Somerset, Wiltshire, Avon and Gloucestershire (SWAG) Cancer Services

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

Tuesday, 14th May 2024, 10:00-15:30

DoubleTree by Hilton Bristol North, Woodlands Lane, Bradley Stoke, Bristol, BS32 4JF / MS Teams

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 Report and Actions	
As there were no amendments to the report from the previous Lung CAG, held on Tuesday 7th November 2023 the report was agreed as finalised.	
From the Work Programme:	
Development of a SWAG Lung Cancer Patient Experience Survey. The Cancer Alliance have been contacted to see if any funding or administrative support could be made available for this purpose.	
Break-out meeting for the Clinical Nurse Specialists to share regional practice. These day-long educational events have yet to reconvene, but there is the appetite to do so.	
Action: CNS team to meet up in the next 6 months	**CNS Team**
Production of a NSCLC neo-adjuvant treatment Standard Operational Procedure (SOP). A draft SOP has been circulated by CNS Sara Gomez. Once finalised, this will be saved in a place that is accessible to all in the region.	**S Gomez**
3. Patient experience	
3.1 Clinical Nurse Specialist update	
Somerset Foundation Trust (SFT) are making progress with the nurse-led surgical follow up clinics and plan to formally commence them in September 2024. Thanks were given to the CNS team in UHBW for sharing all the necessary policies and guidelines. No extra funding has been allocated to get the clinics underway so it will involve reducing CNS attendance at the MDT meeting from 2 to 1, and readjusting schedules wherever possible.	

The team are participating in the Phase 3 circulating tumour (ct) DNA trial run by the Royal Marsden.

An additional CNS has been appointed to the team in UHBW, as has a lung cancer tracker to help coordinate the neoadjuvant pathway and organise CT scans at the earliest available opportunity for patients referred from across the region.

RUH are also involved in the Phase 3 ctDNA trial. It has not been possible to commence nurse-led surgical follow up clinics at present, but SABR follow-up has been established. A Consultant Thoracic Surgeon has a clinic on site, which allows patients to be seen within a rapid timeframe.

Now that the new Dyson Cancer Centre has opened, there are more efficient hospital information systems that can automate letters saving administrative time.

YDH site has two Systemic Anti-Cancer Therapy (SACT) CNS prescribers, and some pharmacists are also undergoing training to prescribe SACT.

Taunton site has SACT CNS prescribers, but they do not have lung cancer in their job plans at present.

Both Band 6 and Band 7 CNS's are currently undertaking extra clinics that used to be the responsibility of the Consultants. It was suggested that the banding should be made uniform and the level of experience be properly recognised.

The CNS teams in the District General Hospitals need to work autonomously at times as there is no thoracic centre on site, although the advice available from the UHBW surgical team is always appreciated.

It was not possible to arrange for existing Band 7 CNSs to solely manage the clinics as this would result in delays to the patient pathway when on leave, plus it was important to upskill the Band 6 team.

4. Coordination of patient care pathways

4.1 Targeted Lung Health Checks Programme (TLHC)

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Respiratory Physician Anna Bibby

National TLHC activity shows the number of lung cancers diagnosed increasing month on month, totalling 3,000 to date, with those diagnosed at an early stage meeting the NHS priority of 75%. Diagnoses now exceed pre-COVID rates and health inequalities have been reversed, as demonstrated by the deprivation quintile, which shows that the majority of diagnoses are in the lowest socio-

economic population.

For the SWAG region, TLHC started in Bath in July 2022, and then moved on to Bridgewater, North Bristol and then Central and South Bristol.

The total number of cancers found is 52 to date, 29 of which have been found at an early stage, again hitting the 75% target.

In addition, some renal cell, myeloma, lymphoma and colorectal cancers have been identified, plus incidental findings of other diseases.

Any abnormality is discussed at the Screening Review Meeting (SRM), including nodules. This is time consuming but allows the team to downgrade approximately 11% of the findings based on previous imaging and clinical history, saving downstream resources.

