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

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

Tuesday, 29th November 2022, 10:00-15:30

Engineers House, The Promenade, Clifton Down, Bristol BS8 3NB / MS Teams

Chair: Dr Adam Dangoor

NOTES **ACTIONS**

(To be agreed at the next CAG Meeting)

1. Welcome and apologies

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

2. Review of Last Meeting Report and Actions

As there were no amendments to the report from the previous Lung CAG, held on 24th November 2020, or the South West Lung Cancer Education Day held on 28th September 2021, both reports were agreed.

Actions from the Work Programme:

MDT service: UHBW Lung CNS team to gather patient feedback on the diagnostic clinic using a questionnaire, with administrative support from H Dunderdale:

During the approvals process, it was confirmed that H Dunderdale cannot brand questionnaires as SWAG Cancer Services; they need to be developed by UHBW. Lead Cancer Nurse R Hendy can be contacted for further assistance.

Clinical Guidelines: Lung cancer diagnostic algorithms - to be adapted, laminated, and made available in clinic rooms:

These four diagnostic algorithms are now used as an aide memoire to triage patients to appropriate investigations. Action closed.

Coordination of patient care pathways: Commissioning of direct access to CT in Somerset CCG:

Somerset GPs currently cannot request direct access to CT via the Order Comms system. However, the CX2 and CX3 pathways are working efficiently.

The Government announced approximately 3 weeks ago that all GPs should have access to request all investigation to rule out suspected cancer.

Somerset Radiologists are working towards direct access from the beginning of December and are merging with YDH; it is hoped that this will be available with parity across the region in the near future. There are some concerns about the effect on CT capacity.

Where direct access is already available, careful vetting of referrals is required to justify that the patient is going for the most appropriate test in the appropriate time frame to answer the clinical question.

A digitalised system called I-Refer has been introduced in RUH that guides referrers to the correct test. It is hoped that this will improve referral quality. This is available in other Trusts but it is not compulsory. An increase in number and drop off in quality did occur following the COVID-19 pandemic, but this appears to be settling down.

The only way to detect lung cancer at an earlier stage is to provide early access to CT scans and, in Gloucestershire, a system has been set up to provide an Advice and Guidance service for one hour a day via ERS to referring GPs; this has helped to manage the additional CT workload.

Advice and Guidance is not provided or job planned in UHBW.

A positive to direct access is that patients with minor haemoptysis can be discharged with a letter following review of the CT, avoiding a clinic appointment.

Salisbury has a hybrid system. Any abnormal chest x-ray will prompt the GP to refer for a CT scan which is then triaged by the team to a clinic or discharged. An Advice and Guidance service is also provided via email, which is very labour intensive; this is due to move to Cinapsis.

Surgical team to agree the pre-operative tests that regional referral centres are required to perform prior to referral, and the tests that will occur in the surgical centre, to prevent delays to the patient pathway:

A SWAG Lung Cancer Curative Intent Pathway has been ratified by the surgeons and sent to the Cancer Managers. Action complete.

Breakout meeting of the Lung CAG: To write a recommendation from Lung CAG to have permission to seek mutual aid from stand-alone centres and send to the Clinical Prioritisation Group:

Approval to seek mutual aid from stand-alone centres has been agreed. Action closed.

To develop a Lung Cancer Research WhatsApp group:

A Research WhatsApp group has been set up that includes clinicians from Cheltenham down to Truro. Any Lung CAG members who want to be included are to send their mobile number to H Dunderdale. Action closed.

Cancer Alliance Representatives H Winter and A Randle to resolve funding issues with Navigational Bronchoscopy service in BNSSG:

Navigational Bronchoscopy is a planned agenda item for the next meeting. Initial funding issues have been resolved and the service is now up and running with two cases already seen and four more referred to date. Training is ongoing in these initial stages.

Patients identified at local MDTs can be referred either by the surgeon attending or directly to A Low.

Initially, cases with lesions that are ≥2cm that are unreachable with standard bronchoscopy or CT guided biopsy are being prioritised until experience in the procedure allows for smaller lesions to be targeted.

At least one case per week is expected once the service is fully up and running. The service is also available in Barts and Southampton.

In the experience of Salisbury, although beneficial, it can result in conundrums when considering continued surveillance, when a biopsied area is benign.

