply with the various rules and regulations pertaining to the pharmaceutical companies' policies and with the NHS rules and regulations as follows:

- Completion of a register of interest form with the CAG support service host Trust, University Hospitals Bristol NHS Foundation Trust
- Declaration of any sponsorship offers
- Confirm with all sponsors that the arrangements would have no effect on purchasing decisions
- Ensure that all pharmaceutical companies entering into sponsorship agreements comply with *the Code of Practice for the Pharmaceutical Industry* (Second Edition) 2012
- Obtain advice from the Medical Director or Chief Pharmacist for sponsorship agreements in excess of £500.00
- Ensure that where a meeting is funded by the pharmaceutical industry, that this is documented on all papers relating to the meetings

- Ensure that the receipt of funding is approved by an Executive Director and recorded in the Register of Gifts, Hospitality and Sponsorship in advance

- Scrutinise contracts with the assistance of Financial Services prior to providing a signature.

9. APPENDICES

9.1 Appendix 1

Template Agenda

Network group membership to attend

Chair, MDT Lead Clinicians, MDT nurse core member, Clinical oncologist, Medical oncologist,

Imaging specialist, Histopathologist, Consultant in Palliative Medicine, User representative 1

User representative 2, Administrative support

- Chair to name nominated network group member responsible for users' issues and information for patients / carers

- Chair to name nominated network group member responsible for clinical trial recruitment function

Template Agenda

1. **Review of last meeting minutes:**

2. **Clinical opinion on network issues:**

   Review of MDT membership changes / service

3. **Clinical guidelines:**

   Review if any amendments to imaging, pathology, chemotherapy, radiotherapy, surgical practices

   Version control process

4. **Coordination of patient care pathways:**

   Review hospital referral processes for TYA / varying indications / investigations and follow up

Review implementation of Primary Care referral pro forma

Breach example to discuss

5. **Patient experience:**

   User representative input

   Review patient experience survey / identified actions

   QOL surveys

   Patient information

   Addressing inequalities

   CNS / keyworker support

6. **Quality indicators, audits and data collection:**

   Current audits / audit outcomes

   Audits in the pipeline

   Data collection issues

7. **Research:**

   Current clinical trials / recruitment / actions to improve recruitment

   Clinical trials in the pipe line

8. **Service development:**

   Genomics

   Immunotherapy

   Early diagnosis

   Training opportunities available

   Sharing best practice

   Innovation

   Awareness campaigns

9. Quality Surveillance:

Annual Report

Constitution

Work Programme Review

- Good practice – specific areas to highlight
- Are there any immediate risks?
- Are there any serious concerns?

10. Any other business:

11. Date and time of next meeting:

9.2 Appendix 2

SWAG CAG User Involvement Brief

9.3 Appendix 3

SWAG CAG Charity Involvement Brief

9.4 Appendix 4

Referral proformas currently in use:

Royal United Hospital Bath NHS Foundation Trust (RUH)

Primary care referral:

2WW referral system operational

Referral from cancer site specific MDT:

Patient Name Hospital ID DOB Contact Telephone Number	

Source of Initial Referral		Date
Initial Referring Investigation		Date
Presenting Symptoms		
Performance Status		Date
CT Staging (Chest Abdo Pelvis)		Date
MRI Scan (as needed)		Date
Routine Bloods Taken (FBC, U+E, LFT, Ca, LDH)		Date
Relevant Tumour Markers*		Date
Myeloma Screen **		Date
Endoscopy (if relevant)		Date
Biopsy	Site	Date
Other		Date
CUP MDM		Date
CUP MDM Outcome		
Initial Oncology OPA	Cons	Date
Definitive Oncology OPA	Cons	Date
Confirmed Diagnosis		
Treatment Plan		

KEY	
Tumour Markers*	PSA – men with primary bone disease Ca125 – women with peritoneal malignancy or ascites AFP and HCG – men with midline nodal disease AFP – suspected primary liver cancer CEA – suspected colorectal cancer or liver only metastasis Ca19.9 – suspected UGI/HPB cancers Ca15.3 – suspected Breast Cancers
Myeloma Screen**	Serum Free Light Chains Bence-Jones Protein Skeletal Survey (if not had CT CAP)

Taunton and Somerset NHS Foundation Trust (TST)

Primary Care referral:

To be confirmed

Referral from cancer site specific MDT:

Malignancy of Undefined Primary Origin Referral

Patient demographics: **sticker**		
Date of Admission:	**Ward:**	**Consultant team:**
CUP team initial review: **Name:**		**Date:**
Source of initial referral:		**Date:**
History:		
Initial referring investigation:		**Date:**

