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

Meeting of the SWAG Gynaecology Clinical Advisory Group (CAG)
Friday 7th October 2022, 16:00-17:40
Holiday Inn Taunton, Deane Gate Avenue, Taunton TA1 2UA/ Hybrid meeting via MS Teams

Chair: Amit Patel **ACTIONS**

REPORT

(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 previous report and Work Programme

As there were no amendments or comments following distribution of the report from the meeting on 18th June 2021, the report was accepted.

Personalised Care and Support (PCS) activity:

End of Treatment (EoT) Summaries will be redrafted to be addressed to the patient rather than the GP, as recommended by the Lead Cancer Nurses. There is no longer a CQUIN attached to completing this activity. Performance is measured nationally but provision of EoT summaries is not always well documented.

All other items in the Report and on the Work Programme are on the agenda.

3. Network Issues / Service Changes

3.1 MDT Meeting Platform Update:

RUH MDT recently returned face to face and then immediately reverted to virtual for another month given the sudden spike in COVID-19 cases which had resulted in alarming queues of ambulances outside the A&E department.

GRH MDT has recently returned face to face.

UHBW MDT hold a hybrid meeting so that people can choose to attend or dial in.

IT infrastructure was found to be inferior in comparison to the virtual platform when attending GRH MDT in person as there was insufficient equipment to view the patient records.

UHBW team members have Trust laptops in addition to the PC used by the MDT Coordinator, allowing results to be accessed during the meeting. Since moving to MS Teams there have been no major issues with the hybrid meetings. The virtual option is ideal when there is the need to share radiotherapy planning. Many team members also value the opportunity to meet face to face.

SFT MDT, which is combined with YDH MDT, has had issues with the hybrid format as it is often difficult to hear conversations in the room when online. It is important to remember to speak directly to the microphone. Good quality equipment placed carefully in the room is essential.

UHBW MDT Lead C Newton continues to undertake pre-MDT triage on a Monday prior to the meeting on Wednesday which is working well, with very straightforward protocolised pathways for some cancers, reducing the number of case discussions. Triaged cases remain on the bottom of the main list and are not discussed unless there is a particular cause for concern.

GRH aspire to undertake pre-MDT triage, but there is no job planned preparation time to facilitate this, although it is very much needed due to the increase in patient numbers. However, the team are now trying to ensure that all referrals are made on a bespoke referral proforma which allows some triaging to occur. If this indicates that feedback is required from three specialists, the case is listed for discussion. If only a one-to-one discussion is required, this is arranged outside the meeting whenever possible.

Recommended MDT Meeting Reforms

The process of arranging this is very time consuming and made more challenging when having to manage the additional Lynch Syndrome workload.

Ideally, protocolised pathways should be integrated into digital systems.

Action: H Dunderdale to circulate UHBW Protocol to MDT Leads **H Dunderdale**

Triaging the Stage 1, Stage 1a1 cervical or endometrial cancers is the easy way to start.

UHBW Radiologists have been working on refining the criteria for standardising imaging using the latest guidelines which will further enable safe triage of early stage cases.

Action: UHBW Imaging Guidance Practice to be shared when finalised **C Newton, H Dunderdale**

4. Clinical Guidelines

4.1 SACT Protocols

Presented by H Dunderdale on behalf of Network Pharmacist K Gregory

After SACT protocols have been reviewed by site specific oncologists and signed off by Consultant Oncologist J Braybrooke and K Gregory, they are version controlled and uploaded on to the SWAG website here, which is used frequently by the regional chemotherapy nurses.

Website activity shows over 27,000 new users over the last 12 months and approximately 300 people accessing the site per day, which currently contains 380 protocols. It is also used by people outside the UK.

There are currently 17 protocols available on the website for Gynae, most of which have recently been updated by A Walther and K Gregory. It is acknowledged that this is a lot of work, but provision of national protocols is not expected soon.

Protocols requiring review include:

- Carboplatin/Etoposide (once updated by Lung Oncologists)
- Treosulfan.

