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

Meeting of the SWAG Network Haematology Clinical Advisory Group (CAG)

Wednesday 12th January 2022, 15:00-17:00 via MS Teams

Chair: Dr Richard Lush (RL)

REPORT | **ACTIONS**
(To be agreed at the next CAG Meeting)

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1. Welcome and apologies

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

The regular meeting schedule had been disrupted due to the COVID-19 pandemic.

2. Review of Last Meeting's Notes and Actions

Notes:

As there were no amendments or comments following distribution of the report from the meeting on Wednesday 22nd November 2020, the report was accepted.

Actions / Review of Previous Discussions:

Lymphoma Risk Stratified Follow Up:

Action: Feedback on regional implementation of the lymphoma risk stratified follow up pathway was requested. — **CAG Members**

The pathway has been discussed in GRH, but the process has yet to be formalised, mostly due to a pause in long term follow up caused by workload pressures and the need to prioritise new and on-treatment patients.

Chemotherapy Protocols: The new protocol request form has been uploaded on to the SWAG website here:
https://www.swagcanceralliance.nhs.uk/protocols/

Systemic Anti-Cancer Therapy Protocol Information

The following Systemic Anti-Cancer Therapy (SACT) clinical protocols and guidance have been developed by local clinicians, with support from the Somerset, Wiltshire, Avon and Gloucestershire (SWAG) provider Trusts, and Cancer Alliance. The information provided is for guidance only, and has no legal or official standing. The guidance does not override the responsibility of Healthcare Professionals to make decisions appropriate to the circumstances of each patient, in consultation with the patient and/or their guardian or carer. Availability of treatments may change, subject to NHS funding agreements. The protocols must be used in conjunction with local and national commissioning guidance.

Protocol Request Form

Generic Consent Forms:

In addition to use of the Cancer Research UK generic consent forms for myeloproliferative disease, chronic lymphocytic leukaemia, acute myeloid leukaemia and other myeloid malignancies, the Clinical Nurse Specialist team in GRH have developed additional disease specific consent information for lymphoma and myeloma that can be shared.

Action: R Lush will forward examples of the consent information for H Dunderdale to circulate	**R Lush / H Dunderdale**

All other relevant items from the last meeting are included on the agenda today.

3. Service Development

3.1 Specialist Integrated Haematological Malignancy Diagnostic Service (SIHMDS) Update

Presented by P Virgo

CAG had agreed that Severn Laboratories in NBT should provide the SIHMDS for the SWAG region approximately 3 years ago. Since that time, P Virgo has been working with the laboratories across the region to define how to work based on a network model. This preserves local reporting at treatment centres and centralises specialized testing, all of which are then reported on to the HiLIS software system.

All centres in SWAG have the HiLIS system in place apart from UHBW.

Integrated marrow reporting is being successfully delivered via the system, after trouble shooting a few technical issues.

As UHBW also hosted an SIHMDS, this caused a delay with the integration, but it has now been possible to reach agreement that the two centres will work together to create a unified service.

Tissue lymphoma reporting is still fragmented, and work needs to be undertaken with histology colleagues to optimise it; the service now has a good foundation to move this forward.

Discussions are underway outside the SWAG region with colleagues in Truro, who will be joining the SIHMDS in 2022, probably beginning with Derriford and then RCH. It is hoped that integrated marrow reporting throughout the South West will be achieved by 2022. Haem CAG were thanked for their input that has helped to achieve this.

Discussion:

In SFT/YDH, it has been attempted to arrange for marrow reports to be reviewed in MDT along with feedback from the SIHMDS; there are some concerns about putting the final diagnostic report together with the Flow and molecular results.

The SIHMDS holds a bi-weekly diagnostic review for complex cases. Attending regional MDTs is difficult to manage with existing resources, but SIHMDS intends to be sufficiently flexible to meet the needs of different teams.

In RD&E, Consultant Haematologist T Coats has taken on the Genomics Laboratory Hub Haematological Cancer Lead role and is planning to hold specific regional MDTs for some of the AML cases and ALL cases with input from genomics.

