Peninsula Cancer Alliance

Meeting of the PCA Thoracic Oncology Site Specific Group

19th September 2017; 14:00-16:00

Lifton Farm Shop (Strawberry Fields Conference Room), Lifton, PL16 0DE

FREEDOM OF INFORMATION

This group will observe the requirements of the Freedom of Information Act (2000) which allows a general right of access to recorded information including minutes of meetings, subject to specific exemptions. No one present today had any objections to their names being distributed in the minutes.

Draft Notes

Chair: Amy Roy (AR)

Reference

1.0 Welcome and Introductions.

Please refer to separate list of attendees here.

2.0 The minutes of the previous SSG meeting were reviewed and actions arising considered;

2.1 Action Planning for Implementation of the National Optimal Lung Cancer Pathway (NOLCP): AR has emailed each Trust Lead to establish their current position.

2.2 The group would like to invite a representative from the NCLA to the next meeting.

2.3 Surgical Resection Rates: refer to section 4.0.

2.4 Access to molecular test results remains problematic. Torbay does not have direct access to the system and are having to utilise medical secretaries as a "go-between". The process of obtaining access had been initiated but has not progressed.

2.5 The PDL system does not identify patients as being under the care of other hospitals; clinicians are unable to ascertain whether or not a test has been requested, nor are they alerted to new results (they have to look them up).

2.6 Victoria Kennington has taken up post as the new Tertiary Patient Pathway Co-ordinator (based at Derriford); Victoria may be able to assist with looking at the transfer of pathology results between trusts-particularly with regards to

supplementary reporting.

2.7 **Action**: AR/NK to contact Victoria Kennington

2.8 **MDTs**-AR is not aware of any current difficulties in relation to the running of MDTs across the Peninsula.

2.9 Exeter discussed the efficiency of their MDT being affected by the availability of investigative results and that this is causative of patient pathway delays. Capacity is also a challenge, with 50 patients being discussed at their most recent MDT.

3.0 **Implementation of the National Optimal Lung Cancer Pathway: Current Status and Barriers:**

3.1 The group were given the opportunity to discuss their current position with regards to implementation of the NOLCP:

3.2 **Exeter**: When a CXR has been requested by the GP, reporting is usually quick-within 48 hours. The practice of radiologists thereafter is varied: some book patients for a CT, others refer into the fast track clinic. The benefit of attending the clinic is that patients can either be discharged and removed from the pathway, or made aware if a PET is required.

3.3 It is thought that radiology in Exeter will struggle to achieve same day CT/ hot reporting. Currently, the wait for a fast track CT is 5-10 days, with a further 7 days to receive the report. From CXR to CT report takes about 14 days.

3.4 **Torbay**: If Lung cancer is suspected, a CT scan request is generated as well as a 2ww request for a chest physician opinion. Some patients are referred on a 2ww where a CT has not been done; in instances where the CXR is normal, but high clinical suspicion remains, a CT is carried out prior to the patient being seen in clinic.

3.5 Chest physicians have discussed triggering a “bundle” of tests and are slowly working towards this; concern has been raised that this can lead to some patients being over investigated.

3.6 Torbay is holding a meeting at local level to look at their lung cancer pathway in relation to the NOLCP. PET scans and EBUS are carried out off site and Torbay is also experiencing a shortage of Lung Cancer Nurse Specialists.

3.7 On average, patients are being seen in clinic on day 13 of the pathway, with CT results, however EBBUS is a challenge.

3.8 The question of whether it would be reasonable for Torbay patients investigated in Exeter, to be put on the Exeter MDT for the discussion of their results would be reasonable was raised.

3.9 **North Devon**: 2ww are being triaged in a similar way and patients are getting their CT before clinic. Current challenges are radiology capacity and a shortage of CNSs and respiratory physicians.

3.10 **Plymouth**: PHT are about to launch a NOLCP pilot scheme; this will involve patients having their CXR and CT on the same day, with reports being available for clinic the following day. It is proposed that patients will attend PHT for their CXR (not their local hospital) and that there will be hot reporting of the CXR. There will be a "navigator" role on site to help direct patients at the hospital. The outcome of the pilot will be shared across the Peninsula.

3.11 **Cornwall**: There were no representatives from Cornwall at the meeting to comment.

3.12 **Amelia Randle** (Clinical Lead for SWAG Cancer Alliance): Amelia explained that there is money available from the recently successful transformation bid at that a Peninsula wide meeting is being held on 10th October to look at the NOLPC implementation plan.

3.13 CCGs will hold the funds, the release of which will be incremental and linked to progression.

3.14 The principle of the bid is to ensure a cross board approach and to enable each Trust to be supported.

3.15 SWAG are implementing the Somerset Decision Making Tool (with local amendments) to assist consistency of CXR reporting for suspected cancer referral. A link to this document can be accessed here.

3.16 How many CX1-CX3s will be generated are unknown, however implementation of the decision making tool for a trial period of 12 weeks will identify information to inform the approximate levels of direct access to CT capacity will be required.

3.17 Plymouth expects that patients who have a negative CXR and negative CT won't need to be seen by a clinician and therefore, there should be a reduction in 2ww clinic appointments.