Separate to nodules, 583 other actional incidental findings have resulted in referrals to other disease specialists.

Discussions are underway about the referral pathway for aortic valve calcification due to pressures on cardiac services.

Standardised letters have been drafted for patients and GPs to report other findings with advice for ongoing management.

Risk scores can be calculated using the TLHC information system.

Smoking cessation support is offered to all smokers seen in the programme, which is 3334 people, 127 of which have been successful at stopping to date (this excludes the Bristol data).

The TLHC programme has had research embedded from the start and is participating in recruiting patients (over 3500 to date) into the Oxford DART trial of Artificial Intelligence, which is looking at developing techniques to analyse images that will hopefully inform the future screening programme.

SCOOT is a sub-trial involving biomarker testing. This has only recruited in NBT due to resource reasons.

An NIHR fellowship is in progress to look at improving participation in trials and Dr Bibby is also collaborating with the University of Bristol on epigenetic biomarkers and the Tobacco and Alcohol Research Group (TARG) to drive opportunistic delivery of smoking cessation.

Funding has been granted to a research fellow who will start in August 2024.

The majority of feedback on the service has been very positive. There were two negative comments. One was about the wait between the scan and reported outcome being too long; this is

usually provided within 4 weeks. The other comment was from a patient who did not get a scan following the initial health check, when they thought that they would have been eligible.

The TLHC will now expand to invite 360,000 people in the SWAG region who are over 50 who have ever smoked over the next 5 to 6 years.

It is anticipated that this will identify a further 3,500 cancer cases.

There have been some delays with the expansion due to the need for contracts to change as the SWAG Cancer Alliance has moved to NBT, but this is now back on track. There will be three scanning trucks roving across the Primary Care Networks.

At present, the BNSSG SRM discuss all cases, but this will split as the service expands into an SRM based in Somerset, and then others based in BSW and Gloucestershire.

Downstream modelling has also been undertaken for local services to assess where extra resources are going to be required.

A number of bottlenecks need to be addressed, including the number of SRM dedicated staff to process the large number of cases coming through. Although there are responsible Respiratory Physicians in each Trust, each also needs a deputy to provide cover. More radiology workforce is also required, but there are insufficient numbers across the region. Downstream therapeutics, in particular thoracic surgery and downstream diagnostics, especially radiology, also present challenges. Further push-back on the management of incidental findings is expected as this increases. Collegial working is vital to ensure that appropriate pathways are developed with relevant specialties.

Discussion:

Screening is expected to reach a steady rate after 2029, following the initial bulge in baseline scans and 2 year follow up scans.

In-Health provides administrative and nursing staff to support the SRM and will recruit additional staff as the programme expands.

The SRM works like an MDT with In-health preparing a colour coded list of the abnormalities found. The radiologists will look for previously reported imaging and then each case will be discussed. All outcomes are protocolised and generate template letters, which then transfer the care to the receiving Trust. Any suspected lung cancer also triggers a phone call to the relevant CNS team and a request for the next required test, streamlining the patient pathway.

Core membership of the SRM is the Radiologist, Clinical Lead, Local Clinician and In-Health Coordinator. When the SRM splits, Dr Bibby

will be available for the first meeting to familiarise the new team with the Standard Operating Processes (SOPs).

Patients with emphysema are advised to seek help from their GP if they don't already have an inhaler and have spirometry undertaken in the community.

The TLHC programme stopped spirometry during the pandemic and has not restarted this because emphysema is not a disease that can be screened as early interventions do not improve outcomes. Research is underway to further define how other respiratory disease should be monitored.

The majority of lung cancers occur in the deprived population, there is therefore a need to disproportionately offer TLHC to this population for equity to be achieved. Once the deprived areas have been served, TLHC will move to less deprived areas.

The prison population will also be targeted.