HiLIS was adopted in GRH approximately 18 months ago. Marrows are reported locally; Flow is reported by Severn Laboratory; Trephines are reported locally but uploaded onto HiLIS, and then the final report is brought together locally. Complex cases are revisited.

Final sign off on HiLIS is completed locally. There is a historical trail of who completes actions on the system. The data gets fed into the local cancer registers, which should be possible to extract.

A research strategy needs to be established once everything becomes imbedded.

It was noted that the service had 3 distinct sections that could not be merged; the Clinical MDT, sign out process, and then review of diagnostically challenging cases.

Regular signing out of the bulk work needs to be tailored to meet the needs of individual centres according to the different materials that are sent centrally and reported locally. Ideally, central engagement with the sign out process was felt to be important, however it is not clear from NICE how SIHMDS should be involved in this process.

If there are cases from the region that people want to add to the bi-weekly diagnostic review meeting, it would be ideal if the Consultant could attend or provide detailed information on those question to answer.

The diagnostic review meeting is held from 09:30-10:30 every other Friday.

It is possible to run reports directly out of HiLIS, which is easier to achieve rather than trying to get an extract from the cancer register.

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3.2 South West Genomic Laboratory Hub

Presented by C Wragg

Genetic reporting times have not been ideal over the last few months due to the impact of the COVID-19 pandemic, although the urgent service has been maintained. The routine service is starting to recover to within normal expected ranges. Chromosome FISH analysis routine testing is now back to reporting time guidelines and Haematology Next Generation Sequencing (NGS) is edging towards meeting guidelines. CAG is to notify the team about any urgent cases, and apologies were given for any inconvenience caused.

Changes have been implemented to the myeloma testing strategy over the last few months, which expands the range of IgH partners to include 11;14, 14;20 as well as 4;14, 14;16. It will be a reflex request based on Flow rather than waiting for morphology.

MPM1 monitoring will be repatriated to the South West, but is currently running in parallel with Richard Dillan's team to ensure compliance with the same standardisation.

Adult ALL molecular testing will no longer be offered in London.
This could be redirected to St Bartholomew's, but alternatively it would be possible to offer molecular alongside Flow MRD testing in NBT if this is agreed by CAG. This uses the same technology as ASA probing.

It is already an accredited test provided by NBT for paediatric AML and can roll out to huddled referrals if linked to CAR-T. This would mean sending the test in one direction instead of multiple directions and results would be uploaded to HiLIS.

CAG support discussions with CCGs to roll out Adult ALL testing in NBT. — **CAG Recommendation**

Reflex NGS testing for AML referrals will also be implemented in the next few weeks.

Referrals for Whole Genome Sequencing (WGS) are being made with some variation across the patch; some centres are requesting routinely while other have not arranged this yet. For paediatric cancers this is now standard care.

Results are starting to come back in a more clinically actionable time frame. It is hoped that these can be presented at a regional meeting in the near future.

As WGS technology progresses, other tests may be able to switched off, such as NGS. This is the future direction of travel that meets the NHS England strategy, making it important to share this learning at the earliest opportunity.

Further haematological and solid tumour cancer indications are being discussed as well.

Action: To arrange for results to be fed back at the next CAG meeting. — **C Wragg/ H Dunderdale**

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The South West Leukaemia Meeting and TYA meeting would also be appropriate forums to feedback results.

Consultant Haematologist T Coats will also arrange ad hoc MDTs to discuss results.

Action: To share CAG distribution list with T Coats **H Dunderdale**

As it is considered difficult to keep up with the current advances with the current set up in the South West region, in particular in the District General Hospitals (DGH) in comparison with larger teaching hospitals in London, additional regional education meetings are welcomed.

Action: DGHs ask that the Teaching Centres hold a regional AML MDT to discuss new cases with the Bristol team. **H Dunderdale**

The set-up in Oxford is recommended, where they have regional teaching days to update guidelines with all DGHs.

Workforce shortages are affecting services across the board at present.

GRH tend to discuss AML patients with the AML team in Bristol or Oxford if suitable for Allograft, depending on where it is possible to access the most relevant clinical trial.

