# Meeting of the *London Cancer* Lung Tumour Pathway Board

Date: **Wednesday 14th December 2017, 16:00-17:30**

Venue: 6th Floor East Meeting Room, 250 Euston Road, London NW1 2PG

Chair: **Neal Navani (deputising for Sam Janes)**

## 1. Welcome and introductions and minutes from last meeting

- 4th October minutes agreed as true record.

## 2. Grail update

- CL confirmed that UCL and Grail had now both signed the contract for the low dose CT screening trial.
- Currently CL is working on a new IT system and methods of pseudo anonymising the data.
- Screening process discussed. Once consent has been given, bloods are taken, a quality of life questionnaire is given and finally patients have a low dose CT.
- If patients do not consent to be in the study they have their history taken, have spirometry test and are given smoking cessation advice. Patients are only given a CT if they agree to be part of the study.
- 48 staff are to be hired including, contact centre workers, radiographers and nurses.
- The plan is for a launch by 15th January with an evening event held. Comms teams are exploring who to invite, of note, they have secured a quote from the Mayor of London Sadiq Khan.
- CL reminded the group that the aim remains to scan 25,000 in the first year with stratification into follow up scans and no scans in the 2nd and 3rd years
- GP comms has focused on GP cancer leads. Now 546 practices will be approached asking consent to pull lists.
- The study has now gone for ethics approval, a selection of letters went to ethics, more have been requested.
- It was noted that despite recruiting well to a smaller screening pilot Homerton would not be a location for the study as there was simply not enough outpatient space or indeed space for a new CT machine.
- 25 radiologists from all Trusts within London Cancer and also some from outside the patch are involved.
- NN noted that getting on the national portfolio of clinical trials would accrue further funding, this would require demonstrable benefit to the wider NHS.
- NN further noted that in a novel development PHE will be giving real-time data for this study.

## 3. NEL EDAG Project

- NN introduced the new project which aims to link primary and secondary care data to understand what happened in primary care before NEL patients presented to the Trust with lung cancer. For example they will be looking at; whether anything other than antibiotics was given to the patient, no. of primary care visits, whether an x-ray was performed, inhalers prescribed and whether new co-morbidities for lung cancer can be identified.
- It is thought to be the first time this linking of data has occurred. It has been stressed to NEL GPs that this is an attempt to understand more about patients not to target blame.

**4. London Cancer LungPREP project**

- This new project, on a similar line to the NEL EDAG, project reviews the histories of 3 to 4 years' worth of patients who were diagnosed with lung cancer via emergency presentation.
- Their histories will be reviewed to understand what factors led them to be diagnosed via A&E rather than a more controlled route. These emergency patients will be compared with those that went down a 2ww route.
- Risk predication models will be evaluated with money from pharma, Quintiles may be used as they serve as an interface between the NHS and industry.
- Project funding comes from Pzizer as an education grant meaning they will not be involved in the project other than releasing funds.
- One year ago, 1 rep from each Trust performed case control for their cohort of patients. A tool was used to screen patients and Pzizer helped with collating and analyzing data.
- The project aims to reveal how to get people to present much earlier and how to reach 'hard to reach' people.
- Help is now needed to analyse the data. Nominated leads would be needed from each Trust, 10-15 parameters were agreed. There is a cohort of 310 for the whole of London Cancer, the spreadsheet has 20 fields. 2016 data is being analysed so 1 year survival can be included.

**ACTION – Board members to volunteer or nominate a representative to anlyse their Trusts' data. To be sent to TAm or NN.**

**5. Nottingham/Homerton Referral Criteria**

- GP referral criteria piloted at the Homerton and based on Nottingham's presented by AB and discussed by the board.
- The criteria documents what to do once x-ray results are received. Referral for CT is allowed even if the x-ray is normal if the GP has clinical concerns for example serious weight loss.
- The system has been running at the Homerton since the summer. AB feels that GPs are not overusing the system, indeed GPs are encouraged to phone AB if they are unsure where to refer.
- CTs within the Homerton are currently performed within a day for new suspected cancer referrals. X-rays are reported by reporting radiographers and CT by consultants.
- GPs are required to manage nodule follow up, the board noted that this had proved controversial in the past.
- The board noted that GP requested CTs have been shown to take longer to book, therefore radiology need to offer an assurance of parity from radiology departments if this system was rolled out.
- NN noted that it would be useful to hear back from Homerton as to how the model works in six months then a decision can be made as to whether it should be rolled out across the sector. The board would furthermore need to see data to then input into a case for GPs and NICE.

