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

Tuesday 20th May 2025, 10:00-15:30

Aztec West Hotel, Aztec West, Almondsbury, Bristol, BS32 4TS / MS Teams

This meeting was sponsored by AMGEN, ASTRAZENECA, MSD and ROCHE

Chair: Dr Ashley Cox

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

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's report and actions

As there were no amendments to the report from the previous Lung CAG, held on Tuesday 3rd December 2024 the report was agreed as finalised.

Actions:

The inclusion criteria for the vaccine trial had been circulated. Any patient receiving neoadjuvant treatment can be recruited to the adjuvant part of the vaccine study.

A QR code for the national BAP1/MTAP survey had also been circulated. This observational data collection is for the purpose of looking at cases of mesothelioma to see where it would have been helpful to know BAP1 and MTAP status as part of the diagnostic criteria.

NBT have been testing for BAP1 for approximately 4 years and MTAP for a year. Results will be returned to the Manchester team in the near future. Anyone in the region is invited to contribute to the data collection.

NBT Consultant Histopathologist Richard Daly confirmed that BAP1 testing is widely used across the region, whereas MTAP was thought to be less commonly used in other laboratories.

Clinical Nurse Specialist led surgical follow up was also discussed at the last meeting to ratify a Standard Operating Procedure for use across the region.

The document has been sent for patient feedback. It is planned to remove the 18 month chest x-ray.

At the end of the 5 year follow up, a decision needs to be made on whether the patient is transferred back to the screening pathway.

Action: To finalise within the next three months and make this available on the SWAG website.	**Henry Steer/Sara Gomez**
A potential pilot of self-referral for chest x-ray was discussed and this had very recently commenced in Somerset.	**Potential future agenda item**

All other actions from the Work Programme are on the agenda today.

3. Clinical Trials Update

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Oncologist Gareth Ayre

Recruitment numbers by hospital site from April 2022 to the present are documented within the presentation, along with the list of research trials available across the region.

The two screening trials are currently not recruiting due to staffing shortages but are both looking at developing Artificial Intelligence to improve outcomes.

For the pleural trials, Meso-ORIGINS is struggling to recruit to the mesothelioma arm due to the number and distribution of biopsies required. Potential patients need to be flagged via the MDT at the pre-diagnosis stage. The trial is included on the Associate Principal Investigator scheme and finding a keen registrar could be key to the trial succeeding. It is looking at the biological evolution of mesothelioma and is open to anyone undergoing bronchoscopy and diagnostic biopsies for suspicion of the disease.

Patients that don't have mesothelioma go into arm A for annual surveillance.

Patients that do have mesothelioma go into ASSES-Meso.

HIT-meso requires patients that are relatively fit as they need to travel to London for the protein radiation. They need to be identified immediately post-diagnosis / pre-treatment by the MDT.

Travel expenses will be reimbursed. Consent needs to take place in NBT.

Action: To investigate if other Patient Identification Centres (PIC) can open in the region.	**Anna Bibby**

Exeter is hoping to open as a PIC as well.

For Interpath, patients must have received 4 cycles of pre-op chemotherapy and pembrolizumab rather than nivolumab and can be recruited at diagnosis and prior to surgery, which means diagnostic work-up and treatment can commence in their local centre. Adjuvant treatment does need to be given in BHOC (7 6-weekly cycles of pembro). A personalised mRNA cancer vaccine, similar to the COVID-19 vaccine, is then synthesized using Next Generation Sequencing (NGS), which is delivered on 9 occasions alongside pembro.

A sufficient viable quantity of tumour is required for the vaccine to be developed. Travel expenses will be reimbursed.

The Lung CAG / surgical team are encouraged to inform the trial team of any patient who is interested prior to surgery as they cannot be listed for surgery on a Friday because of the need for the tissue to be analysed within 24 hours. The surgeons need to be informed to put every single nodal station into a separate pot.

It is anticipated that three quarters of patients may be eligible to progress to the vaccine.

Although there is no data of efficacy for lung cancer at present, early data from the melanoma vaccine study shows a 45% reduction in recurrence rates at 2 years.

Action: To check if patients can still be eligible if the 4 cycles are not completed due to toxicities. **Gareth Ayre**

PACIFIC-9 is due to close in June. PACIFIC-8 is going to continue for another 18 months. REFINE randomises patients to pembro dosing intervals between 6-18 weekly.