3.18 The NOLCP is not mandated, however, we are looking at what we can do, and what can be achieved, if not all of it.

3.19 **Lynne Kilner** (PCA Programme Manager); Pre-referral work can be undertaken by the prevention/early diagnosis groups. Currently, all Trusts are under pressure to achieve the 62 day standard; where there are normal test results, patients will be discharged from the pathway.

3.20 It was discussed that where there are delays to surgery, patient performance status often deteriorates and that surgical resection rates are not yet optimal in the Peninsula.

3.21 Concern was raised that favouring the lung cancer pathway may lead to delays for patients on other cancer pathways-it was highlighted that work is being carried out across all cancer sites in the Peninsula.

3.22 It was noted that same day reporting may not be achievable for some trusts due to the variety of geographical locations in which CXRs are carried out.

3.23 AR encouraged attendance at the planning meeting on 10th October to strengthen joint working across the PCA.

4.0 **Recommendations from the RCS Visit**-Presented by Adrian Marchbank (Consultant Thoracic Surgeon PHT)

4.1 A review of lung resection services carried out at PHT was undertaken by the Royal College of Surgeons. It was recognised that the odds ratio of having resection surgery was 0.5 compared to the National Average. As a result of the review, PHT are keen to implement the recommendations of RCS:

4.2 The need for a prospective audit: Adrian will circulate a proforma in order to capture the relevant information. This will provide data to recognise if there are any difference across the 4 MDTs with regards to the decision making processes for patients who are anatomically a suitable candidate for surgery, but may not be physiologically resectable.

4.3 MDTs need to define what oligometastatic disease is as there is currently no standard definition.

4.4 AR refers to the PCA service recommendations and highlights that patients who are deemed unsuitable for surgery should be offered a second opinion (for further information refer to section 1.12 e (ii) here).

4.5 Information regarding the Spotlight Audit was briefly raised: for further information about the 2017 Spotlight Audit, click here.

4.6 It was noted that patients who are anatomically suitable for resection but whom decline surgical intervention are discussed at the high risk MDT.

4.7 **Action**: NK to liaise with Victoria Kennington to collect this information.

5.0 **Standardising Patient Pathways-**discussion led by Adrian Marchbank-PHT

Capacity at PHT is limited and the introduction of a "pooled" waiting list for surgical patients will need to be introduced.

5.1 There will also be an onco-cardiology pathway-a separate stream for which Adrian will send details on across the Peninsula.

5.2 There also needs to be a focus on choosing what investigations are most helpful before suitability for resection is discussed.

5.3 The North Bristol Trust MDT proforma was discussed and its suitability for use in the Peninsula discussed.

5.4 In circumstances where a patient cannot be seen at a local hospital within a specified timeframe, consideration was given as to the feasibility of that patient being sent to another hospital for certain investigations.

5.5 It was suggested that each site needs to look at the curative intent bundle (frontloading of investigations before surgical referral). Concern was raised about ordering unnecessary tests early on in the pathway and overloading services that are already stretched.

5.6 It was suggested that the only way for the NOLCP to work it to run tests in parallel; this could be trialled and audited to see if this method achievable.

5.7 However, concerns about resource issues (both diagnostics and reporting) were raised again.

5.8 **Action**: Adrian to write guidelines and circulate them; it may be that a separate group may need to be formed outside of the SSG to come to a consensus.

6.0 **Lung Nodules and CWT Guidance**

Reference was made to the recent guidance on Lung Nodules and CWTs. The recommendations have been written by the Lung Cancer Clinical Expert Group to address the 62 day wait, in particular, tracking lung nodule patients. The guidance has been written to try to set out an agreement to remove a set group of patients from the CWT list.

6.1 If this were to be followed, each trust will need guidelines on how to manage patients in the defined category.

6.2 The expert group agree that the identified cohort of patients should be taking off tracking.

6.3 Discussion arose about patients being referred to the fast track clinic via their GP in circumstances where the findings of the CT are clear and patients do not warrant referral.

6.4 A quality statement from the British Thoracic Society on the investigation and management of pulmonary nodules is pending.

Action: NK to circulate BTS quality statement to the group (when published).

7.0 **PD-L1 Testing**

PD-L1 testing takes one day to run and one day to read, and an average of 3 days from test until the report is ready.

7.1 In order to be cost effective a batch of 4-5 tests are needed before running; PD-L1 testing will inevitably lead to delays on the 62 day pathway because clinicians are dependent on the results to guide treatment.

7.2 The IT system used does not lend itself to e-reporting-the paper result has to be posted out. This archaic reporting method is something that needs to be addressed by the Alliance as a lack of supportive technology should not be a reason for delays in the patient pathway.

8.0 **Peninsula Research Update-**Presented by Julie Cunningham

Presentations slides available via the following links:

1. Lung and current recruitment vs target per speciality

8.1 Barriers to recruitment were discussed including;

The sub-speciality lead post is unfunded; clinical leadership is needed to drive the research agenda in the South West.

8.2 Boj Goranov expressed an interest in being the sub-speciality lead for lung across the Peninsula.

9.0 **AOB**

Due to the meeting over-running, it was agreed that the following agenda items

will be discussed at the next meeting:

1. Chemotherapy Guidelines.
2. Patient satisfaction survey results.
3. SABR update.

10.0 **Date of Next Meeting**

TBC