3. Research

3.1 Lung Cancer Clinical Research Network (CRN) Trials Update

Please see the presentation uploaded on to the SWAG website

Presented by A Cox / C Matthews

National recruitment to Lung Cancer trials was 17,103 in 2021/22 and 8,778 this year to date, with an even split between commercial and non-commercial trials. It has not been possible to include data from Somerset and Salisbury on this occasion, which needs to be sourced from the neighbouring CRNs.

Regional recruitment shows similar trends, reflecting the pause in trial activity caused by the COVID-19 pandemic and then a rise that compares favourably with the national average, with many of the thirteen trials that are open meeting or exceeding recruitment targets. A further twelve studies are currently in set up.

A 6 month Associate Principal Investigator (PI) NIHR certified scheme is available to any clinicians interested in research who do not have this as part of their main job role. The role involves working alongside the PI of a study. REFINE-Lung A, ICI Genetics and MITRE are registered with the scheme.

Results from the Participant in Research Experience Survey (PRES) for 2021/2, which had nearly 2,000 responses from 97 studies across 22 specialties, including cancer, were rated well; 93% indicated they would take part in research again. 93% also felt they had received all the information they needed. 92% felt researchers had valued their contribution. Comments included: research participation was easy and well organised, research staff were friendly and professional, and participants felt they were contributing to improve healthcare for others.

Recommendations include improving access to test results, contact details of the research team, access to parking and appointments out of working hours. The CRN will be looking at ways to address these issues.

Useful links and contact details for the Research Delivery Team are within the presentation.

There are two main SABR trials for MDTs to consider:

HALT trial is for patients on Tyrosine Kinase Inhibitors (TKI) that have oligo-progression and will be randomised to standard treatment versus standardised treatment plus SABR.

SARON have approximately 20 more patients to recruit nationally and so closure has been delayed. This is for patients with a radically treatable primary disease and

up to 5 metastatic lesions that can be treated with SABR. All treatment needs to be given in the BHOC. Patients have standard systemic treatment, and if there is no progression after three months, are randomised to standard of care versus SABR or radical radiotherapy to the primary. It is an important trial as the benefit will not be able to be demonstrated in the US where all relevant patients receive SABR as standard.

CAG can also consider referring patients to PASCIFIC-9, which is just about to open. This is a Phase III, randomised, double-blind, placebo-controlled, study assessing the efficacy and safety of durvalumab in combination with different monoclonal antibodies for adults with locally advanced unresectable NSCLC. Patients would need to be motivated to travel to the BHOC for their adjuvant treatment.

Gloucestershire Hospitals have a site visit planned to open the RAMON trial (RAdical Management Of Advanced Non-small cell lung cancer) which is for patients with oligometastatic disease who have systemic treatment followed by radical treatment to the metastatic and primary site.

It will not be opened in the BHOC as it is co-competing with SARON, aside from the option of surgery.

Somerset FT have opened a radical small cell trial with concurrent immunotherapy and PARP inhibitor and are happy to see any patients with localised disease that are motivated to travel.

Mesothelioma trial ASSESS-Meso is recruiting well in NBT. It had not been flagged on the list as it is badged as respiratory rather than oncology. It is an observational cohort trial; patients are enrolled within 6 weeks of diagnosis and followed up until death.

Opening trials has been particularly difficult at present across the region. The Clinical Trials Unit in BHOC has had staffing issues which has extended the length of time taken to go through the set-up process. This is also a national problem which is causing commercial trial companies to withdraw from the UK in preference for setting up in Europe, where processes are far slicker.

Action: A Cox / H Dunderdale will add the Lung CAG trials spreadsheet to the website and CAG members are to send any updates — **A Cox/H Dunderdale**

The team have contacts in The Sarah Cannon Research Institute and UCLH where a few patients with HER2 mutations have been sent to relevant trials. A trials finder is available on the UCLH website: What types of clinical trial are there? : University College London Hospitals NHS Foundation Trust (uclh.nhs.uk).

4. Service Developments

4.1 Genomic Medicine Update

Please see the presentation uploaded on to the SWAG website

Presented by Programme Director, South West Genomic Medicine Service Alliance (GMSA) J Miller

A five-year strategy is underway to deliver equitable access to genomic testing for improved prediction, prevention, diagnosis and precision medicine.

