Meeting of the SWAG Network Oesophago-Gastric Cancer Clinical Advisory Group
Friday 8th December 2023, 13:00-17:00
Hotel Du Vin, Narrow Lewins Mead, Bristol, BS1 2NU / via MS Teams

Chair: Mr Paul Wilkerson

REPORT	ACTIONS

1. Welcome and apologies

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

The aim is to hold the meeting in different areas across the SWAG region. As the last meeting was held in Taunton, it is hoped that the next will be held in Bath.

2. Review of previous meeting report and actions

2.1 Development of record of dysplasia treatment booklet:

Additional information and diagrams have been included on Endoscopic Submucosal Dissection (ESD).

Action: The booklet will be sent to the patient information team for ratification. **P Wilkerson**

2.2 WesFit trial results:

The WesFit trial team are willing to provide a presentation at a future meeting.

Action: To arrange presentation at a future meeting **H Dunderdale**

2.3 National Oesophago-Gastric Cancer Audit (NOGCA) outputs:

Review of emergency admissions needs to be rolled to a future meeting.

An audit of outcome data in relation to neoadjuvant chemotherapy outcomes, proximal margins and patient selection criteria is underway, lead by Consultant Oncologist Tom Bird.

Action: Results will be reviewed at the next meeting. **T Bird**

2.4 Review of Cheltenham's streamlined pathway using combined contrast CT and PET immediately after diagnosis as a single staging intervention:

The published paper from Cheltenham has been shared and discussed briefly with radiology colleagues; further discussion needs to take place.

Action: To ensure radiology colleagues and providers of PET are available to attend the next meeting to discuss combined contrast CT/PET. H Dunderdale

2.5 Employment of genomics navigators, as recommended by the Genomic Medicine Service Alliance (GMSA):

This has not progressed to date.

2.6 Potential solutions to facilitate Somerset Foundation Trust (SFT) Service considering the significant workforce shortages:

Previous discussion involved seeing if it was feasible for the UHBW team to order surveillance tests within Musgrove and to develop an adapted service specification to help inform a business case for appointing additional gastroenterologists.

Action: OG CAG to support workforce planning in Musgrove P Wilkerson / All

3. Research

3.1 NIHR Clinical Trials update

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Oncologist Sharath Gangadhara and Research Delivery Group Manager Claire Matthews

National clinical trial recruitment from April 2023-November 2023 shows that 5,854 patients have been recruited to Upper GI cancer trials across 18 research networks. In 2022/23, 8,948 patients were recruited.

The majority of trials this year are non-commercial and observational, with only 3.9% commercial and 11% interventional this year.

Participation in commercial trials is low in comparison with other cancer sites and needs to be promoted.

Research activity bounced back in 2023/24 following the pause caused by the COVID-19 pandemic and has now returned to pre-pandemic levels.

The majority of studies open and recruiting are in the BHOC, followed by GRH and SFT; data from the RUH is missing. The full list of trials open and in set-up will be circulated.

HERIZON is just about to open and will be recruiting HER2 positive patients with locally advanced and metastatic gastroesophageal adenocarcinomas to compare the safety and efficacy of zanidatamab plus chemotherapy with or without tislelizumab. To optimise recruitment, it would be ideal if the HER2 result is made available at the time of MDT discussion.

ROSE study has been in set-up for over a year as there is an issue with the electronic symptom measuring device.

SARONG (Surveillance After Resection of Oesophageal aNd Gastric cancer) is a randomised controlled trial to establish if routine surveillance guidelines would improve overall survival and quality of life by comparing standard care (where scans are triggered by symptom changes) with intensive surveillance, including chest and abdomen imaging every 6 months for 36 months.

As the aim is to pick up asymptomatic recurrences earlier on, the consent process needs to include how early recurrences will then be managed, ideally with consensus from the oncologists across the region.

It may not be possible to offer the opportunity to consent to the trial with equity across the region due to restrictions with radiological resources.

The patient information leaflet would need to be given to the patient by the surgical team prior to their discharge post-surgery.

A similar trial had significant drop out due to the anxiety caused by waiting for scan results.

Patients randomised to the surveillance arm will need to travel to Bristol for the images.

There is significant work underway to launch cancer vaccine trials to boost patients' immune responses in the early and advanced settings. The infrastructure to support development of the vaccines has been made possible following development of the COVID-19 vaccine. There are several centres across the country that have set up a Phase 1 vaccine for solid tumours with a high mutational burden, which will branch out to additional cancer centres soon. A Phase 2 trial is also available for pancreatic cancer following resection.

Neoadjuvant studies have now progressed 5 year overall survival rates to 45% with implementation of FLOT-Surgery-FLOT, requiring further investigations with targeted treatments. A list of the main trials underway that include anti-HER2 agents is documented in the presentation.