In the Peninsula these patients are also usually only discussed with the wider team in the transplant setting. For other AML cases, advice is sought from the experts on a more ad hoc basis.

There are regular disease specific education days held across the South West region.

SWAG Cancer Alliance Clinical Director H Winter is keen to provide support for educational meetings.

The Inspirata Clinical Trials AI tool pilot is due to launch, and it would be helpful to get the Haem CAG input into this, especially on any inequity of access to clinical trials.

Action: H Winter will put J Crowe in touch with the Inspirata team **H Winter**

A spreadsheet of the Clinical Trials available across the region is routinely available on the SWAG website. This will be discussed in the next section of the agenda.

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4. Research

4.1 Clinical Research Network Update

Please see the presentation uploaded on to the SWCN website

Presented by C Matthews / S Moore

C Matthews is Research Delivery Manager at the West of England Clinical Research Network.

Consultant Oncologist H Winter is also the Research Lead for the West of England CRN as well as Clinical Director for the SWAG Cancer Alliance and works closely with C Matthews. Consultant Haematologist S Moore is the Sub-Specialty Lead for Haematological Cancer Research.

Despite all the difficulties caused by the pandemic when looking at the national overview of recruitment to trials, over 4,401 patients had still been recruited to 104 haematology trials between April 2020-January 2021. Thanks were given for continued efforts to conduct research in these pressured times.

The list of the 48 trials open within the SWAG region is detailed in the presentation. If there are any missing, or recruitment numbers look incorrect, CAG members are to contact C Matthews.

Recruitment is currently a bit patchy, but some trials have only just started up.

Trials in set-up in SWAG and National trials that are open to new sites are also listed, should anyone want to express an interest in opening these locally.

The Clinical Research Network (CRN) remains accountable to the Department of Health and Social Care for delivering the High-Level Objectives detailed in the presentation, in order to secure continued funding. Recruitment to Time and Target is less of a focus, and now there are three 'Efficient Study Delivery' metrics, as detailed in the presentation.

A process called Managed Recovery was implemented over the summer to ensure that the UK continues to be an appealing place to undertake cancer trials. Funders were asked to nominate the priority studies to complete within the appropriate timeline. There are approximately 200 studies on the list.

Another measure is to collect data on patient participation by distributing the Participant Research Experience Survey (PRES). The target this year is 1155, which is high as based on recruitment in the previous year; this target has now been met.

Action: CAG members handing out the survey need to document the study name on the PRES for it to be included in the metric, and can contactC Matthews or R&D Departments for copies of PRES.	**CAG Members**

There is a new Research Scholars Programme for the West of England region

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which offers financial learning and development support for health care staff who wish to become research leader. Further information can be found via the following link:

https://local.nihr.ac.uk/documents/crn-we-research-scholars-programme-2022-2024/29586

Links for additional information and contact details are within the presentation.

Discussion:

It was noted that SFT and YDH sit within the Peninsula CRN.

It would be useful to compare pre-pandemic recruitment activity with current recruitment, to see how much it has been affected by the pause that occurred during the pandemic.

There was also a request for SWAG data to be benchmarked in comparison with other centres across the region.

Action: C Matthews will retrieve the 2018/19 data to compare with recruitment to trials across all centres since the COVID-19 pandemic **C Matthews**

The majority of research nurses were redeployed during the pandemic.

5. Clinical Guidelines

5.1 Review of Outstanding Protocols

Please see the list of outstanding protocols in the separate document distributed with the notes.

Apologies were received from Network Pharmacist K Gregory.

The protocols that have been completed since the last meeting have been crossed out.

New protocols are identified within the CAG meetings and from pending approvals from NICE, or beforehand if known about from another source. Some have been on the list for a while, such as the salvage protocols, which have not been allocated as not yet required.

LEAM was used during a BCNU shortage a few years ago but is no longer in use; to be removed.

Previous Chair D Mannari decided to omit transplant protocols from the list and leave this to the transplant team.

Additional schedules are being made available for myeloma and lymphoma, and there could be a number of new additions to the list.