The NHS will explore the utility of genomic testing to support population screening for cancer.

The multiple related transformation projects include non-cancer, plus Lynch Syndrome, Leukaemia Predisposition, BRCA variants and circulating tumour DNA.

For lung cancer, funding has been received to undertake a detailed pathway mapping exercise, working with several providers' pathology departments to understand local cellular laboratory activities and identify the support required to ensure samples are sent in the most effective and efficient way possible.

Torbay and South Devon NHS Trust are piloting an MDT Coordinator role to assess the resources required to support genomic activity, and Gloucestershire NHS Trust have commenced a genomics pathology project to assess the impact that providing Lynch, BRCA, NTRK as standard tests has on cellular pathology and the wider workforce, patient and Trust. Results will be used to inform development of services in the other organisations.

There are numerous nationally funded projects underway, including the following:

- National Genomics Pathway Accelerator Programme for NSCLC: this involves an audit of 10 cases from each centre to assess and support the pathology pathway. Additional funding for pathology departments is anticipated. A series of workshops will be held to further optimise the pathway, including how to integrate genomic reports with pathology reports
- Optimising and improving clinical effectiveness of the DPYD gene testing pathway to ensure results are available prior to starting fluoropyrimidine
- National circulating tumour (ct) DNA pilot for patients with radiological evidence of Stage 3 or 4 disease, where a blood test will be taken at the beginning of the patient pathway, with a 10-day turnaround time for results. It is hoped this will provide evidence of the need for the test to be routinely commissioned in the next few years; GMSA has procured 100 tests from Roche and all SWAG Trusts are involved, although Gloucestershire Hospitals have been providing the test via a different funding stream. A weekly 30 minute call will be held to check how it is working.

Discussion:

Currently, squamous cell carcinomas are not on the National Test Directory and a special request for Next Generation Sequencing (NGS) is required. L Medley and L Yarram-Smith will be asked if there is a plan to include SCC in the future.

Further work needs to be undertaken to establish the most useful place for ctDNA in a patient's pathway considering how expensive it is. The costs are expected to drop to being comparable with a gene panel once routine.

A pathway navigator had been employed in SFT who provided a vital role in tracking the numerous tests that occur in various different timelines. Unfortunately, as the post was fixed term, the post holder left to find a more secure role.

Evidence and advice on how to retain these posts and make them permanent needs to be discussed with the Cancer Alliance and local Cancer Services.

RUH have 2 WTE navigators who provide a valuable service. It would be helpful to have an additional navigator. These are essential posts that should be supported by Cancer Management.

GRH had had the same problem, with a navigator employed with non-recurrent funding from the Cancer Alliance, however, it had now been possible to make the post substantive by combining it with a secretarial post in respiratory. This had resulted in some lost secretarial time but was the only way to retain the post.

Salisbury FT had managed to get substantive funding for a navigator by demonstrating the time that the post saved for the MDT Coordinator and CNS team; it was reiterated that it is an essential role.

Action: A presentation on the ideal configuration of the lung cancer workforce will be arranged for a future meeting. **To be allocated**

5. Coordination of Patient Care Pathways

5.1 Targeted Lung Health Checks (TLHC)

Please see the presentation uploaded to the SWAG website

Presented by A Bibby

NHS England have set up the TLHC pilot, which is for anyone aged 55 to 74 who has ever smoked. The check includes smoking cessation advice for active smokers, spirometry and a personalised cancer risk score is calculated. If low risk, they are referred back to the GP; if high risk, they are referred for a low dose CT scan.

If the CT shows likely lung cancer, they are referred to the local MDT. If the CT is normal, they have a follow up scan in 2 years time. If a nodule with particular characteristics is identified, the patient will be put on a surveillance pathway.

Originally, the pilot sites were all in deprived areas in the north of England. Now the programme has been expanded to include all Cancer Alliances. Approximately 1100 cases of cancer have been detected since 2019. This has resulted in an increase of 75% in the number of cancers picked up at Stage 1 and 2.

It is important to note that the uptake of people invited is only around 38%; it is likely that those people who are not attending are in the high risk category and so further work needs to be undertaken to improve participation.

The SWAG Cancer Alliance has a population of approximately 2.4 million, and an estimated TLHC screening population of 366,550. The service is currently commissioned to offer TLHC to 27,000 people, which is 7.3% of the total eligible.

