Meeting of the *London Cancer* Lung Tumour Pathway Board

Date: **Wednesday 13th June 2018, 16:00-17:30**

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

Chair: **Mick Peake**

1. Welcome and introductions and minutes from last meeting

- 7th March minutes agreed as true record.
- MP gave an update on development of the lung pathway visualisation tool discussed at the previous board. A working group representing a range of Trusts and specialities has now been established and will be meeting on Wednesday 4th July. The working group will be tasked with offering advice that ensures the tool is useful for all Trusts in our patch and hopefully throughout the NHS.

2. Grail update

- SJ, FB and CL sent apologies for today's meeting so the update was deferred
- Members raised queries as to whether the trial has changed slightly and a further screening site had been added (Post meeting note; CL has confirmed that a further CT screening site has not been added, however additional sites for the non-high risk arm have been included). Members were advised to contact SJ, FB or CL with any trial queries; they have confirmed that they would welcome correspondence.
- There is concern that as screening has not been nationally commissioned a 'postcode lottery' will develop. Of note, screening has begun or will shortly begin in Liverpool, Manchester, Yorkshire, Nottingham, Royal Marsden and Brompton. The position of the National Screening Committee in PHE is that they will not consider establishing a National Screening Programme until the results of the Dutch (Nelson) study are published, the date of which is unkown.NHS England are however supportive of regional initiatives of what they are calling 'high-risk case-finding', so long as they are properly evaluated.

3. Board position on frequency of follow up scans

- Nick Woznitza and Angshu Bhowmik presented results of Homerton's radiographer reporting pilot (radioX) and GP straight to test pathway.
- RadioX is a 12 month block randomised trial of immediate vs. routine GP CXR reporting on time to diagnosis/discharge from lung cancer pathway. NW presented 9months worth of interim data, the project is due to close on 30th June.
- Immediate x-ray reporting mean was 1.96 hours vs 3.9 hours for routine. Results suggest that time to diagnosis was reduced in immediate x-ray reporting.

- All reports were double blind reported by radiologists. Reports are also being reviewed by respiratory physicians. A chest radiologist at the Brompton reviews in case of disagreement.
- Feedback to the chest radiologists is delivered via a discrepancy meeting, a forum with radiologists. There is no real-time feedback, to avoid adding bias to the study.
- A low yield of cancers were identified as chest x-rays for all ages were included in the study.
- NW noted that it takes a 12months post graduate degree for a radiographer to become a reporting radiographer and a period of at least 3 months where reports are double checked. NW estimated that 2-3 years after the post graduate course reporting radiographers are working independently on a high volume of scans.
- NW confirmed that radiographers are covered by their own insurance.
- There are around 1,000 skeletal reporting radiographers in the country. However at some hospitals such as the Whittington they may not be practicing.
- No patient information was provided as the service they received was the same so it was not felt to be necessary.
- The board were encouraged by results and discussed how reporting radiographers could be rolled out in the sector. NW reported that success id dependent on the project being driven by radiographers and radiologists. It was noted that each Trusts needed a champion such as NW to enable roll-out.
- The board needs to consider how to persuade radiologist as to the benefits, the obvious being it would result in a reduced workload.
- It is felt there are appropriately trained radiographers already in place that could be better utilised.
- A culture change is required. AB commented that when reviewing the double blind repots he found it impossible to tell the difference between radiographer and radiologist scan.
- The NOLCP could be used as a vehicle to enable roll-out. Reporting radiographers may be the best method of moving from abnormal x-ray to CT within 72 hours.
- The report is due to be published by the end of the year. The board encouraged NW to submit to BTOG.
- NW then detailed the first 3 months (1 Oct– 30 Dec 2017) of results of the straight to test pathway. Small numbers were received, 51 in the time period. 1 lung cancer diagnosis was identified and 5 were put on nodule follow up. Pick up rate was reduced in the 3 months compared with suspected cancer CTs via the normal route.
- GPs were offered the chance to discuss CT reports and management with AB. AB reported that the majority of the low volume of calls concerned results of x-rays rather than CTs.