K Gregory requests volunteers to help with the updates. It is anticipated that many will need very few amendments and shouldn't take too long.

Protocol under development:

- Trametinib (LGS ovarian/peritoneal) – COVID-19 interim commissioning (draft attached) – please contact K Gregory if happy to review.

RUH and UHBW no longer use Treosulfan; SFT will check to see if this needs to be reviewed.

There is no existing protocol to inform the Trametinib protocol, but this is being looked at by a separate NHS E working group and it is hoped to get funding through this rather than wait for NICE approval so it will still be an option for low grade ovarian serous cancer.

H Dunderdale, R Bowen, K Gregory

Action: R Bowen will liaise with K Gregory to update the outstanding protocols

Additional protocols to draft include Cisplatin three weekly +/- platinum doublet and Calix.

H Dunderdale, L Dumas

Action: H Dunderdale to forward new protocol request template; L Dumas will draft the new protocols

5. Coordination of Patient Care Pathways

5.1 UHBW Menopause Clinics

Presented by K Manley

The pilot Oncology and Complex Menopause MDT Clinics comprises Consultant Obstetrics and Gynaecology Medicine, K Manley, Breast Oncologist, A Jenner and Oncology CNS M Card.

It had not been possible to source complete funding from the Trust due to the increased cost of the MDT clinic; BHOC has funded the CNS post, so the rest has been provided by Above and Beyond for the first year and the second year by James Tudor Trust, which runs out in December 2022.

At the beginning of the pilot, the Cancer Alliance were approached for funding, but at the time they were unable to prioritise this due to the numerous other workstreams which were underway.

The Oncology Menopause Clinic is held over a whole day once a month. The majority of cases seen are breast and gynae cancer related. Due to the large number of breast cancer referrals to this clinic, complex cases, such as all haem, brain, lung and early endometrial cases, are seen in the specific complex case clinic.

R Bowen set up a similar pilot clinic in RUH with a 2 year Macmillan grant in 2018, after which a business case for sustainable funding was submitted. This was initially declined. However, as there was (and still is) a nine month plus waiting list of referrals, it was agreed to continue to hold the monthly clinic with running costs. The service has since developed and now has two clinics a month.

UHBW also has a 9 month waiting list of triaged referrals, with any straightforward cases discharged back to the GP with advice, meaning that all of the patients on the list are very complex with nowhere else to go to manage their symptoms.

Attempting to access funds from Integrated Care Systems (ICSs) is very difficult as they are not calculated on the number of patients seen (payments by results).

Despite submitting a comprehensive business case which included all of the ambitions of the National Cancer Board in terms of improving after-effects following cancer treatment, the UHBW team have been told that it would be classed as a new service and no new services can currently be funded.

CAG Recommendation

It is considered essential to have both breast and gynae expertise present to manage these patients appropriately. NICE guidance needs to be updated to reflect this.

SWAG Cancer Alliance Clinical Lead H Winter has visited the clinic, interviewed patients, and supports its continuation.

Action: The Cancer Alliance will be approached again to see if funding can be made available; H Dunderdale to liaise with H Winter. **H Dunderdale**

6. Personalised Care and Support

6.1 Roll out of PIFU to Cervical and Gynae Cancer Patients

Presented by C Newton

It is thought that each centre is undertaking Patient Initiated Follow Up (PIFU) for appropriate endometrial cancer cases, although evidence for recording this could be improved.

PIFU for some cervix and ovarian cancer can now be explored by first establishing current practice in each centre.

GRH cases of cervical cancer currently remain in medical-led follow up examinations for five years.

Ovarian cancer patients receive a CA125 testing every three months for newly diagnosed, treated and post-treatment patients.

The majority of endometrial cancer cases are on PIFU.

Vulval cancer is kept in clinical follow up.

In UHBW, patients with post operative early cervix cancer are discharged to PIFU if clear after two years.

GRH will review the criteria and consider if the same guidance can be adopted.

