Meeting of the SWAG Systemic Anti-Cancer Therapy (SACT) Clinical Advisory Group (CAG)

Friday 18th October 2024, 15:30-16:30 via MS Teams

Chair: Jeremy Braybrooke

REPORT **ACTIONS**

1. Welcome and apologies

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

2. Review of Previous Notes and Work Programme

As there were no amendments or comments following distribution of the report from the meeting on Friday 22nd March 2024, the report was accepted as finalised.

Actions from the Work Programme:

To contact Consultant Medical Oncologist Emma Kipps from the Royal Marsden to seek the opinion of the National SACT Group on accreditation processes undertaken by UK SACT centres:

Contacted via LinkedIn in March 2024, no response to date.

The SACT CAG want to understand the work that would be involved in undertaking an accreditation process and how this would benefit the service.

A national service specification is being drafted that may answer this question in the near future, and will hopefully provide standards to work towards now that there is no longer the framework that was in place with the original peer review process.

To remain on the agenda. **Potential future agenda item**

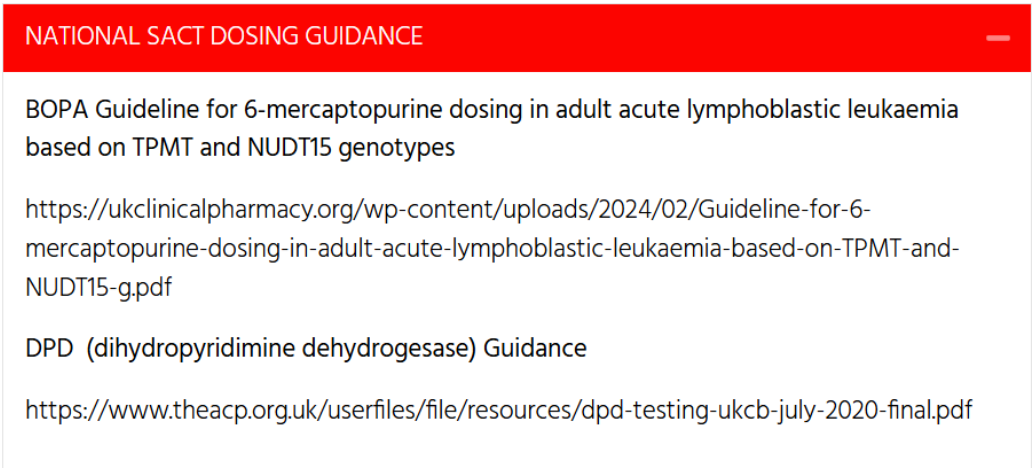
Antiemetic and extravasation policies: To adopt the UHBW version and make it SWAG wide.

The UK Oncology Nurses Society (UKONS) and the UK SACT Board are now drafting national guidance which is due to be published in 2025. It would be preferable to put this on hold and have local documents for contact details and any local arrangements – such as access to Savine.

Confidence in its publication was expressed, and each Trust has their own individual guidance in the interim. Progress will be reviewed next year to see if a SWAG version is still required.

The 6MP adult dosing guidance from the British Oncology Pharmacy Association (BOPA) will be published on the SWAG website at the top of the page, along with generic guidance.

This action was completed today, and has been uploaded here:
Protocols Archive - SWAG Cancer Alliance



To ensure equity of access to IO Biologics across the region.

This was discussed at the recent BOPA and Immunotherapy Specialist Group meetings, and most centres now have equitable access to Vedolizumab as a second line treatment. However, it is not possible to prescribe it in UHBW. Attempts have been made to put forward a formulary request, but this has been refused. The formulary team have fed back that they are waiting for national guidance which has yet to be produced.

This has also been raised in the South West Immunotherapy Group (SWIG) and work is underway to gathering information on the access arrangements in each centre.

This action will remain on the Work Programme until resolved.

Action: To share details of access to biologics in each centre. **H Dunderdale**

Daratumumab observation period: To share Somerset Foundation Trust audit.

This action will be completed after the meeting today. The results were positive with the observation period being safely reduced to three and a half hours.

The team in BHOC had originally put this on the agenda of SACT CAG after doing a similar piece of work and have also reduced the observation period.

Action: To agree the observation period length across the SWAG region. **SACT CAG Members**

As this is not on the SPC it needs to be clearly documented in the protocol that the reduced observation period is an agreed option following completion of audits at both BHOC and SFT.