Targeting the homeless population is complicated due to the higher likelihood of other conditions that may preclude active treatment. TLHC have been working with Homeless Health in Jamaica Street Bristol to discuss holding a dedicated day to screen eligible people in collaboration with key workers, with the TLHC screening van available on site. A similar approach had been arranged by the Brighton TLHC team, with very little pick up rate.

Once the service is more established, particular pockets of underserved populations will become a focus; this will also include patients in psychiatric care and traveller communities.

There are some Trusts where a large proportion of patients come from more affluent communities. Data on local cancer prevalence is also used to inform focus areas and has been included in the metrics developed by Project Manager Hassan Amjad.

Local knowledge is required to advise on ideal Truck locations.

The limitations of screening need to be recognised as there will be patients who are scanned and still present with advanced small cell disease between follow up scans.

Although everything is in place to mitigate the risk of missing a cancer, this is a possibility with any screening programme. All participants need to be made aware via the consent process that screening does not equate to having a clean bill of health, and should still present to their GP should red-flag symptoms develop.

A Multi-Cancer Blood Test (MCBT) is under development. There are concerns about the number of false positive results that this can generate. If the test is found to be positive for lung cancer but no cancer is visible on a scan, six month surveillance by the TLHC has

been suggested as a solution; this would need to be negotiated with In-Health.

1. Quality indicators, audits and data collection

5.1 SWAG Cancer Alliance update

Please see the presentation uploaded on to the SWAG website

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

As discussed in the previous meeting, SWAG elected to prioritise three workstreams from the Getting It Right First Time Peer Review, including an overall radical treatment rate of 85% in early stage cancer, monitoring multimodality treatment in stage IIIA disease and offer radical intent treatment as standard in fit patients, and commencing radical treatment by day 49 of the overall National Optimal Lung Cancer Pathway (NOLCP) plus for surgery, thermos-ablation or radiotherapy, treatment should commence by day 16 after the decision to treat in line with NOLCP.

These high level targets can allow Trusts access to funds from the Cancer Alliance for any related projects.

Monitoring progress is reliant on good quality data collection. A previous attempt to collect data on the pathway had been unsuccessful. Since then, Roche has developed a pathway analyser tool that can be embedded into Trust Hospital Information Systems. This has now been set up in all SWAG centres aside from RUH, although RUH are submitting data to the Cancer Alliance from other systems.

Business Intelligence (BI) teams can set up search queries using the tool, with assistance from Roche, so that the data collection can be pulled from numerous systems into the spreadsheet, which automatically generates outputs. Clinical input is required to ensure that the data quality is correct.

Once optimised, the analyser will enable teams to identify areas where improvements could be made to meet the optimal lung cancer pathway milestones.

The first iteration from Gloucestershire Hospitals shows that the data quality requires improvement. There were some obvious gaps, in that it hadn't recorded all CT scans or EBUS procedures. Gloucestershire uses Infoflex, which has many text box input options that would not be possible for a BI search query to interrogate.

The analyser has started to provide the times in between tests.

BI are now going to link the analyser with the endoscopy, imaging, and pathology systems to see if it can be improved and made meaningful.

The initial set-up between ROCHE and BI took half a day. Having good engagement from a BI analyst is essential for the project to work and, once set up appropriately, can be updated by the press of a button.

The analyser can be updated to measure additional metrics in the future. This should help Cancer Managers with their workload as they have to collect the data from other sources for regular submission nationally.

Action: Clinical teams need to work with BI to set up the pathway analyser tool. **Lung Cancer Clinical Leads**

Discussion:

The analyser is expected to take a lot of time to optimise, and it may be challenging to get BI to prioritise over other projects. Ideally, funding would be provided for dedicated time to improve the data extraction processes.

The analyser has already been set up to extract data from Infoflex and SCR, but further work needs to be undertaken to get information from other hospital information systems.

Bottlenecks in the pathway are generally well known, for example, most recently with surgical capacity, or the number of two week wait slots. However, having details of the number of delayed scans for example, would be useful to inform business cases.