The purpose of PRIMALung for SCLC is to confirm the place of prophylactic cranial irradiation (PCI). Patients receive MRI surveillance and follow up Quality of Life questionnaires for 2 years to understand the impact of treatment. National recruitment is lagging, but it will remain open for another year (end of 2026) and regional referrals to BHOC and Cheltenham would be welcomed.

Patients are more likely to accept PCI if the idea is introduced during the chemotherapy phase of treatment.

The Phase 1b/2 study BNT324-01 is due to open in BHOC. Patients with NSCLC, SCLC and eGFR disease are eligible.

Further details on Pleural, Peri-operative, Adjuvant, Stage 2NCLC, Metastatic NCLC, Radiotherapy, Small Cell, Non-site Specific and Respiratory trials are documented in the presentation.

4. TOURIST Trial

Please see the presentation uploaded on to the SWAG website

Presented by Clinical Trial Coordinators Izabela Eberhart and Siva Saranya Hari

TOURIST comprises two randomised controlled trials; PRINCE and QUARTZ and involved the addition of radiotherapy at an early stage for those with asymptomatic Stage 4 NSCLC.

The study is run from Southampton Clinical Trials Unit, sponsored by The Christie Hospital, and funded by the NIHR.

Dr David Woolf is the Chief Investigator and Prof Matthew Hatton is the Candidate Chief Investigator for PRINCE.

For PRINCE, patients who are receiving systemic treatment and are fit for radiotherapy can be randomised in the first few cycles to standard palliative care versus the addition of palliative radiotherapy.

The QUARTZ arm randomises patients for Best Supportive Care versus treatment with low dose radiotherapy.

Radiotherapy in PRINCE is high dose and in QUARTZ it is low dose.

The overall outcome is to see if the addition of radiotherapy improves patients' Quality of Life.

Most of the fitness assessment can be undertaken over the phone, which involves completion of a questionnaire.

Recruitment commenced in July 2024 and will remain open until June 2027, with the aim to complete analysis by the end of 2028.

PRINCE is open in Bristol and in set-up at Gloucestershire, Somerset and Bath. National recruitment to date is 34.

QUARTZ is open in Bristol and Somerset and in set-up in Gloucestershire and Bath. National recruitment to date is 9.

CNS involvement is felt to be key to identifying and recruiting these patients, and the Clinical Trial Team would appreciate it if contact details could be sent to the following address: tourist@soton.ac.uk

Discussion:

For PRINCE, advanced radiotherapy techniques are recommended in dose fractions of 36 or 39 Gy; this needs to be delivered between Cycle 1 and Cycle 4. For QUARTZ more simple anterior and posterior fields will be used to target the tumour/s with lower dose fractions.

Performance Status for PRINCE is between 0-2 and for QUARTZ, between 0-3.

Referrers need to check that the patient meets the Stage 4 criteria, as a few patients have been referred who are Stage 3 and not eligible.

Identifying QUARTZ patients may be more challenging as they are the cohort of patients that would usually not be referred on to oncology, whereas patients who meet PRINCE criteria can be identified when undertaking SACT.

An amendment to the protocol has been submitted to extend the eligibility criteria to patients with Stage 3B and 3C disease, which is awaiting approval.

Action: To inform teams when the Stage 3B and 3C amendment has been approved.	**Izabela Eberhart/Siva Saranya Hari**

5. South West Regional Lung Cancer Nurses Forum

Presented by CNS Teams

The CNS forum held last week was hosted by SFT with 14 attending from across the region. An interesting presentation on Artificial Intelligence (AI) was provided, which may be of interest to Lung CAG as it detailed the many ways that AI could help with managing workload.

Potential Future Agenda Item

Regional variation in CNS Banding had previously been discussed, with the team in Gloucestershire banded lower than other centres. One CNS has now been up-banded in recognition that the team are separate from the respiratory nurses and required a CNS Lead, but work is still underway to have the CNS skill set recognised; a meeting has therefore been arranged with management to address this.

This also applies to the CNS team in Somerset.

It is going to be particularly hard to get the disparity addressed given the current financial constraints.

The CNS workload activity has evolved over time and needs to be formally recognised, including undertaking tasks that used to be based in Primary Care, and most importantly provision of ongoing emotional support to patients throughout the most difficult time in their lives. This is at risk of being undervalued in comparison with the more technical aspects of an Advanced Nurse Practitioner Job Description, but it is actually the most valuable role from the patient experience perspective and challenging on a personal level for the CNS workforce.