4. National Optimal Lung Cancer Pathway (NOLCP)

- Transformation Funding has now been confirmed. £309k has been secured to enable roll-out.
- The options paper prepared by SEv was discussed. In the opening options Barts have allocated a band 6 biomedical scientist (BMS). In the preferred option this role has been removed and will be funded by Barts instead.
- Funding of patient navigators were felt to be the best way to make a meaningful difference across the network. The role would include receiving 2ww referrals and ensuring the patient has a CT and OPA within 5 days (or as close to it as possible). After the first outpatient appointment navigators would ensure test bundles have been booked.

- It was confirmed that patient navigator can relieve some of the burden on CNS allowing more tie for jobs such as HNAs.
- It was reiterated that joining MDT meetings should be in the job descriptions. SE to add if not already included.
- JC commented that navigators acting as a single point of contact would address a gap commonly identified by patients, namely a lack of consistency in admin support.
- NN views the role as a potentially developing into a patient facing role to include areas such as smoking cessation advice.
- The navigators would work together as a network enabling smoother transition for ITTs and opening up the possibility of PET/EBUS/CT capacity sharing.
- Funds have to be spent within the current financial year therefore the navigators will likely be in post for little over 6 months. The plan is for data to be collected that demonstrates the improvement which will make up a business case for continuing the roles to Trust executive teams and commissioners.
- The board accepted the wider benefits of to NEL for improving their pathology turnaround times. Additionally, if data demonstrates the radiology and respiratory physician PAs that facilitate the daily 'virtual MDT' at Barts' is successful results could be used to facilitate replication across the patch.
- The board discussed how to understand whether the intervention has been successful. The Centre for Cancer Outcomes has collected some baseline data for NCEL. Navigators will also be expected to help us collect data throughout the life of the project.
- The board asked for one amendment to the final option, a sixth navigator at The Whittington. Others will be placed at BHRUT, Barts, UCLH, North Middlesex and Royal Free. SE will readjust the budget and circulate for ratification.
- Pathology challenges discussed. NN and SE met with pathologists and relevant managers to process map the service. There was no way to bring down molecular markers to within 14 days. However EGFR, ALK and PDL1 can be requested can performed by day 5. In short, there are ways to tighten up processes.
- SE commented that he is happy to work with other pathology services and lung teams to similarly process map their services.

ACTION – SE to circulate draft patient navigator job description. ACTION – SE to share UCLH pathology process mapping. ACTION – SE to send an updated options paper for final comments.

5. Board position on frequency of follow up scans

- The paper was agreed as a useful piece of guidance. However the lack of evidence for best practice was again raised as an issue. The board felt this meant that whilst useful as a summary of current practice, the document could not be badged with the status of 'guidance'
- The paper is to be circulated for information but should be reviewed after the publication of the updated NICE lung cancer guidance is published (scheduled for 2019).

6. AOB

- No further business.

7. Next Meeting

Wednesday 12th September 2018 16.00-17.30, 6th Floor Central, East Meeting Room, 250 Euston Road, London NW1 2PG

Attendees

Name	Trust/Organisation
Aliabdulla Mohammed	Barts Health – Whipps Cross
Angshu Bhowmik	Homerton
Catherine Docherty	Royal Free London
David Feur	Barts
Judy Cass	Patient Representative
Mick Peake	UCLH Cancer Collaborative
Neal Navani	UCLH
Nick Woznitza	Homerton
Paula Wells	Barts Health
Sara Lock	The Whittington
Sasha Stamenkovic	Barts
Simon Evans	UCLH Cancer Collaborative

Apologies

Name	Trust/Organisation
Claire Levermore	UCLH Cancer Collaborative
Fanta Bojang	UCLH Cancer Collaborative
John Conibear	Barts
Martin Forster	UCLH
Julian Singer	North Middlesex University Hospital
Karen Sennett	GP – NHS Islington
Konstantinos Giaslakiotis	Barts Health
Sam Hare	RFL – Barnet and Chase Farm
Sajid Khan	RFL
Sam Janes	UCLH
Stephen Burke	Homerton University Hospital
Stephen Edmondson	Barts Health
Subhra Chowdhury	PAH
Tanya Ahmad	RFL (Barnet) and UCLH
Tania Anastasiadis	TH CCG
William Ricketts	Barts