The potential to move to an e-consent system:

RUH Bath are using a cloud based software system called 'wellbeing' which originated from surgery and ophthalmology. It is also used widely in Clatterbridge and Worcestershire.

It needs to be maintained every few years in terms of checking for updates on the Cancer Research UK (CRUK) consent forms or adding toxicities, but this is not particularly time consuming.

Action: Further details of the e-consent system will be shared via email **S Gangadhara**

The National SACT Clinical Advisory Group have raised some concerns about e-consent in terms of version control in different systems when these are already version controlled by CRUK.

Chemocare are also looking to pull e-consent into their system directly from the CRUK website, which would resolve these concerns.

For the system in RUH Bath, CRUK send alerts when any of the forms have been updated so that this can be updated in the system.

The chemocare solution sounds preferable, but this system is not available in RUH.

Cancer Alliance Programme Manager Niki Gowen has been asked to consider if there may be funding for such a system.

Action: To send further details on e-consent to the Cancer Alliance Team. **H Dunderdale**

From the agenda:

3. New and updated protocols 2024

Presentation available on request

Presented by Cancer Alliance Network / Lead Oncology Pharmacist Kate Gregory at BHOC

The presentation contains all of the new protocols developed over the past twelve months and those that have been updated. This includes moving protocols to the new format discussed in the last meeting, which has since been slightly amended according to feedback.

The percentage of completed protocols in comparison to approved NICE TA's has now increased, following an initial phase when new NICE TA's were being approved at a rate that was difficult to manage.

Numerous protocols have also been drafted and are currently with site specific authors to review.

Potential new NICE TA's are being tracked to monitor the upcoming workload.

A meeting was held recently with the lymphoma experts to review the protocol format and ensure that these are all consistent in terms of drug interactions, and the lymphoma brain protocol has been adopted and uploaded, which has been really helpful.

There have been many new myeloma protocols recently and, since agreement of the new protocol template by Haem CAG, this has been used for all new Haem protocols and one solid tumour protocol to date. Another two solid tumour ones are in draft form to see how this works for the oncology teams; how this is rolled out will need to be agreed when there are more available. This could be via the individual CAGs, or via the SACT CAG.

Work is underway to adapt the new VDC/IE protocol for Ewings Sarcoma from an inpatient regimen to an outpatient regimen. SACT CAG are invited to suggest any other protocols that could be converted to the outpatient setting.

Funding has been secured from the Cancer Alliance for additional pharmacist time to help draft the protocols; the related contract is awaiting sign off by UHBW.

Further links to national guidance can be added to the website on request.

National work is underway to draft 8 protocols for newly released regimens. There is not a plan to produce protocols for previously approved regimens. The protocols will be hosted on a website which will require a login, and the website activity will be tracked to assess how widely they are used.

If SACT CAG are happy with the format of the protocols, a link to these could be added to the SWAG website to avoid duplication of work.

Action: To assess national protocols format to ensure there is sufficient content for prescribers and dispensers.	**SACT CAG Members**

The requirement to login to a system every time you want to view a national protocol would impact on the efficiency of the day unit.

4. Uridine Triacetate – usage and network mutual aid proposal

Uridine Triacetate is used for Fluorouracil toxicities. It has been commissioned since 2020, but it hasn't been used in Bristol to date. The Blue Tech states that the patient has to have Grade 3 or 4 toxicity on their first cycle of treatment within 96 hours of either the end of the Fluorouracil infusion or last Capecitabine dose. It is very expensive, being £65,000 for 6 days of treatment, which is funded by NHS England.

The stock is imported from the US and held in Oxford Pharmacy Stores. There is a process already in place for rapidly accessing the store out of hours, as the same process is undertaken for High Dose Methotrexate, and it can be dispatched within 24 hours, making it possible for the patient to receive it within the 96 hour time period. It can be ordered out of normal working hours by certain pharmacists.

Kate Gregory is the Associate Principal Investigator for a trial that has recruited patients who may have been eligible for the treatment.

If there are any delays accessing Uridine Triacetate from Oxford, it may be possible to have a mutual aid agreement where UHBW would hold the stock for the region to optimise the supply route.

Action: Information on the drug, and the need to order it immediately will be relayed to all out of hours Pharmacists.	**K Gregory/Lead Cancer Pharmacists**

A delay with accessing the drug, which initially involves calling a chemotherapy helpline, has been experienced in the region.