**ACTION**: AB/SB to be asked to present results from Homerton's running of this model in 6 months.

**6. National Optimal Lung Cancer Pathway (NOLCP)**

- NN noted that he has met a number of the leads in the network and is confident that each hospital is making steps towards implementation of the NOLCP. Each Trust has varying priorities depending on local challenges.
- There is no further transformation funding for NCL trusts, NEL may have funds released for Q4 as the STP footprint achieved the 62 day standard in the last quarter. Therefore it may be useful to understand the gaps and send to commissioners for review. The board should be clear on what can be achieved and if elements of the pathway cannot the resource required to rectify the situation.
- It would be useful to know median time to treatment across the Trust. NN and SE are due to meet analysts from the Centre for Cancer Outcomes (CFCO) imminently, this issue will be raised. To gain this information Trusts may need to share data with the CFCO analysts.

**ACTION –** SE to send out 2017 NOLCP audit responses. Members to update and return to SE.
SE to present results at next agenda.

**ACTION -** SE to request median time to treatment across the Trust from the centre for cancer oucomes.

**7. MDT Improvement Response**

- The draft letter to Prof Mughal was signed off. SE to send letter to Prof Mughal.

**8. Clinical Trials Recruitment Review**

- SE presented a comparison of last year's recruitment figures with this year.
- Recruitment in the first two quarters of 17/18 was down slightly from a similar period 16/17.
- Low dose CT screening numbers made up the bulk of trial numbers in 16/17, the closing of this trial is the cause of the decrease.
- It was noted that there were many trials with small numbers recruited, this is likely because there have a very specific focus.

**9. AOB**

- Frequency of CTs after treatment discussed. NN noted he requests annual, CD commented that at RFL there is a 3 month post op CT then one year for five years. There is currently no position on follow up scans in the London Cancer guidelines. It was felt this was an oversight and a board position should be documented.
- CD confirmed that she is now the sector representative for the National Lung Cancer Audit.
  It was noted that the NLCA has been criticised in recent years for not being a true reflection of the work going on in Trusts. This is likely down to data quality issues. It was explained that an algorithm links patients without a 'trust first seen' entered with a likely Trust, this leads to inconsistencies between the Trust's expected completion rate and that which appears in the NLCA.
  Some cancers are also added from discharge summaries, last year an additional 6,000 cancers were found which further reduced Trusts completion rate.
  NN suggested Trusts will be given more time to validate their data next year.

**ACTION:** Add board position on frequency of follow up scans to the next agenda.

**10.Next Meeting**

Wednesday 7th March 2018 16.00-17.30, 6th Floor Central, East Meeting Room, 250 Euston Road, London NW1 2PG

**Attendees**

| Name | Trust/Organisation |
|---|---|
| Angshu Bhowmik | Homerton University Hospital |
| Aliabdulla Mohammed | Barts Health – Whipps Cross |
| Catherine Docherty | Royal Free London |
| Claire Levermore | UCLH Cancer Collaborative |
| David Feur | Barts |
| Judy Cass | Patient Representative |
| Neal Navani | UCLH |
| Konstantinos Giaslakiotis | Barts Health |
| Paula Wells | Barts Health |
| Sara Lock | The Whittington |
| Simon Evans | UCLH Cancer Collaborative |
| Tanya Ahmad | RFL (Barnet) and UCLH |

**Apologies**

| Name | Trust/Organisation |
|---|---|
| Sam Janes | UCLH |
| Julian Singer | North Middlesex University Hospital |
| John Conibear | Barts |
| Martin Forster | UCLH |
| Martin Hayward | UCLH& BCFH |
| Tania Anastasiadis | TH CCG |
| Fanta Bojang | UCLH Cancer Collaborative |
| Karen Sennett | GP – NHS Islington |
| Sajid Khan | RFL |
| Will Ricketts | Barts |
| Tony Lawlor | NELCSU |
| Stephen Burke | Homerton University Hospital |
| Stephen Edmondson | Barts Health |
| Subhra Chowdhury | PAH |