Initially, it was assumed that all Cancer Alliances would focus the service in the main associated city but it was decided to have a more equitable approach, moving the service to different supermarket car parks across the region, in order

to include areas where there is more socio-economic deprivation around the outskirts of the region.

Benefits to this approach include helping to address health inequalities, of which lung cancer is the greatest contributor, and sharing practice from each other's local services, for example, community services and smoking cessation are delivered very differently and it will be possible to learn the optimal way that these services are delivered by comparison.

Eventually the pilot will be expanded, and preparations have been made by creating small teams in each area that can upscale when the demand arises.

The process involves GPs scanning records to identify relevant people who, if they hit the high risk threshold, meet the CNS in the truck, have a CT scan, then the results are fed back to the participant and GP.

As there are insufficient resources to provide this within the NHS, much of the process is outsourced to an independent provider. Scans can be transferred to a patient's local hospital and historical scans can be pulled for comparison. Results are colour rated; all the red, orange and yellow ones will be discussed at the TLHC screening weekly review meeting, which includes all relevant members from the MDT. A local clinical representative is invited as the service rotates across the region to accelerate the pathway.

In addition to referring any suspected lung cancer to the two week wait pathway, the TLHC team facilitate the next steps, with the local clinician requesting a PET / Lung Function / CT guided biopsy as required, streamlining the beginning of the pathway.

Onward referrals for non-lung cancer actionable findings are also made following the screening review.

The project started in Bath in July; 1184 people were invited to attend the truck, with 1014 attending, resulting in 958 CT scans and 190 referrals to smoking cessation.

The downstream impact involved referring 23 people to RUH Bath Lung Cancer Clinic, of which 13 were diagnosed with cancer, 12 of which were suitable for radical treatment. There were 165 nodule findings, 154 of which are now on surveillance, and 58 incidental findings, 4 of which were other cancers. The impact on Primary Care is larger.

Although the SWAG model is complex, it should help with the future expansion, which is reliant on excellent communication with participants, Primary and

Community Care and the Secondary Care teams.

TLHC has now moved from Bath to Bridgewater from next week.
The National team aim to upscale the pilot to a National screening programme, which initially will involve upscaling to seeing 25% of the eligible population by April 2024, and 25% a year thereafter, which will have huge implications in terms of the downstream impact on radiologists, pathologists and oncologists. Although there will be some savings associated with diagnosing patients earlier, these will not be evenly distributed.

Discussion:

Teams need to be aware that the patients referred to clinic are significantly more anxious than someone who may have been experiencing symptoms for months.

The people who chose not to participate is an area of research that is being explored. A research team in London, which includes behavioural scientists, is developing resources to try and improve participation.

The pilot in the US saw people dropping out after one scan, and not returning for follow up; this needs to be another area of focus.

The independent company does try to give people who decline to come the opportunity to reconsider.

Outsourcing to an independent company has proved to keep high quality motivation as the company have Key Performance Indicators that they are contractually obliged to meet.

Although there is evidence that a one year interval scan may be optimal, this was not feasible and the 2 year follow up was considered the most effective/cost effective approach to take.

From RUH Bath experience, TLHC is an incredible service improvement, with the small numbers of cancer diagnosed as part of the pilot being diagnosed in a curable timeframe.

A more extensive modelling of work needs to be undertaken that takes into account the number of additional referrals to other services such as cardiology and breast; conversations with these colleagues about the impact of roll out need to commence as soon as possible.

The issues with pathology and radiology workforce / competing interests when working both for the NHS and private sector also need to be recognised.

6. Network Issues / MDT Service

6.1 Service Updates from All Specialties

SABR has changed from a centralised service to being offered in multiple centres. All organisations in the region are now offering lung SABR and some are also offering treatment for metastatic disease; there is likely to be more uptake now that the treatment can be delivered closer to home.

A SABR advisory meeting is held on a Friday morning; any MDT members from across the region are invited to join and share learning.

Indications for SABR is still for up to three metastatic lesions when there has been a 6 months interval between treatment of the primary tumour, unless the patient is enrolled in SARON, which can include treatment of up to 5 lesions.

RUH Bath were commissioned to treat 10 lung patients in the first year, but actually treated 30.

