Peninsula Cancer Alliance

Meeting of the Peninsula Sarcoma Advisory Group

Thursday 31st November 2019

The Devon Hotel, Matford, Exeter

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 (to be ratified at the next SAG meeting)

Chair: Dr Toby Talbot (TT)
Consultant Clinical Oncologist, Royal Cornwall Hospitals NHS Trust

1.0 **Welcome and Introductions**

1.1 (Refer to separate attendance record).

1.2 TT conveyed his thanks to the group for their attendance and highlighted the focus of the meeting; to develop a single Sarcoma Advisory Group (SAG) for the Peninsula that aligns with the requirements set out in the draft (soon to be published) NHSE service specification.

2.0 **Genomic Laboratory Hubs and Genomic Medicine Centres:**

Guest Speakers: John McGrath (Deputy Director SW NHS Genomics Medicine Centre)**,** Ana Juett (Project Manager and Patient Involvement Facilitator) and Chris Wragg (Lead Cancer Scientist)

Please refer to the following presentation links for further information;

100,000 Genomes Project: "*Transforming healthcare through genomic medicine"*

Frequently Asked Questions

3.0 **Service Development**

3.1 TT advised that the date of publication for the finalised NHSE sarcoma service specification is expected to be announced imminently.

3.1.1 Following consultation, it is unlikely that there will be any material changes to the service specification and delivery components. It is anticipated that the commissioning framework will go live in or around April/May 2019.

3.1.2 In order to continue providing sarcoma services locally, the Peninsula will need to be complicit with the national service specifications, and due consideration must be given to the tasks required in order to provide a collaborative, cohesive and clinically effective service.

3.1.3 There will be an element of flexibility within the framework and certainly the

numbers of patients treated will not be as prescriptive; however, the service needs to be robust, well organised and must be able to demonstrate that clinical outcomes are line with other specialist sarcoma service providers.

3.1.4 Currently there are 2 Sarcoma MDTs; Truro and Plymouth (1) and Exeter (2). As the specification currently stands, this would require there to be 2 Sarcoma Advisory Groups; this is neither practical nor desirable.

3.1.5 TT highlighted a recent survey that found 5% of patients would not wish to travel to a distant service provider for cancer treatment; choosing no treatment over travel. This clearly infers potentially catastrophic patient outcomes if a sarcoma service for Devon/Cornwall cannot be agreed.

3.1.6 In order to meet the needs of our local population, the responsibility falls to the Peninsula to ensure that there is provision of a specialist sarcoma service that meets with the national requirements.

3.1.8 The first step is to agree on the amalgamation of the Exeter MDT with Plymouth and Truro; this requires aligning job plans so that all relevant MDT members are available to dial in on Tuesday mornings from 9am.

In addition, the SAG will need to agree on;

i. A service configuration, including designation of specialised and local sarcoma units.

ii. A list of all designated practitioners who may be involved in the delivery of planned care for people with sarcoma.

iii. Agreed network wide treatment protocols and patient pathways.

iv. The criteria for referral to the Sarcoma MDT, in line with the current MDT reforms led by NHSE.

v. Services at a local level; including clinical trial coordination, referral processes and access to genomic testing for patients undergoing surgery.

vi. A coordinated approach to the participation in national and local audits.

3.1.9 Hospital Managers need to facilitate the re-writing of job plans to ensure mandatory attendance of all relevant members at the Tuesday MDT (9am-11am).

4.0 Considerations (per specialty);

4.1 **Surgery**

4.1.1 It was proposed that under the direction of a single, united Peninsula SAG, there will be 2 surgical sites (Exeter and Plymouth).

4.1.2 Confirmation is needed as to the designated soft tissue sarcoma surgeons for Exeter and clear communication processes for service provision in the event of a shortfall in staffing through redeployment/sickness absence (at either trust).

4.2 Abdominal surgery was discussed; PS (Exeter Oncologist) advised that patient numbers for retroperitoneal surgery in Exeter are low (less than 10 cases /year) and the surgeon who usually undertakes this work is currently on leave. It was agreed that for now, these patients will be referred to Plymouth for surgery (PS to confirm).