The interface between Primary and Secondary Care is a topic of interest at present, and it may be worth exploring in collaboration with the Integrated Care Boards (ICBs) as it could be argued that the Band 6 CNS should be upgraded due to the amount of work diverted from the patient's General Practitioner (GP). GPs frequently direct patients to contact the CNS teams for advice on pain relief and other symptoms and to have the complicated conversations about their care.

It would be good to compare CNS job descriptions across disease sites and in other centres across the nation to see if there are any vast differences.

Lung Cancer Nursing UK do have template job descriptions for Bands 6, 7 and 8.

Gloucestershire Cancer Manager is putting together a Business Case that details the impact of immunotherapies and other cancer treatments to make a bid for extra funding for the team, based on using CNS-led clinics as an alternative to medic-led, which will make a cost saving even if upgraded to Band 7.

Action: To benchmark CNS job descriptions across the region. — **CNS Team/Lead Cancer Nurse Chris Levett**

6. Improving Chemotherapy Cycle Communication

Presented by Clinical Fellow in Oncology Nabeel Sheikh

A project is underway in Somerset to develop a communication tool to help patients better understand their chemotherapy and radiotherapy cycles in recognition that treatment cycles are often complex, with multiple dates, tests, and medications.

Patients often feel overwhelmed with verbal explanations and misunderstandings can lead to missed tests and delayed treatments. Although they are supplied with paperwork about their schedule and side effects, there is very little information on how this will be administered.

A survey was first undertaken which included all healthcare professionals involved in consenting and administering SACT, with results showing an unmet need for a visual, simplified and ideally digital resource.

After a search for existing tools found all had limitations, a new treatment cycle diagram was developed.

The name of the regimen appears in the middle of the circular diagram which shows the days when bloods are required, treatment days, pump disconnection days and any other information required.

A simple regimen was used to start with, and now more complex regimens have been drafted.

It is possible to print out the tool and the patient can put it on their fridge so they know exactly what to do on each day and also when to expect a CT response assessment. Stickers can be added on the days that patients need to take certain tablets. Patients can then see their whole cycle at a glance and it helps nurses, doctors and pharmacists explain treatment plans more effectively.

The tool is now being used for selective regimens and early observations show that this has improved understanding and reduced missed steps. Real world feedback is being collected to see if it works effectively before rolling it out to more regimens, provide training sessions to more staff, and consider development into a digital format.

Discussion:

Patient Representative Joe Norman approves of the communication tool and would have found this very beneficial.

The next step will be to distribute it across the SWAG patient population.

A survey is available for feedback via a QR code embedded in the presentation.

7. Lung Cancer Screening (LCS) Programme: Update since December 2024

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Respiratory Physician Anna Bibby

Programme activity shows how the work has accelerated in the last year.

Activity has been broken down to show the number of two week wait referrals to each provider Trust and the conversion rate to cancer, with the majority of referrals going to Somerset, which is the largest ICB, and UHBW close behind who have matched resources to the increased workload for this to be possible. Gloucestershire is trailing behind due to significant problems getting Data Sharing Agreements with the ICB, but this is being gradually worked through, and there is confidence it will be resolved.

The LCS also visited HMP Leyhill aiming to target underserved populations, where there was a higher uptake rate than the general population of 82%, a high percentage of which were deemed as high risk and very positive participant feedback. No other incidental findings were identified.

Results were presented at the SWAG Annual Conference and NCEPOD 'Inside Healthcare' stakeholder meeting.

The original plan was to continue to increase coverage until 100% of the screening population had been targeted by 2029, although it is currently uncertain if it can continue at this pace due to NHS England funding priorities. Funding is guaranteed for next year.

There is however confidence that LCS will remain a priority for the new Government.

The central programme is starting to branch off into devolved ICB led programmes, with Somerset already working independently and the plan for ongoing governance and funding to be held locally. This may need to be paused for the other ICBs until funding agreements are clarified.

Some activity is outsourced to InHealth employees, although the majority of the clinical team are NHS employees, with the aim to bring the Responsible Assessor nursing role in-house and expand to two roles in order to manage the expansion of the service.

A process will be developed for those patients who have been diagnosed and treated for lung cancer who are still under 74, to move them back into the screening programme, plus how to reevaluate people who have not met the high risk threshold at initial assessment and may need to be screened again.

Although the programme has generated more downstream work, it is fulfilling the purpose to diagnose more lung cancer at an earlier stage.

Discussion:

Pick up rate of cancers in SWAG is 1.2%; the National rate was originally set at 3% from the Manchester pilot, but this has now been reduced to 1.5%.