A consultation is underway to explore how to make PACs image sharing more seamless across the region; ideally a shared system would be purchased that would negate the need for different logins; Lung CAG are encouraged to share their opinions with managerial leads to ensure that clinical opinion is taken into consideration. If a shared system was in place, this could allow a radiologist in Bristol to report on a scan made in Yeovil, increasing the capacity to provide cross-cover for the radiology workforce.

To get involved, contact Marcus Bradley: marcus.bradley@nbt.nhs.uk

A national approach to sharing PACs would be welcomed.

Historically, it has been difficult for radiology department to agree to purchase the same systems due to competing priorities.

Investment in IT departments is needed plus recognition of network working when making broad strategic decisions rather than Trust based work. There is a constant turnover of IT staff due to the low banding.

Feedback from Patient Representative J Norman, who has a background in IT, is to recognise that IT services have a focus on maintaining systems, with change being the enemy of continuity; any big strategic changes involving integration require a huge effort to avoid disruptions to services.

6.2 Getting It Right First Time (GIRFT) Progress Report

Please see the presentation uploaded on to the SWAG website

Presented by H Steer

GIRFT is a form of Peer Review that started with orthopaedic surgeons and has evolved to cover multiple specialties.

Each lung cancer service has been assessed across the country, which results in a report based on data from local systems that highlights areas of good practice, actions and opportunities. Visits were delayed in SWAG during the COVID-19 pandemic, and YDH has yet to be assessed.

It was found to be a useful process in GRH, and provides evidence of the service improvements required, which are on the whole comparable across centres and already known by the clinical teams, that can then be used under the GIRFT umbrella as a lever to influence investments.

Further details are documented in the presentation.

Actions on CT, EBUS, PET waits, lung nodule pathways and radical treatment pathways were flagged across the board.

Insufficient job planned time for lead clinicians and administrators was also flagged across the board.

National priorities are to implement lung cancer screening, improve radical treatment rates, improve access to prehabilitation, and to provide a rolling triage to streamline the diagnostic pathway. There are also recommendations on how to implement MDT meeting reforms.

Following analysis by the National Treatment Variation Group, all Cancer Alliances have been asked to submit three priorities to focus on from the GIRFT recommendations, and the following broad, high-level targets have been decided:

1. Radical intent treatment should commence by day 49 of the overall National Optimal Lung Cancer Pathway (NOLCP). Furthermore, for surgery, thermoablation or radiotherapy, treatment should commence by day 16 after the decision to treat in line with NOLCP.
2. Trusts should record and monitor multimodality treatment in Stage IIIA disease and offer radical intent treatment as standard in fit patients.
3. All trusts should have an overall radical treatment rate of 85% or more in those patients with NSCLC Stages I-II and of performance status 0-2. This includes all treatment modalities (surgery, radiotherapy including SABR, multimodality treatment and thermoablative techniques).

These will hopefully make any local service development eligible for the funding available via the SWAG Cancer Alliance.

There does not appear to be any punitive measure attached to these aspirations should they not be possible to achieve in a set time frame.

A pathway analysis tool has been developed by ROCHE to provide a free dashboard to show how these key metrics are performing; work is underway with Trust Business Intelligence (BI) teams to try and get this embedded.

There will be funding available in 2023/24 to help facilitate the faster diagnostic pathway and any service development linked to the priorities.

Action: Lung CAG to consider any service developments that may require funding from the Cancer Alliance. **Lung CAG**

Any other suggestions for work that should be undertaken as a network are welcomed.

Discussion:

The excel spreadsheet developed by Roche would involve the BI team setting up a search that would automatically populate the data fields. It would take approximately half a day working with the Roche team.

Salisbury have agreed to implement it but are waiting for Roche to plan a date as

there is a wait while they implement in numerous other Trusts.

Action: Project Manager D Richards will help facilitate meetings between the Trusts and Roche **D Richards**

A similar tool developed a few years ago was abandoned due to the poor quality of the data.

It was raised again that the key to achieving NOLCP and making positive changes to the pathway during these challenging times was with the provision of administrative support in the form of pathway navigators.

The tool will help build a case to support provision of the navigator role.