Action: MDT Lead Andy Low will look at data from the analyser on scan delays in UHBW. **A Low**

Accurate data is available in RUH due to the spreadsheet used to map each patient's pathway. This is populated with data collected by the Lung Cancer Navigators and reviewed in quarterly service meetings.

5.2 Multi-Cancer Blood Test (MCBT) Pilot

A pilot of the MCBT was discussed. This project has been paused and will be discussed again when further evidence of the test's benefit is available.

5.3 BRI Surgical Service update

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Thoracic Surgeon Igor Saftic

The surgical service has recently reduced what had become a significant backlog of work. This was achieved following numerous meetings with management teams to negotiate additional capacity. Further work needs to be undertaken to further reduce waiting times, which have slightly risen according to recent data, although this was due to patient choice.

Recovery has been achieved by extending the theatre lists until 8pm on Mondays and Wednesdays, extra access to robot time, GLANSO Saturday lists, an additional 4 lists per month to accommodate the new Consultant, and rearranging Consultant Job Plans.

For Theatres, emergency capital was granted to buy an extra 8 sets of VATS instruments, which is important due to the increasing number of segmentectomies being performed, and something that the team have been trying to get for many years.

A business case is being written to try and get 3D operative preplanning equipment to decrease length of stay and intraoperative time, in line with European Guidelines.

Robotic surgery does appear to be reducing length of stay, but the data is not ready to present as of yet. The first 56 cases have been performed with no major issues.

Powered staplers have been trialled as well, which lower the rate of complications and again, should reduce length of stay.

Navigational Bronchoscopy is currently at approximately 60% of diagnostic yield as there is no C-Arm time attached to it. It is hoped that this will be re-considered to improve the diagnostic yield, and an increase in cryo-biopsies will follow. It is also hoped to introduce laser technology next year for endobronchial procedures.

Action: To add provision of 3D Operative Preplanning Equipment, C-Arm time for Navigational Bronchoscopy, and Laser Technology to the Lung CAG Work Programme. **H Dunderdale**

It is planned to restart Lung Volume Reduction Surgery (LVRS), which has agreement from the Division. This was stopped during the COVID-19 pandemic and then not restarted due to the problems

with capacity. As thoracic surgery was the only surgical specialty restricted from commencing benign workload following the pandemic, it will be of great benefit to restart and to evolve to provide other thoracic procedures as well.

The team has grown and has appointed an additional Lung Cancer Clinical Nurse Specialist and a Lung Cancer Navigator. Interviews have been undertaken to employ an Advanced Nurse Practitioner but has now been readvertised as the successful candidate declined the role.

There are 6 doctors in training who are soon to be employed. Another 3 positions have been advertised which have received a high number of applicants. There are now 6 Consultants, including 1 Locum who it is hoped will be made permanent next year. Ward capacity has also been increased from 15 to 25.

It is planned to implement surgical nurse-led follow up with parity across the region so that surgical time can be reallocated.

An additional robot will be made available in 2025 and another list will be added for Thoracic Surgery when the elective centre is opened in NBT. There was a suggestion to move Thoracic Cancer Surgery to NBT, but a letter had been sent from the Respiratory Physicians, Surgical Team, Anaesthesiologists and Oncologists outlining why the service needs to stay in the BRI, and this has been accepted.

It is hoped for more unification of service to further try and streamline the patient pathway, such as seeing the patient in clinic straight after MDT review.

Discussion:

Lung CAG have noticed the reduction in waiting times and are thankful for the efforts that have been undertaken to process the backlog of patients.

To move away from the requirement for Saturday lists, each Consultant needs to be able to have 2 lists in the week so that the centre is comparable with others across the UK.

It is hoped that the service will move away from a reactionary phase to a visionary pre-planning phase in the future as it is not possible to sustain the extra service provision over a long period of time.