It will be more complex and resource heavy to take LCS into higher category prisons than Leyhill, which is an open prison, as every prisoner would need to be accompanied by 2 Guards.

8. Electromagnetic Navigational Bronchoscopy (ENB)

Presented by Foundation Year 1 Doctor Sophie Hole

ENB is being audited as part of the new procedures protocol to biopsy lung nodules. The service commenced in the Trust in September 2022 and the first 50 cases have now been analysed, with the overall aim to look at diagnostic performance, focusing on yield, complication rates and concordance with final histology.

Initially, a national framework for comparing outcomes was not available, but a paper published in 2023 that looked at 95 studies in a patient group of over 10,000 showed an average diagnostic yield of 68.6% and incidence of pneumothorax rate of 2.5%.

UHBW audit data was collected between September 2022 to May 2024, on 46 of the 50 patients referred for the procedure from across the SWAG region, with 4 excluded for data collection reasons.

Results showed that the majority of referrals were from UHBW and RUH and a small but similar number referred from the other centres.

The overall diagnostic rate was 56.5% with 26 patients diagnosed, and 20 non-diagnostic. 89% were day case procedures and 11% required an inpatient stay, with an 8.7% complication rate and 6.5% pneumothorax rate. The majority of biopsies were taken from the right upper lobe.

A re-audit of the next 50 cases is underway, and the location of the lesions and incidence of complications will be assessed to see if there is any correlation.

Discussion:

When looking at the data chronologically, it is possible to see a learning curve as the procedure becomes more embedded as routine.

A 3-D C-Arm has been purchased which will help guide future procedures; the first procedure is planned today, and the kit produces a virtual map of the lesion location, plus a radial EBUS probe is available.

Referrals may be lower from centres who have interventional radiologists providing CT-guided biopsies.

Data on the waiting time from decision to ENB to receipt of histological diagnosis would be helpful to look at. It is definitely lower than the wait for a CT-guided biopsy.

It is aimed to purchase an ION robot to further assist rapid precision surgery in 2026.

Addition to Work Programme To be allocated

Action: To present the next 50 cases at a future CAG meeting.

9. Re-audit of frozen sections (FS) in thoracic pathology

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Histopathologist Nidhi Bhatt

In 2016, the UHBW Cellular Pathology Department merged with and moved to NBT.

In response, a bespoke FS protocol was developed for thoracic surgical patients to minimise any delays that could be caused by transporting the tissue between the two Trusts, and a clinical effectiveness project was undertaken in 2017 to validate the protocol.

The current process is for specimens dissected by the surgeons and tissue for FS are sent to the essential services laboratory (ESL) in UHBW. The tissue is frozen in the cryostat machine, then glass slides are formed and scanned with the whole slide image scanner. Images are then sent to NBT and reported digitally.

As there was no national guidance, the acceptable timings agreed locally was for 90% frozen sections to be reported in 30 minutes, with the exception that only 3 specimens can be sent simultaneously, due to the limitations of having one cryostat machine.

The acceptable accuracy agreed locally was for 95% of frozen section diagnoses to correlate with the final diagnosis, with the exceptions that there may be sampling discrepancy within the remaining tissue.

The re-audit looked at all thoracic FS between 01/01/2024 and 31/12/2024 identified from LIMS (using specimen type codes) by collecting the step times from specimen receipt to the results being phoned to the surgeon or anaesthetists.

A total of 95 cases were reviewed, with 1 case excluded due to including 9 lymph node stations and taking 142 minutes. 14 cases had 2 specimens sent simultaneously and 80 had a single FS.

Turnaround time (TaT) is documented within the presentation, with processing time contributing to most of the delays. Size and anatomical area of sample type can lengthen TaT, making it more complicated to cut and freeze the sample. Overall, 52% met the TaT standard, although the average overall TaT was 34.8 minutes in comparison with 32 minutes from the last audit. Scanner errors had also skewed TaT.

Diagnostic accuracy exceeded the standard at 98%, with 2% downgraded from squamous cell carcinoma to squamous metaplasia.

Actions: Processing of samples and scanner time will be investigated in more detail to ensure timings are optimised, and communication between pathology and the surgeons will also be improved. **Nidhi Bhatt**

Blue lighting multi-part FS to NBT may also be considered as the main laboratory have 3 cryostat machines.

Discussion:

As UHBW ESL has only one member of staff processing FS, which includes Head and Neck Cancer, this can also lead to delays.