It is not licenced and approved by NHS England based on results from a Phase 2 trial.

Patients may have stopped taking Capecitabine a few days before they are admitted, making the window for access very small.

It can also cause vomiting and sweating in 5% of patients and it would be useful to collect data on how patients react to the treatment.

Prescribers are asked to contribute data to a national audit.

Action: To clearly document the process for ordering Uridine Triacetate in the relevant protocols based on the guideline written by Gloucestershire Hospitals team and monitor the Oxford ordering pathway. K Gregory

5. Reducing regional variation and optimising patient access to Compassionate Use/FOC schemes

There are numerous different schemes, most of which are not supported by NHS England and some that are, including the Early Access to Medicine Scheme (EAMS) or Project Orbis.

Other schemes involve individual contracts with companies for individual patients, or early access to a therapy by a company wanting to collect more data on relevant patients.

BHOC estimate that each scheme increases the workload per patient by approximately 1 hour in comparison to 10 minutes for standard care.

Having gathered data on the schemes accessed across the SWAG region, all Trusts are offering access to EAMS, Orbis, and other Compassionate Use options.

The caveat is the need to ensure that there is definite clinical benefit and governance associated with each scheme.

Some feedback suggested that, if the associated workload for a scheme is considered too onerous, or not open for long enough to be of benefit, it may not be opened. This isn't the current stance in BHOC and it may be helpful to discuss this further in a longer slot on the agenda at a future meeting.

It is considered a complex issue that creates inequity of access to new medications which are accessible ahead of expectations of NICE approval.

Drug and Therapeutics committees are making some schemes harder to access in recognition of the impact on pharmacy.

It is a difficult ethical issue as everyone wants to provide patients with equitable access to the best therapeutics. It may be that a scheme could open in one centre to which the other centres could cross-refer.

It could be possible to send a survey to the Chairs of the Drug and Therapeutics committees on the schemes available and how the decision process is governed.

Action: To add as an agenda item for further discussion at the next meeting.

H Dunderdale

6. SACT Capacity and Demand: Feedback from RUH Pilot

Presented by Senior Project Manager Amanda Saunders

A breakout meeting was held in September 2024 to discuss completion of the SACT Capacity and Demand tool, which is an expectation of the National Cancer Board. Concerns had been raised over the feasibility of collecting the data, which has since been piloted in RUH.

The Cancer Alliance approach is to make the Capacity and Demand project as useful as possible and take a practical approach individualised to the needs of each centre.

The tool was developed by MSD who are providing practical support with the data upload which is supported nationally and presents no conflict of interest. The tool is largely focussed on the nursing workforce and has some limitations in that it does not include pharmaceutical capacity. Data is collected on the activity in each chair using a time and motion tool, which should hopefully pick up where any delays occur and produce a report for each centre.

RUH have agreed to pilot it first, and having just moved in to the new Dyson Centre, should in theory have sufficient physical space for their patients, with 29 treatment chairs. However, they currently have the workforce to cover 18 of these chairs, so the survey is including how many of the chairs are occupied during each day.

Information has been gathered on 400 patient records for the first week, which is currently being collated.

The majority of delays picked up to date are all for valid reasons.

The Cancer Alliance has funding available to help backfill posts should other centres want to nominate staff members to collect the data.

The MSD model can be manipulated to look at different day room set ups, for example, to calculate how many extra staff would be needed if an additional 4 chairs were added.

Use of the tool is a way to promote the needs of the SACT service to the national team.

RUH SACT Team found completion of the survey boosted team morale as everyone was involved in the time and motion survey.

The National Team have stated that the survey should be repeated twice a year; this is not going to be mandated by the Cancer Alliance, and it will be repeated when feasible and useful to do so.

Individual Trusts are able to adapt the tool to meet local needs.

As a survey of nursing time had previously been undertaken in BHOC and Weston by Lead SACT Nurse Sally Long, which has led to a good understanding of the nursing ratios required, the time and motion survey will focus more on chair times, delays to treatment, plus the patients on the cancellation and delay forms, the reasons and lost capacity because of these.

Evidence from the surveys will be used to embed service improvements.

It is hoped that each Trust will have a report plan within the next 6 months.