Examination findings: PV/PR/breast/nodal/genital/skin:	**Date:**

Performance status: **Date:**

0 – Asymptomatic (fully active, able to carry on all predisease activities without restriction)
1 – Symptomatic but completely ambulatory (restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature. For example: light housework, office work)
2 – Symptomatic - <50% in bed during the day (ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% if waking hours)
3 – Symptomatic - >50% in bed, nut not bed bound (capable of only limited self-care, confined to bed or chair 50% or more of waking hours)
4 – Bedbound (completely disabled. Cannot carry out any self-care. Totally confined to bed or chair)
5 – Death

CNS informed ☐ **Date:** **PCT informed** ☐ **Date:**

Imaging: **Date:**	**Result:**
CXR ☐	
Staging CT (CAP) ☐	
Other imaging ☐	

Bloods taken: **Date:**

Hb	**Na**	**ALP**
WCC	**K**	**ALT**
Platelets	**Urea**	**Calcium**
Neutrophils	**Creatinine**	**Albumin**
	Bilirubin	**LDH**
Urinalysis		

Tumour markers if indicated: **Date:**

Ca125	**PSA**
Ca199	**AFP**
Ca153	**HCG**
CEA	

Myeloma screen: **Date:**

Serum free light Chains	**Serum electrophoresis**	**Skeletal survey**

Other investigations:	**Date:**
Endoscopy (if indicated)	
Any other investigation (if indicated)	
Biopsy:	**Date:**
CUP Multidisciplinary Meeting Outcome	**Date:**
Confirmed diagnosis	**Date:**
Treatment plan: **a) Refer to site specific MDT** **b) Refer to Palliative Care** **c) Refer to Oncology**	
Outcomes:	

Yeovil District Hospital NHS Foundation Trust (YDH)

Primary Care referral:

To be confirmed

Referral from cancer site specific MDT:

Malignancy of Unknown Origin (MUO) Assessment Form

Please complete for each patient referred from Primary Care or as an inpatient

Patient Name Hospital Number DOB Contact telephone number		
Source of Initial Referral		Date
Initial Referring Investigation		Date
Presenting Symptoms		
Performance Status		Date
CT Chest/Abdo/Pelvis		Date
MRI scan (if needed)		Date
Routine Bloods Tests (FBC, U&Es, LFTs, Ca^{2+}, LDH)		Date
Relevant Tumour Markers		Date
Myeloma Screen		Date
Endoscopy (if relevant)		Date
Biopsy	Site	Date
Other		Date
CUP MDT	Date	
CUP MDT Outcome		

Malignancy of Unknown Origin (MUO) Assessment Form

Initial Oncology OPA	Dr	Date
Definitive Oncology OPA	Dr	Date
Confirmed Diagnosis		
Treatment Plan	Date	

Notes

University Hospital Bristol NHS Foundation Trust (UH Bristol)

Primary Care referral

Two week wait referral system operational. Urgent referral system due to be instigated.

Referral from cancer site specific MDT

University Hospitals Bristol NHS Foundation Trust
CANCER OF UNKNOWN PRIMARY
MDT Request Form

Date of MDT		Consultant	
Patient Name		Referred by	
DOB		Referrers contact number	
Patients' location		Date of Referral to CUP team	
NHS No.		How was patient referred to BRI	
Hospital No.		Referral date to BRI	
Performance Status (see 2nd page for guidance)		Key worker	

History and presenting symptoms

Investigation	**Date of investigation**	**Place of investigation**
Radiology - Specify		
Tumour Markers		
Biopsy		

Cytology		

Current issue for MDT discussion:

Guidance Notes

Referrals:

Requests for MDT discussion should be made by email to the CUP Team email address by 8am **on a Tuesday,** prior to MDT discussion on Thursday. Please send with any attachments that you may think the MDT will find useful, e.g. referral letters. The email address is ubh-tr.CUPTeam@nhs.net

Contact: Julia.Hardwick@UHBristol.nhs.uk Tel: 0117 3423336

Performance Status (WHO Scale)

WHO Grade	Assessment
0	Able to carry out all normal activities without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out light work
2	Ambulatory and capable of all self-care but unable to carry out any work: up and about more than 50% of waking hours
3	Capable of only limited self-care: confined to bed or chair more than 50% of waking hours
4	Completely disabled: cannot carry out any self-care: totally confined to bed or chair

Gloucestershire Hospitals NHS Trust (Glos)

Primary Care referral

To be confirmed

Referral from cancer site specific MDT

To be confirmed

-END-