10. Lung Cancer Genomics – Circulating tumour DNA (ctDNA)

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Clinical Scientist Laura Yarram-Smith

A recently published document called ‘The Liquid Experience’ details what has been learnt from the ctDNA pilots in England and Wales to date, and how this can be used to get a faster diagnosis and faster access to treatment options.

The ctDNA pilot run by the Royal Marsden has been progressing well, with all 9 Trusts in the South West region fully engaged in the pilot.

A pathway survey was carried out in February that showed TaT from the Royal Marsden was an average of 14 days, with the majority of delays found to be related to laboratory processing times.

The number of samples sent by each Trust is documented in the presentation.

NHS England have now added ctDNA for lung cancer to the National Genomic Tests Directory (Test Code M4.14) so that it is a formally commissioned test for 15,000 NSCLC patients in 2025/26.

For the South, Marsden 360 will continue to provide the ctDNA service, and a laboratory in Manchester will provide the service in the North of the country.

Reports are structured so that variants are listed at the top, followed by details on the likelihood of response to treatment and inheritance to children, and details of any available clinical trials.

Regular Lung Cancer Genomic Tumour Advisory Boards (GTABs) are held on a Tuesday and Friday afternoon should complex cases require discussion.

Work is underway to see if ctDNA tests can be processed within the South West Genomic Laboratory Hub to reduce delays. A new test is being validated for this purpose, which is an MKS-ACCESS panel that looks at 146 genes. Patient samples are required to facilitate the validation.

Action: To take an additional blood sample for the ctDNA evaluation when taking a sample for the Marsden 360 test. **Lung CAG**

For further details and extra tubes, please contact the GMSA team: rduh.swgmsaadmin@nhs.net

Results will be compared with the Marsden 360 results.

Discussion:

The GLH do not have access to Marsden 360 results at present, as these go back to the requester, but this is in the process of being resolved.

The Ethics Committee in Exeter concluded that no additional consent is required for the study, as it is for the purpose of quality control only, plus a data sharing agreement is in place with the Royal Marsden.

It is not always easy to take the first blood sample for the Marsden 360 test and so may not be possible to take a second from all patients.

11. BRI Thoracic Surgery Service Update

Please see the presentation uploaded on to the SWAG website

Presented by Stylianos Gaitanakis

The team has expanded to 6 Consultants, 4 Doctors in training and 5 CNSs.

It is hoped to appoint an additional 2 Thoracic Fellows and 1 Advanced Nurse Practitioner (ANP).

An additional 5 operating lists will be made available for September 2025, including 4 new robotic lists and training for 2 more Consultants.

The projected number of referrals from the Lung Cancer Screening route were not as expected which has caused a delay in appointing the 6th Consultant and the plan to appoint a 7th Consultant has now been abandoned. However, in the last month, referral numbers have started to rise, and the situation will be carefully monitored.

The Thoracic Surgery waiting list has very much improved from the previous year, when there were serious issues. This has been achieved by running extended lists from Monday to Thursday which involves three major resections per list, plus running lists on 3 out of 4 weekends a month.

It has been possible to negotiate 4 additional monthly lists for the 6th Consultant.

Changes to job plans are also underway to improve efficiency, and a 2nd robot is arriving in May 2024, which is when Mr Gaitanakis will commence training. The next surgeon will commence training in September 2025.

The Lung Volume Reduction Service has also recommenced with full support from the Division.

3D operative pre-planning for segmentectomies is being undertaken whenever deemed necessary and robotic surgery is going well. The first 150 cases have been carried out with no major issues and led to a decrease in Length of Stay (LOS).

It is planned to increase the number of lung resections with drain removal on Day 0.

There was a plan to refurbish the Theatres, but this has been postponed for another year.

An audit on the early drain removal has shown that patients have less pain and are able to mobilise earlier on, with LOS reduced from 4 to 2 days, and has so far been shown to be safe.

The team aims to take part in as many clinical trials as possible and the list of trials and audits underway are documented in the presentation.

Joint audit meetings are now being held with anaesthetists, radiologists, CNSs and respiratory physicians. In the first two meetings, it became apparent that there was so much of relevance to share, that this will continue.

Regular international VATS segmentectomy courses are also delivered and a cadaveric and live surgery course has been scheduled for November 2025.

It is hoped that a robotic fellowship programme can be established in 2026.

Rapid 'one stop' clinics have been established which have shortened the patients' pathway from referral to treatment. It is hoped to introduce this in other hospitals, and at first this will be piloted in YDH and hopefully combined with a pre-operative assessment.