There is a need to bridge the gap between clinical and managerial teams so that there is better understanding for the service requirements.

Hopefully the extra lists will be able to absorb the extra workload that will come via expansion of the TLHC programme, however, the service needs to grow as a whole.

Action: To explore provision of a joint surgical and oncology one stop clinic for locally advanced and SABR patients.	**To be allocated**
Action: To reduce the gap between MDT and patient clinic, ideally to occur on the same day.	**Igor Saftic/MDT Team**

The patient could then be listed for surgery and a Pre-Operative Assessment Clinic (POAC) on that day.

Reducing the number of frozen sections to increase theatre through-put and replacing this with a difficult biopsy service was recommended.

Robotic surgery has resulted in an increase in piecemeal resections of nodes which can affect interpretation of extracapsular extension when planning radiotherapy. This should be included in the consent process as a possible outcome and the oncology team need to agree how these patients should be managed.

Acton: Surgical and Clinical Oncology colleagues to meet outside the meeting to discuss piecemeal resection of nodes further.	**Surgeons/Oncologists**

As long as there are no complications, nurse-led surgical follow up could consist of one appointment; follow up thereafter can be radiological, with a clear CT surveillance scan generating a letter rather than an appointment.

Action: To form a working group to define regional surgical follow up protocol.	**H Steer**

Action: To investigate re-starting virtual POAC for low risk patients in regional centres **To be allocated**

If there is confidence in a radiological diagnosis of cancer in one segment, the surgical team will proceed to segmentectomy without the need for a CT guided biopsy. If more than one segment is involved or there is lower lobe involvement, then a biopsy will be arranged. The BRI team are providing international training in segmentectomy due to the maturity of experience in this procedure.

5.4 Pathology Activity

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Pathologist Jon Potts

There has been a significant increase in the thoracic resection workload.

It has been projected that there will be 364 extra resection cases between January 2024 to April 2025 in addition to the 700 cases usually processed over the same time period following the increase in cases from the TLHC programme, and also because of the recovery work.

As well as the workload increase, there is also a workforce shortage, with the 10 vacant pathology posts, and difficulties with recruiting and retaining laboratory staff.

This has impacted on surgical resection turnaround time, which had increased from 2 to 4 weeks and so reports have not been ready in time for post-operative clinics.

Reflex requests for molecular testing have also increased which creates additional administrative steps for each patient, and the referral process to genetics is not straightforward.

A business case has been drafted to recruit a 4th pathologist (incentives are being offered). However, Southampton have had an extra post approved to manage the TLHC cases which has been out to advert for over a year, but they have been unable to recruit due to the national shortage of pathologists.

Administrative support has been requested to help process the molecular testing requests.

The training programme has been expanded with 8 trainees recruited for the next year.

A business case for two extra posts had been rejected as the department is currently in debt.

A significant increase in biopsy rates has not been seen to date but is expected.

It is hoped to avoid a delay in diagnostic biopsy turnaround time but, should the team fail to recruit additional staff, this may be unavoidable, although these are always prioritised.

Reduction in the number of frozen sections would be helpful. Although smaller, segmentectomies are more time consuming to dissect.

The pathology team can always be contacted if there is a particular case that needs to be prioritised.

It is the aim of the pathology team to avoid outsourcing.

Action: To report any upcoming developments that impact the thoracic service, such as extra lists and molecular tests, to the lung cancer pathology team — **Surgical and Oncology team**

6. Service Developments

6.1 Lung cancer patient self-management platform

Please see the presentation uploaded on to the SWAG website

Presented by Advanced Research Practitioner Suriya Kirkpatrick

Suriya is based in Southmead Hospital and is also undertaking a PhD fellowship with Oxford University to develop a digital self-management platform for people living with lung cancer.

The application (app) developed is an integration of two existing apps and provides patients with holistic lifestyle recommendations and the ability to track progress and common symptoms. It is also hoped that it will relieve some pressures on cancer services. Lung CAG are asked to help recruit patients to ensure that it is designed to be acceptable to the lung cancer patient population.