7. Patient Experience

7.1 National Cancer Patient Experience Survey Results (2021)

Please see the presentation uploaded on to the SWAG website

Presented by Lead Cancer Nurse (LCN) B Ockrim

LCN B Ockrim represents the regional LCNs at Lung CAG.

A new iteration of NCPES had been circulated which has resulted in a good number of responses from each organisation.

The NCPES annual survey was sent to inpatients or day cases over a three-month period from April-June 2021 and published in July 2022. The survey is designed to help monitor progress in cancer care and inform local service quality improvements.

Results include the absolute Yes and No answers; the in-between scores are omitted.

Commissioners and Charities look at the data to lobby Trusts / Government for improvements.

A total of 3,319 responses were received from across the SWAG CA which represents a 59% response rate; 142 responses were from lung cancer patients which is much lower than the previous year.

The vast majority of responders were of white ethnicity, highlighting the need for further health inequality work to find out why this might be the case.

The vast majority of scores across SWAG are in line with or above the expected national positive rating. The 15 scores above the national positive rating are documented in the presentation.

There are variations between tumour sites, which is why CAGs are asked to review the results as well as discussed at individual MDTs.

Vast majority of responders have had treatment for cancer in the last 6-12 months.

The number of diagnoses given by the Clinical Nurse Specialist has increased.

It is not possible to access free text comments this year as it has been organised differently; this will be addressed in the next iteration.

When looking at the lowest scores ≥60%, these were also low across England for lung and all cancer sites and could be related to the way that the questions are worded. For example, patients may not know what a cancer care review is or require this to be provided by their GP.

There were 14 scores from the lung team that were ≥90%, with the question 'Care Team reviewed the patient's care plan with them to ensure it was up to date' scoring 100%.

Responses to the question 'Beforehand patient completely had enough understandable information about radiotherapy' has greatly improved from a previously relatively low score. Information on Radiotherapy has recently been standardised across the region, which most likely explains this improvement.

It is the first survey to include a question about information on immunotherapy, which again scored very highly.

Overall, they were very successful results for the lung cancer teams and it was apparent that the Personalised Care and Support provided by the CNS teams and Cancer Support Workers has made a tangible difference.

Further details of individual Trust responses to the survey are documented in the presentation, most of which focus on inter-Trust communications.

CAG was asked to identify any priorities for improvements identified from the survey.

Local simple surveys that ask what went well and what could be done better are felt to be the preferred option when identifying more useful information to inform service improvements.

8. Personalised Care and Support

8.1 GRH Prehabilitation Services

Presented by AHP Lead J Sherrington

Prehabilitation has been running for a year and has become more intensified in lung cancer within the last 6 months. Having spoken with the AHPs across the region today, it is also available in UHBW for surgical patients.

A prescription of exercise, nutrition and psychological interventions is provided by the physiotherapist, dietician and psychology support worker, including support from an Occupational Therapist on the activities of daily living.

The team are in the process of recruiting a replacement dietician, which is particularly important for lung cancer patients.

Prehabilitation ensures that the patient's health is optimised prior to treatment to reduce the effects and then is followed by rehabilitation so that the patient can return to their baseline or above as soon as possible.

Prehab begins prior to formal diagnosis when cancer is highly suspected to maximise the time to build up physical status and patients are referred to the service by the CNS or Respiratory Physician.

Four outcome measures are used to screen the patient, including PG-SGA, PHQ-4, Rockwood Frailty Score and IPAQ to tailor the interventions required. This might be a universal intervention that every cancer patient gets or more targeted first

line advice.

Lung cancer patients tend to require more targeted, specialised interventions in comparison with some of the other cancer sites.

Referral rates tend to average around 20 referrals per month, approximately 46% of lung referrals are referred; the patients not referred are most likely either palliative or the pathway was too quick for prehab to commence prior to treatment.

The majority of patients seen are for chemotherapy or radiotherapy and one or two surgical patients.

Performance Status at diagnosis compared with post treatment shows the benefit of Prehabilitation as does increase in patient satisfaction. This is improved when provided face to face. There was an 83% participation rate; work is underway to reduce the number of patients who decline.

Work is underway to facilitate discharge of patients from the Prehabilitation pathway to other community rehabilitation services so that the Prehab service can focus on the new patients coming through.

It is hoped to improve provision of psychological support by appointing a psychologist using cancer transformation funding.

Communications with the lung team have also been optimised to ensure all relevant referrals are received.