As thoracic surgery evolves, it is expected to perform more robotic assisted procedures and less VATS.

Discussion:

The plan for the rapid clinic in YDH is for Mr Saftic to attend the MDT where the PET scan will be discussed and then have a clinic to feedback the surgical plan to the patients; the logistics are currently being explored. This would improve the patient experience, negating the need to travel to UHBW for the appointment.

The pre-operative assessment could be done virtually, but the echocardiogram, bloods and a clinic room would need to be organised locally.

Virtual POAC used to be organised pre-pandemic, and it worked very well. Now that everyone has MS Teams, it would be a lot easier to organise.

Action: To reinstate virtual POAC across the region (starting with YDH) with assistance from the Cancer Alliance Project Management Team.	**Nicola Gowen/To be allocated**

The challenge with organising the rapid clinic is ensuring that the patient's PET scan has actually been reported prior to the MDT before booking the patient into the clinic.

Action: To provide an update on the progress of rapid clinics at a future CAG meeting.	**Stylianos Gaitanakis**

In the future, it is hoped to increase the number of patients that have a diagnosis prior to surgery and reduce the number of FS required. The increase in segmentectomy procedures is already reducing the number of FS, but this is not reflected in the FS audit data as there were significantly more surgeries in 2024 in comparison to previous years.

Action: To audit provision of pre-operative biopsy numbers across the region	**To be allocated**
To audit how many resections result in a benign diagnosis	**Sara Gomez**

12. Greater Manchester one-stop Lung Cancer Clinic

Please see the presentation uploaded on to the SWAG website

Presented by Professor of Respiratory Medicine Matthew Evison

Undertaking the Cancer Treatment and Optimisation Programme has developed much more than just a one stop joint lung cancer clinic. It has created a model of care that is translatable to any situation where there are complex treatment decisions to make, and opportunities to optimise pathways and reduce treatment related adverse events.

It has now been used to optimise the Upper GI pathway and will be adopted by other cancer sites in the near future.

The key challenge in Greater Manchester was management of higher risk patients with NSCLC referred for thoracic surgery, with delays in the pathway leading to poor outcomes.
The previous pathway was taking over a month for the patient to progress to a decision to treat, with a high number 104 day breaches occurring.

Although the one-stop Lung Cancer Clinic solution was a simple concept, it was operationally difficult to implement as it involved working across several organisations in a financially challenging environment.

The Cancer Alliance played an important role in the process with provision of leadership to facilitate the operational changes.

Further information, including Patient Information Leaflets and videos can be found on the GM website here: https://gmcancer.org.uk/lungclinic

The first step was gaining clinical consensus from the regional Lung Cancer Clinical Advisory Group to define the indicators for higher surgical risk, as detailed in the presentation, with recognition that there will be some patients a surgeon feels are higher risk that don't fit into these parameters.

Once the patient group to refer to the clinic was defined, it was decided to bring together the Lung Cancer Physicians, Surgeons, Anaesthetists, Oncologists, Onco-geriatrics, CNSs, Prehab and Smoking Cessation experts in to the clinic, which is held from 8am-1pm, to help modify those risk factors wherever possible.

Transport is provided free of charge by private taxi to ensure it all happens on time; in the past three years there has been one DNA.

After a standardised assessment, an MDT meeting is held while the patient watches the information videos. Sit to Stand videos for each patient are assessed in the MDT meeting, which is very informative to help make shared decision making and provide the same messaging to the patient.

Consultations are then held with the aim to decide the next treatment option on the day. This reduces the days from referral to treatment to an average of 5 days, which is an improvement that has been sustained for 3 years now.

The clinic has increased the uptake of prehab, smoking cessation, malnutrition prevention and alcohol reduction and reduced the number of overall clinics required and LOS. 12 month mortality has also decreased. Significantly more people have progressed to surgery as a result of the clinic.

There was initial concern that patients would find the process too intense, but this had not been found to be the case from the positive patient experience survey results.

A detailed health economic analysis has shown a cost saving of £49.68 per patient.

Since 2023, patients for curative intent multimodality treatment have also been managed in the one-stop clinic, with 78% making a decision for treatment on the day and 88% commencing neoadjuvant treatment progressing to surgery.

The GM Cancer Alliance worked as the delivery arm via their Programme Assurance Group, Cancer Strategy and System Risk Assurance Group and robust governance processes.

The model is considered scalable and transferable across multiple cancer pathways.

Discussion:

SWAG have multiple different oncological centres that feed into one surgical service and would like to understand how the oncological workforce feed into the clinic.