Initial thoughts and recommendations on content are welcomed from Lung CAG.

Results from the usability study from patients who have trialled it to date are documented in the presentation.

A protocol for the feasibility study, called Lung FIT, has now been drafted and 20 English speaking patients with lung cancer over the age of 18 years with a Performance Status no less than 1, who have access to a smart device and are from the Bristol or Oxford region, are now being sought to trial the app.

The feasibility study will involve three face to face follow up sessions.

Action: An advert for the feasibility study will be circulated. — **Suriya Kirkpatrick**

6.2 Genomic Medicine Service Alliance (GMSA) / ctDNA Lung Cancer pilot update

The presentation is available to CAG members on request

Presented by Consultant Oncologist and GMSA Cancer Lead Louise Medley

The South West has been participating in the National ctDNA Lung Cancer pilot which has been running for 18 months.

In Phase 1, 100 samples were sent between September 2022 to 1st July 2023. In Phase 2, an additional 125 samples were sent up until 31st December 2023. Now in Phase 3, any suitable patients are able to have the test. The criteria has slightly widened and now includes any patient with radiologically confirmed Stage 3 or 4 lung cancer that is not radically treatable, and any patient where a biopsy is not possible or a biopsy is insufficient for genomic testing.

Every Trust aside from 2 in the South West submitted tests and uptake was good in comparison with other regions.

Local data collection of results is recommended as this will not be available from the national pilot due to the need to comply with data protection guidance.

Torbay alone submitted 51 samples in an unselected population. Please see the presentation for further details. 25% of the samples had a Tier 1 (actionable for first or second line drugs) variant detected. Tier 2 are variants that have been recognised as occurring in cancers, but a corresponding therapy has yet to be developed. Many other actionable variants are expected to be identified over time.

The majority of patients with actionable variants are now receiving targeted treatments. The ctDNA test results reduced the time to treatment from 42 days to 28 days. It is important to gather data that compares turnaround time from requesting tissue for histology to reporting of histology for future conversations on the possibility of replacing this process with ctDNA.

Time to treatment is only reduced when the blood sample is taken at the earliest opportunity in the pathway, and when the clinician has confidence in using the results to commence targeted treatment in preference to awaiting histological confirmation; there has understandably been some hesitancy while people adjust to the innovation.

Further insight into genetic signatures has been gained during the pilot, which has also made possible the identification of areas for investment and of opportunities for clinical trials.

Challenges have also been identified in the actual process of embedding sample taking and tracking into an already very busy service, plus in the interpretation of results.

Participating sites were thanked for their contributions. It was recognised that the additional associated data collection was difficult, but has helped towards the potential to embed implementing ctDNA testing in the future.

Phase 3 now continues as 'business as usual' and the number of samples sent from the South West is on the increase.

A South West Lung Cancer Genomic Tumours Advisory Board (GTAB) will be established in the near future for any patient that the team wish to discuss with the GMSA team and the Clinical Geneticists. This will include discussion of the research opportunities available across or outside the region and will have an educational component.

A QR code has been provided for feedback on the GTAB, and any queries and concerns can also be fed back to Louise: louise.medley@nhs.net

RUH have sent 30 samples since Phase 1 and have an efficient process in place, with patients identified for potential consent prior to clinics. The CNS then walks with the patient to phlebotomy to get the sample. Eight Tier 1 positive results have been received to date. At least 2 patients have been able to commence treatment 10-12 days earlier than expected. SFT have just started the pathway and sent the first sample.

It is hoped that ctDNA requests will become embedded as routine and CAG are invited to contact the GMSA team for support.

Action: To send out the anonymised audit template so that results can be collated for comparison across the region. **L Medley**

Lung CAG are leading the way with embedding ctDNA and will share learning with other cancer sites.