Action: To share capacity and demand data at the next meeting. A Saunders

7. NICE TA Funding Allocation: Gloucestershire

Presented by Jessica Bailey

An update was provided at the previous meeting to confirm how the funding to support the additional work created by the influx of NICE TA approvals had been spent, with the exception of GRH who will provide this today.

Contact has been made with the finance department and contracting team to try and track where the funding was directed, and an initial business plan has been drafted to fill the roles where the need is most pressing, taking a multi-professional approach.

Action: To share the business case once finalised J Bailey

It is felt that the funding is being spent appropriately in NBT.

This will be kept as an agenda item as it is still not entirely clear how the funding has been allocated in SFT. SACT CAG want full confidence that this recurrent funding is being directed to support SACT services.

8. Highlights from the South West SACT nurses meeting

Presented by Lead SACT Nurse Sally Long

The first half of the most recent meeting was focused on SACT Workforce and Banding.

Colleagues in the Peninsula and NBT are promoting SACT nurses to a Band 6 in recognition of the increasing complexities of the role and the educational requirements, plus to improve retention and reduce agency spend. This has been sent on to UKONs for national consideration.

UHBW have increased the number of Band 6 nurses but haven't agreed to promotions for all nurses due to funding limitations.

The group also discussed the role of Band 4 nurse associates who can support with cannulation, scalp cooling and setting up lines. UKONs recommend that SACT administration is only undertaken by a Band 5 or above.

Peninsula Cancer Alliance have recently founded a Cancer Academy for coordination of training needs.

The Aspirant Cancer Career and Education Development project (ACCEND) was introduced which is for nurses and other Allied Healthcare Professionals and is a national initiative to create a pathway for an educational framework.

SACT CAG support that SACT nurses should progress to a Band 6 once training has been completed to help retain the workforce.

CAG Recommendation

The academic requirement for SACT training makes a good argument for this recommendation.

Devon team also made the point that SACT nurses do not get the out of hours extra pay that nurses can accrue working in other areas.

9. Highlights from the South West Immunotherapy Group

Presented by CAG Manager Helen Dunderdale

REACT: REmission induction of Arthritis caused by Cancer ImmunoTherapy is an NIHR funded randomised multicentre trial to guide initial therapy for checkpoint inhibitor (CPI) induced arthritis.

The trial will compare standard treatment with steroids versus anti-TNF and is due to open in RUH soon.

IO in Primary Care: SWIG CNS, Oncologist and a GP representative are drafting a standardised IO letter for Primary Care, including appropriate coding/content to set up alerts on GP systems.

Faecal Calprotectin (FCP) Turnaround times: SWIG members aim to reduce TATs to use as both a diagnostic tool for inflammatory bowel and for monitoring response to treatment by liaising with laboratories / understanding individual laboratories reference ranges. Pilots of patient pack testing kits are underway.

Access to Biologics for IO colitis: SWIG is collating information on who has access to Infliximab and Vedolizumab and the number of cycles routinely given as there is currently variation across the region.

Baseline cardiac testing: The Immuno-Oncology Clinical Network and British Cardio-Oncology Society have formed a consensus group to draft a statement to enable teams to get the necessary resources for baseline cardiac tests. SWIG recommend producing a financial impact assessment in parallel.

A formal cardio-oncology pathway is being explored.

IO education events: IO nursing team are organising events. Peninsula Cancer Academy are funding in Plymouth. SWAG Cancer Alliance have been asked to fund in SWAG region.

Bone Protection: SWIG to prescribe bone protection as a default (as per osteoporosis society guidelines) at the same time that steroids commence and standardise patients who require bone density assessments / frequency. Vitamin D monitoring to be added to the initial IO order set. SWIG to escalate the need for national guidance.

Prescribing Protein Pump Inhibitors alongside IO: Move to prescribe famotidine instead due to link to poorer outcomes. Further guidance will be sought by SWIG Chair.

10. Hilotherm cooling for neuropathy

Hilotherm devices cool patients fingers and toes to 16 degrees in an attempt to reduce neuropathy and it is being offered in the private sector.

Patients have also been requesting buckets of ice for this purpose when coming in for treatment, and some patients have bought their own Hilotherm devices.

Evidence of the benefit is currently limited and there is some concern about cooling patients who are receiving Oxaliplatin. To be reconsidered when further evidence is available.

Date of next meeting: Face to face in Spring 2025

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