The Manchester service has surgical and systemic oncology in one centre, and multiple satellite services for radiotherapy. The Clinical Oncologists from these centres travel to attend the clinics for two sessions a week to consent the patients for radiotherapy and arrange the planning scan at the same time, which is then delivered in the satellite centres.

There are some unique arrangements in Manchester that allow attendance of certain staff members, for example, the smoking cessation service is managed by the Lung Cancer Directorate.

The cost benefits are system wide and involved decision making with the Cancer Alliance influencing the Integrated Care Board.

SWAG may not be able to replicate the exact Manchester model, due to the different number of ICBs and other geographical differences but are exploring the key elements that could be adopted and are considering virtual options.

The face to face model was considered vital in Manchester, with the provision of transport being key to make savings by reducing the number of DNAs and the filming of sit to stand assisting with decision making.

Leadership at a regional level is required to support clinical leadership and consensus to overcome the challenges of cross-organisational working.

The ICB landscape in SWAG is changing and there may be opportunities for more region wide collaboration.

There seemed to be a larger population of high risk patients in Manchester in comparison with the SWAG population.

SWAG have existing criteria for identifying high risk patients. Peripheral clinics could help identify these patients at an earlier stage.

Accessing smoking cessation services is complicated in SWAG as the service is based in local authorities but potentially could be improved at an ICB level.

It may be adequate to arrange a joint surgical and oncology clinic for the high risk patients.

Action: To develop a regional protocol to enable early identification of high risk patients for rapid referral for relevant tests and onward referral to the surgical and oncology team.	**Henry Steer/Surgical Team**

13. Cheltenham one-stop diagnostic clinic

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Respiratory Physician Henry Steer

A one stop diagnostic clinic commenced in September 2024 which involves a same day CT, OPA and lung function test within 3 days of the CXR report. The clinic is held on Tuesday and Thursday afternoons in the Quayside House Community Diagnostic Centre (CDC).

Historically, Gloucestershire's performance had been impeded by the service activity being split across the two centres and mitigated by having a Consultant of the week to triage referrals.

The straight to CT pathway was implemented in 2018, with suspicious chest x-rays (CXR3) being recalled for CT within 7 days, then telephone triaged depending on the outcome.

The first attempt to arrange a one stop clinic was in 2021, but there were insufficient clinic rooms and CT slots.

With the opening of the CDC in January 2024, and appointment of a new thoracic radiologist in August 2024, the one stop service is now available. The clinic structure, which comprises 4 one stop CT appointments, is documented in the presentation.

Purchase of an ultrasound for diagnostic pleural taps and neck node fine needle aspirations is in progress.

An audit of the first few months was undertaken in comparison with the pre one-stop service, which shows a reduction in the number of patient visits from 2.3 to 1.3, with the majority of patients having one visit.

Time from CXR3 to CT has increased slightly in order to get patients into the designated slots, but the majority of CTs are then same day reported.

The time taken to OPA, PET, biopsy and lung function tests has all been reduced by a week, and the average time from CXR report to treatment MDT has dropped from 30 to 22 days.

The team are in the process of bringing all of the administrative tasks under the management of the respiratory team to mitigate any delays with booking the CT slots.

The pathway needs to start from the CXR3 report and not wait for a GP referral, as the CT is often booked ahead of the GP request.

Working closely with radiology bookers was key to achieving the change.

A patient experience survey had overwhelmingly positive feedback, with the speed preferred by almost all patients.

Discussion:

The majority of patients have access to scan results via the NHS App.

Initially there was concern about bypassing the GP, but the process of contacting the patient 'out of the blue' was already happening.

Attempts had been made to manage patient expectations by providing leaflets and posters which stated that they may be contacted to come for a CT following their chest x-ray, and a patient engagement event was held to discuss this with patients and relatives. This provided feedback that the most important factor was the speed with which the CT is arranged.
CT reporting on the same day is hugely beneficial to manage patient anxiety.

Patient Representative Joe Norman recommends the dedicated taxi service as provided by the Manchester service.

14. UHBW Pathway for Neo-adjuvant Systemic Anti-Cancer Therapy (SACT) followed by surgical resection of NSCLC

The pathway describes the pre-operative treatment pathway for patients undergoing lung cancer resection in the Dept of Thoracic Surgery at UHBW after neoadjuvant SACT.