This will only be relevant for a small number of patients.

SFT offer early cervix cancer patients PIFU after 2-3 years depending on the patient.

Endometrial follow up has been via PIFU for some time.

Intermediate risk patients have nurse-led follow up with a mixture of face to face and PIFU.

Low risk ovarian cases have nurse led virtual or telephone follow up with CA125, which can be classified as a PIFU pathway.

RUH continue to follow up endometrial cancers at present and have a nurse led follow up with an ultrasound examination of the pelvic side wall and visual inspection of the vault for 5 years,, except for very low risk cases.

Capillary cases are followed up for three years.

Cervix follow up depends on the treatment provided. If, after surgery, there is a risk of recurrent disease, nurse led follow up that involves examination of the pelvic side wall is undertaken, as early radiotherapy for disease of the lymph nodes is felt to be of benefit.

Action: C Newton will liaise with RUH team outside the meeting about PIFU **C Newton**

7. Patient Experience

7.1 National Cancer Patient Experience Survey Results (2021)

Please see the presentation uploaded on to the SWAG website

Lead Cancer Nurse for Gloucestershire Hospitals E Hanman, was unable to attend the meeting and so discussion of the results will be rolled over to the next meeting.

7.2 Centralisation of Rare Pelvic Procedures

Presented by A Patel

Centralisation of rare surgical procedures, which has long been a rolling agenda item for Gynae CAG, has led to the decision to stop providing pelvic exenterations in UHBW. The current agreement is to now refer these patients to London, although there have been no referrals since this decision was made and it would be ideal if the rare procedures could be offered by centres within the region. This may only involve 1 to 2 patients per year.

Pelvic exenterations can be referred to GRH instead of London as they have co-located urology and colorectal surgery, plus are moving towards provision of robotic exenterations in Cheltenham and undertake approximately 6 cases per year.

Trachelectomy referrals may need to be provided by a different centre.

Consultant Gynae-oncologist A Wiggans will shortly be finalising analysis of all of the Cheltenham exenteration outcomes which includes the reasons why the procedure was undertaken and details when assisting with joint procedures.

Further work is underway to gather follow up data on a few patients who were referred from Worcestershire and Herefordshire.

Action: To present GRH exenteration data at SWAGGER **A Wiggans**

It would be preferable for patients to be treated locally to reduce travel for the treatment and follow up, and useful to discuss provision for other rare cases.

Periaortic (PA) nodes (apart from those that are enlarged) for low risk ovary are not routinely done as it does not change decision making.

Nodes can be assessed in the small group of patients where the oncologist requests restaging to consider eligibility for chemotherapy.

PA nodes will remain on the curriculum for surgical training at present; it may become centralised as it becomes rarer. GRH often put this on a list with the vascular team.

PA node resection for staging is an entirely different operation than removal of nodal mass.

Plastics for vulval wide local excisions are arranged on a case by case basis. SFT refer to the plastics service in RD&E.

There is a plastic surgeon from NBT who is also employed to work in Cheltenham, but the basic flaps are done by the Gynae surgeons.

Wherever possible, rare procedures should be undertaken within the South West region, with centres working together to achieve this and ensure all training opportunities are available.

Action: To further discuss centralisation of rare surgical procedures with SWAGGER **SWAGGER AGENDA ITEM**

SW Centres could collaborate to provide surgical training. Ideally sub-specialty trainees would automatically have honorary contracts with the Trusts within the Deanery to facilitate working across sites for three years.

The technical competencies to sign off surgical procedures for staging procedures that are becoming obsolete were discussed further, with practice differing depending on the size and population of the surgical centre.

Centralisation of rare surgical procedures will remain a rolling agenda item.

8. Any Other Business

8.1 Chairmanship and Date of Next Meeting

A Patel stepped down as Chair and asked for Expressions of Interest in the role to be sent to H Dunderdale.

Date of the next meeting: Friday 6th October 2023, following SWAGGER **CAG members**

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