Patients are more likely to engage with Prehab if this has been introduced to them via the CNS / Consultant.

PS2 patients are where the biggest impact can be made, but all patients do benefit.

A physio is required in preference to a personal trainer with a cancer qualification due to the number of other comorbidities that this patient cohort often have.

Smoking cessation advice needs to be offered more extensively.

An MDT feedback loop is being devised to ensure that the patient's progress is reported back.

8.2 Prehabilitation Case Study

Please see the presentation uploaded on to the SWAG website

Presented by A Leadbetter

Over a 24-week period, 55 lung cancer patients went through the prehabilitation service. The median age was 75 and the majority of patients were PS2 and went on to have radiotherapy.

All clinicians were asked to complete Rockwood Frailty Score at first clinic as well as PS; PS0 correlated with RFS 1 or 2, PS1 with RFS 3 and PS2 with RFS 4, 5 and 6.

A case study was presented of a patient PS2, RFS 4 with numerous comorbidities with T2aN0M0 disease who was referred for surgery and prehabilitation.

After 10 weeks of prehabilitation, which included aerobic and strengthening exercises, ever increasing stamina and improvements in shortness of breath were

demonstrated, with mean hand strength and sit to stand rate improving.

PS had improved to PS1 prior to undergoing a VATs upper lobectomy. A good recovery was made and the patient continues to improve.

It is hoped that RFS can be used to further tailor patients appropriate to delay treatment and prioritise prehab to improve outcomes.

Discussion:

Initially, funding had been provided by Macmillan and now recurrent funding is being sought.

Evidence is available on reduced length of stay and reduced admissions to inform business cases.

8.3 UHBW Prehabilitation Service

Please see the presentation uploaded on to the SWAG website

Presented by Prehabilitation Lead M Taylor

The surgical prehabilitation service in UHBW is provided for both cancer and non-cancer patients.

Benefits of prehab have been widely reported through Patient Reported Outcome Measures and Physical measures, as documented in the presentation. There is high quality evidence from the Manchester prehabilitation service that shows the reduction in Length of Stay, and ED attendance rates, are making huge cost savings.

Referrals are made via the surgical clinics or from a service order via the electronic hospital information system for any patient requiring an overnight stay with a two week interval prior to surgery.

Initial assessment is by the physiotherapist to establish activity levels, psychological wellbeing and nutritional needs, smoking and alcohol consumption.

Baseline measures include grip strength, sit to stand and other scoring tools, which will then be used to refer to specialist teams for further input, including community service and smoking cessation, although nicotine replacements will be offered within the prehab clinic.

A personalised exercise programme is developed and support provided with other positive lifestyle changes.

Follow ups are predominantly virtual and frequency depends on the individual needs of the patient.

A pre-operative review is then arranged to reassess fitness and give post operative advice on mobilising early / deep breathing etc.

The majority of referrals are from the Thoracic team and are referred on to the Macmillan Cancer Support Team.

The Prehab team also attend the weekly complex case review meeting to feedback patient progress which can inform when surgery can commence or if further prehabilitation is required.

Average sit to stand rate has been shown to improve in all age ranges.

70% of patients feel more prepared for surgery following prehab, and the majority of patients have found the service important or very important and useful.

Future improvements include increasing the number of face to face interventions, and creating a webpage to be used as a portal for universal interventions.

A dashboard is being created for use across BNSSG to gather evidence on the benefits of the service.

8.4 Clinical Nurse Specialist Update

This item was not discussed due to time pressures and will be rolled to the next CAG meeting in 2023.

Future agenda item

9. Clinical Guidelines

9.1 Segmentectomy versus Lobectomy

This item was not discussed today due to time pressures and will be rolled to the next CAG meeting in 2023.

Future agenda item

9.2 Neoadjuvant chemoimmunotherapy prior to surgery

Please see the presentation uploaded on to the SWAG website

Presented by Y Summers

Local centres will make preparations to roll out these new treatment options.

9.3 Any Other Business

A Dangoor stepped down from the role of CAG Chair. Expression of interest in the role are to be sent to H Dunderdale.

Action: An update on the Salisbury service was requested for a future meeting.

Future agenda item

Date of next meeting: To be confirmed by Doodle Poll, Autumn 2023

-END-