Action: To update the pathway to include the additional SACT options and ideal time to plan surgery. Ashley Cox

The surgeons prefer to have a repeat PET post neo-adjuvant as well as a CT to mitigate the risk of operating on patients with metastatic disease, accepting that there is likely to be flare on the PET that can be difficult to interpret.

There have been patients where surgery has had to be delayed for the patient to recover from the effects of neoadjuvant treatment.

15. Cancer Alliance update: data quality improvement plan / NLCA / State of the Nation Review

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Respiratory Physician Henry Steer and Programme Manager Nicola Gowen

Problems with lung cancer data quality persist. Data is submitted and reviewed at a national level and conclusions are drawn from it. It is also important to have accurate data to support business cases.

Clinical validation is required to ensure that the data export to the National Lung Cancer Audit (NLCA) is accurate.

There was a period of time when the list of patients was provided to Trusts for validation prior to generation of a report when errors could be corrected; this is no longer the process and, since 2022, the reports are based on the Rapid Cancer Dataset which links the Cancer Outcomes and Services Dataset (COSD) with multiple other health records. This makes the data more rapidly available but less accurate.

The National Cancer Programme Board highlighted a treatment variation from this data with regards to the quality indicator for 70% of patients with NSCLC stage IIIB-IVB and PS 0-1 to receive SACT, with SWAG data showing the rate below 70% across each of the provider Trusts. This was considered to be a data collection error.

Teams were asked which Trusts clinically validate their data prior to COSD upload.

Discussion:

UHBW Clinical Lead Andy Low has been informed that it is no longer possible to generate a report for clinical validation purposes. It is sometimes made possible to correct a snapshot of past data, but this does not correct the COSD data submission.

Salisbury Clinical Lead Catherine Thompson validates the data using a

report exported from the Somerset Cancer Register, but this is not coordinated in time for the COSD upload, and it is very difficult to get anything corrected once this has been sent. The team have to ensure that they record Operation and SABR rates as often these patients are mistakenly allocated to Southampton.

The data export from SCR required input from the Informatics team to build it into a report that can be used to interpret data fields that are incorrect or missing.

NLCA data can now be viewed in dashboards of quarterly data using the National Rapid Cancer Dataset. The State of the Nation annual report is completed using COSD, so they are sourced from different datasets.

NLCA are also instigating Early Signal Analysis to identify outliers so that it is possible to notify people if quality indicators appear to be deteriorating or improving.

The audit has merged with NATCAN and will become more standardised along with the other national cancer audits.

It is planned to send letters to provider Trusts to highlight areas of good practice and areas that require improvements.

The Gloucestershire Business Intelligence (BI) team have built a dashboard which exports from the Info-flex Hospital Information System which allows Clinical Lead Henry Steer to validate the COSD data. It takes approximately one hour per month to correct the Staging, Performance Status etc. and, for the patients who did not progress to surgery, notes are added on their lung function or any other relevant factors. This has been useful for local audits. For example, it was possible to identify that a high number of late stage referrals were coming from the Forest of Dean, and present that data back to the Primary Care Network.

It would be helpful if the Cancer Alliance could buy some BI time so that everyone could have a validation dashboard.

An anonymised list of the 104 day waits was given to Cancer Alliance Data Analyst Funmi Oladipo. Findings support the need for joint surgical and oncology clinics. Job plans would need to be altered and clinic room made available.

Programme Manager Nicola Gowen is aware that everyone involved in recording cancer data needs to ensure that the correct data fields are completed in SCR or Infoflex for the export to work. A Quality Improvement project is being proposed that hopes to pull together all of the right people from BI and Cancer Management teams to standardise data collection. The Cancer Alliance would need the project to be managed over an agreed time period with clear outcomes; one of which would need to be how data quality can be sustained.

Cancer Waiting Time Dashboards have been developed by Funmi, which are available to review on request.

An early diagnosis dashboard has also recently been developed which can be viewed by ICB or provider, and shows the incidences of diagnoses, staging completeness, demographics, performance status, etc.

Data sharing agreements will be put in place in the near future so that it can be shared. It is also planned to include data from the Lung Cancer Screening service.

The dashboard demonstrates how the Cancer Alliance can help find insights for potential service improvements across the region.

Action: Cancer Alliance / Lung Cancer Teams to encourage Cancer Services to provide BI support to create dashboards for improving COSD data quality.	**Nicola Gowen/Lung Cancer Teams**

Date of next meeting: Tuesday 18th November 2025, Eastwood Park Country House, Falfield, Wotton-under-Edge, Gloucestershire, GL12 8DA / MS Teams

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