The Japanese Phase 2 trial EPOC2003 is of particular interest as this has shown 50% major pathological response rates in a third line setting; it is hoped that this will open in Cambridge.

Action: To aim to obtain HER2 status upfront in the patient pathway. **OG CAG**

PICOSS is a Phase 2 trial of Pressurised Intra-Peritoneal Aerosolised Chemotherapy (PIPAC), open in Cardiff and Vale and planned to open in RUH, for visible measurable peritoneal metastases in patients with a primary diagnosis of adenocarcinoma. The full inclusion and exclusion criteria are within the presentation.

Chemotherapy is aerosolised via one of the ports during a staging laparoscopy. The intervention arm will reduce the overall cycles of SACT. The challenge will be in identifying measurable lesions which is part of the inclusion criteria due to the investigators caution with implementing this new procedure. It will result in an additional 3 general anaesthetics and, as such, is only suitable for young fit patients.

A Phase 2 trial for solid tumours expressing the Claudin protein is due to open in the UK at some point soon.

The NIHR 6-month Associate Principal Investigator (PI) scheme is still open to any interested clinician who doesn't have research in their current role. It allows associates to work alongside current PIs on studies (as documented in the presentation) signed up to the scheme.

Any PI interested in getting help from an associate while helping their personal development is to get in touch.

Results from the National Cancer Patient Experience Survey 2022 show 44% of OG patients responding to Question 58, 'Cancer research opportunities were discussed with the patient'.

This is most likely due to the number of patients eligible for trials and could also be related to how the question is interpreted.

Feedback from patient representatives is to let them know that they have been considered for research trials, but there is nothing available at present.

A website is now available where patients can proactively register their interest in participating in research and there is also e-learning for staff to help facilitate research conversations: https://learn.nihr.ac.uk/.

Results from the Participant in Research Experience Survey are documented within the presentation.

The second cohort of the Principal Investigator Pipeline Programme (PIPP) to support research nurses, midwives and dentists to become PIs, is due to commence in March 2024.

The Clinical Research Networks (CRNs) are transitioning into Research Delivery Networks (RDNs) to reflect that there are increasing amounts of research in non-clinical settings. The primary purpose of the RDNs remains the same: to support delivery of high quality research and increase the capacity and capability of future research. The networks are dropping from 15 to 12. The West of England will expand to include Dorset and Salisbury and will be renamed South West Central.

NIHR website links and team contact details are available within the presentation.

4. Patient experience

4.1 CNS update / Treatment Summaries

Please see the presentation uploaded on to the SWAG website

Presented by Clinical Nurse Specialist Ruth Harding and the CNS Team

Treatment summaries had initially been drafted prior to the pandemic and are now being revisited to ensure that all the correct clinical information is included.

Provision of the summaries was first proposed as one of the national mandatory deliverables included in the Cancer Survivorship Initiative (the initiative is now called Personalised Care and Support) which also includes implementation of Holistic Needs Assessments (HNA's) and Health and Wellbeing events.

Cancer Support Workers have since been appointed and routinely complete HNA's for all cancer patients.

Health and Wellbeing events are now arranged and also include support days for patients with advanced cancer.

An initial meeting, held with Lead Cancer Nurse Ruth Hendy, PCS Programme Manager Catherine Neck, CNS Ruth Harding and CNS Jo Price, has now relaunched the Treatment Summary work to ensure this is available in line with the other cancer sites.

Challenges include gaining consensus on the content across the region, where it is stored on patient information systems; assistance from IT is required to facilitate this, and to decide who is tasked with its completion.

Initial drafts are shared for the opinion of the group, which include a separate surgical and palliative version.

A section on potential Late Effects and Alert Symptoms to prompt re-referral is included, as are the follow up schedules, key contacts, and ongoing responsibilities for the patient's General Practitioner (GP).

Summaries for oncological treatments are already provided by the BHOC team.

The proposal for the content of the summaries, which are in addition to the standard discharge letters, has come from GP representatives.

It could be made into a standardised template to attach to the more personalised discharge letters, which already routinely contain the majority of the information required.

GP feedback is that the summaries are vital to facilitate completion of the patient's cancer care reviews, which are supposed to be completed one month after the patient has been discharged.

Advice from the Lead Cancer Nurses is to address the summaries to the patient with the GP copied in.

The colorectal team have a blank template that can be shared to help inform the structure. This is usually provided after the first follow up appointment.

4.2 National Cancer Patient Experience Survey (2022)

Please see the presentation uploaded on to the SWAG website

Presented by Lead Cancer Nurse Elli Hanman

The main aims and objective of the survey are to monitor national progress on the experience of cancer care to drive local quality improvements.