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Thames Valley protocols can be used to help inform SWAG protocols, but often don't contain the same level of information that the pharmacists need and sometimes do not contain any references; it is not clear how accurate they are. Errors have been spotted and caution is required if cutting and pasting the information.

Pharmacists prefer the governance process involved in developing the SWAG protocols.

A Whiteway agreed to review the Daratumumab protocol. This was noted to be a direct competitor with the RADAR trial.

Action: H Dunderdale to recirculate protocols list; CAG members to review assigned protocols / email any potential new regimens — **H Dunderdale / CAG Members**

The importance of keeping the protocols up to date was re-emphasised due to the preference for the chemotherapy nurses and pharmacists to have this as a resource.

There may be some modifications required to existing protocols in relation to the COVID pathway, for example for the first line treatment for mantle cell.

A number of protocols are out of date and need to be reviewed.

Action: H Dunderdale is to send the list of protocols for volunteers to undertake the reviews. — **H Dunderdale**

SACT protocols are regularly reviewed at the SACT CAG, where there is currently no Haematologist representation.

Action: A Whiteway and R Lush will be invited to the SACT CAG. — **H Dunderdale**

6. Coordination of Patient Care Pathways

6.1 Review of Fast Track Referral forms

In previous meetings, a network wide suspected cancer referral form was agreed. Now that the software system C the Signs has been purchased in Somerset, their form has been adapted, and a comparison of this with the original and a form used by the pan-London team has been made.

The comparison showed that a number of improvements could be made to the existing form, including, for example, the location of lymphadenopathy, especially now most patients are being referred straight to test.

The information provided on suspected cancer referrals is often incomplete. The quality had notably deteriorated over the past year.

A recommendation could be made to the Clinical Commissioning Groups to refresh the form.

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Action: The comparison and forms will be circulated for opinions from the group. **H Dunderdale**

It was recognised that improvements to the form may not result in improvements to completion, and that encouraging GPs to also include a referral letter might be the way to help with this.

7. Patient Experience

7.1 National Quality of Life Survey

This agenda item will be rolled to a future meeting due to technical difficulties.

The main reason for the presentation was to make everyone aware that the National Quality of Life Survey is being sent to 100% of cancer patients across England. Data from the survey will be available on a public facing website, which gives an indication of the main issues 18 months post treatment, for example, pain, low mood and fatigue. It is hoped that this will help guide interventions to holistically manage care.

Action: The presentation will be made available on the website. **H Dunderdale**

8. Clinical Opinion on Network Issues

8.1 COVID-19 Round Table Discussion

The impact on services has been enormous across the entire region, completely altering the way that clinics and the MDT operate, plus the detrimental effect that COVID has had on everyone's patients and staff.

In Gloucestershire, many consultations have moved to telephone, and the MDT has moved to virtual, which has impacted on the educational element of the meeting for the trainees, with limitations sharing some images. It's an ongoing struggle with staff shortages.

NBT MDT is still hybrid but can share all relevant images via MS Teams. Approximately 70% of relevant staff are now back in the room, and it seems to run smoothly.

All centres are experiencing the same; it's often difficult to know how people are coping with their chemotherapy until you see them face to face.

RUH tried a video consultation package that didn't work well; the same was experienced in SFT. UHBW has a video consultation that works well.

Staff wellbeing was a significant concern, and how CAG might help with this will be investigated.

The Psychologist Network has been contacted to see if this would be possible.

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There are daily bulletins in each Trust offering staff wellbeing advice; patience is considered key.

9. Any Other Business

A welcome and farewell section will be included on the next CAG agenda, and new members will be invited to give a brief introduction about areas of special interest / research. Any upcoming vacancies will also be included in this section.

Clinical Nurse Specialist T Peters noted that there were very few nurses attending today and for all to encourage their nursing colleagues to attend in future.

Patient representative, V Barley thanked the Haematology CAG for their hard work over the last two years. His own experiences and interactions during the pandemic have been fantastic and wished this to be fed back to all teams.

Although tenure of the Haematology Chair runs for two years, R Lush will continue for the time being due to the interrupted schedule.

Date of next meeting: To be agreed.

-END-

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