7. Research

7.1 Lung Cancer Clinical Trials update

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Oncologist Gareth Ayres and Research Delivery Manager Claire Matthews

National clinical trial recruitment from April 2023-March 2024 shows that 13,148 patients have been recruited to lung cancer trials across 18 research networks; in 2022/23 a total of 13,921 patients were recruited. There was an even split between commercial and non-commercial trials, with 63.1% interventional, 30.6%

observational, and 6.4% both.

The full list of trials open and in set-up will be circulated.

A surgical study comparing outcomes of robotic surgery with standard treatment is also underway.

Question 58 in the National Cancer Patient Experience Survey 'Cancer research opportunities were discussed with the patient' scored below average across SWAG.

Patient Representative feedback is to let the patient know that research trials have been considered, even if the outcome is that there is no eligible trial available.

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 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.

The second cohort of the Principal Investigator Pipeline Programme (PIPP) to support research nurses, midwives and dentists to become PIs commences today.

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.

Action: To continue investigating ways to update CAG members on the trials opening across the region and facilitate cross referrals. **G Ayre**

8. Clinical Guidelines

8.1 Peri-operative Systemic Anti-Cancer Therapy (SACT) in Lung Cancer

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Oncologist Adam Dangoor

In the 1980's and early 90's chemotherapy was considered to have little benefit for lung cancer, until a meta-analysis in 1995 showed a 10% increase in survival at 1 year. Advances have since been made with platinum doublet increasing survival by 3-5 months, maintenance pemetrexed for non-squamous adding 2.2 months, and pembrolizumab in high PDL1 disease leading to excellent results of 30% 5 year survival rates; Osimertinib in EGFR +ve and Alectinib for ALK fusion +ve have also increased overall survival rates. There are now patients attending clinic who have been living with lung cancer for 6 or 7 years.

Adjuvant chemotherapy works better for those with a good performance status.

NICE approvals in 2022/23 and the associated trial results are listed in the presentation, one of which is Nivolumab, an option for neoadjuvant treatment. This showed significant improvements in survival rates following completion of the CheckMate 816 trial, increasing the proportion of patients getting to surgery and improved surgical outcomes.

Should a patient's disease advance on treatment, further immunotherapy is not funded.

If there is no disease progression but the patient is not eligible for surgery, you can only access adjuvant nivolumab after a 6 month period, unless you have Stage 3 disease and have had chemo-rad.

After surgical resection, the patient can have adjuvant chemotherapy or chemo-rad, but not adjuvant immunotherapy.

In all neoadjuvant immunotherapy trials, there are around 20% of patients that will not progress to surgery and the recommendation is to maintain current standards of resectability criteria.

Chemoradiotherapy for Stage 3 unresectable disease in patients who are PD-L1positive is a good option, with Durvalumab increasing 24 month overall survival to 66.3% versus 55.6%.

Slide 17 contains a useful algorithm that summarises the treatment options.

Points to consider include pre-treatment staging, ensuring all patients have access to Next Generation Sequencing (NGS), reconfiguring the patient pathway to incorporate oncology review at the same point of surgical review, and the points at which to scan patients for response assessments.

8.2 Neo-adjuvant chemo-immunotherapy pathway: Institutional experience in Leeds

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Thoracic Surgeon Alex Brunelli

Leeds team incorporated CheckMate 816 into practice, randomising patients with tumours over 4cm or node positive who must be negative for EGFR or ALK. Surgical resection needs to be arranged within 6 weeks.

Patients are selected at MDT and then referred to both the surgeon and oncologist, ideally meeting the surgeon first to ensure that the patient is considered medically fit and resectable prior to discussion of the neoadjuvant treatment.

A provisional surgical date is booked once the patient commences the neoadjuvant treatment. A restaging CT is arranged after cycle 2 and reassessed at the tumour board and by the surgeon for surgical fitness at that point, as there is still time to rescue the patient to a different treatment plan if there has been no treatment response.