It is sent to patients who have had an inpatient or day case episode associated with a diagnosis of cancer and is not sent to patients that are managed as an outpatient. This is less relevant to the OG patient population, but a significant number of patients are not captured for other cancer sites.

It also needs to be considered that the 2022 results are received in Summer 2023 and are therefore a year out of date.

Overall response rates across SWAG are good, with 58% of patients returning the survey.

Further analysis is underway to look at response rates by patient characteristics. In particular, there is a high number of patients who do not record their ethnicity and work is underway to try and resolve this.

The results from SWAG should be celebrated as a good news story, with the overall experience of care matching the mean across England at 8.9/10 and no scores falling below the expected average.

For Upper GI, approximately 50% of results were above the average for all cancers, with the highest score found in the hospital care and treatment sections.

Lowest scores were noted to be in the 'finding out you had cancer' and 'deciding on treatment options' sections. Teams can analyse their individual results to explore these further, with question 15 'patients were definitely told their result in an appropriate place' being a potential starting place, along with question 21 'patient was definitely involved as much as they wanted to be in decisions about their treatment'; and question 22 'family and/or carers were definitely involved as much as the patient wanted them to be in decisions about their treatment options'.

Trusts should also get free text comments from patients which are usually more helpful in informing areas for potential service improvements.

Ideally, alternative initiatives should be undertaken to capture further information on the patient experience.

Question 15 may relate to the need to convey that there is a suspicion of cancer following endoscopy prior to arranging for the patient to proceed on to a CT.

The move towards faster diagnostic pathways, where investigations, diagnosis and treatment decisions are aimed to be arranged on the same day, has the potential to have a negative impact on the patient experience. Patients' expectations could be managed by including in clinic letters the information that the results of the first investigation may trigger another one to be arranged on the same day.

The results will include patients admitted as an emergency and told about their diagnosis in the ward environment. The clinic environment has also changed post COVID, having reduced in size.

5. Clinical opinion of network issues / MDT service

5.1 MDT meeting reforms

Presented by Consultant Oesophago-Gastric Surgeon Dan Titcomb

A meeting of UHBW Cancer Leads and the new Cancer Clinical Lead, Rachel Cox, convened last week for the purpose of promoting the need to address the imbalance of underinvestment in cancer services, in terms of estate, equipment and staff, that has occurred over the last 13 years.

The group unanimously recommended that a specialist in cancer should be appointed to lead on the improvement project so that the Trust can recover its former reputation as an internationally renowned centre of excellence. All current managerial leads are non-cancer specialists. It is expected to take some time for the service to be optimised.

Following on from the previous anonymous MDT meeting survey results, there were three suggestions for restructuring the meeting:

- For all OG surgeons to attend
- To protocolise cases, embed genomics and clinical trials
- To add Yeovil cases at an earlier time slot.

As existing work schedules would make it impossible for all of the OG surgeons to attend the meeting, it is instead agreed that a minimum of two surgeons will attend.

Protocolising cases, embedding genomics and discussion of clinical trials is work in progress. At present, the majority of genetic tests are being outsourced due to the current workload pressures in pathology, which is why these are often not available in the initial MDT discussion.

Traditionally, the Yeovil slot was scheduled at the end of the meeting to allow for travel time. Now that virtual attendance is possible, an earlier slot has been arranged.

Arranging time for the trainees to prepare and present at the MDT is challenging as there are only three trainee places, not all of them are cancer related roles, and the rota means that there is usually only one present on the day.

At the meeting of the Cancer Leads, the Radiologists also raised the problems relating to accessing images and other IT related issues. Export of images from other centres is still a huge ongoing problem. An additional meeting is being set up to try and address these concerns.

A West of England Imaging Network has been formed to try and influence the Trusts to sign up to the same PACS system across the region. Every radiology department across the region has agreed to this apart from UHBW, where there are still some obstacles to resolve.

Somerset CNS service has recovered to sufficient numbers, however, the shortage of Gastroenterologists has yet to be resolved.

The quality of patient centred MDT discussions can deteriorate in the latter part of meetings due to the intensity of the workload and the subsequent cognitive fatigue, as demonstrated in a recent meeting of the MDT Cancer Leads. This is less apparent in the OG MDT than in some of the other cancer MDTs.

HPB MDT have managed to improve this by introduction of an additional local MDT in NBT, which is managed by a Consultant Hepatologist and, after negotiation with the Cancer Lead, further investment in the OG Cancer Service is expected, including additional CNS time; there are now 2 CNS's in place, which works well, and an additional CNS will shortly be joining the team. A Consultant Lead for OG in NBT has yet to be identified.