4.2.1 Plymouth also undertakes around 10 cases/ year; consideration was given as to whether enough patients are treated to warrant a combined retroperitoneal service, or if patients should be referred out of area.

4.2.2 TT also raised the issue of bone sarcoma treatment and whether there needs to be a consist approach to the chosen referral site (Birmingham/Oxford).

5.0 Pathology

5.1 It was agreed that pathology needs to be undertaken by designated specialist sarcoma pathologists. PSd and CK (Exeter Pathologists) will continue to produce reports to send to KS and AO (Plymouth Pathologists) for presentation at MDT.

5.1.1 PSd will continue to report resection specimens.

5.1.2 Details as to pathology reporting processes will be written into the local SAG framework.

6.0 Oncology

6.1 No specific concerns raised.

7.0 Radiotherapy/ Chemotherapy

7.1 Consensus is required on pre- *vs* post-operative radiotherapy; there are differing opinions at bigger centres as to the best approach.

7.1.1 There is little controversy over chemotherapy treatment; complex patients will however require discussion.

8.0 Radiology

8.1 Exeter and Plymouth have slightly different diagnostic pathway approaches; both pathways can be accommodated as long as patient outcomes are of equal standard.

8.2 Support is required for Exeter to align radiology job plans; there are also finance and video imaging issues that will need to be worked though.

8.3 Radiology reporting was discussed, including whether images require a second check if reported by a specialist. There were differing opinions raised as to the need to send x-rays for review prior to the MDT.

8.4 **Action**: PS agreed to take the logistics of videoconferencing forward at Exeter, with the support of NK; other specific issues may require some scoping.

9.0 Summary of other matters arising

9.1 i. It was agreed that the joint MDT needs to be refined to ensure that only relevant patients are discussed. A joint MDT referral proforma may assist in filtering out patients that do not require MDT discussion; there may be benefit from piecing together a small working group to consider the proposed running order of the joint MDT.

9.2 ii. A trial run of videoconferencing needs to be undertaken in Exeter to ensure from a technological perspective that everything is in place to facilitate an effective dial in.

9.3 Tariffs: there is a need for greater clarification on how tariffs are raised between trusts: TT will approach commissioners for some clarification as to the funding streams.

9.4 **Action**: NK to liaise with PS and the MDTc at Exeter arrange a trial dial in.

9.4.1 **Action**: NK to contact SS (CNS-Exeter) to obtain a list of outstanding job plan issues and key contacts to facilitate resolution.

10.0 Research Update

10.1 Professor Rickard (NIHR Clinical Research Network: South West Peninsula Sub-Speciality Lead for Sarcoma) provided the group with an update on the portfolio of sarcoma studies; with a particular focus on

10.1.1

IMRiS (follow link for further details)

IMRis is a phase 2 trial which aims to assess the feasibility, efficacy and toxicity of Intensity Modulated Radiotherapy (IMRT) in three different cohorts of patients with primary bone and soft tissue sarcoma and to demonstrate whether IMRT can improve current clinical outcomes. The total recruitment to OMRIS across both sites was on target at 7 (the study has now closed to recruitment).

10.1.2 ISKS (follow link for further details)

The ISKS is a unique biological, epidemiological and clinical resource created to investigate the heritable aspects of adult onset sarcoma. Initiated in Australia, ISKS is now active at 23 sites across four continents and has recruited 2933 sarcoma probands and 2623 blood relatives. An initial analysis of 1111 WGS, reported this year at CTOS, has found a new potential genetic marker for Soft Tissue Sarcoma.'

Total Peninsula recruitment to ISKS is now 72 and the study remains open in Plymouth.

10.2 Dr Duncan Wheatley is the NIHR Clinical Research Network South West Peninsula Cancer Cluster Lead.

11.0 AOB

11.1 It was agreed that Living With and Beyond Cancer will be discussed more fully at

the next SAG meeting, to facilitate cross site representation and progress reports.

11.2 Next meeting date: TBC

Summary of Actions

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