One year in, Leeds have randomised 57 patients to the neoadjuvant pathway, 37 of which have proceeded to surgery. 6 could not proceed due to disease progression or poor fitness and 16 are still in the pathway.

Checkpoint versus Leeds results are detailed in the presentation.

One third of patients needed a dose reduction due to toxicities; fitness parameters did worsen following treatment; 21% of patients needed their surgery delayed for a variety of reasons.

A surgical complexity score was used which indicated that resections were moderately more complex, with an increase in adhesions, but not severely. There is a need to continually assess safety.

Pathological outcomes compared very well with CheckMate.

Discussion:

The key to consenting patients to the study has been collaborative working between the surgeons and oncologists.

The upfront resectability and fitness assessment is particularly important when considering if a patient could become unresectable during the course of the neoadjuvant treatment.

It is recognised that there is an inherent bias for clinicians to favour certain oncological treatments; this will only be addressed by taking part in these trials.

Initially, fitness assessments were arranged in the same manner as all other thoracic cases, but now this has been adapted for the patients having neoadjuvant treatment, in that all are sent for a cardio-pulmonary exercise test to try and predict if someone's fitness for surgery might decline during the neoadjuvant treatment period.

Some of the reasons for delayed surgery were due to the need to recover from toxicities. On the other hand, a delay was also due to a complete response to the medication leading to a patient questioning the need to continue with a lobectomy.

The Leeds team are continuing to learn with every case, and it would be beneficial to put together case discussions to share nationally.

CheckMate involved a restaging PET-CT after neoadjuvant treatment. The Leeds team had used this in a few patients where there had been a long delay or concern about disease progression but, for the majority, a CT or CT contrast was considered sufficient.

UHBW Surgeons were pleased to see surgical outcomes from Leeds that are comparable with UK outcomes, with lower pneumonectomy rates than in the CheckMate trial. UHBW team are arranging PET-CT in line with the trial protocol, but this often highlights areas in the lymph nodes that are difficult to interpret.

Lymph nodes can react to the immunotherapy so, as long as there is no progression in the primary, the Leeds team would progress to surgery.

CT is the preference to assess for resectability and because PET-CT can add uncertainty and delays to the pathway. **AGREED**

Action: The SWAG draft neoadjuvant pathway will be circulated for ratification. **UHBW Surgical Team**

UHBW team has job planned time to track surveillance of nodules of uncertain significance outside the main MDT meeting.

9. Clinical opinion on network issues

National Lung Cancer Audit (NLCA) Results 2022

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Respiratory Physician Henry Steer

Key findings from NLCA have ben summarised for each Trust and will be circulated.

SWAG has been found to have higher number of Stage 4 disease in comparison with National data, although staging data could be skewed by those areas where TLHC had already been implemented.

The data from NLCA is no longer sent back to Trusts to undergo a data verification process and so more errors are found to be occurring.

Regular audit is undertaken in GRH of the patients reported as having a good performance status that do not progress to surgery. These have all been found to have other comorbidities that make them unsuitable, or in some cases it was documented as due to patient choice. Almost all patients had radical radiotherapy as an alternative. A cohort of patients being missed for surgery has never been identified. Data on the CNS allocated was missing, as was data on smoking, PS, and Stage.

Action: Each team to look at their data and consider ways to improve data quality. **MDT Leads**

10. Any other business / agenda of next meeting

Potential agenda items:

Action: UHBW team to present neoadjuvant treatment pathway data at the next meeting **A Low**

To explore development of a thermal ablation service in SWAG; two interventional radiologists have expressed an interest. This was a recommendation from GIRFT.

Action: To find a guest speaker that offers the service to present at the next meeting. **H Dunderdale**

To assess the implementation of nurse led surgical follow up at the next meeting.

Action: Project Management time needs to be identified to help Lung CAG develop regional protocols. **N Gowen**

Date of next meeting: Tuesday 3rd December 2024

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