It may be helpful to draft guidance on the role of OG Lead in the tertiary centres to clarify the responsibilities that will be provided by the surgical centres and those that the tertiary centres are expected to undertake. The majority of support is coordinated by the CNS teams, and the Consultant Lead requirement is to provide clinical support in the event of unexpected events. However, it could be challenging to create guidelines due to the different service models in each centre.

With the recent appointment of a joint CEO for the two Bristol hospitals, further changes are expected and arrangements between the two Trusts may need to be revisited once the plans are publicised.

In the interim, NBT Cancer Clinical Lead Martin Plummeridge is negotiating with the UGI surgeons and Gastroenterologists for the responsibility of the patient (in name only) to sit with the clinician

identifying the malignancy until they are formally handed over to the surgical team. This is to ensure that the CNS has a point of contact to request any tests required.

Increasingly, GPs are referring patients directly to outsourced endoscopy units. It has been agreed that patients referred with a malignancy to UHBW from Emerson's Green become the responsibility of the Consultant on call on that day.

GPs within NBT catchment area tend to refer to the Prime endoscopy unit in Bristol City Centre. The responsible Consultant in NBT (in name only) for patients referred with a malignancy also needs to be defined so that the CNS team have access to supervision should a problem arise.

The OG MDT Standard Operating Procedure will be reviewed and updated to include any streamlining initiatives where appropriate.

Action: Cancer Manager H Marder will send the most recent version of the MDT SOP to Consultant Surgeon Dan Titcomb **H Marder**

6. Service developments

6.1 Round table review of recent and future developments and challenges in each site

RUH:

There will be some changes regarding ownership of patients in the coming months. Plans are underway to ensure that the CNS team have seamless support; the CNS team has now increased in numbers in recognition of the workload.

HPB colleagues have started attending the MDT meeting again after pausing during the pandemic; this has been very helpful.

NBT:

Permanent funding has been sourced for the additional full time CNS which will allow the team to provide patients with continuity of care throughout the whole patient pathway.

SFT:

Consultant Gastroenterologist Tim Jobson has stepped down from the role of OG Lead, and been replaced by Consultant Gastroenterologist Tom Johnson. Three new Oncologists have also been appointed and, as mentioned earlier, the CNS team is now complete and they have received training to request imaging.

UHBW:

The CNS team will be at full complement soon, and then it is planned to restart nurse-led clinics for delivering diagnoses and follow up, including palliative and stenting follow ups. All the CNS team are trained in Physical Assessment and Clinical Reasoning (PACR) and have recently updated the training required to request imaging; a member of the team has also completed a prescribing course.

Unfortunately, funding for the Enhanced Supportive Care Service based in BHOC has been withdrawn; this had been helpful service for the patients on a Best Supportive Care pathway.

Robotic Surgery has commenced with simple benign operations, 20 of which require completion to sign off the relevant competencies. This is having an impact on theatre capacity for cancer but will be undertaken as soon as possible so that cancer can then be booked back on to every list. A second period of training on cancer operations will then commence. It is expected that a start date for robotic cancer operations will be known by the next meeting.

Consultant Surgeons Paul Wilkerson and Ben Byrne have completed training to perform ESD, which is currently provided by Consultant Gastroenterologist Efstratios Alexandridis. Further cases need to be undertaken alongside Efstratios to finalise competencies. As the theatre rota is booked one year in advance, it has been difficult to arrange in 2023, but the 2024 rota will be redesigned to accommodate this. In the interim, expectations need to be managed regarding the waiting list for patients recommended for the procedure, which has recently increased. Patients can be referred to alternative units, such as Southampton or London, if the waiting time is felt to be unacceptable.

The MDT will not compromise on offering an alternative procedure if ESD has been decided as the most appropriate treatment.

Waiting times should be resolved towards the end of 2024 when it is hoped all three Consultants will be ready to undertake the procedure.

Tertiary colleagues are also asked to manage patient expectations on attending Bristol for their pre-operative assessment. Although it is recognised how difficult it is for patients travelling from outside Bristol, they need an early slot to accommodate all the requirements of the one-stop clinic and patients should be prepared to be there for the majority of the day.

7. Any other business/agenda of next meeting

The agenda of the next meeting will include a section on neoadjuvant treatment and margins.

Radiologists will be encouraged to attend to discuss CT contrast PET.

Support to further develop the dietetic service also needs to be revisited.

A list of young patients with oesophageal cancer has been sourced for the purpose of identifying potential ways to streamline the patient pathway.

Action: To agree the relevant data fields to collect and allocate a trainee to help with the data collection.	**H Dunderdale/D Titcomb/P Wilkerson**

Date of next meeting: Cancelled due to GIRFT visit – Autumn/Winter date to be confirmed.

-END-